



**DEPARTMENT  
of HEALTH  
and HUMAN  
SERVICES**

**Fiscal Year  
2025**

Centers for Disease Control  
and Prevention

*Justification of  
Estimates for  
Appropriation Committees*

## MESSAGE FROM THE DIRECTOR

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For nearly 80 years, the Centers for Disease Control and Prevention’s (CDC) scientific expertise on data and epidemiology, laboratory capacity, and public health practice, as well as partnerships with state and local health departments, have underpinned the U.S. approach to public health. Now, as the pace and severity of public health threats rise, so does the urgency of investing in the Nation’s response capacity.

CDC is focused on protecting health and improving lives by prioritizing efforts to rapidly identify and respond to health threats; continuing to address the mental health, suicide, and overdose crises; and supporting young families to help children thrive.

The Fiscal Year 2025 President’s Request for CDC invests in the foundational capacities necessary to position the Investing in the nation’s health data ecosystem is critical to knitting public health and the health delivery system together to optimize our ability to truly protect health. Data powers our ability to collectively detect and respond to health threats. Recent investments have resulted in exponential increases in the number of public and private health provider systems that share electronic case record information—from fewer than 200 facilities before the pandemic to 30,500 today. Access to information gathered from healthcare facilities around the country empowers providers to deliver better individual care. Wastewater surveillance data, an innovative and important tool that shows where pathogens have begun to proliferate in specific jurisdictions, empowers decision-makers to launch protective measures that best serve their communities. As data science progresses, CDC is leading the nation in developing tools to allow better response today and forecasting epidemics in the future.

CDC is also investing in communities to prevent the devastating effects of substance use, chronic health conditions, and injuries before they start by supporting programs that improve maternal health, reduce suicides and overdoses, protect children against adverse childhood experiences, and build school mental health programs. For example, through the Overdose Data to Action program, CDC awarded nearly \$280 million to 90 state, local, and territorial health departments in Fiscal Year 2023. This program focuses on using data to drive program implementation and evaluation around primary prevention as well as linking people to care and treatment. States and communities use these resources to track and understand overdoses so they can quickly implement the best strategies to save lives, expand harm reduction strategies such as the purchase of naloxone, and link people who use drugs to life-saving care.

While CDC is unique in its mission, it is not alone: public health is a team sport. America’s success in protecting everyone’s health depends on successful connection and collaboration across health care, public health, government, private sector, academia, and national organizations, both domestically and globally. The Fiscal Year 2025 President’s request supports the necessary capacity to defend the Nation’s health security.

Sincerely,



Mandy K. Cohen, MD, MPH  
Director, CDC  
Administrator, Agency for Toxic Substances and Disease Registry

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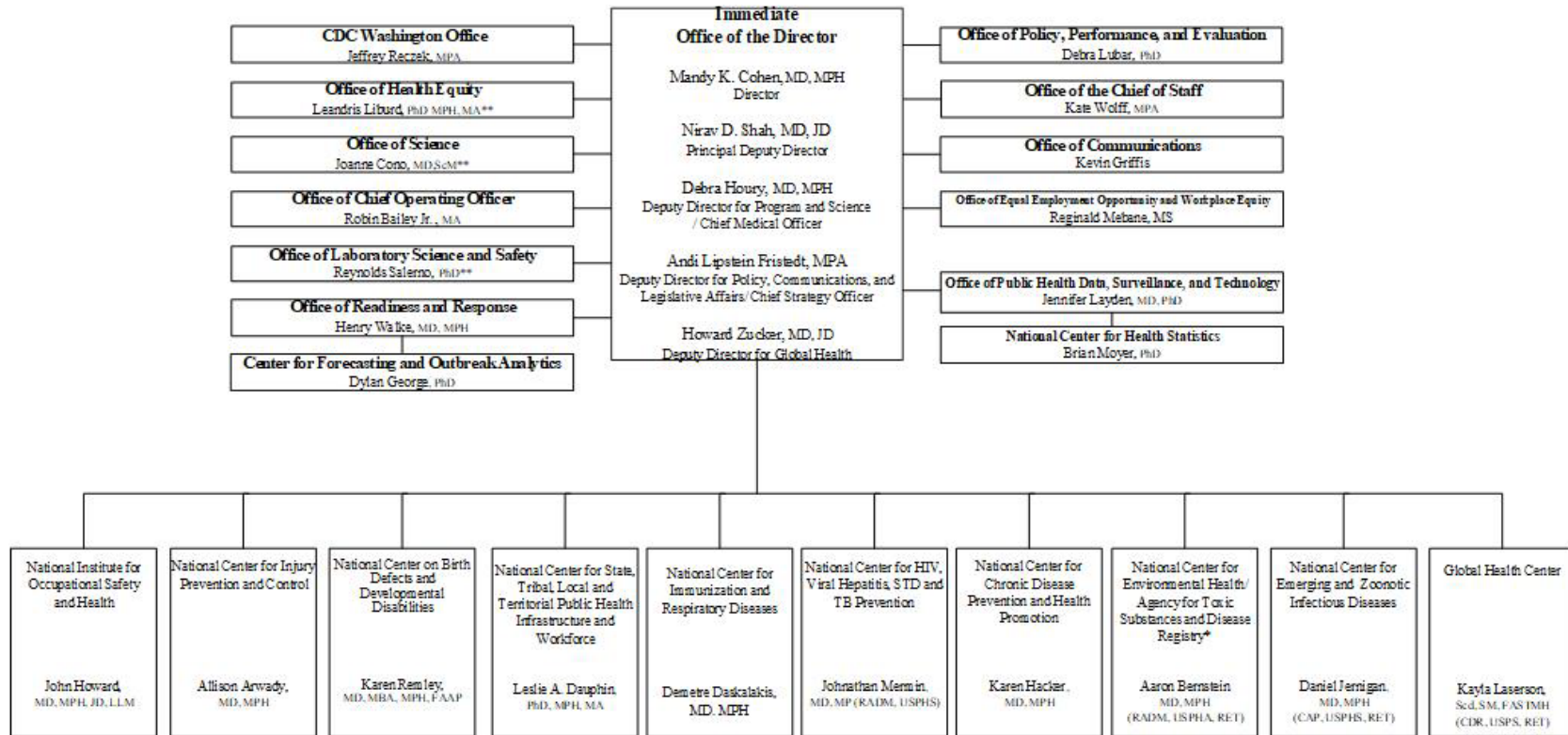
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# CDC ORGANIZATIONAL CHART

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)



Listed personnel are Director of the entity unless otherwise noted.

\*ATSDR is an OPDIV within DHHS but is managed by a common director's office.

\*\*Serving as an acting official

Approved 1/24/2023; Effective 2/8/2023

Names Updated 1/26/2024

## **INTRODUCTION AND MISSION**

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The Centers for Disease Control and Prevention (CDC) is part of the U.S. Department of Health and Human Services and is the Nation's public health protection agency, as well as a critical health security asset.

CDC's mission is to protect America from health, safety, and security threats, both foreign and in the United States. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against dangerous health threats and responds when these threats arise. In doing so, CDC increases the health security of our nation.

CDC works on the cutting edge of health security by detecting and confronting global disease threats through surveillance, epidemiology, and laboratory analysis of huge amounts of data and specimens to quickly find solutions and respond to public health threats. CDC continues to build the capacities to ensure America is increasingly prepared to respond to future threats, including improvements in data, communications, and the public health workforce that centers on strong, well-resourced public health leaders and capabilities at national, state, and local levels.

As the nation's health protection agency, CDC aims to build a sustainable and resilient public health system that can respond effectively to emerging threats and to ongoing public health needs to keep Americans safe and healthy.

# EXECUTIVE SUMMARY



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## **OVERVIEW OF BUDGET REQUEST**

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The Fiscal Year (FY) 2025 budget request to Congress for the Centers for Disease Control and Prevention (CDC) includes total funding of \$9.683 billion in discretionary budget authority, Public Health Service (PHS) Evaluation funds, and transfers from the Affordable Care Act Prevention and Public Health Fund (PPHF). The funding amounts and programmatic approaches described in this document are increases compared to the FY 2023 final level.

CDC's FY 2025 request includes increases for programs that support U.S. readiness and response; improving mental health, overdose, and suicide prevention; and supporting young families.

We are living in an extraordinary moment of scientific breakthrough with more tools available to public health than ever before: new vaccines, more data, and greater ability to leverage scientific advancement and innovation. We have access to powerful detection and diagnostic innovations, such as wastewater surveillance, and are adopting them at an increasingly rapid pace to improve decision-making. We are connected through social media, travel, and commerce, and have a greater public awareness about the need for and contribution of public health.

Interconnectedness is one of our greatest advantages. Public health is a team sport, requiring collaboration among partners from the private sector, other Federal agencies, partner organizations, and state, Tribal, local, and territorial health departments, as well as globally. Currently, nearly 80% of CDC's annual, base funding goes to these partner organizations. Funding increases in this budget will enable greater collaboration and efficiency as CDC and its partners secure the Nation's health and continue to prepare for future health security threats.

## **Rapidly Identifying and Responding to Health Threats**

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Health threats and infectious diseases present more challenges than ever before, with new threats arising through natural, accidental, or intentional sources. The pace at which threats are arriving is increasing because known pathogens are changing in the way they infect and sicken humans and newer pathogens are emerging. CDC's budget request prioritizes actions that enable CDC and its partners to address these challenges.

### **Public Health Data Modernization (+\$49.600 million)**

To ensure that the U.S. public health system is ready for any crisis, the Administration and Congress have prioritized modernizing the public health data system. CDC has invested in state-of-the-art data sharing capacities that create greater efficiency and faster decision-making for health care providers and state and local public health departments. For example, access to information about new infections occurring in one state empowers physicians in other states to test patients with the same symptoms, treat people who are infected, and prevent others from becoming sick.

However, gaps remain in ensuring standardization and interoperability for informing decisions within all U.S. jurisdictions. National health security for the U.S. requires an up-to-date, reliable, core national data infrastructure. At this funding level, CDC will support state, local, tribal, and territorial jurisdictions to build infrastructure necessary for sharing standardized data across interoperable public and private health delivery systems. CDC will continue to support technical assistance and deploy CDC-developed tools that enable health departments to achieve greater efficiency and avoid duplicative modernization costs.

### **Response Ready Enterprise Data Integration platform (RREDI) (+\$38.200 million)**

The FY 2025 Budget Pandemic Preparedness request for CDC proposes **\$60.100 million** to support the Response Ready Enterprise Data Integration platform (RREDI), formerly known as HHS Protect, an integral part of the public health data ecosystem. RREDI operates in concert with the modernized public health data infrastructure system by supporting the national common operating picture and central hub for integrating and sharing public health data in near-real time across federal, state, and local, governments and the healthcare industry. Additional base funding, as reflected in the FY 2025 request, is needed to support this core public health data management platform.

### **Emerging Infectious Diseases – Wastewater Surveillance (+20.000 million)**

The continuous emergence and evolution of pathogens requires constant vigilance. CDC supports ongoing innovation in programs, applied research, laboratories, and outbreak response for diseases having the potential to cause large, disruptive outbreaks. For example, in response to COVID-19, CDC established wastewater surveillance, using supplemental funds, to coordinate and build the nation's capacity to understand infectious disease threats in communities by detecting pathogens in wastewater. The data collected provide a valuable perspective on community transmission that is independent of healthcare seeking behavior, access, or availability. It can also detect signals from both asymptomatic and symptomatic infections. While wastewater surveillance was created for surveillance of respiratory disease, it became pivotal in detecting emergence of mpox and polio. Annual, base funding will allow CDC to support a limited number of states for wastewater surveillance to continue public health laboratory capabilities and wastewater programs and allow innovation for detecting other infectious disease threats once COVID supplemental funds are depleted..

CDC will continue to protect Americans from outbreaks of emerging infectious diseases by leading laboratory research and testing, developing diagnostic tests and other medical countermeasures; responding to outbreaks; monitoring vaccine safety; and training laboratorians, scientists, and public health workers in responding to the increasing number of newly emerging pathogens with potential to cause widespread illness and death.

**Antimicrobial Resistance Initiative (+10.000 million)**

Antimicrobial resistance (AR) occurs when bacteria or fungi do not respond to the drugs designed to kill them, threatening lives, modern medicine and health care, and veterinary and agriculture industries in the United States and around the world. Antimicrobial-resistant infections are difficult to treat and add considerable burden to patients and the U.S. healthcare system. CDC leads the U.S. public health response to combat antimicrobial resistance to achieve the *U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025* (CARB) goals and support the *National Biodefense Strategy*.

CDC’s FY 2025 request continues to support the AR Laboratory Network for rapid AR detection in health care, food, the environment, and communities; improve the types and quality of available data sets addressing health equity and disparity issues about AR threats; promote stewardship of antibiotics to preserve the drugs that are still effective against bacteria and fungi, and support the Global Antimicrobial Resistance Laboratory and Response Network to increase capacity for surveillance, prevention, detection, and response around the world.

**Immunization (+\$50.000 million)**

Vaccines are the best way to protect against certain preventable diseases. CDC supports states, cities, and counties by using immunization information system data to identify areas where people are at higher risk of exposure to vaccine-preventable infectious diseases and find ways to make vaccines more accessible.

This increase will support ongoing work on COVID-19 and the highest priority activities of the immunization program, including building vaccine confidence, while providing dedicated resources to urgent public threats like influenza, COVID-19, and localized outbreaks of vaccine-preventable illness. Funding at this level will also support staffing expertise needed for effective national public health monitoring and prevention of respiratory viruses.

**Environmental Health Activities (+\$10.000 million)**

CDC addresses emerging environmental health risks and responds to environmental health emergencies by developing tools, guidance, and trainings; disseminating best practices; and providing expertise and requested technical assistance on environmental health concerns. CDC provides expertise and guidance relied upon by other federal, state, tribal, local, and territorial partners, including extreme heat, wildfires and hurricanes; cancer cluster investigations; chemical exposures related to the train derailment in East Palestine, Ohio; potential chemical, radiological, nuclear or explosive mass casualty events; and ensuring drinking and recreation water are free from contaminants that can cause waterborne illness. The FY 2025 Budget includes an increase of \$10 million for Climate and Health to pilot the provision of portable High Efficiency Particulate Air (HEPA) filtration systems in homes and communities most affected by wildfire smoke.

**National Occupational Research Agenda (+0.400 million)**

CDC funds the National Occupational Research Agenda (NORA), which stimulates innovative research into worker health and safety, emerging issues in occupational safety and health, and improved workplace practices. For example, the Future of Work Initiative identifies new research solutions, practical approaches, and partnership opportunities to address the changing nature of work and the safety and health implications for the future workforce. Priority topics for intramural and extramural research in this area include work arrangements, artificial intelligence, demographics, worker skills, and innovative technologies such as additive and smart manufacturing. The requested increase will expand capacity for research under the Firefighter Fatality Investigation Program to prevent work-related fatalities among firefighters.

## **Protecting the Health of Young Families**

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### **Youth and Community Violence Prevention (+\$100.000 million)**

Homicide is the third leading cause of death among U.S. youth and young adults aged 10–34; in 2021, 26,031 individuals died by homicide, and it was the leading cause of death among Black individuals in this age group. A youth's exposure to homicide is an Adverse Childhood Experience (ACE) that is likely to cause have short-term and chronic physical and mental health conditions and behavioral difficulties. These include future experiences with violence, smoking, substance use, obesity, high-risk sexual behavior, depression, academic difficulties, school dropout, and suicidal behavior. Addressing ACEs and ensuring youth have positive experiences reduce healthcare costs and future negative physical and mental health outcomes.

With discretionary (+\$100 million) and new mandatory funding in FY 2025, described further below, for the Community Violence Intervention Initiative, CDC will implement a comprehensive Youth and Community Violence Prevention program to prevent community and youth violence in up to 75 communities in geographic areas with the highest number of homicides or highest number of homicides per capita. CDC will use the additional funding to support violence prevention programs specifically tailored to meet needs identified by communities. These can include changing the built environment, adding school-based programs, and providing mental health and trauma recovery services to survivors of gun violence. CDC will provide funding and technical assistance to organizations that are representative of communities most impacted by community violence and have a proven track record of serving them.

### **Safe Motherhood/Infant Health (+\$10.000 million)**

The disproportionately high rates of maternal mortality among Black women in the United States is one of the widest disparities in public health. In 2021, the maternal mortality rate for non-Hispanic Black women was 69.9 deaths per 100,000 live births, almost three times the rate 32.9 deaths per 100,000 among non-Hispanic White women.

Funding will support CDC activities related to building the national infrastructure for maternal mortality prevention, including Maternal Mortality Review Committees (MMRCs), Perinatal Quality Collaboratives (PQCs), CDC Levels of Care Assessment Tool (LOCATe), and the Hear Her Campaign. Funding will also support Community-Based Organizations (CBOs), and key partners to implement multi-level maternal mortality prevention efforts that leverages public health data infrastructure in the state as well as support modernization efforts of the Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.

### **Childhood Lead Poisoning Prevention (+\$10.000 million)**

Lead exposure can cause adverse effects in nearly every system in the body and seriously harm a child's health. Even at low levels, lead exposure has the potential to affect growth and development, hearing and speech, IQ, academic achievement, and behavior. Public health approaches to reducing lead exposure have protected millions of Americans since the 1970s. However, nearly 29 million U.S. homes contain at least one lead hazard, and over 10 million U.S. homes rely on lead-containing service lines to carry water from municipal sources into family dwellings, putting large numbers of children at risk for lead exposure.

CDC's Childhood Lead Poisoning Prevention Program (CLPPP) reduces the number of children exposed to lead and eliminates blood lead level disparities. CDC funds 62 states and localities to conduct blood lead testing and reporting, use data to track trends and identify risks, lead-exposed children to services, and implement tailored, community-based interventions. CDC also conducts lead poisoning prevention research to continuously improve programs and services. CDC operates the Blood Lead Surveillance System and the Flint Lead Exposure Registry, a model for the nation's first lead-free city and support for the Flint community.

In FY 2025, CDC will continue to support childhood lead poisoning prevention activities in state, local, tribal, and affiliated territorial jurisdictions and continue expanding opportunities for capacity building. The funding increase will provide additional resources for childhood lead poisoning surveillance and reporting.

**Firearm Injury and Mortality Prevention Research (+\$22.500 million)**

Firearm-related injuries are among the five leading causes of death for people ages one to 44 in the U.S. Using the same approach for protecting people from infectious disease, CDC is working to protect people from injury and death. This includes carefully defining the problem by studying data; identifying factors that increase or decrease risk; designing and evaluating interventions that target these risk factors; and supporting communities nationwide as they provide interventions locally.

CDC funds communities to use this approach to identify programs that work best for their populations. For example, local programs have identified gun safety training tailored to young adults and safe storage options for families who own guns. Through the Firearm Injury Surveillance Through Emergency Rooms (FASTER) program, CDC funds twelve states to collect near real-time data from emergency departments to identify patterns, respond to surges in gun violence, and determine where to direct intervention efforts. CDC also supports 22 research grants to develop and evaluate promising prevention strategies for protecting against injury and death. CDC will use additional funding to expand the FASTER program to all 50 states, DC, and the territories, and support additional competitively awarded R01 research grants nationwide.

**Tobacco (+\$10.000 million)**

Each year, nearly half a million U.S. adults die prematurely due to smoking-related diseases, including exposure to secondhand smoke. In addition, over 16 million U.S. adults live with a serious illness caused by smoking. Smoking harms nearly every organ of the body and compromises the immune system, costing the United States more than \$600 billion in 2018. In 2023, an estimated 2.8 million U.S. middle and high school students (10.0 percent) reported currently using any tobacco product; 2.13 million of these middle and high school students (7.7 percent) reported currently using e-cigarettes.

In FY 2025, in alignment with the Cancer Moonshot Initiative, CDC will continue tobacco prevention, control, and surveillance efforts, including addressing tobacco use among youth, the successful *Tips From Former Smokers (Tips®)* campaign, which helps adults who smoke quit, and a community-based program to increase awareness of cessation services and coverage options among populations experiencing health disparities.

**Cancer Prevention and Control (+\$90.000 million)**

Cancer affects every age group and is responsible for more years of life lost than all other causes of death combined. Early cancer detection and advances in treatment help reduce deaths, but disparities in prevention, screening, early detection, and quality of care persist. As the U.S. population ages, more people will be at risk for cancer. CDC works with state, tribal, and territorial health departments, and nongovernmental organizations to improve prevention and early detection, including access to screenings and other services.

CDC’s FY 2025 funding will support CDC activities that are part of the Administration’s Cancer Moonshot Initiative, including funding cooperative agreements with states, territories, tribes or tribal organizations, and other eligible organizations to implement four major cancer control programs; and conducting surveillance, education, awareness, and applied research related to breast cancer in young women, cancer survivors, and prostate, ovarian, skin, and gynecologic cancers.

## **Responding to the Mental Health and Opioid Crises**

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### **Suicide Prevention (+\$38.000 million)**

Suicide is one of the leading causes of death in the United States. While suicide prevention has historically focused on crisis intervention and referrals to mental health treatment, CDC data show that about half of individuals who die by suicide do not have a known mental health condition. Multiple factors can contribute to suicide, including substance misuse, physical health, jobs, money, interpersonal violence, stigma, and access to lethal means among people at risk.

CDC will use the proposed increase to expand its Comprehensive Suicide Prevention (CSP) program to recipients in 21 additional states or territories (45 total), and up to 4 additional tribal organizations. The CSP program supports recipients to implement and evaluate a comprehensive public health approach to suicide prevention, with a special focus on populations that are disproportionately affected by suicide. This also includes supporting recipients to collect near real-time data to rapidly track and respond to changing patterns in suicidal behavior.

### **Adverse Childhood Experiences (+\$21.000 million)**

Adverse Childhood Experiences (ACEs) impact how a child's brain develops and functions, significantly affecting lifelong health and opportunities. ACEs are associated with increased risk for at least five of the 10 leading causes of death, including a significant relationship to future risk of suicide and mental health challenges. ACEs are also strongly linked to substance use initiation, including opioid initiation, at a younger age, as well as injection drug use, substance use disorders, and overdose. For children, losing a loved one to suicide or overdose is an ACE, which in turn, increases the child's risk of future overdose or suicide. By understanding and addressing these urgent, related, and preventable issues, we can prevent harm today and for generations to come. The requested increase will support up to 30 states, territories, localities, and tribes to implement prevention strategies and approaches in their communities. This program is designed to support states in the prevention of ACEs, including child abuse and neglect, and promotion of positive childhood experiences (PCEs).

### **School Health (+\$19.000 million)**

CDC's Healthy Schools program advances student health and emotional well-being. CDC funds education and health agencies who work with local communities to implement evidence-based, comprehensive school health policies, practices, and programs designed to improve student and staff health and advance equity using the comprehensive Whole School, Whole Community, Whole Child (WSCC) model. Healthy Schools also funds six national non-governmental organizations to support state education agencies, local school districts, schools, parents, and community partners, helping U.S. 132,000 schools and 78 million students. CDC tools and training reach approximately 40,000 school staff annually with education and resources that promote and support the health and wellbeing of both staff and students.

In FY 2025, CDC will continue to support 19 states and one tribe to implement the Healthy Schools program to advance student health and emotional well-being, training, and technical assistance for school staff. In addition to continuing to fund the existing Healthy Schools Program, CDC will fund an additional 57 state, tribal, and territorial education agencies to implement CDC's Leadership Exchange for Adolescent Health Promotion (LEAHP) initiative. This initiative will support state education and public health agency teams to assess state-level school health organizational policies and practices and develop and implement action plans of model school-based policies and practices that enhance youth mental and behavioral health.

### **Opioid Overdose Prevention and Surveillance (+\$0.500 million)**

CDC will continue local investments to reach communities heavily impacted by the overdose crisis while continuing to support all states, territories, and tribes to track and prevent overdose deaths. CDC will support the collection and reporting of real-time, robust overdose data, building upon the work of Overdose Data to

Action (OD2A) programs that collect contextual and toxicological information and prevent overdose and negative health outcomes in communities, State Unintentional Drug Overdose Reporting System (SUDORS) that collect data on drug overdose deaths. This enables states to spot their community’s substance use trends and exposure to the landscape of illicitly manufactured fentanyl analogs, (which have similar chemical structures to fentanyl but with varying potency), to understand factors leading to overdose deaths.

In addition to CDC’s discretionary funding request for FY 2025, the budget includes the following mandatory proposals within CDC:

**Vaccines for Adults:** The COVID-19 pandemic emphasized the critical need for a strong adult vaccination program. Establishment of a new mandatory program, modeled on the Vaccines for Children program, capped at \$12.000 billion over 10 years, will provide uninsured adults access to vaccines recommended by the Advisory Committee on Immunization Practices at no cost.

**Community Violence Intervention Initiative:** In addition to \$100 million in discretionary funding, the FY 2025 budget includes \$150 million in mandatory funding for the Community Violence Intervention Initiative, for a total of \$2.5 billion in discretionary and mandatory funding over ten years. This investment will support scaling up existing community violence prevention efforts and implementing and evaluating programs, policies, and practices based on the best available evidence for preventing community violence.

The FY 2025 budget request also continues existing mandatory programs, and proposes an expansion of the Vaccines for Children program:

**Vaccines for Children:** \$8.040 billion estimated in FY 2025 under proposed law, an increase of \$2.823 billion above the FY 2023 final level. The FY 2025 budget proposes to expand the program to include all children under age 19 enrolled in CHIP and make program improvements, including setting a floor for provider reimbursements for vaccine administration and covering the vaccine administration fee for uninsured children without state share, eliminating cost sharing for all VFC eligible children.

**World Trade Center Health Program:** \$788.110 million in FY 2025 under current law, an increase of \$78.262 million above the FY 2023 final level to include expanded eligibility to responders at the Shanksville and Pentagon sites (per PL 118-31).

**The Energy Employees Occupational Illness Compensation Program Act (EEOICPA):** \$50.763 million (post-sequester), level with the FY 2023 final level.

The FY 2025 budget also includes the following HHS mandatory proposals that would include CDC:

**Strengthen Biodefense to Protect Against 21st Century Biothreats:** The FY 2025 budget provides \$20.000 billion in mandatory funding across HHS, which is reflected in the Public Health and Social Services Emergency Fund, to prepare for pandemics and other biological threats. Of this total, \$6.100 billion is allocated to CDC to modernize and build laboratory capacity and strengthen public health data systems; enhance domestic and global disease surveillance, biosafety, and biosecurity efforts; and support capabilities for monitoring and evaluation of vaccine and medical countermeasure safety and effectiveness. For more information on the Department-wide pandemic preparedness proposal, please find the detailed narrative in the Public Health Social Services and Emergency Fund budget justification.

## Health Equity

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CDC’s Health Equity Science and Intervention Strategy transforms the approach to health equity at CDC, across the nation, and globally. CDC integrates the health equity and social and structural determinants of health approach into the Agency’s daily work while fostering a more diverse, equitable, inclusive, and accessible workplace.



CDC's CORE strategy for public health research, surveillance, and implementation science enhances science and intervention approaches to identify and address the drivers of health inequities. All parts of the Agency align programmatic priorities and identify transformative goals and action plans to ensure the advancement of health equity in science, intervention, partnerships, and the workforce.

### **FY 2025 Legislative Proposals**

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CDC is submitting several A-19 legislative proposals, with the majority previously proposed in the FY 2024 budget, which will allow CDC to implement lessons learned from recent public health emergencies. Additional detail can be found in the Legislative Proposals section.

## Modernizing CDC's Budget Structure

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The Administration is seeking to revitalize U.S. preparedness by investing in core capacities including public health infrastructure, data modernization, upskilling the public health workforce, and strengthening global health protection. As CDC lays the ground for these investments, it also needs greater operational flexibilities. Over time, CDC's discretionary budget structure has grown increasingly complex. As CDC continues to transform how the agency operates by refining and modernizing its structures, systems, and processes, CDC is revisiting the agency's budget account structure to better meet the needs of the agency, stakeholders, and the health, safety, and security of Americans. A comprehensive restructuring of CDC's budget structure will be included in the FY 2026 Budget. In addition to this effort, the Budget includes the following proposed realignments that increase accountability, reduce administrative burden, and provide needed programmatic flexibility:

- Realignment of \$26.0 million for Lyme Disease to be included as a non-add under the Vector-borne Diseases program, project, or activity (PPA). CDC's Lyme Disease activities are encompassed in a larger program to address vector-borne diseases. This larger program supports activities (e.g., Vector Borne Centers of Excellence) that address multiple vector-borne diseases, including Lyme.
- Consolidation of the following Public Health Preparedness and Response PPAs—Public Health Emergency Preparedness Cooperative Agreement, Academic Centers for PH Preparedness, and All Other CDC Preparedness – to a single PPA labeled *Domestic Preparedness*. The activities funded in this budget account support program objectives for preparedness and response by creating greater flexibility in CDC's ability to respond to public health emergencies and execute resources.
- Consolidation of the PPAs, All Other Environmental Health and Safe Water into a single PPA labeled Environmental Health Capacity under the Environmental Health Activities budget activity. In addition, the PPA, Climate and Health is displayed as a non-add line under Environmental Health Capacity. These activities funded under this budget account are focused on increasing environmental health capacity at the federal, state, local, territorial, and Tribal levels.
- Realignment of the PPAs, Harmful Algal Blooms and Prion Disease as sub-activities under Emerging Infectious Diseases. CDC's Prion Diseases and Harmful Algal Blooms activities are included as part of CDC's larger program to address emerging diseases. In addition, CDC requests funds in FY 2025 for Wastewater Surveillance as a sub-activity under Emerging Infectious Diseases, to begin the establishment of core support for wastewater surveillance.

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## OVERVIEW OF PERFORMANCE

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As the nation's prevention agency and a leader in improving health around the world, CDC is committed to reducing the leading causes of death, disability, and injury. CDC staff work 24/7 to protect America from health, safety and security threats, both foreign and in the United States. To achieve maximum public health impact, CDC conducts research; implements strategic, evidence-based programs; and monitors results through ongoing data collection.

CDC's priorities form the core of its public health programs. These programs require the scientific excellence and leadership of our highly trained staff, who are dedicated to high standards of quality and ethical practice. The agency's priorities include:

- Rapid Response to Outbreaks at their Source
- Strong Global Capacity and Domestic Preparedness
- Diverse Public Health Workforce
- State-of-the Art Laboratories
- World Class Data and Analytics

Performance in each of these areas and in all of CDC's work is strengthened through the use of rigorous and ongoing performance metrics and program evaluation data to monitor program effectiveness and compare performance to established targets. The accomplishments described below highlight the importance of investing in high quality public health programs, preventing disease, and protecting health.

### Rapid Response to Outbreaks at their Source and Strong Global Capacity and Domestic Preparedness

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- In 2023, CDC coordinated the response to several outbreaks of viral hemorrhagic fevers - Sudan ebolavirus in Uganda, Marburg in Equatorial Guinea and Tanzania, and Nipah in Bangladesh. CDC rapidly deployed epidemiology and laboratory teams to provide on-the-ground support and technical assistance, as well as training, communications, and epidemiological investigations for these outbreaks. CDC worked with partners to identify the origins of the outbreaks and scale up testing and diagnostics, when able. CDC's support and leadership were essential for reducing transmission and helping resolve these outbreaks.
- CDC has been instrumental in the ongoing response to the global Highly Pathogenic Avian Influenza (HPAI) outbreak. Since January 2022, CDC and state and local health departments have monitored more than 6,500 people in 52 jurisdictions in the United States. Globally, CDC was instrumental responding to outbreaks of avian influenza infecting six people in 2023 in Cambodia. CDC worked closely with country officials, and in-country partners, to successfully respond to these outbreaks, including sending staff to assist with investigations on the ground, and providing laboratory and communications support from CDC headquarters in Atlanta. These efforts highlight the importance of our strong global partnerships that allow for rapid response and containment of outbreaks.
- CDC and the Mississippi State Department of Health (MSDH) collaborated to stop a rapidly growing regional *Candida auris* (*C. auris*) outbreak. In November 2022, the state's first locally acquired case of *C. auris* was identified and by February 2023, there were 8 clinical cases and at least 42 colonized patients detected in multiple healthcare facilities. CDC trained the MSDH healthcare-associated infection (HAI) team and three regional infection preventionists (IPs) in *C. auris* epidemiology and infection control and conducted infection control assessments with the MSDH IP and HAI staff. These joint efforts resulted in a substantial decline of *C. auris* spread in Mississippi and strengthened the capacity of the HAI team and IPs to respond to future cases.
- CDC's Antimicrobial Resistance Laboratory Network (AR Lab Network), detected a multistate outbreak of extensively drug-resistant *Pseudomonas aeruginosa* linked to artificial tears and eye ointment products,

identifying 81 patients across 18 states to date. CDC, in collaboration with FDA, undertook extensive communication efforts to recommend clinicians and patients stop using and discard the potentially impacted products. Additionally, CDC support in HAI/AR programs and the AR Lab Network enabled CDC staff and health department partners to connect cases through lab sequencing, identify the artificial tear products linked to the outbreak, and work swiftly to contain this outbreak and prevent further infections using CDC’s infection prevention and control (IPC) training and expertise.

- In 2023, the Mississippi State Department of Health (MSDH) requested CDC assistance with the investigation of an expanding cluster of melioidosis cases in the Gulf Coast region of the state. CDC has helped the MSDH investigate several cases in this region, and evidence has led to understand that melioidosis is a newly endemic disease to the continental U.S. CDC helped collect and analyze hundreds of samples in the soil and water in the Gulf Region as well as support epidemiologic interviews. This assistance and subject matter expertise is helping Mississippi partners understand local risk and transmission, which will be essential to informing prevention.
- CDC vaccinated 20.4 million children with polio vaccine in Asia, Africa, and Europe in 2022. CDC’s polio eradication activities resulted in decreasing the geographic expanse of all types of poliovirus – moving from 583 districts to 353 districts in the last two years. Additionally, CDC’s investments in the development and deployment of the novel type 2 oral polio vaccine led to over 500 million doses of vaccine delivered, along with a decrease of new emergences over the last two years.
- In 2022, Eswatini’s second Population-based HIV Impact Assessment (PHIA) showed that in just over 10 years, with CDC and PEPFAR support, Eswatini had significantly reduced new infections in adults and dramatically improved outcomes for people living with HIV (PLHIV), with 93.7% of adults living with HIV being aware of their status. This was a significant change from Eswatini’s 2011 PHIA which showed it had the highest national rate of new HIV infections and proportion of adults living with HIV globally. CDC-supported PHIA survey findings underscore that Eswatini surpassed the UNAIDS 95-95-95 targets for treatment and viral suppression in advance of the 2025 target date, providing clear evidence of the effectiveness of the country’s HIV treatment programs and CDC’s impact.
- On July 7, 2023, CDC, the Department of Defense (DoD), and the Program Executive Office Assembled Chemical Weapons Alternatives (PEO ACWA), celebrated the safe and complete destruction of 100% of the U.S. chemical weapons stockpile, over 30,000 tons of chemical weapons. CDC provides recommendations to DoD on plans for the destruction of stockpiled chemical weapons, protecting the health of the public and workers. On the 40<sup>th</sup> anniversary of CDC’s involvement in the process, CDC helped to successfully eliminate a major public health threat for communities, the U.S., and the world.
- In 2022, CDC developed an additional seven candidate vaccine viruses (CVV) for novel and emerging influenza viruses as a pandemic preparedness measure and evaluated existing CVVs to ensure their continued effectiveness. Developing and sharing CVVs with vaccine manufacturers before an outbreak occurs is essential to speed up vaccine development timelines, which can save lives in a pandemic response.
- CDC has expanded its vaccine effectiveness platforms to better understand the ability of influenza vaccines to reduce risk of severe outcomes in children, immunocompromised adults, and adults over 65. The results of these investments were seen in the 2022-2023 influenza season. In the 2022-2023 flu season, the flu vaccine provided substantial protection to people who were immunized, with vaccination reducing the risk of flu-related emergency department visits, urgent care visits, and hospitalizations by almost half among children and adolescents. Adults who were vaccinated were also nearly half as likely to be hospitalized with influenza compared to those who were not vaccinated. These data are essential to inform education efforts and communications messaging on the protective benefits of vaccines.

## **Diverse Public Health Workforce and State of the Art Laboratories**

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- In 2023, CDC received more than 6,000 seasonal influenza virus samples from humans and more than 3,000 avian and swine influenza virus samples from animals from around the globe as a WHO

Collaborating Center. CDC performed extensive analysis of these samples to inform risk assessments for viruses that have pandemic potential, including epidemiological, antigenic (immune response), antiviral susceptibility, and genetic characterizations.

- In 2022, CDC expanded PrEP access in 40 sexually transmitted infections (STI) clinics, testing nearly 150,000 patients, diagnosing more than 1,100 new cases of HIV, and prescribing PrEP to more than 7,400 patients.
- CDC and FDA continue their collaboration on the CDC & FDA AR Isolate Bank to increase the number of and information available on antimicrobial-resistant pathogen isolates, including whole genome sequencing data. The more than 1,000 unique AR bank isolates are distributed to researchers' clinical laboratories and diagnostic device manufacturers who request the isolates for verification, validation testing, and research and development, while conducting studies for regulatory submissions to FDA. As of June 2023, the AR Isolate Bank has filled more than 4,000 orders, shipping around 8,500 panels containing over 330,000 isolates.
- CDC provided dried blood spot quality assurance materials for 16 proficiency testing and 11 quality control programs to 680 newborn screening laboratories in 88 countries worldwide, covering the core and secondary conditions on the Recommended Uniform Screening Panel (RUSP). These services are vital to ensuring the early and accurate identification of babies born with life-threatening or disabling conditions.
- CDC continues to maintain its local and state chemical threat laboratory capacity. Because of this, in 2022 the LRN-C laboratory in Idaho was able to rapidly test and provide results during a thallium poisoning outbreak involving cattle from a northern Utah ranch. In October 2022, the LRN-C laboratory in Albany, New York provided emergency response testing for 20 workers that were accidentally exposed to mercury at a manufacturing facility in Long Island, New York. New York's LRN-C Level 1 laboratory worked in collaboration with Office of Safety and Health Administration and the state's Center for Environmental Health to investigate symptomatic employees that were likely exposed to unsafe levels of mercury without the benefit of engineering controls to mitigate this exposure. LRN-C laboratories nationwide also continue to work alongside FBI and LRN-B partners to respond to dozens of unknown white powder samples each year.
- CDC has made significant strides to strengthen the quality, safety, and science of the nation's clinical and public health laboratories and CDC's laboratory safety and quality culture evidenced by:
  - Completing a pilot project to pursue external accreditation of International Organization for Standardization/International Electrotechnical Commission (ISO/IEC) 17025 standards, which state requirements for laboratory testing and calibration. This resulted in 5 accredited infectious disease CDC laboratories.
  - Collaborating with CMS to develop the final Clinical Laboratory Improvement Amendment (CLIA) proficiency testing rule that affects 33,000 clinical laboratories.
  - Opening a new Laboratory Training Facility providing biosafety level-3 and -4 trainings in a simulated environment in absence of pathogens.
  - Launching OneLab REACH and OneLab TEST to provide training resources to the laboratory and testing communities. The OneLab initiative is designed to bridge, train, and sustain a capacity-building community among laboratory professionals and testers to support rapid, large-scale responses to public health emergencies.

## World Class Data and Analytics

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- In December 2022, collection of the nation's hospital capacity data from all ~5,300 hospitals in the nation transferred to [CDC's National Healthcare Safety Network](#). These data are now shared with the public on CDC's COVID data tracker. Prior to this, the U.S. federal government had never had near-real time insight into the hospital bed and intensive care unit (ICU) bed occupancy rates and availability rates

for every hospital in the country, and the data proved extremely useful in late 2022 during the “triple threat” of COVID, influenza, and respiratory syncytial virus (RSV). CDC continues to invest in the modernization of this work, and in early 2023 supported three states to pilot the automation of these data, providing quicker, more actionable data at reduced burden to hospitals.

- To assess and disseminate information on equity in COVID-19, flu, and other routine vaccination coverage and vaccine confidence, CDC designed multiple surveys and tools. In 2022, the National Immunization Survey (NIS) Child and Adult COVID modules were updated to reflect new vaccine recommendations. The findings were shared with jurisdictions, and the results were posted regularly on COVIDVaxView.
- In April 2023, CDC launched the Hepatitis C Treatment Locator widget to further promote linkage to hepatitis C care. Since its launch, the widget has been used to search for treatment about 300 times per month on average. As of November 2023, 21 partner organizations are helping their communities find nearby treatment by hosting the widget on their websites.
- CDC is modernizing data collection for children with Fetal Alcohol Spectrum Disorders (FASDs). CDC is analyzing person-level, de-identified claims data for children aged 0-17 years from a national sample of commercially insured enrollees, and Medicaid-ensured enrollees. This information complements in-person studies by providing more timely information about children with recognized and reported FASDs from diverse populations. These findings also underscore the need for efforts to improve identification of and surveillance for children with FASDs.
- CDC implemented a new case definition and data system for tracking autism allowing for the most recent results to be published a full year faster than previous method allowed. In 2023, CDC expanded the Autism and Developmental Disabilities Monitoring (ADDM) Network from 11 to 16 sites across the U.S. and released the first ADDM reports on children aged 16 years with autism, helping communities identify healthcare needs and gaps in planning for transition to adulthood among youth with autism.
- CDC collaborated with Early Hearing Detection and Intervention state programs to collect, for the first time, individual-level data on infants to help ensure timely diagnosis and intervention services for each child who is at risk for permanent hearing loss or who is diagnosed as deaf or hard of hearing.
- CDC developed simulation software, SimPLER, to help state and local jurisdictions understand and improve their capacity to perform radiation screening and decontamination of large populations following a radiation incident. State-led tests found that the SimPLER model had a much higher predictive accuracy - 96% compared to 70% for most other current models. The higher accuracy of SimPLER has called attention to major gaps in planning, particularly for populations with access and functional needs, and will enable state and local partners to better plan for radiation incidents. Over 40 states have tested SimPLER, with over 2,000 state and local public health and emergency management staff across the country trained on the software.
- CDC is improving the timeliness and comprehensiveness of data on fatal and nonfatal overdose, firearm homicide and firearm suicide, and suicide death trends.
  - For the first time, data from CDC’s Overdose Data to Action (OD2A) program and the State Unintentional Drug Overdose Reporting System (SUDORS) have been made widely available through public-facing dashboards. These dashboards provide critical data in an easy-to-understand format for public health partners and the public to engage with and understand rates of fatal and nonfatal overdoses in states and use those data to tailor interventions in states and communities.
  - CDC now highlights provisional monthly mortality data for firearm homicide and firearm suicide on its website. Providing the public with the most current data can support identifying and responding to emerging public health problems. This is the first-time provisional firearm homicide and firearm suicide data are easily accessible on a public webpage.
  - CDC developed the Real-time Analytical Prediction Injury Dashboard (RAPID), an innovative, near real-time prediction and visualization dashboard to understand suicide death trends in a matter of weeks instead of over a year and allowing scientists to “nowcast” suicide death trends

nationally. This is the first time CDC operationalized a machine learning approach to predict injury trends and the resulting dashboard is the first of its kind at CDC. CDC is collaborating with several state and local public health jurisdictions to adapt this “nowcast” approach at the local level and is expanding this model into firearm and drug overdose data.

- During the first 2.5 years of the pandemic, CDC’s MMWR published a COVID-19 report an average of every 48 hours, increasing the release of content from once per week to three times per week. MMWR released content frequently in less than 48 hours after receiving a cleared submission, faster than is feasible for pre-print servers.
- CDC established a process for institutions to submit applications for access to investigational drugs, reducing time required for institutions to apply from 14 days to 6 hours. This was utilized with tecovirimat (TPOXX) for Mpox and allowed clinicians at over 220 facilities/institutions to provide TPOXX treatment more rapidly to nearly 4,900 patients.
- CDC launched the Collaborating Office for Medical Examiners and Coroners in 2022 to coordinate federal support for the medical examiner and coroner community, strengthening the reliability and validity of vital statistics and facilitating research for sudden and unexpected causes of death.
- CDC improved the speed and relevancy of its data by publishing 21 sets of experimental, preliminary, provisional, model-based, or early estimates from October to December of 2022.
- In December 2022, CDC provided data to extend growth charts for children, allowing clinicians to assess the growth and plot body mass indexes of children with severe obesity who previously could not be monitored accurately.
- In March 2023, CDC launched a new quarterly provisional data dashboard allowing policymakers and public health experts to track maternal mortality trends with less than a six-month lag.
- In August 2023, CDC commenced the first study of Direct Care Workers (DCWs) since 2007 to further investigate DCWs in a variety of healthcare settings, address racial and gender equity among this growing workforce, and ensure quality of long-term care services.
- In May 2023, CDC released the 2020 annual National Notifiable Diseases Surveillance System (NNDSS) tables, marking the successful transition from manual processes to a more sustainable data-processing system. CDC also designed and implemented new, robust data validation processes to verify data accuracy across all annual tables, for all combinations of jurisdictions and diseases represented in the tables. With these processes, CDC is poised to save four months in the future annual NNDSS data validation and publication process, eliminate risk of publishing inaccurate case counts, and increase data accuracy for CDC programs to monitor nationally notifiable diseases and improve how CDC prevents and controls diseases.
- Over the last year, multiple enhancements were made to CDC’s public facing NNDSS tables on the CDC WONDER and Data.CDC.gov platforms to improve user experience. These enhancements include combining 42 weekly data tables into a single NNDSS table on Data.CDC.gov and on CDC WONDER, providing querying capability of NNDSS annual data for specific analyses to inform public health actions, and creation of a single menu to improve user’s ability to locate specific condition(s) information.
- Early results from CDC’s electronic case reporting (eCR) reduction in burden study, with two small healthcare organizations, demonstrated that the that the average cost savings using eCR is \$662,898. Electronic case reporting automates case reporting and reduces burden (time/cost) on healthcare providers by offsetting costs and resources otherwise spent on manual reporting.
- CDC supports states to increase use of eCR. For example, in early 2023, a Tennessee (TN) eCR epidemiologist noticed an increase in eCR documents for *Candida auris* in one TN county. The epidemiologist confirmed with the TN HAI team that same county had recently received lab reports for a few *Candida auris* cases and were investigating. These cases turned out to be an outbreak. In mid-July 2023, the TN eCR team saw an increase in carbon monoxide (CO) poisoning eCR documents while reviewing eCR data. The eCR Team confirmed with the TN emergency preparedness team, who monitors



syndromic surveillance data using a system in CDC’s National Syndromic Surveillance Program, that they had also seen a peak in their data and received a report of a CO exposure at a summer camp.

- From January 2022 to August 2023, CDC created and disseminated 20 automated data reports and visualizations with near real-time emergency department and laboratory data for conditions including COVID-19, RSV, influenza, and mpox to establish shared situational awareness and ensure a common operating picture for public health response decisions and actions.

## Other CDC Accomplishments

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- Between 2021 and 2022, health departments used *Ending the HIV Epidemic* (EHE) initiative support to conduct almost 600,000 HIV tests, identifying over 8,500 individuals with HIV, of which 2,400 people received a new HIV diagnosis. During this timeframe, CDC EHE-supported programs provided more than 44,000 people prescriptions for PrEP, and in 2022, six jurisdictions met the 2025 goal of linking 95% of newly diagnosed persons to care. HIV incidence declined by 16% in EHE countries in 2021 compared to 2017.
- In 2023, CDC expanded the Think. Test. Treat TB communications campaign, with a focus on raising latent TB infection awareness among healthcare providers. The campaign was distributed and amplified across digital channels, consistently exceeding industry benchmarks with an estimated 8.79 million impressions. Campaign education materials are available in English, Vietnamese, Chinese, Ilocano, Marshallese, Tagalog, and Spanish.
- In 2023, CDC’s Tips From Former Smokers® (Tips®) campaign celebrated its 12th campaign; it continues to run new compelling ads to raise awareness about the health effects caused by smoking and promote resources to help people quit smoking. For the 2023 campaign, call volume to 1-800-QUIT-NOW was over 40% above the baseline measurement three weeks prior to launch of the campaign. Call volume to the Spanish quitline, was 63% higher compared to the baseline three weeks prior to the launch; opt-ins to the National Texting Portal had a 32% increase compared to baseline. Year after year, the Tips campaign has had a significant and sustained impact, helping more than 1 million U.S. adults quit smoking and inspiring millions more to try.
- In September 2023, CDC launched a new campaign, Empower Vape-Free Youth™. The campaign aims to empower educators in U.S. middle and high schools to speak with youth about the risks of e-cigarettes and nicotine addiction and to encourage youth to avoid and/or quit vaping. As part of the launch, CDC placed new paid digital display and video, search, and social media ads nationally. The ads ran for three weeks from September 4-24, 2023, and will continue to run intermittently throughout the school year. During the first three weeks, the ads had more than 28 million impressions and resulted in approximately 45,000 clicks to the [cdc.gov/vaping](https://www.cdc.gov/vaping) website, where people received more information about risks of youth using e-cigarettes.
- In FY 2023, CDC expanded support for Perinatal Quality Collaboratives (PQCs), which are improving equity in maternal care and outcomes to 36. For example, in two years, the Louisiana PQC achieved a 35% reduction in severe maternal morbidity from hemorrhage overall, with a 49% reduction among Black women.
- In 2022, CDC’s Good Health and Wellness in Indian Country (GHWIC) program supported the development and implementation of 220 commercial tobacco policies (focusing on prevention, tobacco-free environments, and referrals to tobacco cessation therapies and counseling) and helped enroll 8,246 American Indian/Alaska Native (AI/AN) individuals in cessation programs. AI/AN people, compared to other racial and ethnic groups, have a higher risk of death and disease caused by using commercial tobacco products.
- CDC supports state, tribal, local, and territorial health departments in their childhood lead poisoning prevention activities. For example, the Colorado Childhood Lead Poisoning Prevention Program developed a statistical tool to detect changes in the rates of higher blood lead levels in children. In April

2022, the tool helped the program to detect a cluster of 38 children with blood lead levels at or above the BLRV among refugees/newcomers. Colorado worked quickly to connect with the state refugee health program to ensure the appropriate steps were taken for follow-up care.

- CDC’s National Asthma Control Program supports 25 state, city, and territorial to prevent asthma-related emergency department visits and hospitalizations. The Maine health department’s Department of Health and Human Services worked with a certified asthma educator to develop the Asthma Self-Management Education Program (ASMEP), which offers asthma education in clinics and in homes. Evaluations of the precursor program revealed 69% fewer missed school days 79% (up from 30%) of participants reporting well-controlled asthma, and a 60% decrease in hospitalizations due to asthma after completion of the program. For every dollar invested in the program, \$1.80 (at seven months’ follow-up) and \$3.09 (at 12 months’ follow-up) is saved in averted healthcare costs and lost productivity. ASMEP is currently being implemented by Maine Health, a non-profit health system, and the state’s Public Health Nursing Program.
- CDC is investing in the potential of all children by preventing adverse childhood experiences (ACEs) in families and communities. Through CDC’s Essentials for Childhood Preventing Adverse Childhood Experiences: Data to Action program, the [Georgia Department of Public Health](#) created a publicly available resource that includes data on ACEs. These data are part of Georgia’s [Child Abuse and Neglect Prevention Plan](#). Fourteen regional committees are using the data to inform proven prevention strategies, such as increasing implementation of early childhood home visitation, and identifying under-resourced communities to better allocate resources to prevent ACEs.
- CDC is supporting state and locality efforts in overdose prevention through its OD2A programs (OD2A: States and OD2A: LOCAL). These programs will help communities collect more timely, high quality, and comprehensive data to inform prevention and response efforts. For example, xylazine, a non-opioid sedative not approved for human use, is increasingly being linked to overdose deaths. The North Carolina Department of Health and Human Services (NCDHHS), an OD2A recipient, sent an alert to local health directors and harm reduction organizations about the presence of xylazine in the drug supply and shared harm reduction tips developed by the NC Survivors Union. NCDHHS provides ongoing technical assistance to local health departments and community-based organizations about xylazine and are connecting them with partners at UNC Chapel Hill who have a community-based drug checking program.
- CDC’s Comprehensive Suicide Prevention Program (CSP) supports 24 recipients to implement and evaluate a comprehensive public health approach to suicide prevention, with attention to populations that are disproportionately affected by suicide. Vermont used CSP support to create the [Vermont Emergency Department Suicide Prevention Quality Improvement Initiative](#) to improve hospitals’ ability to screen, assess, and educate on how to reduce access to lethal means for persons at risk of suicide, and support follow-up care for those individuals. These activities are helping Vermont hospitals better care for the over 1,000 patients who visit hospital emergency departments for intentional self-harm and 4,000 patients who visit for suicidal ideation and self-directed violence each year.
- As of July 2023, nationally accredited health departments serve 90% of the U.S. population. The CDC-supported Public Health Accreditation Board (PHAB) accredits public health departments to strengthen public health infrastructure and transform governmental public health. There are currently 364 accredited health departments—41 state, 6 tribal, and 321 local health departments. July 2023 evaluation data indicate that the program has stimulated quality improvement (95% of accredited health departments agree), improved accountability and transparency (88%), and improved their health department’s ability to identify and address gaps in employee training and workforce development (90%).
- CDC published the [American Indian and Alaska Native Worker Safety and Health Strategic Plan](#). The Plan serves as a guide for the nation to develop research and outreach activities to prevent injuries, illnesses, and fatalities to American Indian and Alaska Native workers. The plan should be viewed as a starting point to stimulate collaboration and activities to improve American Indian and Alaska Native worker safety and health.

- In April 2023, CDC developed and launched the [National Firefighter Registry \(NFR\) for Cancer](#) to better understand the link between firefighting and cancer. The NFR for Cancer is the largest effort ever undertaken to understand and reduce risk of cancer among U.S. firefighters.
- CDC's San Juan Campus has successfully implemented several energy-efficient systems helping to increase campus resiliency and CDC energy efficiency goals. The campus' new photovoltaic (PV) array is expected to produce approximately 347,000 kilowatt-hour (kwh) per year of energy. Additionally, a 348-kwh lithium-ion battery storage system is sized to power San Juan's walk-in cooler/freezer for 48 hours in order to protect the samples in the event of an emergency where the site loses all utility power, and the backup generator experiences a failure.

## **Agency Performance Planning and Management**

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CDC conducts continuous program improvement through program strategic planning, monitoring and measurement, and evaluation. CDC collects information on program priorities, measurable outcomes, strategies, and progress through annual updates. Additionally, CDC has developed a Performance Improvement Framework to advance a culture of performance improvement and build performance improvement capacity at all levels of the agency.

The CDC awards nearly 75% of its budget through grants, cooperative agreements, and contracts to help accomplish its mission to promote health and quality of life by preventing and controlling disease, injury, and disability. Contracts procure goods and services used directly by the agency, and grants and cooperative agreements assist other health-related and research organizations that contribute to CDC's mission through health information dissemination, preparedness, prevention, research, evaluation, and surveillance. CDC cooperative agreement funding announcements require applicants to specify how they are measuring, monitoring, and evaluating the activities they are implementing and progress toward achieving the intended outcomes.

## **Agency Use of Evaluation and Evidence**

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CDC is a data-driven agency and incorporates use of data for decision making and to continuously improve our programs. CDC continues to focus on the development and use of evidence to enhance all aspects of the Agency's mission. CDC is leveraging the Foundations for Evidence-Based Policymaking Act to strengthen program evaluation activities and data use for decision making across the agency. CDC uses a prospective evidence-building approach to innovate, test, evaluate and model strategies in order to identify those that are most impactful, cost-effective, and feasible for achieving our public health goals. As additional evidence is generated, some of these questions and approaches may shift. By continuously building and assessing the evidence, CDC is better positioned to optimize our impact and strategically drive informed decisions. This prospective generation of key evidence and ongoing data evaluation is critical for data-driven policymaking.

CDC is increasing its internal capacity to oversee and conduct program evaluation by expanding evaluation trainings available to employees through CDC University and webinars, enhancing the CDC Evaluation Fellowship Program to increase program evaluation expertise, and by ensuring CDC programs are implementing standard program evaluation guidelines and recommendations. Each Notice of Funding Opportunity (NOFO) has clear performance measurement and evaluation measures to ensure funded recipients are collecting and using data for continuous program improvement.

## **Alignment to Administration Priorities and Initiatives**

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CDC is committed to supporting the national priorities set by the Administration. CDC leads key activities for 12 measures in the FY 2025 HHS performance plan. These include:

- strengthening public health surveillance, epidemiology, and laboratory capacity,
- protecting Americans in public health emergencies,
- preventing and controlling tobacco use,
- preventing and responding to trauma or violence,
- mitigating and preventing infectious and chronic diseases,
- mitigating the impacts of environmental factors,
- expanding access to high-quality services for older adults and people with disabilities, and
- improving data collection, use, and evaluation.

## LEGISLATIVE PROPOSALS

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### Mandatory Proposals

#### **Adult Immunization Program (Vaccines for Adults)**

The FY 2025 President's Budget includes a proposal for legislative authority and capped mandatory funding, \$12 billion over 10 years, to establish the Vaccines for Adults (VFA) program to begin to expand access to routine and outbreak vaccines for uninsured individuals, at no cost to eligible recipients. The overarching goal of the proposed program is to reduce the spread of vaccine-preventable disease by building an equitable and sustainable adult immunization program to support high vaccination coverage among all adults. Ultimately, the program will reduce vaccination coverage disparities, improve outbreak control of vaccine-preventable diseases, and enhance and maintain the infrastructure needed for responding to future pandemics.

#### **Expand Vaccines for Children Program to All Children Health Insurance Program (CHIP) Children and Make Program Improvements**

The FY 2025 President's Budget proposes to expand the Vaccines for Children (VFC) program to children under age 19 enrolled in separate CHIPs, thereby transitioning coverage of vaccine doses for separate CHIP enrollees from CHIP to the VFC program. This would make the federal government solely responsible for paying for vaccine doses for children in separate CHIPs, rather than responsible for paying only a percentage of that cost. State CHIPs would continue to be responsible for the vaccine administration provider fees for children under the age of 19 in a separate CHIP, similar to how these fees are paid by state Medicaid programs for Medicaid-eligible children under the age of 19, and the federal government would continue to match states' expenditures on this coverage of the administration fees at the applicable federal matching percentage for CHIP expenditures in that state.

The proposal also makes program improvements, including setting a floor for provider reimbursements for vaccine administration fee at 80% of the Medicare Part B fee schedule vaccine administration fee rates for Medicaid, CHIP, and uninsured children and covering the vaccine administration fee for uninsured children without state share, eliminating cost sharing for all VFC eligible children.

#### **Strengthen Biodefense to Protect Against 21st Century Biothreats**

The FY 2025 President's Budget provides \$20 billion in mandatory funding across HHS, which is reflected in the Public Health and Social Services Emergency Fund, to prepare for pandemics and other biological threats. Of this total, \$6.1 billion is allocated to CDC. With these resources, CDC will modernize and build laboratory capacity and strengthen public health data systems; enhance domestic and global disease surveillance, biosafety, and biosecurity efforts; and support capabilities for monitoring and evaluating vaccine and medical countermeasure safety and effectiveness.<sup>1</sup>

### Discretionary Proposals

#### **Public Health Data Reporting Authority**

The current framework for collecting and sharing public health data has resulted in fragmented and inconsistent reporting to CDC, and to state and local public health partners. As part of the HHS legislative proposal to provide the HHS Secretary with new data authority, CDC will be able to allow for more complete and timely data sharing to support decisions at the federal, state, and local levels, while reducing burden on providers. For example, authority included in the CARES Act requiring COVID-19 laboratory test reporting during the PHE greatly improved the availability of laboratory data.

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<sup>1</sup> For more information on the Department-wide biodefense proposal, please reference the detailed narrative in the Public Health Social Services and Emergency Fund FY 2025 Congressional Justification.

### **Public Health Ready Response**

The FY 2025 President's Budget proposes to allow CDC to dedicate a small percentage of funding across CDC appropriations account for the purpose of supporting a cadre of response-ready staff that would be available to respond to public health challenges. These staff would be trained and available for rapid deployment in the case of a Public Health Emergency (PHE), an event with significant potential to become a PHE, or other urgent threat to the nation's health security, and then return to their regular duties when the event is resolved. With this new cadre, CDC will be able to surge faster and stop the spread of disease before it becomes a widespread outbreak. This approach will allow for faster response, and significantly reduce the administrative burden that is in place today. This proposal would allow the use of funds from CDC's budget activities to support the cadre on an ongoing basis and allow CDC to draw on all of its resources, with appropriate notification to Congress, to respond to large-scale threats.

### **Student Loan Repayment Tax Waiver**

CDC seeks a tax code provision to exclude student loan repayments made for CDC fellows (authorized under section 317F of the Public Health Service Act (42 U.S.C. 247b-7)) from gross income. The exception will relieve CDC of the tax burden on program funds that provide student loan repayment to new employees enabling CDC to use more of its program funds to provide this benefit to more individuals.

### **Retired Annuitants**

CDC requests authority for one year to hire reemployed annuitants to fill full-time roles in emergency responses without hour limitations during a declared Public Health Emergency response. The identified positions are needed to meet the emergency response requirements and to provide substantive support, without limitation, in carrying out public health crises to support the CDC's mission criteria.

## ALL PURPOSE TABLE

(dollars in thousands)	FY 2023 Final <sup>1</sup>	FY 2024 CR <sup>2</sup>	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Immunization and Respiratory Diseases</b>	<b><u>\$919,291</u></b>	<b><u>\$919,291</u></b>	<b><u>\$969,291</u></b>	<b><u>\$50,000</u></b>
Budget Authority	\$499,941	\$499,941	\$499,941	\$0
ACA/PPHF	\$419,350	\$419,350	\$469,350	\$50,000
<b>HIV/AIDS, Viral Hepatitis, STI and TB Prevention</b>	<b><u>\$1,391,056</u></b>	<b><u>\$1,391,056</u></b>	<b><u>\$1,391,056</u></b>	<b><u>\$0</u></b>
<b>Emerging and Zoonotic Infectious Diseases</b>	<b><u>\$750,772</u></b>	<b><u>\$750,772</u></b>	<b><u>\$780,772</u></b>	<b><u>\$30,000</u></b>
Budget Authority	\$698,772	\$698,772	\$728,772	\$30,000
ACA/PPHF	\$52,000	\$52,000	\$52,000	\$0
<b>Chronic Disease Prevention and Health Promotion</b>	<b><u>\$1,430,414</u></b>	<b><u>\$1,430,414</u></b>	<b><u>\$1,559,414</u></b>	<b><u>\$129,000</u></b>
Budget Authority	\$1,175,464	\$1,175,464	\$1,304,464	\$129,000
ACA/PPHF	\$254,950	\$254,950	\$254,950	\$0
<b>Birth Defects, Developmental Disabilities, Disability and Health</b>	<b><u>\$205,560</u></b>	<b><u>\$205,560</u></b>	<b><u>\$205,560</u></b>	<b><u>\$0</u></b>
<b>Environmental Health</b>	<b><u>\$246,850</u></b>	<b><u>\$246,850</u></b>	<b><u>\$266,850</u></b>	<b><u>\$20,000</u></b>
Budget Authority	\$229,850	\$229,850	\$249,850	\$20,000
ACA/PPHF	\$17,000	\$17,000	\$17,000	\$0
<b>Injury Prevention and Control</b>	<b><u>\$761,379</u></b>	<b><u>\$761,379</u></b>	<b><u>\$943,379</u></b>	<b><u>\$182,000</u></b>
Budget Authority	\$761,379	\$761,379	\$843,379	\$82,000
PHS Evaluation Funds	\$0	\$0	\$100,000	\$100,000
<b>Public Health Scientific Services</b>	<b><u>\$754,497</u></b>	<b><u>\$754,497</u></b>	<b><u>\$804,097</u></b>	<b><u>\$49,600</u></b>
Budget Authority	\$754,497	\$754,497	\$621,197	-\$133,300
ACA/PPHF	\$0	\$0	\$182,900	\$182,900
<b>Occupational Safety and Health</b>	<b><u>\$362,800</u></b>	<b><u>\$362,800</u></b>	<b><u>\$363,200</u></b>	<b><u>\$400</u></b>
<b>Global Health</b>	<b><u>\$692,843</u></b>	<b><u>\$692,843</u></b>	<b><u>\$692,843</u></b>	<b><u>\$0</u></b>
<b>Public Health Preparedness and Response<sup>1</sup></b>	<b><u>\$905,100</u></b>	<b><u>\$905,100</u></b>	<b><u>\$943,300</u></b>	<b><u>\$38,200</u></b>
<b>Cross-Cutting Activities and Program Support</b>	<b><u>\$723,570</u></b>	<b><u>\$723,570</u></b>	<b><u>\$723,570</u></b>	<b><u>\$0</u></b>
Budget Authority	\$563,570	\$563,570	\$513,570	-\$50,000
ACA/PPHF	\$160,000	\$160,000	\$210,000	\$50,000
<b>Buildings and Facilities</b>	<b><u>\$40,000</u></b>	<b><u>\$40,000</u></b>	<b><u>\$40,000</u></b>	<b><u>\$0</u></b>
<b>Total CDC – Budget Authority<sup>1</sup></b>	<b><u>\$8,280,832</u></b>	<b><u>\$8,280,832</u></b>	<b><u>\$8,397,132</u></b>	<b><u>\$116,300</u></b>
<b>Total CDC – BA &amp; PHS Evaluation Transfer</b>	<b><u>\$8,280,832</u></b>	<b><u>\$8,280,832</u></b>	<b><u>\$8,497,132</u></b>	<b><u>\$216,300</u></b>
<b>CDC Program Level - BA, PPHF, &amp; PHS Eval</b>	<b><u>\$9,184,132</u></b>	<b><u>\$9,184,132</u></b>	<b><u>\$9,683,332</u></b>	<b><u>\$499,200</u></b>
Agency for Toxic Substances and Disease Registry (ATSDR)	\$85,020	\$85,020	\$85,020	\$0
Prevention and Public Health Fund (PPHF) Transfer	\$903,300	\$903,300	\$1,186,200	\$282,900
PHS Evaluation Transfer	\$0	\$0	\$100,000	\$100,000
Energy Employees Occupational Illness Compensation Program Act (EEOICPA) <sup>3</sup>	\$50,763	\$50,763	\$50,763	\$0
World Trade Center Health Program <sup>4</sup>	\$709,848	\$768,392	\$788,110	\$78,262
Vaccines for Children <sup>5</sup>	\$5,216,952	\$7,212,743	\$8,039,718	\$2,822,766
Vaccines for Adults (Proposed Law)	\$0	\$0	\$1,004,000	\$1,004,000
Other User Fees	\$2,226	\$2,226	\$2,226	\$0
Community Violence Intervention (CVI) Mandatory <sup>6</sup>	\$0	\$0	\$150,000	\$150,000
<b>Total CDC/ATSDR</b>	<b><u>\$15,248,941</u></b>	<b><u>\$17,303,276</u></b>	<b><u>\$19,803,169</u></b>	<b><u>\$4,554,228</u></b>
Nonrecurring Expenses Fund (NEF) Transfer – Notification <sup>7</sup>	\$35,000	\$154,500	\$209,036	
Strengthening Biodefense, Proposed Law Mandatory via PHSSEF <sup>8</sup>	\$0	\$0	\$6,100,000	\$6,100,000

<sup>1</sup> FY 2023 Final and FY 2024 CR Level is comparably adjusted to reflect \$21.9 million within CDC's total for HHS Protect. The FY 2023 Joint Explanatory Statement provides \$21.9 million from the Public Health and Social Services Emergency Fund (PHSSEF) for HHS Protect, to support activities implemented by CDC. The FY 2025 Budget level proposes directly appropriating funding to CDC for HHS Protect/Response Ready Enterprise Data Integration platform (RREDI).

<sup>2</sup> FY 2024 CR Level is displayed in the absence of a full year FY 2024 appropriations. FY 2024 assumes level with FY 2023 Final Level and comparably reflects \$21.9 million annualized amount from the PHSSEF that would be available to CDC for HHS Protect.

<sup>3</sup> EEOICPA levels reflect post-sequester amounts.

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<sup>4</sup> World Trade Center Health Program reflects Federal share estimated obligations only; NYC share estimated obligations are not included. FY 2023 Final Level excludes supplemental funding of \$1 billion in the FY 2023 Appropriations Act (P.L. 117-328).

<sup>5</sup> FY 2023 and FY 2024 levels reflect actual and estimated spending under current law. The VFC proposed law total for FY25 does not include changes to Medicaid provider administration fees, and does not include estimated costs associated with establishing, implementing and overseeing an administration fee reimbursement mechanism.

<sup>6</sup> The FY 2025 PB proposes to fund CDC's Community Violence Initiative at a total of \$2.5 billion over ten years in mandatory and discretionary funds. The PB assumes \$100 million in discretionary funding, which is reflected in CDC's Injury Account totals, and \$150 million in mandatory funding.

<sup>7</sup> HHS has not yet notified for FY 2025.

<sup>8</sup>The FY 2025 PB Level provides \$20 billion in mandatory funding across HHS to strengthen biodefense, which is reflected in the Public Health and Social Services Emergency Fund chapter. Of this total, CDC will receive \$6.1 billion.



# BUDGET EXHIBITS

## **APPROPRIATIONS LANGUAGE**

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### *IMMUNIZATION AND RESPIRATORY DISEASES*

*For carrying out titles II, III, XVII, and XXI, and section 2821 of the PHS Act, and titles II and IV of the Immigration and Nationality Act, with respect to immunization and respiratory diseases, \$499,941,000.*

### *HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED DISEASES, AND TUBERCULOSIS PREVENTION*

*For carrying out titles II, III, XVII, and XXIII of the PHS Act with respect to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis prevention, \$1,391,056,000.*

### *EMERGING AND ZOO NOTIC INFECTIOUS DISEASES*

*For carrying out titles II, III, and XVII, and section 2821 of the PHS Act, and titles II and IV of the Immigration and Nationality Act, with respect to emerging and zoonotic infectious diseases, \$728,772,000: Provided, That of the amounts made available under this heading, up to \$1,000,000 shall remain available until expended to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under Federal or State quarantine law.*

### *CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION*

*For carrying out titles II, III, XI, XV, XVII, and XIX of the PHS Act with respect to chronic disease prevention and health promotion, \$1,304,464,000: Provided, That funds made available under this heading may be available for making grants under section 1509 of the PHS Act for not less than 21 States, tribes, or tribal organizations: Provided further, That the proportional funding requirements under section 1503(a) of the PHS Act shall not apply to funds made available under this heading.*

### *BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH*

*For carrying out titles II, III, XI, and XVII of the PHS Act with respect to birth defects, developmental disabilities, disabilities and health, \$205,560,000.*

### *PUBLIC HEALTH SCIENTIFIC SERVICES*

*For carrying out titles II, III, and XVII of the PHS Act with respect to health statistics, surveillance, health informatics, and workforce development, \$621,197,000.*

### *ENVIRONMENTAL HEALTH*

*For carrying out titles II, III, and XVII of the PHS Act with respect to environmental health, \$249,850,000: Provided, That of the amounts appropriated under this heading, up to \$4,000,000 may remain available until expended for carrying out the Vessel Sanitation Program, in addition to user fee collections available for such purpose: Provided further, That the Committees on Appropriations of the House of Representatives and the Senate are notified at least 15 days in advance of any use of funds pursuant to the preceding proviso.*

### *INJURY PREVENTION AND CONTROL*

*For carrying out titles II, III, and XVII of the PHS Act with respect to injury prevention and control, \$843,379,000: Provided, That in addition to amounts provided under this heading, \$100,000,000 shall be available for implementation of the Community Violence Intervention initiative from amounts made available under section 241 of the PHS Act.*

### *NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH*

*For carrying out titles II, III, and XVII of the PHS Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act, section 13 of the Mine Improvement and New Emergency Response Act, and sections 20, 21, and 22 of the Occupational Safety and Health Act, with respect to occupational safety and health, \$363,200,000.*

**ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM**

*For necessary expenses to administer the Energy Employees Occupational Illness Compensation Program Act, \$55,358,000, to remain available until expended: Provided, That this amount shall be available consistent with the provision regarding administrative expenses in section 151(b) of title I of division B of Public Law 106-554.*

**GLOBAL HEALTH**

*For carrying out titles II, III, and XVII of the PHS Act with respect to global health, \$692,843,000, of which: (1) \$128,921,000 shall remain available through September 30, 2026 for international HIV/AIDS; and (2) \$293,200,000 shall remain available through September 30, 2027 for global public health protection: Provided, That funds may be used for purchase and insurance of official motor vehicles in foreign countries.*

**PUBLIC HEALTH PREPAREDNESS AND RESPONSE**

*For carrying out titles II, III, and XVII of the PHS Act with respect to public health preparedness and response, and for expenses necessary to support activities related to countering potential biological, nuclear, radiological, and chemical threats to civilian populations, \$943,300,000.*

**BUILDINGS AND FACILITIES**

*For acquisition of real property, equipment, construction, installation, demolition, and renovation of facilities, \$40,000,000, which shall remain available until September 30, 2029: Provided, That funds made available to this account in this or any prior Act that are available for the acquisition of real property or for construction or improvement of facilities shall be available to make improvements on non-federally owned property, provided that any improvements that are not adjacent to federally owned property do not exceed \$2,500,000, and that the primary benefit of such improvements accrues to CDC: Provided further, That funds previously set-aside by CDC for repair and upgrade of the Lake Lynn Experimental Mine and Laboratory shall be used to acquire a replacement mine safety research facility: Provided further, That funds made available to this account in this or any prior Act that are available for the acquisition of real property or for construction or improvement of facilities in conjunction with the new replacement mine safety research facility shall be available to make improvements on non-federally owned property, provided that any improvements that are not adjacent to federally owned property do not exceed \$5,000,000: Provided further, That in addition, the prior year unobligated balance of any amounts assigned to former employees in accounts of CDC made available for Individual Learning Accounts shall be credited to and merged with the amounts made available under this heading to support the replacement of the mine safety research facility.*

**CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT**

*(Including Transfer of Funds)*

*For carrying out titles II, III, XVII and XIX, and section 2821 of the PHS Act, and for cross-cutting activities and program support for activities funded in other appropriations included in this Act for the Centers for Disease Control and Prevention (CDC), \$513,570,000, of which \$350,000,000 shall remain available through September 30, 2026, for public health infrastructure and capacity: Provided, That paragraphs (1) through (3) of subsection (b) of section 2821 of the PHS Act shall not apply to funds appropriated under this heading and in all other accounts of the CDC: Provided further, That of the amounts made available under this heading, \$35,000,000, to remain available until expended, shall be available to the Director of the CDC for deposit in the Infectious Diseases Rapid Response Reserve Fund established by section 231 of division B of Public Law 115-245: Provided further, That funds appropriated under this heading may be used to support a contract for the operation and maintenance of an aircraft in direct support of activities throughout CDC to ensure the agency is prepared to address public health preparedness emergencies: Provided further, That employees of CDC or the Public Health Service, both civilian and commissioned officers, detailed to States, municipalities, or other organizations under authority of section 214 of the PHS Act, or in overseas assignments, shall be treated as non-Federal employees for reporting purposes only and shall not be included within any personnel ceiling applicable to the Agency, Service, or HHS during the period of detail or assignment: Provided further, That CDC may use up to \$10,000 from*

*amounts appropriated to CDC in this Act for official reception and representation expenses when specifically approved by the Director of CDC: Provided further, That in addition, such sums as may be derived from authorized user fees, which shall be credited to the appropriation charged with the cost thereof: Provided further, That with respect to the previous proviso, authorized user fees from the Vessel Sanitation Program and the Respirator Certification Program shall be available through September 30, 2026: Provided further, That any amounts made available by this Act to the CDC may be used to support the salaries and expenses of any CDC employee or fellow responding to an emergency or other urgent public health crisis.*

## APPROPRIATIONS LANGUAGE ANALYSIS

Language Provision	Explanation
<b>IMMUNIZATION AND RESPIRATORY DISEASES</b>	
<i>For carrying out titles II, III, XVII, and XXI, and section 2821 of the PHS Act, and titles II and IV of the Immigration and Nationality Act, with respect to immunization and respiratory diseases, \$499,941,000.</i>	Appropriates funding to support activities related to immunization and respiratory diseases.
<b>HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED DISEASES, AND TUBERCULOSIS PREVENTION</b>	
<i>For carrying out titles II, III, XVII, and XXIII of the PHS Act with respect to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis prevention, \$1,391,056,000.</i>	Appropriates funding to support activities related to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis prevention.
<b>EMERGING AND ZONOTIC INFECTIOUS DISEASES</b>	
<i>For carrying out titles II, III, and XVII, and section 2821 of the PHS Act, and titles II and IV of the Immigration and Nationality Act with respect to emerging and zoonotic infectious diseases, \$728,772,000:.</i>	Appropriates funding for activities related to emerging and infectious diseases.
<i>Provided, That of the amounts made available under this heading, up to \$1,000,000 shall remain available until expended to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under Federal or State quarantine law.</i>	Provides availability of up to \$1,000,000, available until expended, to address state and local expenditures for federal isolation or quarantine orders.
<b>CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION</b>	
<i>For carrying out titles II, III, XI, XV, XVII, and XIX of the PHS Act with respect to chronic disease prevention and health promotion, \$1,304,464,000:</i>	Appropriates funding for activities related to chronic disease prevention and health promotion.
<i>Provided, That funds made available under this heading may be available for making grants under section 1509 of the PHS Act for not less than 21 States, tribes, or tribal organizations:</i>	Provides a permissive override of limits in the authorization on the number of States that can receive funds for a WISEWOMAN program.
<i>Provided further, That the proportional funding requirements under section 1503(a) of the PHS Act shall not apply to funds made available under this heading.</i>	Provides a permissive override of proportional funding requirements for breast and cervical cancer grants.
<b>BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH</b>	
<i>For carrying out titles II, III, XI, and XVII of the PHS Act with respect to birth defects, developmental disabilities, disabilities and health, \$205,560,000.</i>	Appropriates funding for activities related to birth defects, developmental disabilities, and disabilities and health.
<b>PUBLIC HEALTH SCIENTIFIC SERVICES</b>	
<i>For carrying out titles II, III, and XVII of the PHS Act with respect to health statistics, surveillance, health informatics, and workforce development, \$621,197,000.</i>	Appropriates funding for public health scientific services.

Language Provision	Explanation
<b>ENVIRONMENTAL HEALTH</b>	
<i>For carrying out titles II, III, and XVII of the PHS Act with respect to environmental health, \$249,850,000:</i>	Appropriates funding for activities related to environmental health.
<i>Provided, That of the amounts appropriated under this heading, up to \$4,000,000 may remain available until expended for carrying out the Vessel Sanitation Program, in addition to user fee collections available for such purpose:</i>	Specifies funding to support operation of the Vessel Sanitation Program in the case that user fees cannot be collect or are insufficient.
<i>Provided further, That the Committees on Appropriations of the House of Representatives and the Senate are notified at least 15 days in advance of any use of funds pursuant to the preceding proviso.</i>	Use of funds for this purpose require advance congressional notification.
<b>INJURY PREVENTION AND CONTROL</b>	
<i>For carrying out titles II, III, and XVII of the PHS Act with respect to injury prevention and control, \$843,379,000.</i>	Appropriates funding for activities related to injury prevention and control.
<i>Provided, That in addition to amounts provided under this heading, \$100,000,000 shall be available for implementation of the Community Violence Intervention initiative from amounts made available under section 241 of the PHS Act.</i>	Reflects amounts made available from PHS Evaluation funds for the Community Violence Intervention Initiative.
<b>NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH</b>	
<i>For carrying out titles II, III, and XVII of the PHS Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act, section 13 of the Mine Improvement and New Emergency Response Act, and sections 20, 21, and 22 of the Occupational Safety and Health Act, with respect to occupational safety and health, \$363,200,000.</i>	Appropriates funding for activities related to occupational safety and health.
<b>ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM</b>	
<i>For necessary expenses to administer the Energy Employees Occupational Illness Compensation Program Act, \$55,358,000, to remain available until expended:</i>	Appropriates funding for the Energy Employees Occupational Illness Compensation Program Act.
<i>Provided, That this amount shall be available consistent with the provision regarding administrative expenses in section 151(b) of title I of division B of Public Law 106-554.</i>	Continues the requirement that funds appropriated to this program be considered direct spending.
<b>GLOBAL HEALTH</b>	
<i>For carrying out titles II, III, and XVII of the PHS Act with respect to global health, \$692,843,000,</i>	Appropriates funding for activities related to global health.
<i>of which: (1) \$128,921,000 shall remain available through September 30, 2026 for international HIV/AIDS;</i>	Specifies amount of funding available through the end of FY 2026 to support activities related to international HIV/AIDS.

Language Provision	Explanation
<i>and (2) \$293,200,000 shall remain available through September 30, 2027 for global public health protection:</i>	Specifies amount of funding available through the end of FY 2027 to support global public health protection activities.
<i>Provided, That funds may be used for purchase and insurance of official motor vehicles in foreign countries.</i>	Permits the funds appropriated in this account to be used for insuring official motor vehicles in foreign countries.
<b>PUBLIC HEALTH PREPAREDNESS AND RESPONSE</b>	
<i>For carrying out titles II, III, and XVII of the PHS Act with respect to public health preparedness and response, and for expenses necessary to support activities related to countering potential biological, nuclear, radiological, and chemical threats to civilian populations, \$943,300,000.</i>	Appropriates funding to support activities related to public health preparedness and response.
<b>BUILDINGS AND FACILITIES</b>	
<i>For acquisition of real property, equipment, construction, installation, demolition, and renovation of facilities, \$40,000,000, which shall remain available until September 30, 2029:</i>	Appropriates funding to support repair and improvement of buildings and facilities, specifying 5-year availability.
<i>Provided, That funds made available to this account in this or any prior Act that are available for the acquisition of real property or for construction or improvement of facilities shall be available to make improvements on non-federally owned property, provided that any improvements that are not adjacent to federally owned property do not exceed \$2,500,000, and that the primary benefit of such improvements accrues to CDC:</i>	Provides funding, capped at \$2,500,000, for improvements on non-federally owned property when the primary benefit accrues to CDC.
<i>Provided further, That funds previously set-aside by CDC for repair and upgrade of the Lake Lynn Experimental Mine and Laboratory shall be used to acquire a replacement mine safety research facility:</i>	Provides funds previously set-aside for repair and upgrade of the Lake Lynn Experimental Mine and Laboratory to support the replacement of the mine safety research facility.
<i>Provided further, That funds made available to this account in this or any prior Act that are available for the acquisition of real property or for construction or improvement of facilities in conjunction with the new replacement mine safety research facility shall be available to make improvements on non-federally owned property, provided that any improvements that are not adjacent to federally owned property do not exceed \$5,000,000:</i>	Allows limited funding for improvements on non-federal owned property in conjunction with the replacement mine safety research facility.
<i>Provided further, That in addition, the prior year unobligated balance of any amounts assigned to former employees in accounts of CDC made available for Individual Learning Accounts shall be credited to</i>	Allows unobligated amounts from Individual Learning Accounts to be merged with amounts

Language Provision	Explanation
<i>and merged with the amounts made available under this heading to support the replacement of the mine safety research facility.</i>	made available under this heading to support the replacement of the mine safety research facility.
<b>CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT</b>	
<i>For carrying out titles II, III, XVII and XIX, and section 2821 of the PHS Act, and for cross-cutting activities and program support for activities funded in other appropriations included in this Act for the Centers for Disease Control and Prevention (CDC), \$513,570,000,</i>	Appropriates funding to support CDC-wide activities and crosscutting program support.
<i>of which \$350,000,000 shall remain available through September 30, 2026, for public health infrastructure and capacity:</i>	Provides funding for Public Health Infrastructure and Capacity with availability through the end of FY 2026.
<i>Provided, That paragraphs (1) through (3) of subsection (b) of section 2821 of the PHS Act shall not apply to funds appropriated under this heading and in all other accounts of the CDC:</i>	Specifies that selected paragraphs in section 2821 of the PHS Act do not apply to CDC accounts.
<i>Provided further, That of the amounts made available under this heading, \$35,000,000, to remain available until expended, shall be available to the Director of the CDC for deposit in the Infectious Diseases Rapid Response Reserve Fund established by section 231 of division B of Public Law 115-245:</i>	Provides CDC with the authority to transfer funds available under this heading to the Infectious Diseases Rapid Response Reserve Fund.
<i>Provided further, That funds appropriated under this heading may be used to support a contract for the operation and maintenance of an aircraft in direct support of activities throughout CDC to ensure the agency is prepared to address public health preparedness emergencies:</i>	Authority to support a contract for aircraft operations.
<i>Provided further, That employees of CDC or the Public Health Service, both civilian and commissioned officers, detailed to States, municipalities, or other organizations under authority of section 214 of the PHS Act, or in overseas assignments, shall be treated as non-Federal employees for reporting purposes only and shall not be included within any personnel ceiling applicable to the Agency, Service, or HHS during the period of detail or assignment:</i>	CDC and PHS employees detailed to other organizations are to be treated as non-Federal employees for reporting purposes and are not included within any personnel ceiling.
<i>Provided further, That CDC may use up to \$10,000 from amounts appropriated to CDC in this Act for official reception and representation expenses when specifically approved by the Director of CDC:</i>	Specifies \$10,000 of funds appropriated to CDC for official reception and representation expenses approved by the CDC Director.
<i>Provided further, That in addition, such sums as may be derived from authorized user fees, which shall be credited to the appropriation charged with the cost thereof:</i>	Indicates that user fees are credited to the CDC appropriation account.



Language Provision	Explanation
<p><i>Provided further, That with respect to the previous proviso, authorized user fees from the Vessel Sanitation Program and the Respirator Certification Program shall be available through September 30, 2026:</i></p>	<p>Extends the availability of funds through FY 2026.</p>
<p><i>Provided further, That any amounts made available by this Act to the Centers for Disease Control and Prevention may be used to support the salaries and expenses of any CDC employee or fellow responding to an emergency or other urgent public health crisis.</i></p>	<p>Authorizes CDC to use funds appropriated to any CDC program to support staff who are engaged in a response to an emergency or other urgent public health crisis, including deployments to the field through the Emergency Operations Center. This authority would be used instead of authority to detail people to the Emergency Operations Center for a specific period of time. Authority to detail CDC staff to the emergency operations center was previously included in the Preparedness and Response account.</p>

CDC-RELATED GENERAL PROVISIONS	
<p><i>Sec. 210. In order for HHS to carry out international health activities, including HIV/AIDS and other infectious disease, chronic and environmental disease, and other health activities abroad during fiscal year 2025:</i></p> <p><i>(1) The Secretary may exercise authority equivalent to that available to the Secretary of State in section 2(c) of the State Department Basic Authorities Act of 1956. The Secretary shall consult with the Secretary of State and relevant Chief of Mission to ensure that the authority provided in this section is exercised in a manner consistent with section 207 of the Foreign Service Act of 1980 and other applicable statutes administered by the Department of State.</i></p> <p><i>(2) The Secretary is authorized to provide such funds by advance or reimbursement to the Secretary of State as may be necessary to pay the costs of acquisition, lease, alteration, renovation, and management of facilities outside of the United States for the use of HHS. The Department of State shall cooperate fully with the Secretary to ensure that HHS has secure, safe, functional facilities that comply with applicable regulation governing location, setback, and other facilities requirements and serve the purposes established by this Act. The Secretary is authorized, in consultation with the Secretary of State, through grant or cooperative agreement, to</i></p>	<p>Proposed subsection (4) adds authority to acquire, lease, construct, alter, renovate, equip, furnish, or manage facilities outside of the United States to support its overseas programs.</p>

<p><i>make available to public or nonprofit private institutions or agencies in participating foreign countries, funds to acquire, lease, alter, or renovate facilities in those countries as necessary to conduct programs of assistance for international health activities, including activities relating to HIV/AIDS and other infectious diseases, chronic and environmental diseases, and other health activities abroad.</i></p> <p><i>(3) The Secretary is authorized to provide to personnel appointed or assigned by the Secretary to serve abroad, allowances and benefits similar to those provided under chapter 9 of title 1 of the Foreign Service Act of 1980, and 22 U.S.C. 4081 through 4086 and subject to such regulations prescribed by the Secretary. The Secretary is further authorized to provide locality-based comparability payments (stated as a percentage) up to the amount of the locality-based comparability payment (stated as a percentage) that would be payable to such personnel under section 5304 of title 5, United States Code if such personnel's official duty station were in the District of Columbia. Leaves of absence for personnel under this subsection shall be on the same basis as that provided under subchapter 1 of chapter 63 of title 5, United States Code, or section 903 of the Foreign Service Act of 1980, to individuals serving in the Foreign Service.</i></p> <p><i>(4) The Secretary may acquire, lease, construct, alter, renovate, equip, furnish, or manage facilities outside of the United States, as necessary to conduct such programs, in consultation with the Secretary of State, either directly for the use of the United States Government or for the use, pursuant to grants, direct assistance, or cooperative agreements, of public or nonprofit private institutions or agencies in participating foreign countries.</i></p>	
<p><i>Sec. 220. Funds appropriated in this Act that are available for salaries and expenses of employees of the Department of Health and Human Services shall also be available to pay travel and related expenses of such an employee or of a member of his or her family, when such employee is assigned to duty, in the United States or in a U.S. territory, during a period and in a location that are the subject of a</i></p>	<p>This provision allows CDC to Medevac its employees or their family members for medical care under certain circumstances, if needed.</p> <p>This provision may also be relevant to other HHS OpDivs.</p>

<p><i>determination of a public health emergency under section 319 of the Public Health Service Act and such travel is necessary to obtain medical care for an illness, injury, or medical condition that cannot be adequately addressed in that location at that time. For the purposes of this section, the term “U.S. territory” means Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, or the Trust Territory of the Pacific Islands.</i></p>	
<p><i>SEC. 225. Funds appropriated in this Act that are available for salaries and expenses of employees of the Centers for Disease Control and Prevention shall also be available for the primary and secondary schooling of eligible dependents of personnel stationed in a U.S. territory as defined in section 229 of this Act at costs not in excess of those paid for or reimbursed by the Department of Defense.</i></p>	<p>This language allows CDC to reimburse private schools for tuition costs for dependents of CDC employees.</p> <p>Historically, CDC’s Dengue Branch has had an Interagency Agreement with Department of Defense to send dependents to the base school. This is costly and does not provide bilingual instruction at the level needed for families that plan to stay in Puerto Rico long-term. This authority now allows CDC to provide that benefit to employees and saves money when compared to DOD schools.</p>
<p><i>SEC. 231 (a) PREMIUM PAY AUTHORITY.— If services performed by a Department employee during a public health emergency declared under section 319 of the Public Health Service Act are determined by the Secretary of Health and Human Services to be primarily related to preparation for, prevention of, or response to such a public health emergency, any premium pay that is provided for such services shall be exempted from the aggregate of basic pay and premium pay calculated under section 5547(a) of title 5, United States Code, and any other provision of law limiting the aggregate amount of premium pay payable on a biweekly or calendar year basis.</i></p> <p><i>(b) OVERTIME AUTHORITY.—Any overtime that is provided for such services described in subsection (a) shall be exempted from any annual limit on the amount of overtime payable in a calendar or fiscal year.</i></p> <p><i>(c) APPLICABILITY OF AGGREGATE LIMITATION ON PAY.—In determining, for purposes of section 5307 of title 5, United States Code, whether an employee’s total pay exceeds the annual rate payable under such</i></p>	<p>This General Provision would provide certain administrative flexibilities, to be available during a public health emergency declared under section 319 of the PHS Act. Specifically:</p> <ul style="list-style-type: none"> <li>• Overtime Pay Cap Waiver: Authority to allow senior response leadership, including the incident management staff, and subject matter experts to accrue overtime during a public health response that will be disregarded in applying the statutory pay cap on aggregate of basic pay and premium pay.</li> <li>• Danger Pay for Service in Public Health Emergencies: Authority to allow HHS to provide danger pay to any employee who is serving in an area deemed to threaten physical harm or imminent danger to the health and well-being of the employee</li> </ul>

<p><i>section, the Secretary of Health and Human Services shall not include pay exempted under this section.</i></p> <p><i>(d) LIMITATION OF PAY AUTHORITY.—Pay exempted from otherwise applicable limits under subsection (a) shall not cause the aggregate pay earned for the calendar year in which the exempted pay is earned to exceed the rate of basic pay payable for a position at level II of the Executive Schedule.</i></p> <p><i>(e) DANGER PAY FOR SERVICE IN PUBLIC HEALTH EMERGENCIES — The Secretary of Health and Human Services may grant a danger pay allowance under section 5928 of title 5 of the United States Code, without regard to the limitations in the first sentence of such section, for work that is performed [in a foreign area] by a Department employee during a public health emergency declared under section 319 of the Public Health Service Act and that the Secretary determines is primarily related to preparation for, prevention of, or response to such a public health emergency and is performed under conditions that threaten physical harm or imminent danger to the health or well-being of the employee.</i></p> <p><i>(f) EFFECTIVE DATE.— Sections “a” through “d” shall take effect as if enacted on September 30, 2021; section “e” shall take effect as if enacted on September 30, 2022.</i></p>	
<p><i>SEC. 232.</i></p> <p><i>Section 317G of the Public Health Service Act (42 U.S.C. 247b-8) is amended by adding at the end the following: "The Secretary may, no later than 120 days after the end of an individual's participation in such a fellowship or training program, and without regard to those provisions of title 5, United State Code, governing appointments in the competitive service, appoint a participant in such a fellowship or training program to a term or permanent position in the Centers for Disease Control and Prevention."</i></p>	<p>This General Provision would authorize the conversion of CDC fellows in training programs to term or permanent positions in the competitive service—enabling CDC to retain trained, talented fellows when needed to fill workforce gaps.</p>
<p><i>Sec. 227.</i></p> <p><i>Funds made available to the Centers for Disease Control and Prevention in this or any other Act, or any prior Act, that are available for construction or renovation of facilities for the Centers for Disease Control and Prevention shall be available for such</i></p>	<p>This General Provision would allow CDC to make significant renovations on property it leases for its labs in Fort Collins, Colorado.</p>

<p><i>purposes on property leased by the United States Government in Fort Collins, Colorado.</i></p>	
<p><i>Sec 239.</i></p> <p><i>Funds made available to the Secretary of Health and Human Services in this or any other Act or prior Acts that are available for acquisition of real property or for construction or improvement of facilities may be used to make improvements on property owned or leased by the Federal Government and property located directly adjacent to or within one mile from such property, provided that the primary benefit of such improvements accrues to the Department or the component thereof funding such improvements.</i></p>	<p>This General Provision would allow HHS to make improvements on property owned or leased by the Federal Government, including property located directly adjacent to (or within one mile) of the property.</p>

Note.—A full-year 2024 appropriation for this account was not enacted at the time the Budget was prepared; therefore, the Budget assumes this account is operating under the Continuing Appropriations Act, 2024 and Other Extensions Act (Division A of Public Law 118-15, as amended). The amounts included for 2024 reflect the annualized level provided by the continuing resolution.

## AMOUNTS AVAILABLE FOR OBLIGATION<sup>1</sup>

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
<b>Discretionary Appropriation:</b>			
Enacted	\$8,258,932,000	\$8,258,932,000	\$8,397,132,000
Permissive Transfer	\$0	\$0	\$0
Reprogramming	\$0	\$0	\$0
ATB Rescission	N/A	N/A	N/A
<b>Subtotal, adjusted Appropriation</b>	<b>\$8,258,932,000</b>	<b>\$8,258,932,000</b>	<b>\$8,397,132,000</b>
<b>Mandatory and Other Appropriations:</b>			
Transfers from Other Accounts <sup>2</sup>	\$903,300,000	\$903,300,000	\$1,186,200,000
Receipts from User Fees	\$2,226,000	\$2,226,000	\$2,226,000
Receipts from CRADA <sup>3</sup>	\$169,705	\$169,705	\$169,705
Receipts from Royalties <sup>3</sup>	\$8,989,463	\$8,989,463	\$8,989,463
Appropriation (EEOICPA, post-sequester)	\$50,763,000	\$50,763,000	\$50,763,000
<b>Subtotal, adjusted Mandatory and Other Appropriations</b>	<b>\$965,448,168</b>	<b>\$965,448,168</b>	<b>\$1,248,348,168</b>
Recovery of prior year Obligations	\$28,704,179	\$0	\$0
Unobligated balance start of year	\$863,617,969	\$2,068,015,636	\$2,308,346,175
Unobligated balance expiring	\$16,702,969	\$0	\$0
Unobligated balance end of year	(\$2,068,015,636)	(\$2,308,346,175)	(\$2,443,553,148)
<b>Total Obligations</b>	<b>\$8,065,389,649</b>	<b>\$8,984,049,630</b>	<b>\$9,510,273,195</b>

<sup>1</sup> Excludes Vaccines for Children, World Trade Center Health Program, and Supplemental Funding. Excludes \$21.9 million appropriated to PHSSEF, for CDC to implement HHS Protect.

<sup>2</sup> Reflects Prevention and Public Health Fund.

<sup>3</sup> FY 2023 amount represents actual receipts. FY 2024 and FY 2025 amounts are estimates assuming level receipts. Actual FY 2024 and FY 2025 amounts may vary.

## CDC SUMMARY OF CHANGES

	Dollars	FTEs <sup>1</sup>
<b>FY 2023 Final (Discretionary Program Level, includes PPHF)<sup>2</sup></b>	\$9,184,132	12,706
<b>FY 2025 President's Budget (Discretionary Program Level, includes PPHF)</b>	\$9,683,332	13,238
<b>Net Change</b>	<b>\$499,200</b>	<b>532</b>

(dollars in thousands)	FY 2023 Final		FY 2025 President's Budget		FY 2025 +/- FY 2023	
	BA	FTE	BA	FTE	BA	FTE
<b>Increases:</b>						
<b>Immunization and Respiratory Diseases</b>		1,009		1,100		91
Immunization and Other Respiratory Diseases	\$681,933	---	\$731,933	---	\$50,000	---
<b>Emerging and Zoonotic Infectious Diseases</b>		1,638		1,663		25
Antimicrobial Resistance Initiative	\$197,000	---	\$207,000	---	\$10,000	---
Emerging Infectious Diseases <sup>3</sup>	\$213,997	---	\$233,997	---	\$20,000	---
<b>Chronic Disease Prevention and Health Promotion</b>		876		949		73
Tobacco	\$246,500	---	\$256,500	---	\$10,000	---
School Health	\$19,400	---	\$38,400	---	\$19,000	---
Cancer Prevention and Control	\$409,549	---	\$499,549	---	\$90,000	---
Safe Motherhood/Infant Health	\$108,000	---	\$118,000	---	\$10,000	---
<b>Environmental Health</b>		483		517		34
Environmental Health Activities	\$52,600	---	\$62,600	---	\$10,000	---
Childhood Lead Poisoning Prevention	\$51,000	---	\$61,000	---	\$10,000	---
<b>Injury Prevention and Control</b>		549		712		164
Intentional Injury	\$164,550	---	\$323,550	---	\$159,000	---
Opioid Overdose Prevention and Surveillance	\$505,579	---	\$506,079	---	\$500	---
Firearm Injury and Mortality Prevention Research	\$12,500	---	\$35,000	---	\$22,500	---
<b>Public Health Scientific Services</b>		1,601		1,570		-31
Public Health Data Modernization	\$175,000	---	\$224,600	---	\$49,600	---
<b>Occupational Safety and Health</b>		1,047		1,065		18
National Occupational Research Agenda (NORA)	\$119,500	---	\$119,900	---	\$400	---
<b>Public Health Preparedness and Response</b>		493		498		5
Domestic Preparedness <sup>1</sup>	\$905,100	---	\$943,300	---	\$38,200	---
<b>Total Increases</b>	<b>\$3,851,208</b>	<b>12,706</b>	<b>\$4,350,408</b>	<b>13,238</b>	<b>\$499,200</b>	<b>532</b>
<b>Decreases:</b>						
<b>All Other Decreases</b>	\$0	---	\$0	---	\$0	---
<b>Total Decreases</b>	<b>\$0</b>	<b>---</b>	<b>\$0</b>	<b>---</b>	<b>\$0</b>	<b>---</b>
<b>Transfers</b>						
	\$0	---	\$0	---	\$0	---
<b>Built-In:</b>						
1. Annualization of 2024 Pay Raise	\$0	---	\$0	---	\$0	---
2. FY 2025 Pay Increases	\$0	---	\$0	---	\$0	---
3. Changes in Day of Pay	\$0	---	\$0	---	\$0	---
4. Rental Payments to GSA and Others	\$0	---	\$0	---	\$0	---
<b>Total Built-In</b>	<b>\$0</b>	<b>---</b>	<b>\$0</b>	<b>---</b>	<b>\$0</b>	<b>---</b>
<b>Total Increases (Program Level)</b>	<b>\$3,851,208</b>	<b>12,706</b>	<b>\$4,350,408</b>	<b>13,238</b>	<b>\$499,200</b>	<b>532</b>
<b>Total Decreases (Program Level)</b>	<b>\$0</b>	<b>---</b>	<b>\$0</b>	<b>---</b>	<b>\$0</b>	<b>---</b>
<b>NET CHANGE - L/HHS/ED Program Level</b>	<b>\$9,184,132</b>	<b>12,706</b>	<b>\$9,683,332</b>	<b>13,238</b>	<b>\$499,200</b>	<b>532</b>

<b>Other Program Level Changes</b>						
1. Vaccines for Children <sup>4</sup>	\$5,216,952	---	\$8,039,718	---	\$2,822,766	---
2. World Trade Center <sup>5</sup>	\$709,848	---	\$788,110	---	\$78,262	---
3. Energy Employees Occupational Illness Compensation Act (EEOICPA)	\$50,763	---	\$50,763	---	\$0	---
4. User Fees	\$2,226	---	\$2,226	---	\$0	---
5. Vaccines for Adults (Proposed Law)	N/A	---	\$1,004,000	---	\$1,004,000	---
6. Community Violence Intervention (CVI)	N/A	---	\$150,000	---	\$150,000	---
<b>Total - Other Program Level Net Increase</b>	<b>\$5,979,789</b>	<b>---</b>	<b>\$10,034,817</b>	<b>---</b>	<b>\$4,055,028</b>	<b>---</b>
<b>NET CHANGE: CDC BUDGET AUTHORITY &amp; PROGRAM LEVEL</b>	<b>\$15,163,921</b>	<b>---</b>	<b>\$19,718,149</b>	<b>---</b>	<b>\$4,554,228</b>	<b>---</b>
<b>Strengthening Biodefense - Mandatory via PHSSEF (non-add)<sup>6</sup></b>	<b>N/A</b>	<b>---</b>	<b>\$6,100,000</b>	<b>---</b>	<b>\$6,100,000</b>	<b>---</b>

<sup>1</sup> FTE Levels by Fiscal Year reflect totals by Account and not individual PPA.

<sup>2</sup> FY 2023 Final Level is comparably adjusted to reflect \$21.9 million within CDC's total for HHS Protect. The FY 2023 Joint Explanatory Statement provided \$21.9 million from the Public Health and Social Services Emergency Fund (PHSSEF) for HHS Protect, to support activities implemented by CDC. The FY 2025 Budget proposes directly appropriating funding to CDC for HHS Protect/Response Ready Enterprise Data Integration platform (RREDI).

<sup>3</sup> FY 2023 Level is comparably adjusted to reflect the proposed budget structure realignment of Harmful Algal Blooms and Prion Disease as sub-activities under Emerging Infectious Diseases.

<sup>4</sup> FY 2023 Level reflects actual spending under current law. The VFC proposed law total for FY25 does not include changes to Medicaid provider administration fees, and does not include estimated costs associated with establishing, implementing and overseeing an administration fee reimbursement mechanism.

<sup>5</sup> Reflects Federal share estimated obligations only; NYC share estimated obligations are not included. FY 2023 Final Level excludes supplemental funding of \$1 billion in the FY 2023 Appropriations Act (P.L. 117-328).

<sup>6</sup> The FY 2025 PB provides \$20 billion in mandatory funding across HHS to strengthen biodefense, which is reflected in the Public Health and Social Services Emergency Fund chapter. Of this total, CDC will receive \$6.1 billion.



## BUDGET AUTHORITY BY ACTIVITY

(dollars in thousands)

Budget Activity/Description	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Immunization and Respiratory Diseases	\$499,941	\$499,941	\$499,941
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	\$1,391,056	\$1,391,056	\$1,391,056
Emerging and Zoonotic Infectious Diseases	\$698,772	\$698,772	\$728,772
Chronic Disease Prevention and Health Promotion	\$1,175,464	\$1,175,464	\$1,304,464
Birth Defects, Developmental Disabilities, Disability and Health	\$205,560	\$205,560	\$205,560
Environmental Health	\$229,850	\$229,850	\$249,850
Injury Prevention and Control	\$761,379	\$761,379	\$843,379
Public Health Scientific Services	\$754,497	\$754,497	\$621,197
Occupational Safety and Health	\$362,800	\$362,800	\$363,200
Global Health	\$692,843	\$692,843	\$692,843
Public Health Preparedness and Response <sup>1</sup>	\$905,100	\$905,100	\$943,300
Cross-Cutting Activities and Program Support	\$563,570	\$563,570	\$513,570
Buildings and Facilities	\$40,000	\$40,000	\$40,000
<b>Total CDC, Budget Authority -</b>	<b>\$8,280,832</b>	<b>\$8,280,832</b>	<b>\$8,397,132</b>
<b>Total CDC, FTEs</b>	<b>12,706</b>	<b>13,040</b>	<b>13,238</b>

<sup>1</sup> FY 2023 Final and FY 2024 CR level are comparably adjusted to reflect \$21.9 million within CDC's total for HHS Protect. The FY 2023 Joint Explanatory Statement provides \$21.9 million from the Public Health and Social Services Emergency Fund (PHSSEF) for HHS Protect, to support activities implemented by CDC. The FY 2025 Budget level proposes directly appropriating funding to CDC for HHS Protect/Response Ready Enterprise Data Integration platform (RREDI).

## AUTHORIZING LEGISLATION

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
<b>Immunization and Respiratory Diseases</b>					
PHSA § 301	Permanent	Direct Federal/	\$919,291	\$919,291	\$969,291
PHSA § 307,	Indefinite	Intramural;			
PHSA § 310		Competitive			
PHSA § 311		Cooperative			
PHSA § 313		Agreements/			
PHSA § 317		Grants,			
PHSA § 317N		including			
PHSA § 317S		Formula			
PHSA § 319		Grants;			
PHSA § 319C-1		Contracts; and			
PHSA § 319E*		Other			
PHSA § 319F					
PHSA § 322					
PHSA § 325					
PHSA § 327					
PHSA § 340C					
PHSA § 352					
PHSA § 2102					
PHSA § 2125					
PHSA § 2126					
PHSA § 2127					
PHSA § 2821					
Social Security Act § 1928 (42 U.S.C. 1396s)					
<b>HIV/AIDS, Viral Hepatitis, STD, and TB Prevention</b>					
PHSA § 301	Permanent	Direct Federal/	\$1,391,056	\$1,391,056	\$1,391,056
PHSA § 306*	Indefinite	Intramural,			
PHSA § 307		Competitive			
PHSA § 308		Grants/			
PHSA § 310		Cooperative			
PHSA § 311		Agreements,			
PHSA § 317*		Formula			
PHSA § 317E*		Grants/			
PHSA § 317N*		Cooperative			
PHSA § 317P*		Agreements,			
PHSA § 318*		Contracts, and			
PHSA § 318A*		Other			
PHSA § 318B*					
PHSA § 322					
PHSA § 325					
PHSA § 327					
PHSA § 352					
PHSA § 2315					
PHSA § 2320					
PHSA § 2341					
PHSA §§ 2521*2522*					
Departments of Labor, Health and Human Services, and Education, and					

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Related Agencies Appropriations Act, 1995 (P. L. 103-333, Title II)					
<b>Emerging and Zoonotic Infectious Diseases</b>					
PHSA § 264	Permanent	Direct Federal/	\$750,772	\$750,772	\$780,772
PHSA § 301	Indefinite	Intramural, Contracts, and Competitive Grants/Cooperative Agreements			
PHSA § 304					
PHSA § 307					
PHSA § 308(d)					
PHSA § 310					
PHSA § 311					
PHSA § 317*					
PHSA § 317P*					
PHSA § 317R*					
PHSA § 317S					
PHSA § 317T*					
PHSA § 317U*					
PHSA § 319					
PHSA § 319D					
PHSA § 319E*					
PHSA § 319F					
PHSA § 319G*					
PHSA § 321					
PHSA § 322					
PHSA § 325					
PHSA § 327					
PHSA § 352					
PHSA § 353					
PHSA § 361-369					
PHSA § 399V-5					
PHSA § 1102					
PHSA § 2821					
PHSA § 2822					
Bayh-Dole Act of 1980 (P. L. 96-517)					
Immigration and Nationality Act, Titles II & IV (8 USC §§ 1182, 1222, 1252, 1522*)					
Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics (PREVENT) Act (P.L. 117-328, Title II)					
The American Rescue Plan Act § 2404					
<b>Chronic Disease Prevention and Health Promotion</b>					
PHSA § 301	Permanent	Direct Federal	\$1,430,414	\$1,430,414	\$1,559,414
PHSA § 307	Indefinite	Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; and Competitive Contracts			
PHSA § 310					
PHSA § 311					
PHSA § 317*					
PHSA § 317D*					
PHSA § 317H*					
PHSA § 317K					
PHSA § 317L					
PHSA § 317M*					
PHSA § 317P*					

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
PHSA § 330E*					
PHSA § 398A					
PHSA § 399B-F*					
PHSA § 399Q*					
PHSA § 399R					
PHSA § 399V-3*					
PHSA § 399W-Z*					
PHSA § 399LL – LL-2					
PHSA § 399NN					
PHSA § 417E					
PHSA § 1501 et seq*					
PHSA § 1706*					
Comprehensive Smoking Education Act of 1984					
Comprehensive Smokeless Tobacco Health Education Act of 1986					
Federal Cigarette Labeling and Advertising Act					
Fertility Clinic Success Rate and Certification Act of 1992 (P. L. 102-493)					
<b>Birth Defects, Developmental Disabilities, Disability and Health</b>					
PHSA § 301	Permanent	Direct Federal/	\$205,560	\$205,060	\$205,560
PHSA § 304	Indefinite	Intramural, Competitive Grants, Cooperative Agreements and Contracts			
PHSA § 307					
PHSA § 308(d)					
PHSA § 310					
PHSA § 311					
PHSA § 317*					
PHSA § 317C*					
PHSA § 317J*					
PHSA § 317K					
PHSA § 317L					
PHSA § 317Q					
PHSA § 327					
PHSA § 352					
PHSA § 399M					
PHSA § 399Q*					
PHSA § 399S					
PHSA § 399S-1*					
PHSA § 399T					
PHSA § 399V-2					
PHSA § 399AA					
PHSA § 399BB					
PHSA § 399CC					
PHSA § 1102					
PHSA § 1106					
PHSA § 1107					
PHSA § 1108*					
PHSA § 1110					
PHSA § 1113					
PHSA § 1114					
PHSA § 1115					

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
PHSA § 1132* PHSA § 1706* The Prematurity Research Expansion And Education For Mothers Who Deliver Infants Early Act § 2* (42 U.S.C. 247b-4f*)					
<b>Environmental Health</b>					
PHSA § 301	Permanent	Direct Federal/	\$246,850	\$246,850	\$266,850
PHSA § 307	Indefinite	Intramural,			
PHSA § 310		Contracts,			
PHSA § 311		Competitive			
PHSA § 317*		Grants/			
PHSA § 317A*		Cooperative			
PHSA § 317B		Agreements			
PHSA § 317I*					
PHSA § 317O*					
PHSA § 327					
PHSA § 352					
PHSA § 361					
PHSA § 366					
PHSA § 399V-6					
PHSA § 1102					
PHSA § 1706*					
<b>Injury Prevention and Control</b>					
PHSA § 203*	Permanent	Direct Federal/	\$761,379	\$761,379	\$943,379
PHSA § 214	Indefinite	Intramural;			
PHSA § 301		Competitive			
PHSA § 304		Cooperative			
PHSA § 307		Agreements/			
PHSA § 308		Grants,			
PHSA § 310		including			
PHSA § 311		Formula			
PHSA § 317*		Grants; and			
PHSA § 317N		Competitive			
PHSA § 319		Contracts			
PHSA § 319D					
PHSA § 327					
PHSA § 352					
PHSA § 391*					
PHSA § 392*					
PHSA § 392A					
PHSA § 393*					
PHSA § 393A					
PHSA § 393B					
PHSA § 393C					
PHSA § 393D*					
PHSA § 393A					
PHSA § 393B					
PHSA § 393C					
PHSA § 393D					
PHSA § 394*					
PHSA § 399*					
PHSA § 3939					

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
PHSA § 399O PHSA § 399P* PHSA § 1102 PHSA § 1706* Bayh-Dole Act of 1980 (P. L. 96-517) Family Violence Prevention and Services Act §§ 314* Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act §§ 7011, 7131 (P. L. 115-271) Comprehensive Addiction and Recovery Act of 2016 § 102 (P. L. 115-271) Violence Against Women and Department of Justice Reauthorization Act of 2022 § 301 (P. L. 117-103)					
<b>Public Health Scientific Services</b>					
PHSA § 241	Permanent	Direct Federal/	\$754,497	\$754,497	\$804,097
PHSA § 301	Indefinite	Intramural,			
PHSA § 304		Competitive			
PHSA § 306*		Grants/			
PHSA § 307		Cooperative			
PHSA § 308		Agreements,			
PHSA § 310		Contracts			
PHSA § 317*					
PHSA § 317F					
PHSA § 317G					
PHSA § 318*					
PHSA § 319					
PHSA § 319A					
PHSA § 319D					
PHSA § 353					
PHSA § 391*					
PHSA § 399S-1*					
PHSA § 399V*					
PHSA § 768					
PHSA § 778*					
PHSA § 1102					
PHSA § 2315					
PHSA § 2341					
Coronavirus Aid, Relief, and Economic Security Act § 18115					
E-Government Act of 2002 (P. L. 107-347)					
Food, Conservation, and Energy Act of 2008 § 4403 (7 U.S.C. 5311a)					
Intelligence Reform and Terrorism Prevention Act of 2004 § 7211*					
National Nutrition Monitoring and Related Research Act of 1990 § 5341 (P. L. 101-445)					
Title V (44 U.S.C. 3501 note)					

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
<b>Occupational Safety and Health</b>					
PHSA § 301 PHSA § 304 PHSA § 306* PHSA § 307 PHSA § 308(d) PHSA § 310 PHSA § 311 PHSA § 317 PHSA § 317A* PHSA § 317B PHSA § 319 PHSA § 327 PHSA § 352 PHSA §§ 399MM – 399MM-3 PHSA § 399V-6 PHSA § 1102 PHSA § 2695 Bureau of Mine Act (as amended by P.L. 104-208) Energy Employees Occupational Illness Compensation Program Act of 2000 Federal Mine Safety and Health Act of 1977 (P.L. 91-173, as amended by P.L. 95-164 and P.L. 109-236) Mine Improvement and New Emergency Response Act § 13 Firefighter Cancer Registry Act of 2018 (P.L. 115-194)* Never Forget the Heroes: James Zadroga, Ray Pfeifer, and Luis Alvarez Permanent Authorization of the September 11th Victim Compensation Fund Act (P.L. 116-34) Occupational Safety and Health Act of 1970 §§ 20–22 (P.L. 91-596, as amended by P.L. 107-188 and P.L. 109-236, 29 U.S.C. 669–671) Radiation Exposure Compensation Act, §§ 6 and 12 Toxic Substances Control Act (P.L. 94-469, as amended by P.L. 102-550)* P.L. 118-31, National Defense Authorization Act for FY 2024 §§ 1851-1853	Permanent Indefinite	Direct Federal/ Intramural, Competitive Grant/ Cooperative Agreements, Contracts, Other	\$362,800	\$362,800	\$363,200
<b>Global Health</b>					
PHSA § 214 PHSA § 301 PHSA § 304 PHSA § 307 PHSA § 310 PHSA § 317T*	Permanent Indefinite	Direct Federal/ Intramural, Competitive Grants/ Cooperative Agreements,	\$692,843	\$692,843	\$692,843

(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
PHSA § 319		Direct			
PHSA § 322		Contracts,			
PHSA § 327		Interagency			
PHSA § 340C		Agreements			
PHSA § 361-369					
PHSA § 2315					
PHSA § 2341					
Foreign Assistance Act of 1961 §§ 104A* & 104C* and 627 & 629					
Federal Employees International Organization Service Act § 3					
Foreign Employees Compensation Program					
Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria (P.L. 110-293, as amended by P.L. 115-305)					
PEPFAR Stewardship & Oversight Act of 2013 (Pub. L. 113-56)					
<b>Public Health Preparedness and Response</b>					
PHSA § 301	Permanent	Direct, Federal	\$905,100	\$905,100	\$943,300
PHSA § 307	Indefinite	Intramural,			
PHSA § 310		Cooperative			
PHSA § 311		Agreements,			
PHSA § 319		including			
PHSA § 319C-1		Formula			
PHSA § 319D		Grants/			
PHSA § 319F		Cooperative			
PHSA § 319F-2*		Agreements;			
PHSA § 319G*		and Contracts			
PHSA § 351A*					
PHSA § 361					
PHSA § 2801					
PHSA § 2812					
<b>CDC-Wide Activities and Program Support</b>					
PHSA § 241	Permanent	Direct Federal/	\$723,570	\$723,570	\$723,570
PHSA § 301	Indefinite	Intramural,			
PHSA § 304		Contracts,			
PHSA § 306*		Competitive			
PHSA § 307		Grants/			
PHSA § 308		Cooperative			
PHSA § 310		Agreements			
PHSA § 310A*					
PHSA § 311					
PHSA § 317					
PHSA § 317F					
PHSA § 317G					
PHSA § 318					
PHSA § 319					
PHSA § 319A					
PHSA § 319D					
PHSA § 322					



(dollars in thousands)

Enabling Legislation Citation <sup>1</sup>	Enabling Legislation Status	Allocation Methods	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
PHSA § 325					
PHSA § 327					
PHSA § 353					
PHSA § 361-369					
PHSA § 391*					
PHSA § 399S-1*					
PHSA § 399G					
PHSA § 399V*					
PHSA § 399U					
PHSA § 768					
PHSA § 778					
PHSA § 1102					
PHSA § 1901 – 1909					
PHSA § 2315					
PHSA § 2341					
PHSA Title XIX, part APHSA § 2821					
PHSA § 2825					
Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019 (P.L. 115-245, Division B)					
The American Rescue Plan Act § 2404 Prepare for and Respond to Existing Viruses, Emerging New Threats Pandemics (PREVENT) Act (P.L. 117-328, Title II)					
Coronavirus Aid, Relief, and Economic Security Act § 18115					
E-Government Act of 2002 (P. L. 107-347)					
Food, Conservation, and Energy Act of 2008 § 4403 (7 U.S.C. 5311a)					
Intelligence Reform and Terrorism Prevention Act of 2004 § 7211*					
National Nutrition Monitoring and Related Research Act of 1990 § 5341 (P. L. 101-445), Title V (44 U.S.C. 3501 note)					

<sup>1</sup> Expired/Expiring noted with \*

## APPROPRIATIONS HISTORY TABLE<sup>1,2</sup>

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2014 Budget Authority	5,216,509,000	--	5,757,052,000	5,792,542,000
2014 Public Health Prevention Fund	755,110,000	--	839,000,000	831,300,000
2015 Budget Authority	5,399,706,000	--	5,999,348,000	5,968,118,000
2015 Public Health Prevention Fund	809,510,000	--	887,300,000	886,300,000
2015 CR Ebola Funding (PL 113-164)	--	--	--	30,000,000
2015 Ebola Response and Preparedness <sup>3</sup>	--	--	--	1,771,000,000
2016 Budget Authority	6,095,803,000	6,095,803,000	5,747,306,000	6,270,745,000
2016 Public Health Prevention Fund	914,300,000	914,300,000	892,950,000	892,300,000
2017 Budget Authority <sup>4</sup>	5,967,376,000	6,875,144,000	6,153,448,000	6,293,503,000
2017 Public Health Prevention Fund	944,470,000	908,300,000	891,300,000	891,300,000
2018 Budget Authority	4,991,675,000	6,010,153,000	6,318,953,000	--
2018 Public Health Prevention Fund	840,600,000	840,600,000	800,900,000	--
2018 Disaster Relief Supplement (PL 115-123)	--	--	--	200,000,000
2019 Budget Authority	5,524,935,000	6,781,908,000	7,004,483,000	6,477,883,000
2019 Public Health Prevention Fund	--	848,000,000	808,300,000	804,500,000
2019 Disaster Relief Supplement (PL 116-20)	--	--	--	20,000,000
2020 Budget Authority	5,214,882,000	7,177,725,000	6,608,665,000	6,839,946,000
2020 Public Health Prevention Fund	891,100,000	854,250,000	854,250,000	854,250,000
2021 Budget Authority	5,565,318,000	7,100,396,000	6,908,446,000	6,963,296,000
2021 Public Health Prevention Fund	893,950,000	856,150,000	856,150,000	856,150,000
2022 Budget Authority	8,454,861,000	9,625,761,000	8,636,611,000	7,498,546,000
2022 Public Health Prevention Fund	903,300,000	903,300,000	903,300,000	903,300,000
2023 Budget Authority	9,620,961,000	9,540,696,000	9,542,171,000	8,258,932,000
2023 Public Health Prevention Fund	903,300,000	903,300,000	903,300,000	903,300,000
2023 Disaster Relief Supplement (PL 117-328)	--	--	--	86,000,000
2024 Budget Authority	\$10,217,311,000	\$6,350,008,000	\$7,711,702,000	--
2024 Public Health Prevention Fund	1,186,200,000	1,186,200,000	1,186,200,000	--
2025 Budget Authority	\$8,397,132,000	--	--	--
2025 Public Health Prevention Fund	1,186,200,000	--	--	--

<sup>1</sup> Does not include funding for ATSDR.

<sup>2</sup> The Prevention and Public Health Fund (PPHF) amounts reflect CDC's request and final amount allotted from the PPHF to CDC from HHS.

<sup>3</sup> Ebola Response and Preparedness is one-time emergency funding appropriated in FY 2015 for the U.S. Government response to contain, treat, and prevent the spread of Ebola.

<sup>4</sup> FY 2017 Enacted includes funding for Flint, Michigan response, which includes \$15 million for Lead Poisoning Prevention and \$20 million for a Lead Exposure Registry and Advisory Council.

## APPROPRIATIONS NOT AUTHORIZED BY LAW

(dollars in millions)				
Program*	Last Year of Authorization	Authorization Level**	Appropriations in Last Year of Authorization	Appropriations at FY 2024 CR Level
Sexually Transmitted Infections (STIs) (PHSA 318A)	FY 1998	Such Sums...	\$112.117	\$174.310
National Center for Health Statistics (PHSA 306)	FY 2003	Such Sums...	\$125.899	\$187.397
WISEWOMAN (PHSA 1509)	FY 2003	Such Sums...	\$12.419	\$34.620
National Cancer Registries (PHSA 399B-399F)	FY 2003	Such Sums...	N/A	\$53.440
Asthma Surveillance & Grants (PHSA 317I)	FY 2005	Such Sums...	\$32.422	\$33.500
Folic Acid (PHSA 317J)	FY 2005	Such Sums...	\$2.188	\$3.150
Oral Health Promotion (PHSA 317M)	FY 2005	Such Sums...	\$11.204	\$20.250
Childhood Lead Poisoning Prevention (PHSA 317A)	FY 2005	\$40.000	\$36.474	\$34.000
Birth Defects, Developmental Disability, Disability and Health (PHSA 317C)	FY 2007	Such Sums...	\$122.242	\$205.560
Breast and Cervical Cancer (PHSA 1501 et seq.)	FY 2012	\$275.000	\$204.779	\$235.500
CDC Public Health Workforce and Career Development (PHSA 778)	FY 2013	\$39.500	\$41.500	\$71.000
National Diabetes Prevention Program (PHSA 399V-3)	FY 2014	Such Sums...	\$10.000	\$37.300
Johanna's Law (PHSA 317P(d))	FY 2014	\$18.000	\$5.131	\$11.500
Section 317 Immunization (PHSA 317(I))	FY 2014	Such sums...	\$610.847	\$681.933
Center for Research and Demonstration of Health Promotion and Disease Prevention (PHSA 1706)	FY 2003	Such Sums...	\$26.830	\$28.961
Preventive Health Measures with regard to Prostate Cancer (PHSA 317D)	FY 2004	Such Sums...	\$14.091	\$15.205
Tourette Syndrome (PHSA 1108)	FY 2005	Such sums...	\$1.811	\$2.500
Epilepsy; seizure disorder (PHSA 330E)	FY 2005	Such sums...	\$7.560	\$11.500
Prevention of Falls Among Older Adults (PHSA 393D)	FY 2005	Such sums...	N/A	\$3.050
Combating Antimicrobial Resistance (PHSA 319E)	FY 2006	Such Sums...	\$17.443	\$197.000
National Strategy for Combating and Eliminating Tuberculosis (PHSA 317E)	FY 2013	\$243.101	\$132.997	\$137.034
Newborn Screening Laboratory Quality and Surveillance (PHSA 1113)	FY 2019	\$8.000	\$17.250	\$22.250

(dollars in millions)

<b>Program*</b>	<b>Last Year of Authorization</b>	<b>Authorization Level**</b>	<b>Appropriations in Last Year of Authorization</b>	<b>Appropriations at FY 2024 CR Level</b>
Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) (Family Violence Prevention and Services Act 302 et seq)	FY 2021	\$180.000	\$34.200	\$38.200
Surveillance for Neurological Diseases (PHSA 399S-1)	FY 2022	\$5.000	\$5.000	\$5.000
Firefighter Cancer Registry (PHSA 399B)	FY 2022	\$2.500	\$2.500	\$5.500
Safe Motherhood (PHSA 317K)	FY 2023	\$58.000	\$83.000	\$108.000
Surveillance and education regarding infections associated with illicit drug use and other risk factors (PHSA 317N)	FY 2023	\$40.000	\$23.000	\$23.000
Improving State and Local Public Health Security (Grants for public health emergency preparedness) (PHSA 319C-1(e))	FY 2023	\$685.000	\$735.000	\$735.000
Preventing overdoses of controlled substances (PHSA 392A)	FY 2023	\$496.000	\$505.579	\$505.579

\*Summarizes major authorities of CDC programs.

\*\* Authorization Level at last year of authorization.

# **NARRATIVE BY ACTIVITY**

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## IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$499.941	\$499.941	\$499.941	\$0
PPHF	\$419.350	\$419.350	\$469.350	+\$50.000
<b>Total Request</b>	<b>\$919.291</b>	<b>\$919.291</b>	<b>\$969.291</b>	<b>+\$50.000</b>
FTEs	1,009	1,100	1,100	91
-- Immunization and Other Respiratory Diseases	\$681.933	\$681.933	\$731.933	+\$50.000
-- Immunization Program	\$262.583	\$262.583	\$262.583	\$0
-- <i>Immunization Program (PPHF)</i>	<i>\$419.350</i>	<i>\$419.350</i>	<i>\$469.350</i>	<i>+\$50.000</i>
-- Acute Flaccid Myelitis	\$6.000	\$6.000	\$6.000	\$0
-- Influenza/Influenza Planning and Response	\$231.358	\$231.358	\$231.358	\$0
<b>Mandatory Program Total</b>	<b>\$5,216.952</b>	<b>\$7,212.743</b>	<b>\$9,043.718</b>	<b>+\$3,826.766</b>
-- Vaccines for Adults (VFA)	N/A	N/A	\$1,004.000	+\$1,004.000
-- Vaccines for Children (VFC) <sup>1</sup>	\$5,216.952	\$7,212.743	\$8,039.718	+\$2,822.766

<sup>1</sup> FY 2023 and FY 2024 estimates reflect actual and estimated transfers from Medicaid under current law. The VFC proposed law total for FY25 does not include changes to Medicaid provider administration fees that are captured in the Medicaid account, and does not include estimated costs associated with establishing, implementing and overseeing an administration fee reimbursement mechanism.

**Enabling Legislation Citation:** PHS A § 301, PHS A § 307, PHS A § 310, PHS A § 311, PHS A § 313, PHS A § 317\*, PHS A § 317N, PHS A § 317S, PHS A § 319, PHS A § 319C-1\*, PHS A § 319E\*, PHS A § 319F, PHS A § 322, PHS A § 325, PHS A § 327, PHS A § 340C, PHS A § 352, PHS A § 2102\*, PHS A § 2125, PHS A § 2126, PHS A § 2127, PHS A § 2821, Social Security Act § 1928 (42 U.S.C. 1396s)

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; Contracts; and Other

CDC prevents disease, disability, and death of children, adolescents, and adults through immunization and the control of respiratory and other related diseases. These activities are key to CDC’s goal to protect Americans from infectious diseases. Through the discretionary immunization program and mandatory Vaccines for Children (VFC) Program, CDC improves access to immunization services for uninsured and underinsured U.S. populations and supports the scientific evidence base for vaccine policy and practices. CDC also provides critical epidemiology and laboratory capacity to detect, prevent, and respond to vaccine-preventable respiratory diseases and related infectious disease threats, including influenza and COVID-19.

CDC’s FY 2025 budget request of **\$969,291,000** for Immunization and Respiratory Diseases is **\$50,000,000** above the FY 2023 final level. This request includes **\$469,350,000** from the Prevention and Public Health Fund, which is **\$50,000,000** above the FY 2023 final level. This increase will provide resources needed to support the nation’s readiness to detect and respond to respiratory viruses capable of causing a public health emergency. Investments will support ongoing work on COVID-19, including the continued enhancement of respiratory surveillance systems and platforms, which are critical for the monitoring and early detection of disease outbreaks. CDC will focus investments on the highest priority activities of the immunization program including building vaccine confidence, while providing dedicated resources to urgent public threats like influenza, COVID-19, and localized outbreaks of vaccine-preventable illness. These funds support the prevention of vaccine-preventable diseases across the lifespan by sustaining high vaccination coverage rates for routine immunizations, including polio, measles, and influenza. CDC will also continue to support Acute Flaccid Myelitis surveillance capacity in states and initiate follow-up of cases to better understand long-term effects and risk factors.

The FY 2025 budget continues to propose a mandatory Vaccines for Adults (VFA) program to provide access to routine and outbreak vaccines at no cost for uninsured adults, funding the program at \$12 billion over ten years as a capped mandatory program. This program would reduce the spread of preventable disease by building an equitable and sustainable adult immunization program to support high vaccination coverage, reduce disparities in vaccination coverage, and support the infrastructure needed for adult immunization during future pandemics. The proposed VFA program will be modeled on the successful VFC program and will be tailored to meet the unique needs of adults.

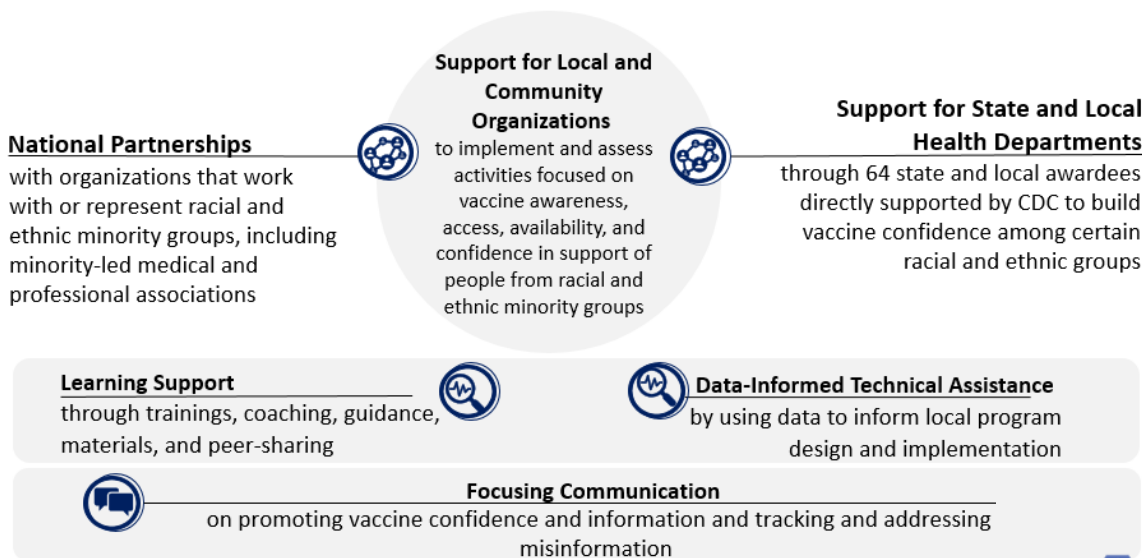
The FY 2025 budget will also continue the policy proposal to expand the VFC program to all Children’s Health Insurance Program (CHIP) enrolled children and make program improvements, including setting a floor for provider reimbursements for vaccine administration and covering the vaccine administration fee for uninsured children without state share, eliminating cost sharing for all VFC eligible children.

CDC is committed to vaccine equity, which is when everyone has fair and just access to vaccination. There are many social, geographic, political, economic, and environmental factors that create challenges to vaccination access and acceptance, often disproportionately affecting racial and ethnic minority groups.

To help combat these disparities, CDC is working to increase vaccination rates among racial and ethnic minority groups. One way CDC is accomplishing this is through a special communication campaign<sup>2</sup> to inform the general population about the importance of flu vaccination, with a focus on Black and Latino audiences. Last year, around 57% of Black people and 56% of Hispanic people reported being aware of the messages from this campaign.

**Figure 1. Reducing Racial Disparities through Community-Level Action**

*To reduce the Racial/Ethnic disparities that have long existed, CDC is focusing on funding, support, and communications for racial and ethnic minority communities.*



<sup>2</sup> CDC Digital Media Toolkit: 2022-2023 Flu Season, Available at: <https://www.cdc.gov/flu/resource-center/toolkit/index.htm>



## IMMUNIZATION AND RESPIRATORY DISEASES

### BY THE NUMBERS

- CDC estimates that vaccination of children born between 1994 and 2021<sup>1</sup>:
  - Prevented 472 million illnesses.
  - Prevented 29.8 million hospitalizations.
  - Prevented 1,052,000 deaths from infectious disease.
  - Saved \$479 billion in direct costs and \$2.2 trillion in total societal costs.
  - Every dollar spent on childhood vaccination saves \$10.90.
- CDC estimates that for the 2022-2023 influenza season, influenza vaccination:
  - Prevented approximately 6 million influenza illnesses.
  - Prevented 2.9 million influenza-associated medical visits.
  - Prevented 65,000 influenza-associated hospitalizations.
  - 3,700 deaths were prevented by flu vaccination.
- **16** – Diseases prevented by vaccination during the first 24 months of life. **99%** of children had received some vaccinations by age 24 months.<sup>2</sup>
- **85 million** – Estimated number of people who are now eligible to be better protected from severe Respiratory Syncytial Virus (RSV) disease through the new immunizations recommended by CDC in 2023.
- **984 million**—The number of COVID-19 vaccine doses delivered in the United States through May 2023, equivalent to eight years of vaccine distribution for the VFC program.
- **450**—Local and community-based organizations funded through CDC’s Partnering for Vaccine Equity (P4VE) grant program working to improve COVID-19 and flu vaccination coverage among racial and ethnic minority groups: nearly **300,000** community spokespersons trained and over **500,000** clinicians and over **860** healthcare organizations reached by **nearly 300** nationwide educational campaigns in 43 languages.

References:

<sup>1</sup> Updated 2021 analysis using methods from “Benefits from Immunization during the Vaccines for Children Program Era—United States, 1994-2021.” <https://www.cdc.gov/vaccines/programs/vfc/protecting-children.html>

<sup>2</sup> [Vaccination Coverage by Age 24 Months Among Children Born in 2019 and 2020 — National Immunization Survey-Child, United States, 2020–2022 | MMWR \(cdc.gov\)](https://www.cdc.gov/mmwr/preview/mmwrhtml/6107a1.htm)

Note: Unless otherwise noted, all information and calculations are from CDC program data.

<b>Immunization and Respiratory Diseases Funding History</b>	
Fiscal Year	Dollars (in millions)
FY 2021 (BA)	\$447.428
FY 2021 (PPHF)	\$372.200
FY 2022 (BA)	\$448.805
FY 2022 (PPHF)	\$419.350
FY 2023 (BA)	\$499.941
FY 2023 (PPHF)	\$419.350
FY 2024 CR (BA)	\$499.941
FY 2024 CR (PPHF)	\$419.350
FY 2025 President's Budget (BA)	\$499.941
FY 2025 President's Budget (PPHF)	\$469.350

<b>Immunization Program Ten-Year Funding History</b>	
Fiscal Year	Dollars (in millions)
FY 2015 (BA)	\$400.547
FY 2015 (PPHF)	\$210.300
FY 2016 (BA)	\$285.247
FY 2016 (PPHF)	\$324.350
FY 2017 (BA)	\$281.771
FY 2017 (PPHF)	\$324.350
FY 2018 (BA)	\$285.529
FY 2018 (PPHF)	\$324.350
FY 2019 (BA)	\$287.106
FY 2019 (PPHF)	\$320.550
FY 2020 (BA)	\$419.705
FY 2020 (PPHF)	\$370.300
FY 2021 (BA)	\$240.706
FY 2021 (PPHF)	\$372.200
FY 2022 Final (BA)	\$231.447
FY 2022 Final (PPHF)	\$419.350
FY 2023 Enacted (BA)	\$262.583
FY 2023 Enacted (PPHF)	\$419.350
FY 2024 CR (BA)	\$262.583
FY 2024 CR (PPHF)	\$419.350
FY 2025 President's Budget (BA)	\$262.583
FY 2025 President's Budget (PPHF)	\$469.350

## Program Accomplishments

### **Vaccinate with Confidence**

CDC is working to build trust, increase collaboration, and create tools and resources for all communities. CDC developed the [Vaccinate with Confidence](#) strategy, which advances three key priorities to strengthen public trust in vaccines: protect communities, empower families, and stop myths. This strategy combines CDC's existing work with new investments, partnerships, and activities to protect communities at risk by increasing vaccine acceptance. To stop misinformation from eroding public trust in vaccines, CDC will continue to work with local partners and trusted messengers to improve confidence in vaccines among at-risk groups, establish partnerships to contain the spread of misinformation, and reach critical stakeholders to provide clear information about vaccination and the critical role it plays in protecting the public.

CDC has made significant investments in vaccine confidence strategy implementation, providing funding and technical assistance to traditional and non-traditional partners, including partnerships with approximately 20 national organizations to improve COVID-19, flu, and routine immunization coverage. To date, CDC has helped 100 organizations to educate and empower trusted messengers, build community partnerships, and identify and address barriers to vaccine uptake. CDC has also supported capacity development through trainings and talks with health departments and partners on vaccine confidence basics, demand generation and community engagement strategies, and social listening and misinformation management.

Recent investments have allowed state, local, and territorial health departments to develop activities aimed at targeting specific, underserved communities for more effective messaging. Examples include enhanced community-based efforts to increase vaccine confidence in hard-to-reach communities as well as developing facts sheets and pamphlets in a variety of languages including, Vietnamese, Cantonese, and Spanish.

### **Influenza World-Class Data and Analytics**

To more comprehensively track which influenza viruses are circulating and where, CDC worked with partners to expand U.S. sequencing capacity by funding Influenza Sequencing Centers (ISC) in five additional state health departments. These labs provide additional, invaluable data to allow CDC experts to optimize the effectiveness of flu vaccines and treatments.

### **New Immunization Recommendations for Respiratory Syncytial Virus (RSV) Prevention**

In FY 2024, CDC issued new recommendations for the use of multiple new RSV immunization products. This was essential to putting our nation in its strongest position ever to help protect babies, toddlers, and older adults from severe RSV. The new recommendations included: an RSV vaccine for people who are 32-36 weeks pregnant to protect their babies from severe RSV, a new RSV immunization called nirsevimab to protect babies and some toddlers from severe RSV during the RSV season, and an RSV vaccine for adults ages 60 and over.

## **Immunization and Other Respiratory Diseases**

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### Program Overview

CDC's Immunization Program plays a fundamental role in sustaining high vaccination coverage rates and provides guidance to prevent the spread of disease, disability, and death from 18 vaccine preventable diseases (VPDs) across the lifespan. Immunization funding supports the public health capacity for effective immunization programs and scientifically sound immunization policy. A strong immunization infrastructure at the national, state, and local levels is vital to sustain high vaccination coverage levels and low incidence of VPDs. The importance of the Immunization Program's work was heightened as CDC distributed the COVID-19 vaccine

across the nation. To address pandemic-related declines in routine immunization coverage across the lifespan, CDC launched the *Let's RISE* initiative to provide a broad range of communication and enhanced technical assistance, including back-to-school campaigns, to urge jurisdictions to get routine vaccination coverage back to pre-pandemic levels as quickly and equitably as possible. Since its implementation, *Let's RISE* has successfully identified 20 jurisdictions to focus on catch-up efforts that resulted in increased vaccination rates among children <2 years of age living below poverty and/or in rural communities, kindergarten students, and increased HPV vaccination in adolescents. This funding supports public health preparedness and response to a vaccine-preventable national emergency, such as a pandemic or bioterrorism. This program aligns with CDC's core capabilities to build strong domestic preparedness and to quickly respond to outbreaks at their source.

CDC purchases routinely recommended vaccines to protect populations at higher risk and not eligible for immunizations through the mandatory Vaccines for Children (VFC) Program and to meet urgent public health needs such as controlling VPD outbreaks. The flexibility of the Program is critical-- the discretionary Immunization Program allows states to use their purchased vaccines to meet their unique needs and priorities in responding to VPD outbreaks. The public health functions supported by the discretionary program include:

- Providing a safety net for those who cannot otherwise access immunization services
- Managing vaccine shortages
- Conducting continual quality improvement efforts with immunization providers
- Monitoring the safety and effectiveness of vaccines and vaccine programs
- Preventing disease outbreaks and responding early and rapidly should they occur
- Responding quickly to other emergencies, such as a pandemic

### Budget Request

CDC's FY 2025 budget request of **\$731,933,000** for the Immunization and Other Respiratory Diseases program is **\$50,000,000** above the FY 2023 final level. The request includes **\$469,350,000** from the Prevention and Public Health Fund (PPHF), which is **\$50,000,000** above the FY 2023 final level.

With this increase, CDC will support ongoing work on COVID-19, including building enhanced respiratory disease surveillance systems and platforms. These systems are critical for the monitoring and early detection of disease outbreaks, which enable rapid response and provide timely and accurate information to public health authorities. In addition, these systems can also help identify emerging threats like novel respiratory viruses and new variants of known respiratory viruses and inform decision-making with clear data and data visualizations. Funding at this level will also support staffing expertise needed for effective national public health monitoring and prevention of respiratory viruses.

CDC's budget request supports the prevention of VPDs across the lifespan by leveraging programs and immunization infrastructure to increase vaccination coverage rates and helping to control respiratory diseases, including influenza and COVID-19. CDC continues to build on the investments made in the immunization program by supporting essential activities aimed at strengthening the immunization infrastructure for adults, addressing disparities in adult vaccine coverage, and supporting vaccine efforts across the lifespan. CDC will also work to expand the evidence base to further understand the emerging science of SARS-COV-2 through enhanced epidemiology, surveillance, and laboratory efforts, as well as other respiratory pathogens capable of causing a public health emergency, such as RSV, Middle East Respiratory Syndrome (MERS), and SARS-COV-1.

### **Immunization**

In FY 2025, CDC will work to prevent outbreaks of VPDs in the United States by focusing on three critical areas: national, state, and local immunization program operations, vaccine purchase, and a multicomponent vaccine

confidence strategy. CDC will support state and local health departments, use data to identify communities placed at higher risk and provide them with assistance before outbreaks, and promote the importance of vaccination and science-based information through social and digital platforms, partnerships, and healthcare providers. These investments will help ensure all Americans are protected by a strong immunization system that provides coverage and access to life-saving vaccines that are safe and effective. CDC will continue to provide technical assistance and laboratory support to states and local communities responding to VPD investigations, including outbreaks.

Vaccination rates for routine immunization remain strong nationally, but pockets of under-vaccination persist in some locations, putting communities at risk for outbreaks. CDC supports states, cities, and counties by using immunization information system data to pinpoint areas of low vaccination coverage and take steps to protect people who live/work in communities that put them at higher risk of becoming infected. CDC is working with key partners to strengthen parent-provider conversations about vaccines. Trust in vaccines is not built through a top-down approach, but through millions of conversations between parents, doctors, nurses, pharmacists, and community members. To stop misinformation from eroding public trust in vaccines, CDC will continue its work with local partners and trusted messengers to improve [confidence in vaccines](#) among groups placed at higher risk, including racial and ethnic minorities, parents of very young infants, and expectant parents. CDC will continue to fund immunization recipients to implement targeted vaccine confidence efforts, with a focus on integrating and creating opportunities to build vaccine confidence within their relevant populations.

CDC will focus investments towards sustaining improvements to the Immunization Information Systems (IIS), which help providers, families, and public health officials by consolidating immunization information into one reliable source. The information is then used to guide patient care and improve vaccination coverage. IIS investments will be about integrated and modernized systems, linking different systems so that we can get a more complete picture. State, local, and jurisdictional efforts will focus on quality of data and production.

### **Preserving Public Health Immunization Infrastructure**

CDC supports the public health workforce and systems at the national, state, and local levels that protect all Americans from disability and death from VPDs. CDC conducts scientific studies about the burden of disease, vaccine effectiveness and safety, economic considerations, and program feasibility, which provide the basis for national immunization recommendations and programs. The Advisory Committee on Immunization Practices (ACIP) evaluates the safety and immunogenicity data for new vaccine candidates and develops vaccine policy options that ACIP may consider for recommendation to the CDC Director. In addition, CDC collects, analyzes, and reports scientific data about vaccines to ensure the effectiveness and safety of national vaccine recommendations and programs and informs changes to the recommendations and programs as needed. The evidence base built by science facilitates CDC's support for the public health workforce and systems at the national, state, and local levels that protect all Americans from disability and death from VPDs. CDC works with national, state, and local public health partners to respond to disease outbreaks by:

- Rapidly identifying and investigating cases.
- Conducting surveillance and laboratory testing.
- Implementing targeted vaccination efforts and other measures to control the spread of disease and prevent future outbreaks.

For example, CDC worked with New York State Department of Health in response to a case of paralytic polio in Rockland County, New York, which was confirmed and genetically sequenced by CDC's Polio Laboratory after an unvaccinated person contracted the disease. In the United States, the risk to the public of paralytic polio is low because most people are vaccinated against polio during childhood. CDC's robust routine immunization program

and case-based surveillance, combined with good sanitation and other measures, helps risk of paralytic polio remain low in the general public.

CDC also worked with the Ohio Department of Health to control a measles outbreak in November 2022 after investigators identified 85 confirmed cases of measles in Ohio. Although the United States has maintained measles elimination since 2000, measles outbreaks continue to occur in countries around the world, which means there is always a risk of measles importation into the United States. The measles-mumps-rubella (MMR) vaccine is the best and safest protection against measles. The measles vaccine is highly protective. One dose of the MMR vaccine provides 93% protection against measles and two doses provide 97% protection. While national two-dose MMR coverage remains high at 93%, pockets with lower coverage persist and remain vulnerable to measles outbreaks linked to international travel.

In FY 2025, CDC will work collaboratively with its recipients and providers to sustain high childhood immunization coverage rates and help ensure that all Americans have equitable access to vaccines. The discretionary immunization program funding can be used to vaccinate non-VFC-eligible populations in a public health emergency. For example, in April 2023 immunization funding supported the purchase of over 2,000 doses of MMR vaccine to prevent an outbreak of measles in American Samoa. Similarly, in July 2023 New York City purchased over 2,300 doses of varicella vaccine to respond to a localized outbreak.

### **Supporting State and Territorial Immunization Programs**

In FY 2025, CDC will continue to provide immunization infrastructure funding to 64 recipients—including all 50 states, Washington, D.C., five large cities, five territories, and three freely associated states—through a non-competitive, formula-based, cooperative agreement program that provides financial assistance for state and local immunization operations. Through population-based awards, collaboration, and a strong public-private partnership, the discretionary Immunization Program establishes a comprehensive immunization system providing:

- Public sector vaccine ordering and distribution
- Continual quality assurance
- Provider recruitment and enrollment in the VFC Program
- Provider education and public awareness focused on new and expanded vaccine recommendations
- Management of vaccine shortages

In addition, CDC will continue to provide its 64 recipients with direct assistance for vaccine purchased from the federal contracts. CDC monitors spend plans developed by recipients and makes further adjustments as needed throughout the year so that no vaccine goes to waste.

CDC provides national public health expertise in VPDs that supports the 64 recipients, including expertise in:

- Epidemiology and surveillance
- Laboratory methods and science
- Immunization policy
- Health communications science
- Vaccine management
- Program implementation and evaluation

**Immunization Cooperative Agreements<sup>1</sup>**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President's Budget
Number of Awards	64	64	64
- New Awards	0	0	0
- Continuing Awards	64	64	64
Average Award	\$5.007	\$5.011	\$5.011
Range of Awards	\$0.734–\$36.982	\$0.735- \$37.008	\$0.735- \$37.008
<b>Total Awards</b>	<b>\$320.465</b>	<b>\$320.690</b>	<b>\$320.690</b>

<sup>1</sup>These funds are awarded by formula.

**Immunization’s Role in Public Health**

Funding Category	Impact
State Infrastructure	Cooperative agreements support immunization workforce and core infrastructure at the state and local levels to do the following: <ul style="list-style-type: none"> <li>• Recruit and educate networks of immunization providers</li> <li>• Provide continual vaccine management quality assurance</li> <li>• Promote public awareness of new and expanded vaccine recommendations</li> <li>• Manage vaccine shortages</li> <li>• Respond to vaccine preventable disease outbreaks</li> </ul>
Vaccine Purchase	Allocated through direct assistance to provide federally purchased vaccines to vaccinate populations that are uninsured and non-VFC-eligible and to meet urgent public health needs such as controlling vaccine preventable disease outbreaks.
Extramural Program Operations	Supports national immunization policies and programs including: <ul style="list-style-type: none"> <li>• Disease surveillance</li> <li>• Vaccine coverage assessment</li> <li>• Post-marketing evaluation of vaccine effectiveness and safety</li> <li>• Immunization information technologies</li> <li>• Centralized vaccine ordering and distribution systems</li> <li>• Payer of last resort</li> <li>• Public awareness campaigns and resources</li> <li>• Provider education and tools</li> </ul>
Intramural Program Operations	Provides national public health expertise in immunization and vaccine preventable diseases to national, state, and local vaccination program efforts, including expertise in epidemiology and surveillance, laboratory methods and science, immunology, immunization policy, health communications science, vaccine management, and program implementation.

**Addressing Respiratory Disease Threats:**

Sound, evidence-based, immunization policy is rooted in advanced disease surveillance, laboratory diagnostics, and vaccine effectiveness conducted by CDC. These activities support the nation’s readiness to detect and respond to respiratory viruses capable of causing a public health emergency, including COVID-19, MERS, SARS-CoV-1, and Respiratory Syncytial Virus (RSV) and other VPDs.

CDC conducts surveillance and research to detect new respiratory viruses and variants of known respiratory viruses. Surveillance systems are critical for monitoring and early detection of disease outbreaks, which enable rapid response and provide accurate information to public health authorities. In addition, these systems identify emerging threats like novel respiratory viruses and new variants of known respiratory viruses. They also inform data-driven decision-making for governments, communities, institutions, and individuals about prevention and treatment, as well as medical system decisions on patient care, staffing, and resource allocation.

CDC develops and maintains laboratory assays to detect and identify respiratory viruses that are crucial for diagnosing cases, monitoring trends, and guiding public health interventions. This capacity helps to characterize respiratory viruses through laboratory testing to determine the risk of transmission and disease severity and support public health investigations to identify the source and prevent further transmission.

CDC will continue to assess the impact of vaccines on disease incidence and mortality while providing quality science to inform domestic and global policy decisions about vaccines. CDC accelerates and informs the



development and deployment of new diagnostics, vaccines, and treatments and provides essential data and analysis to evaluate their effectiveness over time.

RSV is a common respiratory virus that causes annual epidemics that usually peak in winter. RSV is the leading cause of hospitalization in infants. Hospitalization risk decreases with increasing age in young children. For children younger than 5 years old, each year in the United States, RSV leads to approximately 2.1 million outpatient visits, 58,000–80,000 hospitalizations, and 100–300 deaths. During the 2022-2023 season, CDC responded to a surge in RSV cases that overwhelmed many pediatric hospitals and emergency departments around the country. Among adults  $\geq 65$  years of age in the United States, RSV is associated with about 6,000-10,000 deaths, 60,000-160,000 hospitalizations, and 0.9-1.4 million medical encounters per year. In FY 2025, CDC is working to expand and facilitate uptake of the new immunization products for RSV. These products could reduce incidence and severity of RSV infections in infants and older adults. Broad access and uptake of these products could result in significant public health impact. In FY 2025, CDC will work to facilitate uptake of the new immunization products to help protect babies, toddlers, and older adults from severe RSV.

CDC will address emerging respiratory pathogens by continuing to:

- Fund 10 Active Bacterial Core surveillance (ABCs) sites through the Emerging Infections Program to monitor respiratory bacterial pathogens such as Group A and Group B Streptococcus, and VPDs such as *Haemophilus influenzae* and *Neisseria meningitidis*. Maintain epidemiologic and laboratory activities for non-influenza respiratory viruses allowing CDC to maintain expertise to conduct surveillance, perform diagnostics, and respond to outbreaks of known viruses such as adenoviruses and enterovirus D68, as well as emerging respiratory threats capable of causing a public health emergency.
- Support CDC experts to conduct surveillance, track antibiotic resistance, and provide guidance for treatment and prophylaxis for meningococcal disease, through maintaining epidemiologic and laboratory activities on meningococcal disease.
- Support state and local health department planning, laboratory testing, domestic and global surveillance, and technical assistance for MERS.
- Increase capacity at state and local health departments to identify and prevent cases and outbreaks of Legionnaires' disease, developing advanced tools to rapidly identify potential sources of exposure during outbreaks, by partnering with states and non-governmental organizations to develop and monitor the impact of prevention measures, and developing laboratory techniques to quickly identify the most dangerous strains.

## Vaccines for Adults Budget Request

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The COVID-19 pandemic highlighted the importance of a strong adult vaccination program, including support for adult vaccine purchase and operational infrastructure within the broader immunization program.

The Vaccines for Adults (VFA) program would establish mandatory funding that would leverage the lessons learned from the Vaccines for Children program and the COVID-19 pandemic, while tailoring its approach for adults. This program would also build on the investments made during implementation of the CDC COVID-19 Vaccination Program, which was the largest adult vaccination program in U.S. history. Since adults visit healthcare settings with a less predictable frequency than children and without the societal and institutional pressures that exist for immunizing children, a comprehensive program specific to the unique needs of adult vaccination is needed. Such a program would include specific funding for adult vaccines, support the infrastructure needed to implement a safe and effective science-based program, and increase among adults the willingness and opportunities to be vaccinated.

The goal of the VFA program is to reduce the spread of preventable disease by building an adult immunization program to support high vaccination coverage and equitable access for all adults. Ultimately, the program aims to reduce vaccination coverage disparities, improve outbreak control of vaccine-preventable diseases (VPDs), and enhance and maintain the infrastructure needed for responding to future pandemics. In addition, this proposal supports the National Biodefense Strategy, which calls for transformative improvements in the ability to surge the development, manufacturing, distribution, and administration of safe and effective vaccines in response to a biological incident.

### Budget Request

CDC's FY 2025 budget requests **\$12 billion** in capped mandatory funding over ten years to maximize public health impact. This includes **\$1,004,000,000** for FY 2025 to establish a Vaccine for Adults (VFA) program to expand access to routine and outbreak vaccines for uninsured adults. Given that no national counterpart to the VFC program that functions as a safety net for all uninsured adults exists, creating a separate VFA program would help to expand access to adult immunizations and address vaccination coverage disparities. Ensuring sustainability of the components of an adult immunization program will not only enable much-needed strides in vaccinating the adult population but will also facilitate a more agile and effective response to pandemics caused by VPDs and support the continued administration of COVID-19 boosters over the coming years.

Activities in the proposed budget include:

- **Vaccine Purchase:** Includes purchase of vaccines for VFA eligible adults for ACIP-recommended routine immunizations, as well as vaccines to control outbreaks, such as hepatitis A vaccine.
- **Provider Fees:** Covers costs associated with supplies, patient education, storage and handling, and staffing by establishing a consistent provider fee that covers all beneficiaries.
- **Provider Fee Reimbursement Mechanism:** Proposes the establishment of a reimbursement mechanism, such as through contracts with private sector entities with specialized expertise in claims processing and provider reimbursement.
- **Program Operations:** As a complement to discretionary immunization funding, VFA includes funding to support operational activities such as vaccine distribution, tracking, and management systems, and other program activities.

CDC aims to create a holistic and equitable program which bolsters the nation's immunization infrastructure to address and mitigate disparities, including supporting accessibility for uninsured adults. Such a program would address factors such as accessibility, availability, and confidence, just as the VFC program has done for children. CDC will also work with jurisdictions to leverage base immunization funding and other resources to support

associated program operations costs, vaccine confidence, and vaccine equity activities including communications, partnerships, education, and technical assistance.

## **Acute Flaccid Myelitis Budget Request**

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### Program Description

CDC's Acute Flaccid Myelitis (AFM) program reviews each suspected AFM case reported by health departments and examines possible risk factors and causes of AFM, including why some people develop this condition, monitors AFM activity nationwide, and updates clinicians about AFM diagnosis, management, and possible treatment options.

### Budget Request

CDC's FY 2025 budget request of **\$6,000,000** for Acute Flaccid Myelitis is level with the FY 2023 final level. CDC will continue working on AFM to help determine its cause and improve tailored prevention efforts. CDC continues to work closely with healthcare providers, state and local health departments, and parents to:

- Promote awareness of AFM among front-line clinicians.
- Monitor AFM activity nationwide--via enhanced surveillance capacity in states.
- Collect and test clinical specimens from cases to identify possible viral cause.
- Update possible treatment and prevention options.
- Track outcomes of those affected by AFM.
- Improve surveillance for viruses that cause AFM.

## Program Accomplishments

CDC provides guidance and tools for health departments for reporting AFM cases. For states confirming cases independently, CDC provides standard operating procedures, a medical chart abstraction tool, and training on how to interpret the information. CDC collaborates with health departments and partners to educate clinicians on the symptoms of AFM, how to report suspected cases of AFM to the health department, and what information to collect for suspected cases. Educational activities and materials include health alerts, job aids, toolkits, webinars, and scientific publications and presentations. CDC collaborates with several AFM parent groups who offer support to children with AFM and their families. This collaborative effort raises awareness about AFM and shares information and resources. Lastly, CDC and experts in a range of disciplines continue to update clinical guidance for the acute medical treatment of patients with AFM as more information is discovered about AFM.

Funding is used to support laboratory activities to maintain diagnostic testing for AFM cases, including testing clinical specimens for viruses and using genetic sequencing to characterize viruses when they are detected developing new antibody tools, and designing serologic assays for AFM testing. The program uses existing cooperative agreements and contracts to fund these activities.

## **Influenza Planning and Response Budget Request**

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### Program Description

CDC's influenza (flu) program detects, controls, and prevents influenza disease. Each year, flu causes millions of illnesses, hundreds of thousands of hospitalizations, and tens of thousands of deaths in the United States. To reduce this burden, CDC recommends an annual influenza vaccine for everyone six months and older. The vaccine must be produced and administered annually to account for seasonal variations and requires an annual reassessment of viruses included in the vaccine that is based on up-to-date CDC surveillance data of influenza viruses in circulation. CDC continues to invest in improving influenza vaccines through expanded vaccine effectiveness studies, monitoring, and evaluation.

CDC works to increase the number of people who get a vaccine each year through special efforts to reach populations that historically have lower rates of vaccine uptake or who are at risk of severe outcomes from flu, such as children and older adults, pregnant people and racial and ethnic minorities, and people with underlying health conditions. CDC is enhancing virus characterization which is critical to identifying influenza variants before they cause widespread outbreaks increasing the speed of the detection and analysis of variants of concern. CDC influenza surveillance systems are essential public health infrastructure to identify when and where influenza is circulating and helping to guide public health decisions to prevent and treat influenza. This core infrastructure provides a robust and comprehensive public health data system for influenza and includes: the National Influenza Reference Center (NIRC) program, Influenza Sequencing Centers (ISC), emergency department syndromic surveillance, electronic health record (EHR) based hospitalization surveillance, and conducting long-term care facility surveillance.

## Budget Request

CDC’s FY 2025 budget request of **\$231,358,000** for Influenza Planning and Response is level with the FY 2023 final level.

CDC will continue supporting influenza surveillance and preparedness efforts to help the United States detect, prepare for, and respond to emerging influenza threats whenever and wherever they emerge. These activities include monitoring at the human-animal interface, expanded next-generation sequencing to better characterize emerging influenza viruses, and international support for seasonal influenza surveillance.

CDC works closely with other federal agencies such as USDA, NIH, BARDA, and ASPR to monitor and prepare for human infections (spillover viruses) detected at the human-animal interface, including for the monitoring and response to the current outbreak of influenza A(H5) in wild birds and poultry in the United States. CDC works to ensure appropriate planning and response to prepare for influenza pandemics. CDC will continue to evaluate existing, and develop new, candidate vaccine viruses to provide optimal protection against any potential pandemic threats. CDC will also expand genetic sequencing efforts to enhance flexibility and increase speed for developing vaccine candidates. Further,

CDC will support improvements in influenza vaccines as well as domestic and global influenza laboratory capacity. The request will also continue to support funding for implementation of the activities outlined in the 2020–2030 National Influenza Vaccination Modernization Strategy.<sup>3</sup> These activities include enhancing vaccine effectiveness monitoring and evaluation, which will be particularly critical in the advent of new vaccine technologies (e.g., mRNA-based influenza vaccines, flu vaccines that offer broader and longer-lasting protection). CDC is enhancing virus characterization and improving the speed of vaccine virus development, increasing genomic testing of influenza viruses through enhanced capacity in states and partner countries, and increasing flu vaccine use.

## Program Accomplishments

### **Influenza Prevention**

CDC is a leader in developing and improving influenza vaccines and supports U.S. Government efforts to modernize the domestic influenza vaccine enterprise so that it is responsive, flexible, scalable, and effective in preventing influenza. In recent years, CDC has expanded its vaccine effectiveness platforms to gather better quality and more representative data each year to better understand how well influenza vaccines are working. The results of these investments were seen in the 2022-2023 influenza season. That season’s vaccine provided substantial protection to people who were immunized with vaccination reducing the risk of flu-related emergency department visits, urgent care visits, and hospitalizations by almost half among children and adolescents.<sup>4</sup> While the vaccine was effective in preventing and lessening the severity of influenza in 2022-2023, CDC continues to be concerned about recent drops in vaccination uptake, especially among people at higher risk of serious outcomes. Because increasing vaccination coverage in these groups is key in preventing severe disease and death from influenza, CDC launched the Wild to Mild communication campaign. This campaign focuses on reaching key audiences with information that flu vaccination not only prevents infection but can “tame” symptoms in people who do still get sick with flu. The campaign has performed extremely well – as of

<sup>3</sup> <https://www.phe.gov/Preparedness/planning/nivms/Pages/default.aspx>.

<sup>4</sup> Vaccine Effectiveness Against Pediatric Influenza-A-Associated Urgent Care, Emergency Department, and Hospital Encounters During the 2022–2023 Season, VISION Network | Clinical Infectious Diseases | Oxford Academic (oup.com)

the end of October 2023, it had been seen more than 16 million times, and reached 8.7 million parents and 7.8 million pregnant people.



### Influenza Detection and Monitoring

Detecting and monitoring influenza involves a network of surveillance systems at state and international levels that routinely:

- Determine severity of the [influenza season](#).
- Identify viruses that are causing disease and may pose a pandemic threat.
- Determine the effectiveness of the influenza vaccine and other interventions.

Ongoing work to improve laboratory and surveillance methods ensures that CDC can adequately respond to both epidemic and novel influenza outbreaks. As noted above, CDC also implemented several surveillance enhancements to prepare for the possibility of a more severe influenza season, as well as the potential co-circulation of influenza and other respiratory viruses. Examples of these enhancements include working with partners to expand U.S. sequencing capacity by funding Influenza Sequencing Centers (ISC) in five additional state health departments. These labs are equipped to sequence approximately 500 viruses per center annually and are strategically placed to ensure the greatest variety of viruses possible, providing additional, invaluable data to CDC to be able to optimize the effectiveness of flu vaccines and treatments. These labs will conduct sequencing along with four National Influenza Reference Centers, which last year sequenced 5,191 viruses.

CDC’s influenza laboratory capabilities and epidemiologic networks have strengthened national security by improving influenza surveillance and vaccine strain selection and have provided the underpinning for other respiratory disease surveillance. CDC’s training and support of epidemiologists and laboratorians serving as influenza surveillance coordinators in every state and multiple local jurisdictions have allowed for continuous improvement of surveillance systems providing data to inform a timely response to annual influenza epidemics and the emergence of novel viruses.

The same data systems used by countries to monitor seasonal epidemics contribute to vaccine composition decision-making and are the foundation for pandemic preparedness. CDC has engaged in collaborations in 125 countries and currently maintains cooperative agreements in more than 40 countries to increase capacity to respond to seasonal and pandemic flu. These efforts expand virus sample sharing among countries and increase data reporting to global surveillance systems like WHO’s FluNet. This ensures that CDC and the global public health community have data needed to equitably produce vaccines and diagnostic tests for viruses with pandemic potential, keeping people safe around the world and bolstering global health security in the United States.

In the United States, CDC funds 57 jurisdictions to conduct influenza surveillance and diagnostic activities. CDC continues to fund public health departments to support seasonal influenza surveillance and improve detection of infections with novel influenza viruses. CDC's collaboration with state and local health authorities is essential for risk assessment and response in novel influenza virus cases.

### **Planning for and Responding to Influenza Pandemics**

CDC's domestic and global seasonal influenza work is the foundation of its pandemic preparedness activities. CDC characterizes viruses to ensure the effectiveness of medical countermeasures and develops new ones when necessary, including candidate vaccine viruses against novel influenza threats. In the past year alone, CDC has characterized thousands of influenza viruses to track epidemic and novel viruses and developed more than a dozen new vaccine viruses to protect against novel influenza viruses that have the potential to cause a pandemic.

CDC collaborates with domestic and global health partners, including USDA, to monitor the occurrence of avian and swine influenza viruses, which have historically resulted in pandemics more often than other animal influenza viruses. The recent detections of avian influenza in wild birds and poultry in the United States underscores the importance of routine monitoring and collaboration to protect human health. Strong surveillance systems can rapidly provide the information needed to understand the risk and prepare effective countermeasures.

In 2023, Cambodia experienced three separate outbreaks of highly pathogenic avian influenza in humans. CDC worked closely with country officials to respond to these outbreaks, including sending staff to assist with investigations on the ground, and providing laboratory and communications support from CDC headquarters in Atlanta. CDC also conducted a training in southeast Asia on avian flu preparedness. Cambodia health officials, in-country partners, and CDC successfully worked together and were well-equipped to rapidly respond to the six human cases of avian influenza. These efforts highlight the importance of our strong global partnerships that allow for rapid response and containment of outbreaks.

CDC continues to support influenza pandemic planning efforts among health departments, hospitals, and emergency responders, including for hospital surge and equitable vaccine prioritization and distribution planning. To ensure response readiness, CDC tests response capabilities with federal, state, and local partners using techniques such as virtual tabletop and functional exercises to evaluate and improve response plans based on lessons from the COVID-19 response. CDC has created response tools to enhance pandemic preparedness that could be applied to different emerging threats.

**State Table: Discretionary (Section 317)<sup>1,2</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$4,979,932	\$4,983,421	\$4,983,421	\$3,489
Alaska	\$1,986,148	\$1,987,540	\$1,987,540	\$1,392
Arizona	\$7,622,404	\$7,627,744	\$7,627,744	\$5,340
Arkansas	\$2,860,744	\$2,862,748	\$2,862,748	\$2,004
California	\$36,982,323	\$37,008,233	\$37,008,233	\$25,910
Colorado	\$4,740,378	\$4,743,699	\$4,743,699	\$3,321
Connecticut	\$4,298,528	\$4,301,540	\$4,301,540	\$3,012
Delaware	\$1,669,731	\$1,670,901	\$1,670,901	\$1,170
District of Columbia	\$2,403,017	\$2,404,701	\$2,404,701	\$1,684
Florida	\$14,904,543	\$14,914,985	\$14,914,985	\$10,442
Georgia	\$8,700,456	\$8,706,551	\$8,706,551	\$6,095
Hawaii	\$2,733,084	\$2,734,998	\$2,734,998	\$1,914
Idaho	\$2,491,782	\$2,493,528	\$2,493,528	\$1,746
Illinois	\$7,142,809	\$7,147,814	\$7,147,814	\$5,005
Indiana	\$4,850,827	\$4,854,225	\$4,854,225	\$3,398
Iowa	\$3,665,258	\$3,667,826	\$3,667,826	\$2,568
Kansas	\$3,461,579	\$3,464,004	\$3,464,004	\$2,425
Kentucky	\$3,702,071	\$3,704,664	\$3,704,664	\$2,593
Louisiana	\$4,438,337	\$4,441,446	\$4,441,446	\$3,109
Maine	\$2,986,910	\$2,989,003	\$2,989,003	\$2,093
Maryland	\$4,264,928	\$4,267,916	\$4,267,916	\$2,988
Massachusetts	\$5,772,024	\$5,776,068	\$5,776,068	\$4,044
Michigan	\$9,359,018	\$9,365,575	\$9,365,575	\$6,557
Minnesota	\$5,392,329	\$5,396,107	\$5,396,107	\$3,778
Mississippi	\$3,569,904	\$3,572,405	\$3,572,405	\$2,501
Missouri	\$2,999,912	\$3,002,014	\$3,002,014	\$2,102
Montana	\$1,445,162	\$1,446,175	\$1,446,175	\$1,013
Nebraska	\$2,685,252	\$2,687,133	\$2,687,133	\$1,881
Nevada	\$3,072,833	\$3,074,986	\$3,074,986	\$2,153
New Hampshire	\$1,818,470	\$1,819,744	\$1,819,744	\$1,274
New Jersey	\$8,544,329	\$8,550,315	\$8,550,315	\$5,986
New Mexico	\$2,705,634	\$2,707,529	\$2,707,529	\$1,895
New York	\$8,650,876	\$8,656,937	\$8,656,937	\$6,061
North Carolina	\$8,895,689	\$8,901,921	\$8,901,921	\$6,232
North Dakota	\$2,027,222	\$2,028,643	\$2,028,643	\$1,421
Ohio	\$9,234,307	\$9,240,776	\$9,240,776	\$6,469
Oklahoma	\$3,695,586	\$3,698,175	\$3,698,175	\$2,589
Oregon	\$4,163,617	\$4,166,534	\$4,166,534	\$2,917
Pennsylvania	\$8,178,474	\$8,184,204	\$8,184,204	\$5,730
Rhode Island	\$1,647,316	\$1,648,470	\$1,648,470	\$1,154
South Carolina	\$2,849,200	\$2,851,196	\$2,851,196	\$1,996
South Dakota	\$1,522,319	\$1,523,385	\$1,523,385	\$1,066
Tennessee	\$5,809,811	\$5,813,881	\$5,813,881	\$4,070
Texas	\$22,059,680	\$22,075,135	\$22,075,135	\$15,455
Utah	\$2,889,218	\$2,891,242	\$2,891,242	\$2,024
Vermont	\$1,848,845	\$1,850,140	\$1,850,140	\$1,295
Virginia	\$6,149,341	\$6,153,650	\$6,153,650	\$4,309
Washington	\$6,669,677	\$6,674,350	\$6,674,350	\$4,673
West Virginia	\$2,025,032	\$2,026,451	\$2,026,451	\$1,419



	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Wisconsin	\$4,513,288	\$4,516,450	\$4,516,450	\$3,162
Wyoming	\$858,196	\$858,797	\$858,797	\$601
<b>Subtotal States</b>	<b>\$281,938,351</b>	<b>\$282,135,878</b>	<b>\$282,135,878</b>	<b>\$197,527</b>
<b>Cities</b>				
Chicago	\$4,554,082	\$4,557,273	\$4,557,273	\$3,191
Houston <sup>2</sup>	\$2,755,161	\$2,757,091	\$2,757,091	\$1,930
New York City	\$10,550,371	\$10,557,762	\$10,557,762	\$7,391
Philadelphia	\$2,575,429	\$2,577,234	\$2,577,234	\$1,805
San Antonio <sup>2</sup>	\$1,462,749	\$1,463,774	\$1,463,774	\$1,025
<b>Subtotal Cities</b>	<b>\$21,897,792</b>	<b>\$21,913,134</b>	<b>\$21,913,134</b>	<b>\$15,342</b>
<b>Territories</b>				
American Samoa	\$1,008,548	\$1,009,254	\$1,009,254	\$706
Guam	\$1,081,624	\$1,082,382	\$1,082,382	\$758
Marshall Islands	\$2,868,749	\$2,870,758	\$2,870,758	\$2,009
Micronesia	\$4,572,270	\$4,575,473	\$4,575,473	\$3,203
Northern Mariana Islands	\$1,100,330	\$1,101,101	\$1,101,101	\$771
Puerto Rico	\$3,668,846	\$3,671,417	\$3,671,417	\$2,571
Republic of Palau	\$734,161	\$734,675	\$734,675	\$514
Virgin Islands	\$1,594,949	\$1,596,067	\$1,596,067	\$1,118
<b>Subtotal Territories</b>	<b>\$16,629,477</b>	<b>\$16,641,128</b>	<b>\$16,641,128</b>	<b>\$11,651</b>
<b>Total States/Cities/Territories</b>	<b>\$320,465,621</b>	<b>\$320,690,140</b>	<b>\$320,690,140</b>	<b>\$224,519</b>
<b>Other Adjustments<sup>3</sup></b>	<b>\$107,736,379</b>	<b>\$107,811,860</b>	<b>\$107,811,860</b>	<b>\$75,481</b>
<b>Total Resources</b>	<b>\$428,202,000</b>	<b>\$428,502,000</b>	<b>\$428,502,000</b>	<b>\$300,000</b>

<sup>1</sup> This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). Includes vaccine direct assistance and immunization infrastructure/operations grant funding. For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>

<sup>2</sup> Vaccine direct assistance for Houston and San Antonio is included with the state of Texas.

<sup>3</sup> Other adjustments include vaccine that is in inventory at the centralized distribution center but has not been ordered by immunization providers, funds for centralized vaccine distribution activities, a centralized vaccine ordering system, pediatric stockpile, influenza stockpile, stockpile storage and rotation, and program support services.

**CFDA Number: 93.268 State Table: Vaccines for Children<sup>1,2,3,4</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$83,219,452	\$116,745,574	\$121,560,397	\$38,340,945
Alaska	\$12,762,248	\$16,161,058	\$16,827,572	\$4,065,324
Arizona	\$118,108,469	\$165,871,504	\$172,712,380	\$54,603,911
Arkansas	\$52,140,928	\$72,732,276	\$75,731,902	\$23,590,974
California	\$568,188,362	\$792,905,623	\$825,606,649	\$257,418,287
Colorado	\$65,547,269	\$91,458,839	\$95,230,786	\$29,683,517
Connecticut	\$46,484,931	\$62,864,868	\$65,457,542	\$18,972,611
Delaware	\$14,709,148	\$19,736,158	\$20,550,116	\$5,840,968
District of Columbia	\$12,535,254	\$16,582,134	\$17,266,015	\$4,730,761
Florida	\$345,507,255	\$486,225,386	\$506,278,302	\$160,771,047
Georgia	\$185,104,979	\$260,459,648	\$271,201,530	\$86,096,551
Hawaii	\$19,983,901	\$26,357,672	\$27,444,715	\$7,460,814
Idaho	\$25,831,373	\$35,648,607	\$37,118,828	\$11,287,455
Illinois	\$106,515,795	\$148,267,878	\$154,382,744	\$47,866,949
Indiana	\$101,160,408	\$141,847,732	\$147,697,818	\$46,537,410
Iowa	\$45,211,197	\$62,180,259	\$64,744,698	\$19,533,501
Kansas	\$35,029,357	\$48,366,698	\$50,361,438	\$15,332,081
Kentucky	\$68,093,185	\$95,596,036	\$99,538,609	\$31,445,424
Louisiana	\$95,985,181	\$134,827,372	\$140,387,925	\$44,402,744
Maine	\$17,449,338	\$22,862,189	\$23,805,072	\$6,355,734
Maryland	\$96,734,300	\$135,435,547	\$141,021,182	\$44,286,882
Massachusetts	\$90,117,404	\$124,208,567	\$129,331,179	\$39,213,775
Michigan	\$109,016,327	\$150,004,789	\$156,191,289	\$47,174,962
Minnesota	\$57,053,840	\$78,578,030	\$81,818,746	\$24,764,906
Mississippi	\$50,701,704	\$70,954,649	\$73,880,962	\$23,179,258
Missouri	\$78,945,264	\$110,851,553	\$115,423,295	\$36,478,031
Montana	\$11,078,534	\$14,816,891	\$15,427,970	\$4,349,436
Nebraska	\$28,356,642	\$39,052,750	\$40,663,364	\$12,306,722
Nevada	\$46,071,345	\$63,976,146	\$66,614,652	\$20,543,307
New Hampshire	\$13,263,424	\$17,686,025	\$18,415,433	\$5,152,009
New Jersey	\$110,028,572	\$152,263,395	\$158,543,045	\$48,514,473
New Mexico	\$38,702,515	\$53,284,082	\$55,481,625	\$16,779,110
New York	\$149,365,867	\$206,406,652	\$214,919,278	\$65,553,411
North Carolina	\$169,071,877	\$239,612,168	\$249,494,257	\$80,422,380
North Dakota	\$9,366,546	\$12,546,309	\$13,063,744	\$3,697,198
Ohio	\$158,862,787	\$223,088,349	\$232,288,962	\$73,426,175
Oklahoma	\$74,862,082	\$104,231,293	\$108,530,002	\$33,667,920
Oregon	\$43,935,323	\$59,928,181	\$62,399,740	\$18,464,417
Pennsylvania	\$124,704,682	\$172,148,577	\$179,248,331	\$54,543,649
Rhode Island	\$17,642,814	\$23,571,376	\$24,543,507	\$6,900,693
South Carolina	\$85,508,035	\$120,466,993	\$125,435,294	\$39,927,259
South Dakota	\$11,814,731	\$16,182,783	\$16,850,194	\$5,035,463
Tennessee	\$113,903,351	\$159,653,151	\$166,237,569	\$52,334,218
Texas <sup>2</sup>	\$643,500,859	\$906,544,633	\$943,932,362	\$300,431,503
Utah	\$31,810,572	\$43,435,901	\$45,227,285	\$13,416,713
Vermont	\$8,421,223	\$10,744,692	\$11,187,825	\$2,766,602
Virginia	\$98,788,557	\$139,836,080	\$145,603,201	\$46,814,644
Washington	\$100,661,731	\$139,411,011	\$145,160,602	\$44,498,871
West Virginia	\$26,151,302	\$35,846,920	\$37,325,319	\$11,174,017

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Wisconsin	\$54,975,981	\$75,929,562	\$79,061,051	\$24,085,070
Wyoming	\$5,919,844	\$7,714,131	\$8,032,277	\$2,112,433
<b>Subtotal States</b>	<b>\$4,678,906,065</b>	<b>\$6,526,108,696</b>	<b>\$6,795,258,578</b>	<b>\$2,116,352,513</b>
<b>Cities</b>				
Chicago	\$48,150,763	\$67,265,875	\$70,040,056	\$21,889,293
Houston <sup>2</sup>	\$0	\$0	\$0	\$0
New York City	\$173,661,542	\$241,315,485	\$251,267,822	\$77,606,280
Philadelphia	\$34,812,532	\$47,135,254	\$49,079,207	\$14,266,675
San Antonio <sup>2</sup>	\$0	\$0	\$0	\$0
<b>Subtotal Cities</b>	<b>\$256,624,838</b>	<b>\$355,716,615</b>	<b>\$370,387,085</b>	<b>\$113,762,247</b>
<b>Territories</b>				
American Samoa	\$2,052,478	\$2,722,471	\$2,834,752	\$782,274
Guam	\$3,347,190	\$4,011,973	\$4,177,435	\$830,245
Marshall Islands <sup>3</sup>	\$0	\$0	\$0	\$0
Micronesia <sup>3</sup>	\$0	\$0	\$0	\$0
Northern Mariana Islands	\$1,821,339	\$2,332,156	\$2,428,339	\$607,000
Palau <sup>3</sup>	\$0	\$0	\$0	\$0
Puerto Rico	\$44,352,588	\$60,409,027	\$62,900,417	\$18,547,829
Virgin Islands	\$3,001,715	\$2,263,061	\$2,356,394	(\$645,321)
<b>Subtotal Territories</b>	<b>\$54,575,310</b>	<b>\$71,738,689</b>	<b>\$74,697,337</b>	<b>\$20,122,027</b>
<b>Total States/Cities/Territories</b>	<b>\$4,990,106,213</b>	<b>\$6,953,564,000</b>	<b>\$7,240,343,000</b>	<b>\$2,250,236,787</b>
Other Adjustments <sup>5</sup>	\$226,893,787	\$259,179,000	\$471,375,000	\$244,481,213
Undistributed proposed law <sup>6</sup>	\$0	\$0	\$328,000,000	\$328,000,000
<b>Total Resources<sup>7</sup></b>	<b>\$5,217,000,000</b>	<b>\$7,212,743,000</b>	<b>\$8,039,718,000</b>	<b>\$2,822,718,000</b>

<sup>1</sup> This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). Includes vaccine direct assistance and immunization infrastructure/operations grant funding. For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

<sup>2</sup> Vaccine direct assistance for Houston and San Antonio is included with the state of Texas.

<sup>3</sup> Awardee does not receive VFC funding.

<sup>5</sup> Other adjustments include vaccine that is in inventory at the centralized distribution center but has not been ordered by immunization providers, funds for centralized vaccine distribution activities, a centralized vaccine ordering system, pediatric stockpile, influenza stockpile, stockpile storage and rotation, and program support services.

<sup>6</sup> Reflects estimated funding impacts for VFC program under proposed law. Includes additional vaccine purchase costs for eligible populations and administration fees for uninsured individuals under proposed law. Estimated state allocations based on proposed law are not yet available.

<sup>7</sup> Total resources are based on the FY 2025 VFC PB 10 Year Table. The FY 2023 and FY 2024 estimates reflect current law. The FY 2025 PB includes a legislative proposal to expand the VFC program to include CHIP beneficiaries.

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## HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$1,391.056	\$1,391.056	\$1,391.056	\$0
<b>Total Request</b>	<b>\$1,391.056</b>	<b>\$1,391.056</b>	<b>\$1,391.056</b>	<b>\$0</b>
FTEs	1,119	1,144	1,144	24
-- Domestic HIV Prevention and Research	\$1,013.712	\$1,013.712	\$1,013.712	\$0
-- <i>Ending HIV Initiative (non-add)</i>	\$220.000	\$220.000	\$220.000	\$0
-- <i>School Health—HIV (non-add)</i>	\$38.081	\$38.081	\$38.081	\$0
-- Viral Hepatitis	\$43.000	\$43.000	\$43.000	\$0
-- Sexually Transmitted Infections (STIs)	\$174.310	\$174.310	\$174.310	\$0
-- Tuberculosis	\$137.034	\$137.034	\$137.034	\$0
-- Infectious Diseases and the Opioid Epidemic	\$23.000	\$23.000	\$23.000	\$0

**Enabling Legislation Citation:** PHS A § 301, PHS A § 306\*, PHS A § 307, PHS A § 308, PHS A § 310, PHS A § 311, PHS A § 317, PHS A § 317E\*, PHS A § 317N, PHS A § 317P\*, PHS A § 318\*, PHS A § 318A\*, PHS A § 318B\*, PHS A § 322, PHS A § 325, PHS A § 327, PHS A § 352, PHS A § 2315, PHS A § 2320, PHS A § 2341, PHS A §§ 2521, 2522, Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act of 1995 (Pub. L. 103-333, Title II).

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Formula Grants/Cooperative Agreements, Contracts, and Other

CDC envisions a future free of human immunodeficiency virus (HIV), viral hepatitis, sexually transmitted infections (STIs), and tuberculosis (TB). In working toward that future, CDC prioritizes cost-effective, scalable programs, policies, and research to achieve the greatest reduction in the incidence and disparities of these conditions—all of which have substantial individual, societal, and economic costs for all Americans, and an even greater cost for certain populations.

The nation has seen an increase in the transmission of infectious diseases such as viral hepatitis and HIV as well as drug use-related hospitalizations, overdoses, and fatalities. Eliminating the severe and disproportionate impact of these diseases would move the nation toward achieving health equity. CDC remains committed to strengthening the collaborative work across HIV, viral hepatitis, STIs, and TB programs, and improving the health of people who use drugs, including people who inject drugs and are at increased risk for hepatitis C, hepatitis B, and HIV to facilitate efficiency and integration of services to the public.

CDC’s FY 2025 budget request of **\$1,391,056,000** for HIV, Viral Hepatitis, Sexually Transmitted Infections and Tuberculosis is level with the FY 2023 final level.

## Syndemic Approach

Many of the diseases and conditions addressed by CDC share similar populations, geographic locations, and social and structural determinants. Certain populations in the United States experience a greater health burden of HIV, viral hepatitis, STIs, TB, and youth risk behaviors. The latest HIV incidence data show that gay, bisexual, and other men who reported male-to-male sexual contact accounted for the highest percentage of estimated HIV infections in 2021. This population was also disproportionately affected in the 2022 mpox outbreak in the United States. In addition, lesbian, gay, and bisexual high school students are two to four times more likely to experience violence, use drugs, or attempt suicide.<sup>5</sup> Treatment and prevention efforts are not reaching everyone equitably, which leads to health disparities.

CDC is using a syndemic approach that recognizes these commonalities across HIV, viral hepatitis, STIs, and TB, to address these related infections and develop capacities that can be shared across programs. This approach bolsters collaborative work across disease areas and continues to integrate services to improve efficiency, cost effectiveness, and achieve optimal health outcomes.

This approach looks across diseases, conditions, communities, and service sites to identify opportunities to integrate delivery of services to the public more efficiently and effectively. CDC aims to achieve these outcomes by ensuring:

- People who inject drugs are screened for infections like hepatitis C and HIV, receive vaccines, and are successfully linked to substance use treatment and care at healthcare encounters.
- STI clinics not only provide testing and treatment for STIs, but also offer services for hepatitis B, and provide pre-exposure prophylaxis (PrEP) for HIV.
- Clinics and community-based organizations that serve gay and bisexual men provide HIV, STI, and viral hepatitis testing and treatment and PrEP.
- People at higher risk for TB and hepatitis B are screened for both infections; and
- People who are experiencing homelessness receive comprehensive testing, prevention and care services, and housing assistance resources.

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<sup>5</sup> [https://www.cdc.gov/healthyouth/data/yrbs/pdf/YRBS\\_Data-Summary-Trends\\_Report2023\\_508.pdf](https://www.cdc.gov/healthyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf)

## HIV, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS AND TUBERCULOSIS

### BY THE NUMBERS

- **1,928,806**—HIV tests were conducted in 2022 by 60 CDC-funded state and local health departments and 119 community-based organizations (CBOs); 8,070 persons were newly diagnosed as HIV-positive.<sup>1</sup>
- **333,587**—Lab tests CDC conducted from 2015 to 2022 for outbreak investigations and surveillance for HIV, viral hepatitis, STIs, and TB.<sup>2</sup>
- **4,785**—Potential cases of congenital syphilis prevented by CDC-funded STI prevention programs in 2021 with a potential cost savings of \$69,411,210 in excess hospitalization costs at birth only, not including lifetime costs<sup>3</sup>.
- **34**—States that have declared an end to their hepatitis A outbreaks among people who used drugs or are experiencing homelessness. CDC continues to support the three states with active hepatitis A outbreaks and assist all states in surveillance, preparedness, and vaccination programs as needed.<sup>4</sup>
- **18**—State and local health departments funded to expand and facilitate access to viral hepatitis testing, treatment, and vaccination (contingent on funding) for people who inject drugs.
- **300**—Web searches per month for the new Hepatitis C Treatment Locator widget to find nearby treatment.<sup>5</sup> At least 20 partners per month are helping their communities to further promote linkage to hepatitis C care by hosting the widget on their websites.
- **480**—Syringe Services Programs (SSPs) responded to the National Survey of Syringe Services Programs (NSSSP), a survey that aims to improve information available regarding program and operational characteristics of SSPs within the United States, its territories, and tribal nations.
- **493**—U.S. tuberculosis genotype clusters for which CDC has performed whole-genome sequencing in 2022. Health departments use CDC’s whole-genome sequencing service to identify similarities or differences in the bacterial genomes of people who are diagnosed with TB disease. Whole genome sequencing data can show whether the cases are related or not, guiding health departments’ decisions on how to conduct outreach or contact investigations.
- **>10,000**—M. tuberculosis samples tested since 2009 by CDC’s Molecular Detection of Drug Resistance (MDDR) service to rapidly identify multidrug-resistant TB, helping clinicians prescribe the most effective treatment.
- **>30,000**—Unique gonorrhea isolates contained in CDC’s gonorrhea specimen bank – the largest in the world. CDC’s syphilis serum bank contains syphilis serum from more than 650 patients and is replenished yearly.

\*References: Unless otherwise noted, all information and calculations are from CDC program data.

<sup>1</sup> Internal CDC Data.

<sup>2</sup> Data point is not exclusive to outbreak activities, but inclusive of these activities.

<sup>3</sup> Hospitalization cost of congenital syphilis diagnosis from insurance claims data in the United States - PubMed (nih.gov).

<sup>4</sup> As of December 2023.

<sup>5</sup> Since its launch in April 2023.

## **Program Accomplishments**

Between 2017 and 2021, approximately 9,000 HIV infections were prevented which saved an estimated \$5 billion in lifetime medical costs. CDC found a significant decrease in HIV incidence in 2021 compared to 2017 in *Ending the HIV Epidemic in the U.S.* (EHE) Initiative counties across the country, declining 16 percent. This finding provides evidence that the EHE initiative and its resources are having an additional impact on the HIV epidemic in the United States and the number of new infections that occurred since the initiative began. Between 2019 and 2021 alone, approximately 2,020 HIV infections have been prevented in EHE jurisdictions, which saved an estimated \$1 billion in medical costs. The many successes for EHE include:

- CDC supported an innovative partnership between the Baltimore City Health Department, and the public health service program I Want the Kit (IWTK). Referrals from Baltimore City’s sexual health clinics resulted in a 645 percent increase in monthly orders. Between 2021 and 2022, they processed over 3,000 HIV self-tests after in-person visits resumed.
- South Carolina’s CDC-funded HIV testing programs conducted 216,196 HIV tests, identifying 960 persons who were newly diagnosed with HIV infection during 2019 through 2022. The South Carolina Department of Health and Environmental Control (DHEC) has introduced community health workers (CHWs) serving as “boots on the ground” bringing additional momentum to DHEC’s HIV prevention activities especially in hard-to-reach populations of the state.
- Oklahoma’s CDC-funded HIV testing programs conducted 2,901 HIV tests in 2022, identifying 40 persons who were newly diagnosed with HIV infection. In 2022, Oklahoma’s CDC funded HIV programs also linked 100 percent of persons with newly diagnosed HIV infection to HIV medical care within 30 days of diagnosis.
- Jefferson County Department of Health in Birmingham, Alabama, increased clinic capacity at all three of its sexual health clinics by implementing an express STI service model, known as Fast Track. From 2020 to 2022, the Fast Track Program increased its patient volume by almost 210 percent, with plans to further expand Fast Track services through the implementation of online self-scheduling. As of July 2023, clinics have completed 1,252 visits since the start of the year. With Fast Track in place, providers can dedicate more of their appointment time to patients with symptoms suggestive of an STI, and patients with or without symptoms can more easily receive the timely STI and HIV testing services they need.

In 2023, to further enhance Syringe Services Programs’ (SSPs) surveillance capacity, the survey team prioritized outreach to tribal organizations to improve National Survey of Syringe Services Programs (NSSSP) survey participation as part of the Strengthening Syringe Services Programs funding agreement. From this outreach, CDC hopes to gain a better understanding of the experiences of SSPs in tribal communities, gain insights into the types of support needed for SSPs that serve tribal communities and any resource deficits they are experiencing, and highlight their life-saving work. Preliminary data reveal strong participation with 73 percent of invited SSPs participating in the survey. The NSSSP report will likely be disseminated in the spring of 2024.

Over a 20-year period, U.S. tuberculosis (TB) control efforts averted as many as 319,000 cases of TB and up to \$14.5 billion in medical and societal costs from TB deaths. In addition, the percentage of eligible patients completing treatment in one year rose from 63.4 percent in 1993 to 89.0 percent in 2020. Further, CDC’s support and funding over the period from 2008 to 2022 for syphilis, gonorrhea, and chlamydia prevention activities averted an estimated \$3.8 billion in lifetime medical costs.<sup>6</sup> Beginning in 2021, CDC invested an additional \$1.5 million to fund four jurisdictions to develop, implement, and evaluate interventions to reduce congenital syphilis. One site partnered with a local jail to provide testing for women of reproductive age. In June 2023, the overall syphilis positivity rate was 26 percent, and the treatment completion rate was 73 percent with an additional 7 percent in progress to complete treatment. Another site partnered with a prenatal clinic

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<sup>6</sup> Chesson HW, Ludovic JA, Berruti AA, Gift TL. Methods for sexually transmitted disease prevention programs to estimate the health and medical cost impact of changes in their budget. *Sex Transm Dis* 2018; 45(1):1-7. DOI: 10.1097/OLQ.0000000000000747.



targeting pregnant persons experiencing homelessness or substance use disorders. At this clinic, 92 percent of patients diagnosed with syphilis completed treatment. Syphilis screening for women in emergency departments is also being pursued. In one month, 1,144 syphilis tests were conducted with 101 syphilis diagnoses; of those, five were currently pregnant.

<b>HIV, Viral Hepatitis, Sexually Transmitted Infections, and TB Funding History</b>	
Fiscal Year	Dollars (In millions)
FY 2021	\$1,310.019
FY 2022	\$1,345.056
FY 2023 Final	\$1,391.056
FY 2024 CR	\$1,391.056
FY 2025 President’s Budget	\$1,391.056

<b>CDC-Wide HIV/AIDS Funding</b>			
Fiscal Year	Domestic HIV/AIDS Prevention and Research (Infectious Disease) (Dollars in millions)	Global HIV/AIDS Program (Dollars in millions)	CDC-Wide HIV Total (Dollars in millions)
FY 2021	\$964.712	\$128.421	\$1,093.133
FY 2022	\$986.712	\$128.921	\$1,115.633
FY 2023 Final	\$1,013.712	\$128.921	\$1,142.633
FY 2024 CR	\$1,013.712	\$128.921	\$1,142.633
FY 2025 President’s Budget	\$1,013.712	\$128.921	\$1,142.633

**Budget Request**

CDC’s FY 2025 budget request of **\$1,013,712,000** for Domestic HIV/AIDS Prevention Research is level with the FY 2023 final level. This request includes **\$220,000,000** for the Ending the HIV/AIDS Initiative and **\$38,081,000** for School Health, which is also level with the FY 2023 final level.

In FY 2025, CDC will continue:

Funding health departments, and national and community-based organizations (CBOs) to:

- Conduct HIV testing,
- Provide critical prevention interventions like PrEP and post-exposure prophylaxis (PEP), and
- Improve linkages to care to reach and maintain greater rates of viral suppression.

CDC [awards more than \\$400 million each year to health departments](#) in all 50 states, Washington, D.C. and U.S. territories to reach populations and geographic areas with the greatest needs. Health departments are required to partner directly with CBOs that have a long history of meeting the HIV prevention needs of disproportionately affected groups. In FY 2022, CDC also awarded approximately \$61 million to CBO partners. This includes [96 CBOs](#) to implement HIV prevention activities and to address HIV-related health disparities and an additional [36](#)

[CBOs](#) to provide focused HIV prevention and care services to young MSM and transgender persons of color and their partners.

Additionally, CDC partners with national and community level organizations to develop and maintain a well-trained HIV prevention workforce that is representative of the communities they serve. CDC’s [Capacity Building Assistance \(CBA\) programs](#) help implement and sustain science-based and culturally appropriate HIV prevention interventions in communities. Nationally, learners from 216 unique organizations completed 565 HIV prevention courses with the most requested content area being increasing awareness of, access to, and adherence to PrEP.

**Conducting public health [surveillance](#) activities:** CDC’s surveillance activities, which take place in all 50 states, Washington, D.C., and U.S. territories, gather information to help us know if collective HIV prevention efforts are working. This information is critical to understanding the HIV epidemic and should be secure and used for strictly for public health purposes. This information is critical to understanding the HIV epidemic and should be secure and used strictly for public health purposes. Once compiled and analyzed, the data are disseminated to other federal, state, and local partners to inform programmatic planning and resource allocation. In addition, CDC and health departments analyze HIV data to identify areas where there is rapid HIV transmission through HIV cluster detection and response (CDR). CDR helps public health agencies and communities identify where to boost HIV prevention and treatment services and programs. From 2022 to 2023, 266 clusters of HIV infections were reported to CDC and addressed by 46 health departments.

**Investing in adolescent and school health:** CDC strengthens schools’ capacity to promote adolescent health and well-being, create safe and supportive environments, increase school connectedness, and prevent HIV, STDs, and unintended pregnancies. Experiences and behaviors during the adolescent years can present immediate risk for HIV and STDs, which can cause serious health consequences into adulthood. CDC collects data to monitor adolescent health risk behaviors and experiences and conducts school-based prevention activities such as health education, health services, and providing safe environments, which have been proven to improve health behaviors and experiences and support students’ mental health.<sup>7</sup> Data from the Adolescent Behaviors and Experiences Survey (ABES)<sup>8</sup> show that most Asian, Black, and multiracial students experienced racism during their life. Experiencing racism was associated with poor mental health among students. Additionally, [data from the 2021 Youth Risk Behavior Survey](#) show that six out of 10 girls felt persistently sad or hopeless and nearly one-third had seriously contemplated suicide. This data informs the Administration’s national mental health strategy.<sup>9</sup>



CDC implements the [What Works in Schools \(WWIS\)](#) program to ensure young people have the skills, information, and support they need for a healthy adolescence and into adulthood. This evidence-based approach for education agencies reaches nearly 2 million students and reduces sexual risk behavior, experience of violence, substance use, and poor mental health among students in schools. Schools served by CDC-funded local education agencies (LEAs) have seen significant declines in the percentage of students engaged in sexual risk behavior, who used substances like marijuana, and experienced violence like sexual

<sup>7</sup> [Local Education Agency Impact on School Environments to Reduce Health Risk Behaviors and Experiences Among High School Students - ScienceDirect](#)

<sup>8</sup> [https://www.cdc.gov/mmwr/volumes/71/su/su7103a4.htm?s\\_cid=su7103a4\\_w#suggestedcitation](https://www.cdc.gov/mmwr/volumes/71/su/su7103a4.htm?s_cid=su7103a4_w#suggestedcitation)

<sup>9</sup> <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/>

assault<sup>10</sup>. Schools in funded districts that implemented policies and practices to support LGBTQ youth saw improved mental health and decreased suicidal ideation in both LGBTQ and heterosexual students.<sup>11</sup>

**Supporting effective HIV prevention programs:** CDC continually improves domestic HIV prevention through world class scientific expertise, cutting edge technology, communication science, and translating prevention research into practice through investments in:

- **Workforce Development:** CDC builds workforce capacity by providing national training programs, regional technical assistance, marketing support, field assignees, and quality improvement. CDC also provides sustainability support for health departments and CBOs.
- **Laboratory Science:** CDC’s cutting-edge HIV laboratory works in collaboration with the National Institutes of Health, industry, and academia to identify new biomedical approaches to HIV prevention and innovative diagnostic techniques. The laboratory also serves as a world-renowned HIV reference laboratory, which monitors HIV resistance patterns. From 2015 to 2022, the HIV lab has conducted more than 27,000 tests to support outbreak investigations and surveillance across the country.
- **Translation Research and Guidelines:** CDC uses [prevention research](#) to identify promising HIV prevention strategies and programs, evaluate their effectiveness, and inform implementation of [new HIV prevention practices](#).
- **Education Campaigns:** CDC uses communication science to reduce stigma, raise awareness about HIV in the United States, and promote HIV prevention and testing focused on populations most affected by HIV through the [Let’s Stop HIV Together campaign](#), including CDC’s #ShesWell initiative which aims to increase PrEP awareness among women and their healthcare providers. In 2023, the Let’s Stop HIV Together campaign outreach generated an estimated 12.2 million media impressions to reach health care providers, and 334 million media impressions to reach priority populations across the country.

## Domestic HIV Prevention and Research Budget Request

An estimated 1.2 million people with human immunodeficiency virus (HIV) live in the United States, and there were approximately 32,100 new HIV infections in 2021. HIV prevention and treatment efforts have yielded major successes—saving lives and money. Between 2017 and 2021, approximately 9,000 HIV infections were prevented which saved an estimated \$5 billion in lifetime medical costs. CDC’s high-impact HIV prevention approach uses public health data to inform decision-making and prioritizes the implementation of scientifically proven, cost-effective, and scalable HIV prevention interventions. This approach has resulted in:

1. Elimination of perinatal transmission (when HIV is passed from a person with HIV to their child during pregnancy) in 2019.
2. Reduction in the annual number of new diagnoses of HIV infection by 12 percent from 2017 to 2021.
3. Increase in the percentage of persons with diagnosed HIV who are virally suppressed from 63 percent in 2017 to 66 percent in 2021.
4. Increase in PrEP coverage from 23 percent in 2019 to 36 percent in 2022.

CDC is committed to achieving health equity for all people living in the United States affected by HIV. CDC’s HIV prevention and care efforts are aligned with the 2022-2025 National HIV/AIDS Strategy (NHAS) which established bold targets for ending the HIV epidemic in the United States by 2030. However, stigma, poverty, lack of access to care, and other social determinants of health continue to drive disparities. CDC’s nationwide surveillance is essential to understand the status of the HIV epidemic, progress towards goals, and where disparities exist. CDC data illustrates progress on the NHAS indicators that are critical for advancing HIV

<sup>10</sup> <https://www.cdcgov/healthyyouth/whatworks/index.htm>

<sup>11</sup> <https://www.sciencedirect.com/science/article/pii/S1054139X21006789>

prevention in the United States. Key 2021 surveillance information that informs our high-impact prevention approach includes:

- Southern states accounted for about 52 percent of all people with an HIV diagnosis in the United States, despite representing only about 39 percent of the U.S. population. In addition, people with HIV in the South are less likely to be aware of their infection than those living in other U.S. regions.
- Gay, bisexual, and other men who have sex with men (MSM) accounted for 67 percent of HIV diagnoses in the United States, women accounted for 1 in 5 HIV diagnoses, and persons who inject drugs accounted for about 1 in 15 HIV diagnoses.
- Diagnoses continued to be the highest among Black persons compared to other racial and ethnic groups. Black persons accounted for 40 percent of new HIV diagnoses in the United States.

### **Ending the HIV Epidemic in the U.S. (EHE) Initiative**

The EHE initiative builds on CDC’s core investments in HIV prevention and provides affected communities with the expertise, technology, and resources to address the HIV epidemic locally. EHE was first announced in 2019 and its comprehensive approach focuses resources in 57 jurisdictions where they are needed most, including seven states with a substantial rural burden, and strives to meet people where they are with the services they need.

### **Budget Request**

CDC’s FY 2025 budget request of **\$220,000,000** for the EHE Initiative is level with the FY 2023 final level.

In FY 2025, CDC will continue to employ cross-cutting approaches to maximize the impact of resources, including expanding innovations in HIV prevention delivery to improve access to prevention and care services, engaging community partners meaningfully in planning and implementation of HIV prevention programs, using syndemic collaborations to broaden reach of services to key populations, and creating efficiencies and reducing stigma. CDC also supports early career public health professionals through placement in EHE-funded jurisdictions based on needs identified by health departments across the United States. This is critical when the health departments do not have the capacity to hire staff.

CDC’s EHE efforts continue to focus on four strategies—Diagnose, Treat, Prevent, and Respond—that when augmented by EHE funding and the collaborative efforts of other HHS partners, can end the HIV epidemic in the United States:

**Diagnosing** all individuals with HIV as early as possible can lead to improved health outcomes, rapid treatment, and prevention of transmission to others. Approximately one in seven of the estimated 1.2 million people with HIV in America still don’t know they have HIV. CDC partners with state and local organizations to focus testing where it is needed most. Between 2021 and 2022, health departments used EHE funding to conduct nearly 600,000 HIV tests, identifying over 8,500 individuals with HIV, of which 2,400 people received a new HIV diagnosis. CDC health department recipients also distributed an additional 40,000 HIV self-test kits locally. In addition, CDC distributed 400,000 HIV self-test kits to populations disproportionately affected by HIV and recently awarded funding<sup>12</sup> to provide at least 875,000 HIV self-test kits across the United States. This program focuses distribution of these kits to populations disproportionately affected by HIV.

**Treating** people with HIV rapidly and effectively using preventive medicine that reduces viral load to the point where an infected individual cannot transmit HIV to their sex partner. CDC estimates that people with HIV who are unaware they have HIV or are not receiving HIV care and treatment transmit 80 percent of new HIV

<sup>12</sup> <https://www.cdc.gov/hiv/funding/announcements/ps22-2210/index.html>

infections. In 2021, CDC recipients used EHE funding to link 84 percent of persons newly diagnosed with HIV to medical care within 30 days, and 100 percent of previously diagnosed persons who were not receiving care were provided or referred to medication adherence support. In 2022, six jurisdictions funded through CDC EHE-funded programs met the 2025 goal of linking 95 percent of newly diagnosed persons to care.

**Preventing** new HIV transmissions by using effective interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs). When taken as directed, PrEP can reduce the risk of HIV infection by about 99 percent, and SSPs are associated with an estimated 50 percent reduction in HIV and hepatitis C (HCV) incidence. When combined with medication-assisted treatment, HIV and HCV transmission is reduced by over two-thirds. CDC funding supports:

- **Improved uptake of PrEP:** From 2021 to 2022, CDC EHE-funded programs provided more than 44,000 people prescriptions for PrEP. Among CDC EHE-funded programs, five jurisdictions met the 2025 goal, linking or prescribing PrEP for at least 50 percent of eligible people. CDC investments in STI clinics also identified more than 15,000 patients as PrEP eligible, and of these, 40 percent of the patients were newly prescribed PrEP or continued on PrEP.
- **Implementation of SSPs:** From 2021 to 2022, CDC EHE-funded programs increased connections to SSPs from 108 to 261 SSPs, of which 93 are fixed locations and 168 are mobile or outreach locations. CDC also funds technical assistance providers who work to ensure that recipients implement high quality and comprehensive SSPs.

**Responding** quickly to HIV clusters or outbreaks ensures that prevention and treatment services are delivered to people who need them most. Rapidly available data allow health departments and partners to quickly direct resources to communities that need them most by identifying and addressing gaps in services. Among people who were tested as part of a cluster response, the positivity rate was almost 20 times higher than other testing programs. In addition, more than 500 people (40 percent) who were not virally suppressed at the time they were found to be part of a cluster, reached viral suppression within six months. From 2022 to 2023, 266 [clusters of HIV infections](#) were reported to CDC and addressed by 46 health departments. Fifty-two jurisdictions use a bioinformatics tool developed and managed by CDC that allows these health departments to identify molecular clusters of HIV infections in near-real time.

### School Health Budget Request

CDC’s FY 2025 budget request of **\$38,081,000** for School Health is level with the FY 2023 final level.

CDC works to strengthen schools to prevent HIV, other STDs, and unintended pregnancy, and help youth become healthy, successful adults. Experiences and behaviors during adolescence not only present immediate risk for HIV and STDs but can have serious health consequences into adulthood. Sexual behavior, substance use, experience of violence, and mental health problems all place adolescents at increased risk for HIV and STIs.

As part of the Secretary’s HHS, Roadmap for Behavioral Health,<sup>13</sup> CDC will continue to build upon the success of the *What Works in Schools Program*, investing in LEAs nationwide, and impacting the lives of approximately 2 million middle and high school students in FY 2025. This investment will continue to bolster CDC’s established evidence-based approach that, when implemented in schools, positively impacts adolescent health and well-being, and will continue to add to the success of existing adolescent health prevention and promotion activities within HHS.

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<sup>13</sup> <https://www.hhs.gov/about/news/2022/12/02/hhs-roadmap-for-behavioral-health-integration-fact-sheet.html>

CDC's *What Works in Schools Program* strengthens the integrated delivery of mental health promotion and treatment interventions to students and families by allowing school administrators to create programs for their schools and students that are tailored to respond to the specific needs of different communities.

**Evaluation of CDC HIV/AIDS School Health Activities:** CDC's school health program is building new evidence and strengthening capacity for rigorous evaluation and data analytics through:

- Developing and maintaining internet-based data collection systems to gather information about funding recipients' program activities.
- Linking existing data collection systems such as the Youth Risk Behavior Surveillance System (YRBSS) and School Health Profiles (Profiles) with program performance monitoring systems to enable assessment of population level behavior change correlated with program implementation activities.
- Implementing and evaluating demonstration projects in LEAs to fill gaps in existing evidence about school health and inform future program direction.

Linking YRBSS with Profiles and other school-based federal data sets enables large scale evaluation of the impact of school policies and practices on youth health behaviors and experiences. These activities have helped support the strongest and most rigorous evaluation of the CDC funded programs to date. Findings from this evaluation were published across multiple peer-reviewed manuscripts. The evaluation has shown that students participating in CDC's *What Works in Schools* program reported lower prevalence of several risk behaviors across sexual risk, substance use, and violence domains. In addition, analyses have documented that specific aspects of the program approach that address safe and supportive school environments were linked to reduced sexual risk behaviors, violence victimization, substance use, and suicide attempts among students.

## Viral Hepatitis Budget Request

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Millions of people are living with viral hepatitis, but about one in three people with hepatitis C and about one in two people with hepatitis B are unaware of their infection. CDC estimated that in 2021 there were 13,300 acute hepatitis B and 69,800 hepatitis C virus infections in the United States. Viral hepatitis is a serious public health threat and a leading cause of liver cancer. Although hepatitis B can be treated and hepatitis C can be cured, viral hepatitis kills thousands of Americans every year. Viral hepatitis is costly and puts significant burden on the U.S. healthcare system. The estimated cost of providing health care services for people living with chronic hepatitis C virus infection is \$15 billion annually.<sup>14</sup> Caring for individuals affected by recent hepatitis A outbreaks has cost the nation more than \$445 million between July 1, 2016, and July 7, 2023.<sup>15,16</sup>

### Budget Request

CDC's FY 2025 budget request of **\$43,000,000** for Viral Hepatitis is level with the FY 2023 final level. In FY 2025, CDC will continue to support 59 health departments to conduct viral hepatitis outbreak response and surveillance, support jurisdictional viral hepatitis elimination planning and implementation, and work with health clinics and community organizations to promote awareness and uptake of updated national viral hepatitis testing and vaccination recommendations. This funding begins to advance efforts to achieve viral hepatitis elimination in the United States through local community viral hepatitis awareness and education, training of health care providers on clinical care, management, and treatment of hepatitis B and C, and syringe services programs (SSPs).

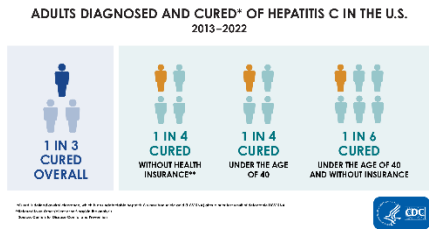
<sup>14</sup> Chahal, H. S., et al. (2016, January). Cost-effectiveness of early treatment of hepatitis C virus genotype 1 by stage of liver fibrosis in a U.S. treatment-naive population. *The Journal of the American Medical Association*, 176(1), 65–73. Retrieved October 25, 2017, from <https://pubmed.ncbi.nlm.nih.gov/26595724/>.

<sup>15</sup> Hofmeister MG, et. al. Hepatitis A Hospitalization Costs, United States, 2017. *Emerg Infect Dis*. 2020;26(5):1040-1041. <https://dx.doi.org/10.3201/eid2605.191224>.

<sup>16</sup> This does not include costs of the public health response for state health departments, making the estimated burden even greater.

## Testing and Linking to Care and Treatment

Testing for hepatitis B and C is cost saving and improves health outcomes. In March 2023, CDC released updated hepatitis B screening and testing recommendations, calling for universal screening at least once in a lifetime for all adults aged 18 years or older. CDC is partnering with viral hepatitis organizations to promote these updated screening recommendations with health professionals’ organizations.



Despite the availability of highly effective medications capable of curing hepatitis C, a recent CDC analysis found that the number of people being treated declined from 2014 to 2020; an average of 171,000 people were treated each year, falling far short of national public health goals published in 2015 stating that at least 260,000 people with hepatitis C should be treated annually to achieve hepatitis C elimination in the United States by 2030. The cost of hepatitis C treatment has decreased to

an average of \$25,000 due to increased competition from drug makers, programs contracting for lower costs, and innovative state treatment models. However, while the cost of treatment has decreased in recent years, cost is still a barrier for many people. A systematic review found that the median price at which second generation direct-acting antivirals (DAAs) become cost-saving was \$70,900 (IQR: \$43,300-\$103,700) in 2014 U.S. dollars. While hepatitis C treatment has been shown to save lives, another CDC analysis found that from 2013 – 2022, only 34 percent of all persons diagnosed with hepatitis C were cured (i.e., achieved viral clearance). During this period, the cure rate was lowest among adults aged 20-39 years without medical insurance (16 percent). To improve access to life saving treatment, CDC continues to promote uptake of the screening and testing recommendations through collaborations with health departments, community-based organizations (CBOs), national policy and provider organizations, health systems, and public health and commercial laboratories.

With financial support from CDC, the National Viral Hepatitis Roundtable (NVHR) and the National Alliance of State and Territorial AIDS Directors (NASTAD) hosted a two-day virtual meeting, Unlocking HCV Care in Key Settings, in September 2023. The purpose of the meeting was to examine promising models and best practices for integrating hepatitis C testing and treatment in high-impact settings such as federally qualified health centers (FQHCs), state correctional facilities, SSPs, and programs providing medications for opioid use disorder (MOUD) as well as facilitating conversations on barriers to providing HCV testing and treatment in each key setting. To assist with further accelerating access to treatment, CDC released updated operational guidance for HCV testing in 2023 that includes a recommendation that HCV testing be completed in a single healthcare visit and explicitly calls out hepatitis C antibody testing without HCV RNA testing of antibody-positive samples as incomplete testing. CDC also published recommendations in 2023 to increase identification and treatment of children with HCV infection acquired during pregnancy or delivery (also known as perinatal HCV infection). Rates of new HCV infections in the United States tripled among reproductive-aged persons during 2010—2021, leading to an increasing number of infants acquiring hepatitis C during pregnancy or delivery. Only about 30 percent of infants and children perinatally exposed to hepatitis C are tested, and many children with chronic HCV infection are lost to follow-up.

## Preventing Viral Hepatitis

To reach national hepatitis B vaccination goals, CDC provides data and analyses to medical providers and public health experts to improve existing vaccination or development of new vaccination recommendations. In 2022, CDC published updated hepatitis B vaccination recommendations among adults, now recommending all adults aged 19-59 years be vaccinated against hepatitis B infection.

CDC leverages its expertise and resources to prevent new infections by providing technical assistance to jurisdictions to implement SSPs, which play a critical role in preventing viral hepatitis among people who inject drugs (PWID). CDC also trains state and local health department staff to actively identify networks of viral hepatitis transmission among PWID and other disproportionately affected populations to precisely target

prevention interventions and prevent outbreaks. In 2022, CDC funded 17 health departments to complete special projects addressing infectious diseases transmitted through injection drug use; of which, 12 provided support to SSPs. CDC provides technical assistance to 17 health departments to develop and implement a PWID service bundle, which is a list of services designed to prevent, reduce, or treat infectious disease complications of injection drug use, including testing for hepatitis C, hepatitis B, and HIV, vaccination for hepatitis A and hepatitis B, assessment for opioid use disorder, and medication for opioid use disorder for those with known opioid use disorder. In 2023, CDC funded and supported two health departments to develop systems for integrating genomic and epidemiologic surveillance for detection of HCV transmission clusters and public health response, to build jurisdictional capacity to integrate genomic surveillance into the existing epidemiological surveillance of HCV infections, and to assess effectiveness of integrated genomic and epidemiologic surveillance to improve identification of HCV transmission networks.

### **Monitoring and Supporting Data-to-Action**

Public health surveillance provides data needed to monitor and control the spread of viral hepatitis. Surveillance also ensures that resources target areas and populations most at risk. Surveillance for viral hepatitis is labor intensive and health departments have limited capacity for collecting, verifying, and reporting the many cases of viral hepatitis in the United States.<sup>17</sup> CDC's viral hepatitis laboratory supports viral hepatitis surveillance and uses innovative research techniques to develop novel diagnostic methods and studies how viruses replicate and cause disease. In support of state and local health department surveillance efforts, CDC performed more than 15,000 viral hepatitis tests in 2022. Molecular epidemiologic analysis using Global Hepatitis Outbreak Surveillance Technology (GHOST) has been utilized successfully to map HCV transmission networks. To support health departments in developing an integrated epidemiological and molecular surveillance system for HCV infection to identify HCV transmission clusters and outbreaks for public health action, CDC awarded additional funding to two states to conduct a pilot project integrating epidemiologic and surveillance data to improve hepatitis C outbreak detection and response.

### **Responding to Outbreaks**

CDC continues to provide technical assistance for outbreaks of hepatitis A, other hepatitides, and SARS-CoV-2. In FY 2023, CDC's viral hepatitis laboratory performed more than 15,000 hepatitis C tests as part of the National Health and Nutrition Examination Survey (NHANES) studies. In addition, CDC's viral hepatitis laboratory also continued to support the COVID-19 response by testing over 3,500 samples for various markers of SARS-CoV-2 exposure and immunity from January 2023 to September 2023.

Thirty-seven states reported outbreaks of hepatitis A involving person-to-person transmission since 2016. CDC has provided technical assistance to all states on preventing and responding to these outbreaks, and has deployed epidemiologists, laboratorians, public health advisors, and disease intervention specialists, to provide on-the-ground support in nine states. Further, CDC continues to support vaccine supply and vaccine policy development. In 2023, CDC stood down its incident management system (IMS) for coordinating its hepatitis A outbreak. As of December 2023, only three states (Indiana, Maryland, Pennsylvania) remain with declared outbreaks.

## **Sexually Transmitted Infections Budget Request**

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Sexually transmitted infections (STIs) continue as a national public health problem – spanning various communities and groups and all regions of the United States. In 2021, more than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported. Beyond individual and community health impacts, STIs are costly for the

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<sup>17</sup> Not all states report data to CDC or permit CDC to publish their data in national surveillance reports.



U.S. healthcare system. There are more than 26 million estimated new STI cases annually,<sup>18</sup> costing the healthcare system \$17.2 billion in lifetime direct medical costs, including 2,500 new STI-attributable HIV cases annually at a cost of more than \$1.1 billion.<sup>19</sup>

Adverse health outcomes of STIs include infant death, birth defects, neurological conditions, increased risk of HIV infection, infertility, and pelvic inflammatory disease (PID). The Southern states, some racial and ethnic minority groups, gay and bisexual men, and our nation’s youth continue to experience higher rates of STIs.

### Budget Request

CDC’s FY 2025 budget request of **\$174,310,000** for Sexually Transmitted Infections is level with the FY 2023 final level. In FY 2025, CDC will continue to support state and local health departments to mitigate the spread of STIs. CDC will continue to conduct STI surveillance and support states to conduct STI prevention and control activities. This funding level will also support training and educational resources for healthcare professionals, research and evaluation studies, and the translation of findings to improve STI prevention programs. CDC will also continue to support efforts in alignment with the 2020 HHS STI National Strategic Plan and the Federal Implementation Plan released in June 2023.

### **Providing direct funding to health departments to prevent and control STIs**

CDC is the only federal agency that directly supports and funds STI prevention and control activities of state, territorial, and local health departments. CDC is prioritizing investing in state and local health departments in all 50 states, the District of Columbia, and select cities and territories to:

- Collect and analyze information on notifiable STIs (i.e., syphilis, gonorrhea, chlamydia, and chancroid). In 2021, health departments reported a record number of syphilis cases (176,713) and gonorrhea cases (710,151). There were 1.6 million chlamydia cases, a slight increase from 2020.
- Conduct disease investigations, contact tracing, and linkage to treatment for patients diagnosed with STIs, including HIV, to reduce adverse health outcomes and prevent further spread.
- Respond and contain outbreaks.

STI public health department staff have made extraordinary efforts to respond to COVID-19 and mpox in their jurisdictions. CDC also supports health departments to identify and report mpox and offer vaccination to priority populations.

### **Investing in preventing new infections and containing outbreaks**

Reported cases of syphilis (all stages) have increased 74 percent since 2017, totaling more than 176,000 cases in 2021. Despite being preventable, congenital syphilis (CS) continues to surge, increasing 203 percent in the past five years. In 2021, 37 states and the District of Columbia reported increases in CS cases. CS results in infant death in up to 40 percent of cases. Among infants who survive, CS can cause developmental delays, permanent deafness, neurological impairment, and bone deformities. CDC released a new Vital Signs on Missed Opportunities for Preventing Congenital Syphilis to raise awareness and provide strategies to increase timely testing and treatment.<sup>20</sup> The reasons for STI increases are multifaceted – and so are the solutions. As we reach historic highs in case reports, innovation is critical.

<sup>18</sup> The total number of prevalent and incident infections in the United States for 8 STIs: chlamydia, gonorrhea, trichomoniasis, syphilis, genital herpes, human papillomavirus, sexually transmitted hepatitis B, and sexually transmitted HIV.

<sup>19</sup> Chesson et al. The Estimated Direct Lifetime Medical Costs of Sexually Transmitted Infections Acquired in the United States in 2018. *Sex Transm Dis.* 2021;48(4):215-221. DOI: <https://doi.org/10.1097/olq.0000000000001380>.

<sup>20</sup> McDonald R, O’Callaghan K, Torrone E, et al. Vital Signs: Missed Opportunities for Preventing Congenital Syphilis — United States, 2022. *MMWR Morb Mortal Wkly Rep* 2023;72:1269–1274. DOI: <http://dx.doi.org/10.15585/mmwr.mm7246e1>

CDC provides national leadership, programmatic research, policy assessment, and scientific information about STIs to the clinical community and the public. CDC invests in innovations for STI testing and service delivery to support new syphilis diagnostics for point of care applications for treponemal and non-treponemal tests and for assays to diagnose active infections in a variety of biological samples. CDC also conducts scientific investigations to better understand how diseases spread throughout communities and promotes evidence-based STI care through the publication of the gold standard STI Treatment Guidelines and its mobile medical app, and through the National Network of STD Clinical Prevention Training Centers (NNPTCs). CDC's STI program also works collaboratively on the U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB) initiative, monitoring and mitigating the spread of antibiotic resistant gonorrhea and supporting surge capacity in health departments. Through CDC's AR Lab Network, CDC continued to provide Antimicrobial Susceptibility Testing (AST) testing of nearly 3,700 gonorrhea isolates and whole genome sequencing of more than 2,950 gonorrhea isolates collected through its gonococcal surveillance programs between October 2022 and October 2023. In 2024, CDC will release final Guidelines for the Use of Doxycycline Post-Exposure Prophylaxis (Doxy PEP) for Bacterial STI Prevention, representing a new approach to STI prevention. Doxy PEP has demonstrated substantial benefit in reducing new chlamydia, gonorrhea, and syphilis infections when implemented in the context of a comprehensive sexual health approach. CDC's existing systems will facilitate monitoring for the development of antimicrobial resistance in STI and non-STI pathogens though enhanced implementation and evaluation studies are needed to better understand the impact of Doxy PEP. CDC's STI program webpage continues to be a trusted and highly visited source of information with more than 38 million views in 2022.

In September 2023, CDC's STI program broadened their partnership with national reach organizations to provide technical assistance to state, local, and territorial, STD/HIV public health programs on systems, policy and communication, partnerships, special and emerging STD program projects, and leadership education and training to advance STD prevention objectives. CDC's STI program also developed an STI Impact Research Consortium to support service delivery research, field-based prevention research, and research to develop, test, and implement STI diagnostic tools to increase the proportion of people tested and diagnosed. To support the *Ending the HIV Epidemic in the U.S. (EHE) initiative* in 2023, CDC awarded \$11.6 million in fourth year funding to strengthen capacity of STI clinics, which serve a high volume of racial/ethnic and sexual minorities. In 2022, the funded STI clinics tested nearly 150,000 patients, diagnosed more than 1,100 new cases of HIV, and prescribed PrEP to more than 7,400 patients. Further innovation in STI prevention is critical to turn the tide. There is a need for investment in new STI research, technology, innovation, program capacity, and community partnerships that work directly with priority populations.

In addition, CDC staff enhanced the capacity of public health programs to respond to STIs by embedding ~70 field staff across the country in state and local STI programs. In 2023, CDC conducted an Epi-Aid for the Great Plains Tribal Leaders' Health Board in response to an outbreak of syphilis and congenital syphilis. The Epi-Aid enhanced understanding of the syphilis outbreak in the Great Plains Area, facilitated communication and collaboration among key partners, identified potential avenues for enhancing local syphilis prevention and control, and furthered primary and secondary prevention efforts for persons with syphilis or at risk of syphilis, including women of reproductive age, through disease intervention activities.

## **Tuberculosis Budget Request**

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CDC is the lead agency for eliminating tuberculosis (TB) in the United States and a global expert in programmatic TB research, laboratory science, TB surveillance, epidemiology, education, and training. CDC data show that TB incidence increased for a second year in a row in the United States. During 2022, 8,331 TB cases were reported in the United States, compared with 7,870 cases reported in 2021. The rate of TB cases per 100,000 in Black or African American persons is seven times higher than the rate of TB cases in non-Hispanic White people, ten times higher for Hispanic/Latino people, eleven times higher for American Indian or Alaska Native people, and 33 times higher for Asian people. People who spend time in crowded living conditions with poor access to medical care, such as homeless shelters and correctional facilities also have higher rates of TB.

## Budget Request

CDC's FY 2025 budget request of **\$137,034,000** for Tuberculosis is level with the FY 2023 final level. In FY 2025, CDC will continue to support 50 states, eight cities, Washington, D.C., and two territories to conduct TB surveillance and oversee the medical and public health management of persons with TB disease and their contacts. CDC will fund four TB Centers of Excellence (COEs) to provide training and technical assistance for contact tracing, outreach and case management, TB educational materials, and medical consultation for healthcare professionals treating TB patients. CDC continues to offer state-of-the-art TB laboratory services to health departments, free of charge.

Through CDC's support, state health departments across the nation:

- Investigate and report every case of TB disease.
- Ensure provision of medical care, laboratory testing, and other services to achieve complete cure of TB patients, which halts further transmission and prevents drug resistance.
- Identify contacts and provide treatment to prevent future TB cases.
- Examine genetic fingerprints of TB isolates (purified TB samples) to find out whether cases are related, and to test for drug resistance.

CDC's TB elimination program embraces a dual approach that includes case finding and treatment for TB disease, plus prevention of new cases by testing and treating people with latent TB infection (LTBI). CDC estimates that up to 13 million people in the United States have LTBI with more than 80 percent of U.S. TB cases resulting from reactivated LTBI. To achieve TB elimination, LTBI must be addressed.

### **Investing in health departments to control and avert TB**

CDC funds 61 state, local, and territorial health departments to find and treat cases of TB disease, and to identify, evaluate, and treat close contacts who may be infected to avert them from developing TB disease. In addition, CDC provides on-site epidemiologic and programmatic assistance, called Epi-Aids, at the request of state health departments to assist with large or complex outbreaks. In 2023, CDC worked with FDA and state and local health departments to investigate a cluster of TB cases linked to suspected contaminated viable bone matrix material used in spinal and dental surgeries. This product was distributed to 13 facilities in seven states. CDC and its partners worked with hospitals to locate and successfully remove unused units of the allograft and ensure that the patients who received the product were treated for TB disease.

### **Providing world-class training in workforce and laboratory services**

Delayed diagnosis and treatment of TB disease remain challenges in TB prevention and elimination. CDC funds TB COEs, which have increased human resource development through education and training activities and increased the capacity for appropriate medical evaluation and management of persons with TB disease and LTBI through medical consultation. Between 2019-2022, the COEs provided over 3,187 hours of training to 45,220 participants and provided 11,145 medical consultations to providers with TB patients. The COEs are regionally assigned to cover all 50 states and the U.S. territories.

CDC serves as the National Tuberculosis Reference Laboratory and as a source of innovation, including development and deployment of advanced molecular detection methods. CDC continues to offer health departments molecular detection of drug resistance for isolates upon request, allowing the rapid identification of cases of drug-resistant TB. Molecular tests produce results within days, instead of the weeks required for culture-based testing, providing health departments and clinicians with timely information on how to best treat patients and protect their communities. CDC developed a targeted next generation sequencing assay that enhances early detection of mutations associated with drug resistance and is essential for the effective treatment of patients. In 2023, CDC transitioned to this assay as the primary method for CDC's Molecular Detection of Drug Resistance service.

## Leading domestic TB clinical and field research with global impact

CDC's TB Trials Consortium (TBTC) conducts clinical and epidemiologic trials that drive domestic and global treatment guidelines and programmatic practice for diagnosing, preventing, and treating TB. CDC released new interim guidance in 2022 for a 4-month treatment regimen to treat drug-susceptible TB disease that is as effective as the standard 6-month regimen for TB treatment. Shortening treatment enables patients to be cured faster, and has the potential to reduce treatment costs, improve patient quality of life, and increase completion of therapy. CDC has additional clinical trials underway in the United States and around the world to identify even shorter regimens to treat LTBI and TB disease in children and adults. These new regimens may improve drug tolerability and minimize drug interactions, giving healthcare providers more options to treat TB disease.

## Addressing TB program preparedness at the national level

Approximately one percent of U.S. TB cases are multidrug-resistant, and 10 percent are resistant to one of the four front-line TB drugs. Drug-resistant TB cases are expensive to treat, and the regimens are difficult for patients to tolerate. CDC works extensively to prevent drug-resistant TB from developing. One of the most effective ways to prevent drug-resistant TB is to ensure treatment is completed without interruption; however, TB drug shortages have affected more than 90 percent of TB programs, impacting patient completion of treatment. As a temporary, stop-gap measure, CDC maintains a small stockpile of TB drugs that is distributed to TB programs free of charge in the event of a nationwide shortage.

## Infectious Diseases and the Opioid Epidemic Budget Request

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The United States is experiencing a public health crisis involving drug use of opioids,<sup>21</sup> synthetic opioids like fentanyl and xylazine, and other drugs such as methamphetamines and cocaine. For over a decade, our nation has seen a rise in drug use-related hospitalizations, overdoses, and fatalities, and in the transmission of infectious diseases such as viral hepatitis, HIV, and other drug use-related bacterial and fungal infections. Rates of hepatitis C have more than quadrupled since 2010, and HIV transmission associated with injection drug use began to rise after years of declines. Further, bacterial skin and soft tissue infections are extremely common among people who inject drugs and are one of the most common causes for hospital admission and emergency room visits for this population. The COVID-19 pandemic exacerbated this danger and created an uncertain post-pandemic landscape for the health of people who use drugs.<sup>22,23</sup>

### Budget Request

CDC's FY 2025 budget request of **\$23,000,000** for Infectious Diseases and the Opioid Epidemic is level with the FY 2023 final level. CDC will invest in the implementation of harm reduction services, bringing life-saving services and linkages to care to improve the health of people who use drugs. CDC's program to address the infectious diseases associated with substance use focuses on four key strategies:

### **Ensuring implementation of and access to high quality Syringe Services Programs (SSPs) nationwide**

SSPs are a core component of the U.S. public health system, serving not only people who use drugs, but greater communities in which they are located and have proven effectiveness in preventing infectious diseases, reducing needlestick injuries experienced by law enforcement officers, and linking people to substance use

<sup>21</sup> <https://www.cdc.gov/opioids/basics/epidemic.html>

<sup>22</sup> <https://emergency.cdc.gov/han/2020/han00438.asp>

<sup>23</sup> Glick SN, Prohaska SM, LaKosky PA, Juarez AM, Corcorran MA, Des Jarlais DC. The Impact of COVID-19 on Syringe Services Programs in the United States. *AIDS Behav.* 2020;24(9):2466-2468. doi:10.1007/s10461-020-02886-2

disorder treatment and other healthcare and social services.<sup>24,25</sup> SSPs are safe, effective, and cost-saving interventions vital to reducing the transmission of viral hepatitis, HIV, and other infections. One study showed that efforts in two SSPs (in Philadelphia and Baltimore) averted almost 12,000 new HIV infections over ten years, saving more than \$290 million in medical costs in one year alone.<sup>26</sup> As of August 2023, 44 states and Washington D.C., Cherokee Nation (Oklahoma), and Puerto Rico have conducted CDC-guided data collection confirming the need to support SSPs. Through the [Strengthening Syringe Services Programs](#) cooperative agreement, CDC increases access to harm reduction services for people who use drugs and reduces incidence of infectious diseases and other complications of injection drug use. This program increases support and resources to SSPs for implementation of syringe distribution and disposal, testing, treatment, and prevention of infectious diseases and infectious complications from injection drug use, and mitigation of other harms due to drug use and linkage to substance use treatment and other needed healthcare. This cooperative agreement also improves data about SSPs by conducting an annual survey to document capacity, needs, access, and service gaps.

### **Increasing testing and linkage to care in local communities**

In 2023, CDC supported the implementation of services in 65 SSPs to increase access to harm reduction services for people who currently inject or have a history of injecting drugs to reduce incidence of infectious diseases. These efforts build on investments from supplemental funding from FY 2018-2021, in which nine jurisdictions tested almost 50,000 people in high-risk settings for hepatitis B or C infections and linked 90 percent (almost 5,000) of people with infections to care and treatment. [CDC also supports 18 jurisdictions](#) to complete special projects addressing infectious diseases transmitted through injection drug use, thus expanding access to sterile injection equipment; assessment and medication to treat opioid use disorder; testing for hepatitis B and C, and HIV; vaccination for hepatitis A and B; linkage to care and treatment for infectious diseases; and access to PrEP for people who test negative for HIV. Finally, the Linkage to Care among Transgender Women project aims to conduct HIV and hepatitis B and C testing to estimate prevalence and incidence rates within this population; this is the first time CDC will be able to estimate hepatitis B and C sero-prevalence and incidence rates within this at-risk group.

### **Increasing state and local capacity to detect and respond to infectious disease clusters and prevent further transmission**

In FY 2023, CDC funded viral hepatitis surveillance and prevention projects in 59 jurisdictions. CDC provides epidemiological, laboratory, and other technical assistance to state and local jurisdictions experiencing concerning increases, clusters, and outbreaks of infectious diseases associated with drug use. CDC partners with health departments and CBOs to test, link to care and treatment, prevent, monitor, and respond to viral hepatitis outbreaks in the United States. CDC worked with national partners to identify cross-jurisdictional outbreak preparedness measures that enable a more streamlined, agile, and effective response to clusters in neighboring jurisdictions. This was designed to highlight the experiences of three neighboring jurisdictions—Kentucky, Ohio, and West Virginia, which experienced HIV outbreaks and conducted cluster response efforts near their state borders. Of the 266 clusters of HIV infections reported to CDC and addressed by health departments from 2022 to 2023, approximately 10 percent were primarily related to injection drug use. In 2023, CDC dedicated funds to preventing the transmission of opioid use disorder (OUD) and its sequelae between pregnant women and their infants, including information about infectious diseases (e.g., hepatitis A, B, and C; HIV; syphilis; gonorrhea; chlamydia; and tuberculosis). Hepatitis A cases increased over 800 percent from 2016-2019 due to large outbreaks involving dozens of states in association with person-to-person transmission among

<sup>24</sup> Fernandes, R. M., Cary, M., Duarte, G., Jesus, G., Alarcao, J., Torre, C., ... Carneiro, A. V. (2017). Effectiveness of needle and syringe programmes in people who inject drugs – An overview of systematic reviews. *BMC Public Health*, 17(1), 309. doi:10.1186/s12889-017-4210-2

<sup>25</sup> Tookes HE, Kral AH, Wenger LD, Cardenas GA, Martinez AN, Sherman RL, Pereyra M, Forrest DW, Laota M, Metsch LR, “A comparison of syringe disposal practices among injection drug users in a city with versus a city without needle and syringe programs”, *Drug and Alcohol Dependence*, 2012 ;123(1-3):255-9

<sup>26</sup> Ruiz MS, et al. Using interrupted time series analysis to measure the impact of legalized syringe exchange on HIV diagnoses in Baltimore and Philadelphia. *J Acquir Immune Defic Syndr*. 2019;82(suppl 2):S148–S154.

people who use drugs and people experiencing homelessness. During 2021, there were an estimated 11,500 hepatitis A infections. For over a decade, injection drug use has been a leading cause of increases in new viral hepatitis cases. In hepatitis C, new viral hepatitis cases continue to rise, with the highest rates among adults 20-59 years of age, and injection drug use being the most reported risk factor. From 2014 to 2021, the United States experienced an almost 130 percent increase in the number of estimated cases of acute hepatitis C, from 30,500 in 2014 to 69,800 in 2021. Also in 2021, there were an estimated 13,300 hepatitis B virus infections in the United States, a 5 percent decrease from 2020. Hepatitis B cases were driven by injection drug use, with 30 percent of acute hepatitis B cases that included risk factor data reporting injection drug use. Prior to the receipt of these CDC funds, resources were not available to analyze and disseminate information related to the transmission of infectious disease in this unique, complex, and high burden population.

### **Increasing linkage to substance use disorder treatment at healthcare encounters for drug-use-related infections**

CDC continues to monitor bacterial infectious diseases associated with injection drug use and link persons to substance use disorder treatment at healthcare encounters. For example, CDC developed a service bundle package for healthcare providers, that includes linkage to medication-assisted treatment for patients with bacterial infections from injection drug use presenting to hospitals and emergency departments. Data indicates that most outpatient encounters of PWID seeking care for skin and soft tissue infections were in the emergency department setting; however, a higher proportion of patients in non-ED outpatient settings (mostly visits with an established provider) were already receiving medication-associated treatment for opioid use disorder. These findings point to the importance of connecting and maintaining patients in an outpatient setting with continuity of care.

CDC funds are also supporting technical assistance and capacity building to state and local government officials to identify, select, and fund evidence-based strategies, such as substance use disorder treatment, through opioid settlement dollars to prevent drug overdose and reduce the infectious consequences of substance use.

**State Table: HIV/AIDS, Viral Hepatitis, STI and TB Prevention Programs State Funding<sup>1,2,3</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$10,440,778	\$10,440,778	\$10,440,778	\$0
Alaska	\$2,314,125	\$2,314,125	\$2,314,125	\$0
Arizona	\$11,590,002	\$11,590,002	\$11,590,002	\$0
Arkansas	\$5,801,590	\$5,801,590	\$5,801,590	\$0
California	\$47,216,281	\$47,216,281	\$47,216,281	\$0
Colorado	\$7,106,182	\$7,106,182	\$7,106,182	\$0
Connecticut	\$5,738,523	\$5,738,523	\$5,738,523	\$0
Delaware	\$2,311,879	\$2,311,879	\$2,311,879	\$0
Florida	\$59,115,314	\$59,115,314	\$59,115,314	\$0
Georgia	\$30,202,069	\$30,202,069	\$30,202,069	\$0
Hawaii	\$2,870,174	\$2,870,174	\$2,870,174	\$0
Idaho	\$2,198,999	\$2,198,999	\$2,198,999	\$0
Illinois	\$9,172,480	\$9,172,480	\$9,172,480	\$0
Indiana	\$9,807,158	\$9,807,158	\$9,807,158	\$0
Iowa	\$2,933,594	\$2,933,594	\$2,933,594	\$0
Kansas	\$2,720,387	\$2,720,387	\$2,720,387	\$0
Kentucky	\$6,674,993	\$6,674,993	\$6,674,993	\$0
Louisiana	\$13,995,180	\$13,995,180	\$13,995,180	\$0
Maine	\$2,205,712	\$2,205,712	\$2,205,712	\$0
Maryland	\$14,461,272	\$14,461,272	\$14,461,272	\$0
Massachusetts	\$12,914,436	\$12,914,436	\$12,914,436	\$0
Michigan	\$12,524,895	\$12,524,895	\$12,524,895	\$0
Minnesota	\$5,939,761	\$5,939,761	\$5,939,761	\$0
Mississippi	\$7,277,906	\$7,277,906	\$7,277,906	\$0
Missouri	\$9,896,427	\$9,896,427	\$9,896,427	\$0
Montana	\$1,847,670	\$1,847,670	\$1,847,670	\$0
Nebraska	\$2,139,864	\$2,139,864	\$2,139,864	\$0
Nevada	\$7,023,028	\$7,023,028	\$7,023,028	\$0
New Hampshire	\$1,876,714	\$1,876,714	\$1,876,714	\$0
New Jersey	\$21,744,771	\$21,744,771	\$21,744,771	\$0
New Mexico	\$2,930,103	\$2,930,103	\$2,930,103	\$0
New York	\$17,309,049	\$17,309,049	\$17,309,049	\$0
North Carolina	\$17,817,521	\$17,817,521	\$17,817,521	\$0
North Dakota	\$1,838,905	\$1,838,905	\$1,838,905	\$0
Ohio	\$16,312,636	\$16,312,636	\$16,312,636	\$0
Oklahoma	\$6,562,045	\$6,562,045	\$6,562,045	\$0
Oregon	\$4,837,719	\$4,837,719	\$4,837,719	\$0
Pennsylvania	\$10,171,623	\$10,171,623	\$10,171,623	\$0
Rhode Island	\$2,311,314	\$2,311,314	\$2,311,314	\$0
South Carolina	\$11,509,472	\$11,509,472	\$11,509,472	\$0
South Dakota	\$1,599,182	\$1,599,182	\$1,599,182	\$0
Tennessee	\$9,438,581	\$9,438,581	\$9,438,581	\$0
Texas	\$42,551,325	\$42,551,325	\$42,551,325	\$0
Utah	\$2,541,452	\$2,541,452	\$2,541,452	\$0
Vermont	\$1,797,794	\$1,797,794	\$1,797,794	\$0
Virginia	\$12,487,444	\$12,487,444	\$12,487,444	\$0
Washington	\$11,179,228	\$11,179,228	\$11,179,228	\$0
West Virginia	\$2,640,382	\$2,640,382	\$2,640,382	\$0
Wisconsin	\$4,755,207	\$4,755,207	\$4,755,207	\$0
Wyoming	\$1,807,701	\$1,807,701	\$1,807,701	\$0

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
<b>Cities</b>				
Baltimore	\$8,920,240	\$8,920,240	\$8,920,240	\$0
Chicago	\$14,792,233	\$14,792,233	\$14,792,233	\$0
Dallas	\$315,000	\$315,000	\$315,000	\$0
Houston	\$13,031,257	\$13,031,257	\$13,031,257	\$0
Los Angeles	\$29,177,846	\$29,177,846	\$29,177,846	\$0
New York City	\$52,973,566	\$52,973,566	\$52,973,566	\$0
Philadelphia	\$12,274,120	\$12,274,120	\$12,274,120	\$0
San Diego	\$1,921,236	\$1,921,236	\$1,921,236	\$0
San Francisco	\$9,658,445	\$9,658,445	\$9,658,445	\$0
Washington, D.C.	\$10,221,240	\$10,221,240	\$10,221,240	\$0
<b>Territories</b>				
Puerto Rico	\$10,262,527	\$10,262,527	\$10,262,527	\$0
Virgin Islands	\$1,474,761	\$1,474,761	\$1,474,761	\$0
<b>Subtotal States</b>	<b>\$514,460,847</b>	<b>\$514,460,847</b>	<b>\$514,460,847</b>	<b>\$0</b>
<b>Subtotal Cities</b>	<b>\$153,285,183</b>	<b>\$153,285,183</b>	<b>\$153,285,183</b>	<b>\$0</b>
<b>Subtotal Territories</b>	<b>\$11,737,288</b>	<b>\$11,737,288</b>	<b>\$11,737,288</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$679,483,318</b>	<b>\$679,483,318</b>	<b>\$679,483,318</b>	<b>\$0</b>

<sup>1</sup>This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial awardees). This table includes consolidated amounts for multiple awards. Amounts include Integrated HIV Prevention and Surveillance (CFDA NUMBER: 93-940 [Discretionary]). FY 2023 estimates include Ending the HIV Epidemic (EHE) awards; Sexually Transmitted Infections (STI) Prevention (CFDA NUMBER: 93-977 [Discretionary]). Amounts reflect new assistance and include HIV/STD co-infection funds. For STI funding amounts reflected, the grant cycle has been extended by one month and will end January 31, 2024. Awardees have received one extra month of funding for this extension which is not reflected in this table; Viral Hepatitis Surveillance and Prevention (CFDA NUMBER: 93-270). Amounts reflects viral hepatitis resources and additional resources provided to states from the Infectious Disease Consequences of the Opioid Epidemic; TB Prevention and Control (CFDA NUMBER: 93-116 [Discretionary]). Amounts reflect new assistance and include HIV/TB coinfection funds. Amounts do not include funding under Direct Assistance.

For a more comprehensive view of grant and cooperative agreement funding to awardees by jurisdiction, visit <http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>

<sup>2</sup>FY 2023 amounts are subject to funding availability and other determinations based on annual program application requirements.

<sup>3</sup>FY 2024 amounts are subject to funding availability and final appropriations.



## EMERGING AND ZONOTIC INFECTIOUS DISEASES

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$698.772	\$698.772	\$728.772	+\$30.000
PPHF	\$52.000	\$52.000	\$52.000	\$0
<b>Total Request</b>	<b>\$750.772</b>	<b>\$750.772</b>	<b>\$780.772</b>	<b>+\$30.000</b>
FTEs	1,638	1,648	1,663	25
-- Antimicrobial Resistance Initiative	\$197.000	\$197.000	\$207.000	+\$10.000
-- Vector-Borne Diseases	\$88.603	\$88.603	\$88.603	\$0
-- <i>Lyme Disease and other Tick-Borne Diseases (non-add)</i> <sup>1</sup>	\$26.000	\$26.000	\$26.000	\$0
-- Chronic Fatigue Syndrome	\$5.400	\$5.400	\$5.400	\$0
-- Emerging Infectious Diseases <sup>2</sup>	\$213.997	\$213.997	\$233.997	+\$20.000
-- <i>Wastewater Surveillance (non-add)</i>	N/A	N/A	\$20.000	+\$20.000
-- <i>Prion Disease (non-add)</i>	\$7.500	\$7.500	\$7.500	\$0
-- <i>Harmful Algal Blooms (non-add)</i>	\$3.500	\$3.500	\$3.500	\$0
-- Food Safety	\$71.000	\$71.000	\$71.000	\$0
-- National Healthcare Safety Network	\$24.000	\$24.000	\$24.000	\$0
-- Quarantine	\$58.772	\$58.772	\$58.772	\$0
-- Advanced Molecular Detection (AMD)	\$40.000	\$40.000	\$40.000	\$0
-- <i>Epi and Lab Capacity Program (PPHF)</i>	\$40.000	\$40.000	\$40.000	\$0
-- <i>Healthcare-Associated Infections (PPHF)</i>	\$12.000	\$12.000	\$12.000	\$0

<sup>1</sup> FY 2023 Final level is comparably adjusted to reflect the proposed budget structure realignment of Lyme Disease.

<sup>2</sup> FY 2023 and FY 2024 Levels are comparably adjusted to reflect the proposed budget structure realignment of Harmful Algal Blooms and Prion Disease as sub-activities under Emerging Infectious Diseases, and requests funds in FY 2025 for Wastewater Surveillance as a sub-activity under the same line.

**Enabling Legislation Citation:** PHS A § 252, PHS A § 264, PHS A § 265, PHS A § 301, PHS A § 304, PHS A § 307, PHS A § 308(d), PHS A § 310, PHS A § 311, PHS A § 317\*, PHS A § 317P\*, PHS A § 317R\*, PHS A § 317S, PHS A § 317T\*, PHS A § 317U, PHS A § 319, PHS A § 319D, PHS A § 319E\*, PHS A § 319F, PHS A § 319G\*, PHS A § 321, PHS A § 322, PHS A § 325, PHS A § 327, PHS A § 352, PHS A § 353, PHS A § 361-369, PHS A § 399V-5, PHS A § 1102, PHS A § 2821, PHS A § 2822, Bayh-Dole Act of 1980 (Pub. L. 96-517), Immigration and Nationality Act, Titles II & IV (8 U.S.C. §§ 1182, 1222, 1252, 1522\*)

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural, Contracts, and Competitive Grants/Cooperative Agreements

CDC defends the country against public health threats by preventing and controlling a wide range of infectious diseases, including threats caused by bacteria (like anthrax, Lyme, Salmonella), viruses (like mpox, Zika, or Ebola), or fungi (like Valley fever). CDC also prevents and controls zoonotic disease outbreaks using a One Health approach that brings together human, animal, and environmental health sectors. Many of these outbreaks are from Select agents and high consequence pathogens that pose threats to our national security. Factors like climate change, travel, migration, and disruption to the natural environment contribute to our increasing contact with animals and the potential spread of zoonotic diseases. CDC’s world-class scientists, researchers, laboratorians, and outbreak responders reduce illness, death, and inequities associated with infectious diseases through several core functions, including:

- **Public health surveillance:** CDC’s disease surveillance systems serve as early warning systems, enabling CDC experts to respond rapidly to identify emerging threats, control outbreaks, save lives globally, and protect the American public. Surveillance is critical for identifying pathogens, tracking disease, and monitoring prevention efforts.

- **Outbreak preparedness and response:** CDC has unique scientific expertise with more than 800 pathogens and works closely with partners to rapidly contain outbreaks at the source, thereby securing the safety of the United States.
- **Laboratory expertise:** CDC laboratories advance disease detection and identification and serve as world-renowned reference laboratories for the United States and abroad. These laboratories develop state-of-the-art diagnostic tools, support essential confirmatory testing activities to identify pathogens, research new targets for drug and vaccine development, and house pathogens for research that does not exist elsewhere in the United States. CDC’s virtual reference laboratory provides tools to identify rare and complex pathogens quickly and accurately, leading to early diagnosis, tailored approaches to treatment, and prevention of new infections.
- **Improving healthcare quality, health systems resilience, and patient safety:** CDC uses science, data, and expertise to protect patients, keep healthcare workers safe, and strengthen healthcare delivery systems both internationally and domestically through surveillance and tracking, infection prevention and control capacity, improving health systems, and workforce training.
- **Protecting and promoting the health of those at greatest risk of emerging infectious diseases:** CDC works with partners to take an equity-centered approach to protecting and promoting the health of all people in all communities. CDC systematically and intentionally takes action to understand and address infectious disease inequities in the United States and globally.
- **Support to state and local health departments:** The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) program works to reduce illness, death, and inequities associated with a wide range of infectious diseases. The ELC cooperative agreement is one of CDC’s key mechanisms providing direct financial support to 64 jurisdictions, including all 50 states, six localities, and U.S. territories and affiliates for surveillance, detection, response, and prevention of infectious diseases while offering recipients strategic direction and technical assistance.
- **Protecting our borders:** CDC works to prevent the introduction, transmission, and spread of infectious diseases, including highly lethal diseases with pandemic potential, into the United States. CDC rapidly responds to reports of sick travelers who arrive in the United States at U.S. ports of entry, alerts travelers to health threats, and restricts the importation of animals and products that may carry disease.

CDC’s FY 2025 budget request of **\$780,772,000** for Emerging and Zoonotic Infectious Diseases is **\$30,000,000** above the FY 2023 final level. This request includes **\$52,000,000** from the Prevention and Public Health Fund, which is level with the FY 2023 final level.

CDC is committed to understanding, preventing, and eliminating inequities associated with emerging and zoonotic infectious diseases. CDC has made ambitious plans for advancing health equity that is intentional, inclusive, and integrates the principles into CDC’s disease-specific programs. CDC recognizes the role of public health to identify and address the social, economic, and environmental factors that affect infectious disease risks and outcomes. CDC is prioritizing the following collaborative and coordinated efforts:

1. **Strengthening Public Health Capacity:** CDC will enhance workforce diversity, skills, and resources and support a multidisciplinary approach to advance health equity science and practice.
2. **Modernizing Data Systems and Translating Data to Public Health Action:** CDC will collect, analyze, and disseminate data on inequities to understand patterns and underlying contributors and translate them into actions that reduce them.
3. **Implementing Equitable Interventions:** CDC is partnering to plan, implement, and evaluate interventions that reach populations experiencing inequities.

These efforts will help CDC understand drivers of health disparities, identify solutions, and build partnerships to address them using evidence-based public health solutions.

## NATIONAL CENTER FOR EMERGING AND ZONOTIC INFECTIOUS DISEASES

### BY THE NUMBERS

- **>1 million**—Tests conducted from 2016 to 2023 by the Antimicrobial Resistance Laboratory Network (AR Lab Network) to rapidly detect and respond to AR threats across healthcare, the community, food supply, and environment, showing progress in meeting the pivotal goals in the *National Action Plan for Combating Antibiotic-resistant Bacteria* and the *National Biodefense Strategy*.<sup>1</sup>
- **>\$173 million**— Critical funding awarded to state, local, and territorial health departments through the ELC cooperative agreement in FY 2023 to strengthen jurisdictions’ core and cross-cutting epidemiology, laboratory, and health information systems capacity to address infectious diseases.
- **>144 million** people protected as a result of wastewater surveillance and analysis of **>230,000** unique wastewater samples from across **>1500** sites in **50** states, **3** territories, and **6** Tribal communities to inform public health actions and individual health choices.
- **>800**—Pathogens the CDC protects against, including those transmitted via food, water, or vector: bioterror threats like anthrax, infections spread in healthcare settings, and drug-resistant threats.
- **168**—Multi-state clusters of enteric infections investigated by CDC from Oct 2022–Sept 2023, resulting in better understanding of the causes of, and strategies to prevent against, similar outbreaks in the future.
- **>60,000 people** have registered in CDC’s new RSV V-safe module (launched on October 20, 2023) for older adults to complete health surveys related to their RSV vaccinations. V-safe data provides crucial information to monitor the safety of new vaccines in near-real time and help communicate this information extensively to healthcare providers and the public.
- **>200** healthcare-related outbreaks across **49** state and local health jurisdictions and **3** non-U.S. locations were supported and responded to by CDC subject matter experts.
- **5 out of 6** key healthcare-associated infections (HAIs) in **4** major healthcare settings have been reduced significantly between 2021 and 2022, demonstrating important progress toward the goal of eliminating HAIs and improving patient safety and health care quality<sup>2</sup>.

All statistics are from CDC program data unless otherwise stated.

<sup>1</sup> CDC’s Antimicrobial Resistance (AR) Laboratory Networks, Available at: <https://www.cdc.gov/drugresistance/ar-lab-networks/domestic.html>

<sup>2</sup> 2022 CDC HAI Progress Report, Available at: <https://www.cdc.gov/hai/data/portal/progress-report.html>

Emerging and Zoonotic Infectious Diseases Funding History	
Fiscal Year	Dollars (in millions)
FY 2021 (BA)	\$594.442
FY 2021 (PPHF)	52.000
FY 2022 (BA)	\$641.272
FY 2022 (PPHF)	52.000
FY 2023 (BA)	\$698.772
FY 2023 (PPHF)	52.000
FY 2024 Annualized CR (BA)	\$698.772
FY 2024 Annualized CR (PPHF)	52.000
FY 2025 President’s Budget (BA)	\$728.772
FY 2025 President’s Budget (PPHF)	52.000

## Antimicrobial Resistance Initiative Budget Request

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Antimicrobial resistance (AR)—when bacteria or fungi do not respond to the drugs designed to kill them—is a threat to lives, modern medicine and health care, and veterinary and agriculture industries in the United States and around the world. Antimicrobial-resistant infections are difficult to treat and add considerable burden to patients and the U.S. healthcare system. The United States must support a comprehensive response against AR and ensure resilient public health infrastructure is in place to fight AR when and where it emerges.

CDC works to quickly prevent, detect, contain, and respond to outbreaks of antimicrobial-resistant infections. Through CDC's *AR Initiative*, CDC leads the U.S. public health response to combat AR and is working to achieve the pivotal goals in the *U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025* (CARB)<sup>27</sup>. CDC continues to implement successful activities to improve the foundational public health system needed to address AR, thus bolstering how the nation combats these threats.

### Budget Request

CDC's FY 2025 budget request of **\$207,000,000** for the Antimicrobial Resistance Initiative is **\$10,000,000** above the FY 2023 final level.

CDC's FY 2025 request increases support to state, local, and international capacities to address AR, including the development and implementation of improved and innovative approaches for combating AR and preventing infections. CDC's AR investments will enhance support to implement and achieve the goals under CARB, including efforts to address AR globally and in the environment.

CDC will increase its investments in state, territorial, and local capacity to detect and prevent emerging and existing threats through strengthened infection prevention and control, antibiotic stewardship data collection, and healthcare quality improvement efforts. CDC will also expand:

- Funding for critical AR testing capacity through the AR Laboratory Network<sup>28</sup>, which supports laboratories nationwide for rapid AR detection in health care, food, the environment, and communities.
- Work with key partners to ensure antibiotic stewardship is a core principle and consideration in the development of treatment guidelines for AR infections.
- The types and quality of available data sets addressing health equity and disparity issues about AR threats.
- The Global Antimicrobial Resistance Laboratory and Response Network to increase capacity for surveillance, prevention, detection, and response around the world.

Through these investments, CDC is supporting the framework needed for global action to combat AR infections wherever they emerge and spread. This expansive work reflects cross-cutting initiatives across CDC and accelerated progress toward meeting the pivotal goals of CARB and the *National Biodefense Strategy*.

### Program Accomplishments

**State, Local, and Territorial Investments:** CDC invested more than \$70 million of annual appropriations to sustain core laboratory and epidemiological capacity in all 50 states, as well as several large cities and territories to address AR infections related to healthcare, foodborne, and community infections. These investments are critical to rapidly detect, respond to, and contain outbreaks of antimicrobial-resistant pathogens and save lives. In FY 2023, CDC's AR Lab Network, in collaboration with epidemiologists from CDC-supported Healthcare-

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<sup>27</sup> U.S. National Action Plan, Available at: <https://www.cdc.gov/drugresistance/us-activities/national-action-plan.html>

<sup>28</sup> About the AR Lab Network, Available at: <https://www.cdc.gov/drugresistance/ar-lab-networks/domestic.html>

Associated Infections and Antimicrobial Resistance (HAI/AR) Programs<sup>29</sup> and CDC laboratory staff, detected a multistate outbreak of extensively drug-resistant *Pseudomonas aeruginosa* linked to artificial tears and eye ointment products, identifying 81 patients across 18 states to date. CDC’s infection prevention and control (IPC) training and expertise helped states prevent further infections. In March 2023, CDC’s HAI/AR Program worked with the West Virginia Department of Health and Human Resources to respond to the first confirmed case of *Candida auris* in the state, identified through CDC’s AR Lab Network. Early detection and appropriate response activities were critical to successfully containing *Candida auris* cases to only one case as of May 2023.

**Strengthening laboratory capacity through the AR Lab Network to detect AR threats in all states:** CDC’s AR Lab Network closes a gap between local capabilities and the data needed to combat AR by providing comprehensive lab capacity and infrastructure, cutting-edge technology, and data to drive response and prevent infections. CDC has increased antimicrobial susceptibility testing for suspected *Neisseria gonorrhoeae* cases from two to 16 jurisdictions, expanded colonization screening of carbapenemase-producing organisms and *Candida auris* from seven regional labs to more than 26 labs nationwide, and increased whole-genome sequencing capacity to 45 laboratories across the AR Lab Network. As of June 2023, the AR Lab Network has performed more than one million different tests to rapidly detect and respond to AR threats across healthcare, the community, food supply, and the environment.

**Improving Antibiotic Use:** Antibiotics can save lives, but any time antibiotics are used, they can cause side effects and contribute to the development of antimicrobial resistance. CDC collaborates with a broad range of healthcare facilities to improve appropriate antibiotic prescribing and implement Antibiotic Stewardship Programs, resulting in more than 97 percent of acute care hospitals meeting all of CDC’s Core Elements of Hospital Antibiotic Stewardship,<sup>30</sup> and leads the implementation of the *Be Antibiotics Aware: Smart Use, Best Care*, a national educational effort for healthcare professionals, patients, and their families to help improve antibiotic use.

**Supporting alternative treatment and prevention options that may be as—or more—effective as antibiotics in fighting AR (e.g., vaccines, diagnostics, and other therapeutics):** In FY 2023, CDC invested nearly \$60 million in annual appropriations to develop innovative approaches to address antimicrobial-resistant infections. These investments, through programs such as CDC’s Prevention Epicenters<sup>31</sup>, the Safety and Healthcare Epidemiology Prevention Research Development Program (SHEPheRD)<sup>32</sup>, and the Modeling Infectious Diseases in Healthcare Network (MIND-Healthcare)<sup>33</sup>, identify new ways to prevent infections and slow the spread of AR. CDC also works with U.S. Government partners such as the Food and Drug Administration, to identify developmental and regulatory approval pathways for novel pharmaceutical agents to better prevent the spread of resistant infections and protect patients.

**Enhancing AR surveillance efforts globally:** CDC protects the United States and its citizens from AR threats by building partner country capacity for rapid detection and containment of AR and stopping its spread to the United States. CDC is expanding the Global AR Lab and Response Network, through a One Health<sup>34</sup> approach that currently spans nearly 50 countries and works with nearly 20 organizations worldwide. New network activities in fiscal year 2023 include strengthening enteric (gut) disease surveillance in the Middle East / North

<sup>29</sup> Health Department HAI/AR programs, Available at: <https://www.cdc.gov/hai/HAI-AR-Programs.html>

<sup>30</sup> Core Elements of Antibiotic Stewardship, Available at: <https://www.cdc.gov/antibiotic-use/core-elements/index.html>

<sup>31</sup> CDC Prevention Epicenters, Available at: <https://www.cdc.gov/hai/epicenters/about.html>

<sup>32</sup> Developing Healthcare Safety Research, Available at: <https://www.cdc.gov/hai/research/safehealthcare.html>

<sup>33</sup> Modeling Infectious Diseases in Healthcare Network, Available at: <https://www.cdc.gov/hai/research/MIND-Healthcare.html>

<sup>34</sup> One Health is an approach that recognizes that the health of people is closely connected to the health of animals and our shared environment. One Health is a collaborative, multisectoral, and transdisciplinary approach — working at the local, regional, national, and global levels — with the goal of achieving optimal health outcomes by recognizing the interconnection between people, animals, plants, and their shared environment.

Africa region, improving understanding of colonization with carbapenem-resistant Enterobacterales in community settings in Guatemala, and expanding testing capacity for *Candida auris* in Georgia.

## **Quarantine and Migration Budget Request**

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Modern air and maritime travel have enabled extraordinary global interconnectivity, providing economic, cultural, and social benefits. However, these connections also allow an infected person to fly or sail to any location in the world, often in less time than it takes to develop symptoms. CDC's global migration and quarantine activities work to create a multi-layered system of public health defenses to mitigate the risk of communicable diseases spreading into and within the United States.

### **Budget Request**

CDC's FY 2025 budget request of **\$58,772,000** for Quarantine is level with the FY 2023 final level. CDC will use these funds to maintain public health security at key ports of entry throughout the United States and maintain public health programs that support efforts to mitigate the spread of any potential international outbreaks or pandemics in the future. CDC will continue to leverage its expertise, surveillance systems, and global partnerships to develop public health alerts, recommendations, and education for travelers and healthcare providers. These efforts help prevent travelers from falling ill and spreading disease after they return to the United States.

### **Program Accomplishments**

**Preparedness and response:** CDC maintains 20 port health stations, positioned at strategic ports of entry in the United States, to detect and respond to reports of illness, strengthening public health security at the border by preventing transmission of disease into U.S. communities. As of December 1, 2023, CDC responded to more than 2,000 reports of ill travelers at U.S. land, air, and seaports of entry and distributed life-saving drugs to hospitals for patients with rare diseases on 121 occasions. For example, in April 2023, the Seattle Port Health Station received a call from a hospital in Idaho about a patient ill with botulism. Since botulism antitoxin is only available from CDC, CDC port staff sprang into action to initiate the transport of this life-saving medication.

**Travelers' health:** Travelers are an important population to consider when tracking new and emerging infectious diseases because they move from place to place quickly and can spread pathogens across borders. CDC's Traveler Genomic Surveillance (TGS) program is a public-private partnership that collects samples at seven airports to enable the timely detection of SARS-CoV-2 variants and other pathogens of public health importance to fill in gaps in global biosurveillance. TGS uses two kinds of approaches for monitoring: voluntary nasal sampling of arriving international travelers and airplane and airport wastewater sampling. As of November 2023, TGS enrolled and collected nasal swab samples voluntarily from over 375,000 arriving international travelers from 135 countries. In Fall 2023, TGS expanded testing and sequencing of samples to enable early detection of flu, RSV, and other select respiratory viruses, in addition to SARS-CoV-2. TGS is entirely supported by COVID supplemental funding. CDC will have to end this program once COVID supplemental funds are depleted.

**Animal importation:** CDC prevents the introduction and spread of zoonotic diseases from animals and animal products by regulating their importation. As one of the deadliest zoonotic diseases, dog rabies accounts for an estimated 59,000 human deaths globally each year. Dog rabies was eliminated from the United States in 2007. To prevent the reintroduction of this deadly disease, CDC regulates the entry of dogs into the United States through a permitting process to ensure they are properly vaccinated for rabies and have a valid rabies serologic titer from an approved laboratory. As of November 30, 2023, CDC issued almost 30,000 permits allowing people to bring their pet dogs into the United States from countries where dog rabies still exists.

## Emerging Infectious Diseases Budget Request

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CDC scientists play a critical role in protecting the United States from dangerous viruses, bacteria, and organisms that emerge as new threats<sup>35</sup>. Emerging Infectious Diseases funding provides flexible resources that sustain and strengthen the critical foundation for many of CDC's world-renowned programs, applied research, laboratories, and outbreak responses. These flexible resources are particularly important because they support cross-cutting public health activities that may not have dedicated resources but warrant ongoing CDC engagement.

For instance, CDC's Wastewater Surveillance Program was established in 2020 using COVID supplemental funds to coordinate and build the nation's capacity to understand infectious disease threats in communities by detecting pathogens in wastewater. Wastewater surveillance has been pivotal in ensuring that our states and communities have the best possible guidance and data to inform public health action

CDC provides fundamental support to state and local public health agencies and partners (both domestic and global) who rely on CDC to confirm unusual pathogens, diagnose mystery illnesses, and rapidly coordinate multi-jurisdictional investigations and responses when they are needed to protect the public.

### Budget Request

CDC's FY 2025 budget request of **\$233,997,000** for Emerging Infectious Diseases, is **\$20,000,000** above the FY 2023 final level, to begin the establishment of core support for wastewater surveillance. The request also reflects a proposed budget structure realignment of Harmful Algal Blooms and Prion Disease as sub-activities under Emerging Infectious Diseases. With these resources, CDC will continue to conduct core emerging infectious disease work, including:

- Leading laboratory research and testing and supporting the development of diagnostic tests and other medical countermeasures to prevent illness and death.
- Identifying, tracking, and responding to outbreaks of a range of emerging and critical pathogens of pandemic potential that pose a risk to national security.
- Improving data science proficiency and cutting-edge analytics, including integration of epidemiologic, laboratory, and genomics data.
- Promoting innovation and implementing quality initiatives.
- Providing training to laboratory scientists.
- Monitoring the safety of vaccines.

CDC will ensure staff are ready to respond to the increasing number of newly emerging pathogens and able to effectively partner across agencies and sectors to protect human health. With sustained investment in strategies to address emerging infections, CDC will continue to strengthen the nation's health and security, as well as support preparedness efforts by:

- Accelerating the development of innovative tests, treatments, and vaccines that are vital to support outbreak prevention and response.
- Investing in strategies that improve response times for investigating and responding to rare and deadly pathogens, including mpox, Ebola, Nipah, anthrax, and rabies, using a One Health<sup>36</sup> approach.
- Ensuring the ability to implement a response structure within 24-72 hours during public health emergencies.
- Updating CDC's unique and specialized pathology laboratories that work with the most cutting-edge tools and expertise to investigate all emerging and mysterious infectious illnesses.

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<sup>35</sup> Division Diseases and Specialty Areas, Available at: <https://www.cdc.gov/nceid/dhcpp/diseases-specialty-areas.html>

<sup>36</sup> One Health, available at: <https://www.cdc.gov/onehealth/index.html>

- Conducting cutting-edge public health research and investigations to understand infection transmission patterns in animals and people with a focus on animal transmission of disease to people.
- CDC has built a multilayered system that monitors vaccine safety. CDC works with partners and other federal agencies to conduct vaccine safety monitoring, clinical research, and to communicate timely, transparent information about the safety of vaccines. These activities are critical to informing vaccine policy decisions and vaccination uptake by the public that protect the health of Americans.

Wastewater surveillance is currently entirely supported by COVID-19 supplemental funds, allowing CDC to support wastewater surveillance in all states. Without base funding, once supplemental funds are expended CDC will not be able to sustain wastewater surveillance. The increase of \$20 million for Wastewater Surveillance will allow CDC to establish a small, focused program in a limited number of states in locations, such as major metropolitan areas and areas of high social vulnerability. CDC would maintain COVID-19 surveillance and develop testing capabilities for a limited number of infectious diseases for emergencies and pandemic preparedness.

### Program Accomplishments

**Wastewater Surveillance:** With COVID-19 supplemental funding, CDC stood up a robust wastewater surveillance system. In November 2023, CDC launched an updated, publicly available data dashboard and visualizations for wastewater surveillance. The online dashboard offers views of national, regional, and state trends of COVID-19 detected in wastewater based on data from all 50 states, U.S. territories, and select tribal nations. These data allow CDC to work with health departments to track SARS-CoV-2 levels in wastewater so communities can act quickly to prevent the spread of COVID-19. CDC has invested nearly \$500 million of supplemental funds in state health agencies, building capacity for wastewater surveillance that includes testing capabilities, data analysis tools and expertise, as well as support for an experienced workforce that can translate that into public health action. In 2023, CDC expanded to include four wastewater surveillance Centers of Excellence (in California, Colorado, Houston, Texas, and Wisconsin) which foster innovation, advance workforce development and training, and improve data sharing.

Wastewater surveillance has proven to be a critical public health surveillance and detection tool. Increases of SARS-CoV-2 levels in wastewater generally occur 4-6 days before corresponding increases in clinical cases of COVID-19, so wastewater surveillance can serve as a early-warning system for the emergence, or reemergence, of COVID-19 in a community. Also, wastewater surveillance offers an efficient way to monitor for pathogens in sewer sheds that serve several thousand to several million residents. Research indicates wastewater surveillance can detect mpox even when there are only a few cases in the community. During the 2022–2023 respiratory disease season, four Centers of Excellence translated wastewater surveillance data for influenza, respiratory syncytial virus (RSV), and COVID-19 into real-time public health action, such as updating clinical guidance, issuing health alerts, and planning for vaccination clinics.

**High consequence viral pathogen outbreaks:** In early 2023, there were outbreaks of Sudan ebolavirus in Uganda, Marburg virus in Equatorial Guinea and Tanzania, and Nipah virus in Bangladesh. In response, CDC rapidly deployed epidemiology and laboratory teams to provide on-the-ground support and technical guidance to contain the outbreaks. CDC subject matter experts provided training, communications, and epidemiological investigations for these outbreaks. CDC worked with partners to identify the origins of outbreaks and scale up testing and diagnostics to reduce transmission and stop these outbreaks, so they did not spread globally.

**Identification of emerging infections:** In 2023, the Mississippi State Department of Health requested CDC’s assistance with the investigation of an expanding cluster of melioidosis cases in the Gulf Coast region. Evidence suggests that melioidosis is newly endemic to the continental United States. CDC is helping Mississippi partners understand local risk and transmission, which will inform prevention.



**Rabies detection and prevention:** As the National Rabies Reference Laboratory, CDC provided financial and technical support to the Nebraska Rabies Laboratory to conduct genetic testing that identified the spread of a raccoon rabies strain in a stray kitten. CDC participated in an Epi-Aid and partnered with USDA to support the Nebraska Department of Health and Human Services in establishing an enhanced rabies surveillance system to better understand if this variant was spreading. Rapid response was critical to ensure this variant, which had not previously circulated west of the Appalachian Mountains, did not spread to local wildlife. If the virus had gone undetected, this strain of rabies would easily spread to neighboring states, putting an estimated 7 million people at increased risk of exposure within just five years. CDC support for enhanced surveillance will continue to ensure that this variant is eliminated from the area.

**Mycotic diseases:** In FY 2023, CDC reported an increase in infections caused by the fungal pathogen *Candida auris* and an increase in *C. auris* antimicrobial resistance to all currently available antifungal medications. *C. auris* continues to be an emerging threat in the United States, especially to patients in healthcare facilities with underlying conditions. To address the need for rapid outbreak detection, CDC's *FungiNet*<sup>37</sup>, successfully onboarded seven state health departments for *C. auris* whole genome sequencing (WGS). This new testing capacity has collectively contributed more than 3,000 isolates to a publicly available sequence database.

CDC also collaborated with state public health bioinformaticians to enhance how state health departments conduct fungal whole genome sequencing and use that data for public health action. This tool, called MycoSNP, has equipped labs with WGS results that can detect antimicrobial resistance markers in *C. auris* to support public health surveillance and response efforts.

**Waterborne disease outbreak surveillance and response.** CDC works with state, tribal, local, territorial, and federal partners to prepare for waterborne disease outbreaks and emergencies. From drinking water, recreational water, and water used for healthcare, safe water is a vital resource for the health and productivity of communities. In 2022 and 2023, 36 states (including Puerto Rico and Washington DC) reported 182 waterborne disease outbreaks, resulting in more than 1,120 illnesses, 264 hospitalizations, and 28 deaths. Evidence suggests that warmer water and other environmental changes may be associated with high levels of disease, outbreaks, and cost burden of biofilm-related waterborne pathogens. CDC supports state efforts to understand and mitigate waterborne disease, especially in areas with aging water systems and those vulnerable to extreme weather. For example, in 2023 CDC provided epidemiological and environmental testing support to Utah to investigate and control an outbreak of *E. coli* O157:H7 infections related to an untreated irrigation water system.

**Monitoring the safety of vaccines:** Vaccine safety is a vital part of the nation's response to emerging infectious diseases, including respiratory viruses (e.g., COVID-19 and influenza), public health emergencies (e.g., mpox), and other vaccine-preventable diseases (e.g., measles). CDC uses multiple complementary systems to rapidly detect and assess possible safety concerns. In FY 2024, CDC released an updated version of one such system—V-safe—to help monitor the safety of respiratory syncytial virus (RSV) vaccines for older adults (60+ years and older) and pregnant women<sup>38</sup>. In mid-2024, CDC will launch an update to its COVID-19 V-safe module. The data collected through V-safe will help CDC inform the public about what adverse reactions or side effects to expect following these new vaccines. CDC continues to work with FDA and other partners to monitor and evaluate adverse event reports and take necessary action to ensure the safety of vaccines and provide transparency to maintain the public's trust.

## Prion Diseases

Prion diseases are a group of rare brain diseases affecting humans and animals that are uniformly fatal. CDC provides funds and expertise to support medical personnel and health authorities with state-of-the-art

<sup>37</sup> *FungiNet* is a network for advancing fungal pathogen genomics in public health and is part of CDC's Antimicrobial Resistance Laboratory Network.

<sup>38</sup> CDC Ensuring Vaccine Safety: V-safe, Available at: <https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/v-safe/index.html>

laboratory diagnostics to confirm human prion diseases through the *National Prion Disease Pathology Surveillance Center* (NPDPSC).<sup>39</sup> CDC's prion program also collaborates with animal health experts to track the spread of chronic wasting disease, a prion disease that affects deer, elk, and moose. Through close partnerships and continued research, CDC has found no definite chronic wasting disease infections in humans. However, chronic wasting disease strains evolve, and studies suggest that some strains of the disease may pose a risk to humans.

CDC's FY 2025 budget request of **\$7,500,000** for Prion Diseases is level with the FY 2023 final level. In FY 2025, CDC will continue to conduct U.S. mortality surveillance and fund laboratory-based surveillance for prion diseases. CDC will partner with medical staff and health officials to investigate and diagnose possible prion diseases using state-of-the-art diagnostics. CDC will also continue to monitor groups at the highest risk of exposure to chronic wasting disease.

### Program Accomplishments

**Innovative diagnostics:** In 2023, CDC worked with partners on evaluating a new skin biomarker for prion diagnoses. Although continued evaluations are needed, early data look promising for this diagnostic, which would greatly increase prion surveillance and reduce the cost of testing.

### **Harmful Algal Blooms**

Harmful algal blooms (HABs) of algae or cyanobacteria can harm people, animals, and environmental resources. Blooms in fresh water, such as lakes and rivers, and salt water, such as oceans or bays, have impacted all 50 states, Puerto Rico, and the U.S. Virgin Islands. HABs can look like foam, scum, paint, or mats on the surface of water. They can vary in color and smell bad when they decay. These blooms can produce toxins that make people and animals sick and cause socioeconomic impacts to communities relying on affected water bodies. People and animals get sick when they eat contaminated seafood, drink contaminated water, or go in contaminated water. HABs cause a range of mild-to-life-threatening illnesses depending on the type of algae, the amount of toxins, and how people or animals were exposed. Common symptoms in people include stomach pain, rashes, and headaches. Illnesses caused by HABs are costly and estimated to be as much as \$14,600 per illness<sup>40</sup>. CDC's Harmful Algal Blooms program is working with state and federal agencies to understand and mitigate health effects, and supporting states' work to protect the public from this emerging threat, especially in states such as Florida, Ohio, and Oregon, which have had large-scale emergencies.

CDC's FY 2025 budget request of **\$3,500,000** for Harmful Algal Blooms is level with the FY 2023 final level. In FY 2025, CDC will continue to protect people, animals, and the environment by detecting, investigating, and preventing illnesses caused by HABs in the following ways:

- **Addressing data gaps** by tracking HABs and human and animal illnesses nationally with CDC's One Health Harmful Algal Blooms System (OHHABS), supporting public health departments and their partners to collect and submit data to OHHABS, and analyze and share data about HABs, associated illnesses, and outbreaks through national surveillance systems.
- **Increasing capacity** by providing funding and technical assistance to public health departments to support HABs work and partnering with organizations that support local, state, and territorial public health departments to prepare and respond to HABs

<sup>39</sup> Case Western Reserve University, National Prion Disease Pathology Surveillance Center, Available at: <https://case.edu/medicine/pathology/divisions/prion-center/>

<sup>40</sup> Kouakou CRC, Poder TG. Economic impact of harmful algal blooms on human health: a systematic review. J Water Health 2019;17(4):499–516.

- **Increasing knowledge** of the impact of HABs by reporting how exposure to HABs affects health, working with federal partners to share expertise and the latest science, and educating the public and healthcare providers about HABs and how to prevent human and animal illnesses.

### Program Accomplishments

**Harmful algal blooms:** In 2023, CDC funded 16 jurisdictions to build their public health capacity and coordinated a public health network of 30 states and six federal agencies. Additionally in 2023, CDC published a 2021 Data Summary <sup>41</sup> detailing information gathered through OHHABS and finished data collection for the 2022 data report. For 2021, 16 states reported 368 HAB events, 117 human illnesses, and 2,715 animal illnesses, including a mass mortality of over 2,000 bats. CDC works with federal agencies, increasing coordination and information sharing through the Harmful Algal Bloom and Hypoxia Research and Control Amendments Act of 2010 <sup>42</sup> and other activities. CDC continues to partner with the Great Lakes Restoration Initiative on their work to restore and protect the Great Lakes.

## **Vector-Borne Diseases Budget Request**

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The United States is increasingly vulnerable to diseases transmitted by ticks, mosquitoes, fleas, and other insects, as vectors expand into new areas and put more Americans at risk. CDC leverages state-of-the-art advanced molecular detection techniques and collaborations with academic, federal, state, and local partners to identify new threats and take multi-sectoral prevention and response actions. CDC also uses climate and other vector-borne disease risk factors to build and evaluate forecasting and modeling tools to predict outbreaks.

### Budget Request

CDC's FY 2025 budget request of **\$88,603,000** for Vector-Borne Diseases, including **\$26,000,000** for Lyme Disease, is level with the FY 2023 final level. In FY 2025, CDC will continue to:

- Build vector-borne disease prevention and control capacity through the vector-borne disease Centers of Excellence (COEs); new Training, and Evaluation Centers (TECs); and the Epidemiological and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreements. CDC will continue supporting states by responding to outbreaks and emerging disease threats.
- Prioritize prevention by developing better vector control tools, vaccines, and other prevention tools, work with state, local, and university partners to evaluate and implement these strategies through public health programs, and provide education to the public and healthcare providers.
- Improve and develop diagnostic tests, including diagnostic tests for new and emerging diseases as well for existing diseases, like Lyme and other tickborne diseases for which diagnosis at multiple stages of illness is difficult.
- Expand tick surveillance to better understand the risk factors for tickborne diseases, including the factors driving the expansion and emergence of tickborne diseases.

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<sup>41</sup> Summary Report – One Health Harmful Algal Bloom System (OHHABS), U.S., 2021, Available at :<https://www.cdc.gov/habs/data/2021-ohhabs-data-summary.html>

<sup>42</sup> See Public Law 113-21.

## Program Accomplishments

**Research, evaluation, and training in vector-borne diseases:** In FY 2022, CDC re-established the *Centers of Excellence in Vector-Borne Diseases (COE)*<sup>43</sup> program. In July 2022, CDC awarded four regional university-based research centers.<sup>44</sup> These centers conduct applied prevention research; train the next generation of public health entomologists; and strengthen collaboration to develop, evaluate, and implement prevention strategies.

With an increase provided in FY 2023, CDC established five *Regional Training and Evaluation Centers (TEC)*.<sup>45</sup> The non-research TEC program complements the COE research program and provides greater regional capacity for vector-borne disease prevention and control through training, evaluation, and partnerships. Two additional recipients are conducting specific evaluation projects, including one project that supports hurricane-related response activities in Puerto Rico. Together, the COE and TEC programs expand the nation's vector-borne disease prevention and control capacity across nine regions of the United States.

**New estimates of the tick-associated meat allergy, alpha-gal syndrome:** Alpha-gal syndrome (AGS) is a serious, potentially life-threatening allergic condition associated with tick bites. AGS is also called alpha-gal allergy, red meat allergy, or tick bite meat allergy. Symptoms can range from a mild rash to life-threatening anaphylaxis. In 2023, CDC reported that from 2010 to 2022 there were more than 110,000 suspected cases of AGS. However, because AGS diagnosis requires a positive diagnostic test and a clinical exam, some people may not get tested. An estimated 450,000 people might be affected by AGS in the United States.<sup>46</sup> CDC has expanded messaging and training to healthcare providers to raise awareness of this tick bite-associated condition.<sup>47</sup>

**Modernized data systems:** CDC maintains and operates *ArboNET*<sup>48</sup>, the national surveillance system for arboviruses. In 2023, *ArboNET* was re-released as a public-facing and interactive dashboard for six<sup>49</sup> of the arboviruses in the United States. Interactive arboviral maps are now available at the state and county levels, making these data more timely and readily accessible to the public. Further, data for Lyme disease are now available through a new set of interactive dashboards that make data available by year, region, and state.<sup>50</sup> Syndromic surveillance also allows for near real-time monitoring of emergency department visits for tick bites, which directly reflects more immediate risks for tickborne disease in areas with endemic disease.<sup>51</sup>

**Vaccine-based prevention:** In FY 2023, CDC continued to focus efforts on promising vaccine program activities, including program planning and implementation for existing and candidate vaccines for dengue, Lyme disease, West Nile virus, chikungunya, and Zika. For example, CDC worked closely with the health departments of dengue-endemic Puerto Rico and the U.S. Virgin Islands to prepare for and implement dengue vaccine through serosurveys, development of local policies, training, education, coordination with laboratories and insurance providers, and modifications to surveillance systems. In 2022, vaccination of eligible children began in Puerto Rico and is expected to be a part of routine pediatric practice in 2024.

<sup>43</sup> The Centers of Excellence in Vector-Borne Diseases, Available at:

<https://www.cdc.gov/ncezid/dvbd/coevbd/index.html#:~:text=The%20Centers%20of%20Excellence%20combine%20innovative%2C%20applied%20research,and%20mosquitoes%20and%20their%20associated%20human%20disease%20pathogens.>

<sup>44</sup> Research and Evaluation: Prevent and Control Vector-Borne Diseases, Available at: <https://www.cdc.gov/ncezid/dvbd/about/prepare-nation/coe.html>

<sup>45</sup> See *supra* note 13.

<sup>46</sup> Geographic Distribution of Suspected Alpha-gal Syndrome Cases – United States, January 2017-December 2022, Available at:

<https://www.cdc.gov/mmwr/volumes/72/wr/mm7230a2.htm>

<sup>47</sup> Health Care Provider Knowledge Regarding Alpha-gal Syndrome – United States, March-May 2022, Available at:

<https://www.cdc.gov/mmwr/volumes/72/wr/mm7230a1.htm>

<sup>48</sup> ArboNET, Available at: <https://www.cdc.gov/mosquitoes/mosquito-control/professionals/ArboNET.html>

<sup>49</sup> The six arboviruses are: eastern equine encephalitis, Jamestown Canyon, La Crosse encephalitis, St. Louis encephalitis, West Nile virus disease, and Powassan virus.

<sup>50</sup> Surveillance Data, Available at: [https://www.cdc.gov/lyme/datasurveillance/surveillance-](https://www.cdc.gov/lyme/datasurveillance/surveillance-data.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flyme%2Fdatasurveillance%2Frecent-surveillance-data.html)

[data.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Flyme%2Fdatasurveillance%2Frecent-surveillance-data.html](https://www.cdc.gov/lyme/datasurveillance/surveillance-data.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flyme%2Fdatasurveillance%2Frecent-surveillance-data.html)

<sup>51</sup> Tick bite data tracker, Available at: <https://www.cdc.gov/ticks/tickedvisits/index.html>

Chikungunya is transmitted to people through the bite of an infected mosquito with at least 5 million cases reported worldwide in the past 15 years. Chikungunya is a major risk to those living in endemic areas, including the Caribbean and Pacific U.S. territories, and represents a travel risk to those traveling to endemic areas. In 2023, U.S. Food and Drug Administration approved the first chikungunya vaccine. The vaccine is approved for individuals 18 years of age and older who are at increased risk of exposure to chikungunya virus. CDC is providing technical support to the Advisory Committee for Immunization Practices and will support the domestic vaccination program if recommended for domestic use.

In August 2022, a new Lyme disease vaccine entered Phase 3 of a clinical trial.<sup>52</sup> In anticipation of the vaccine becoming available, CDC is planning a vaccine-based prevention program for Lyme disease and researching disease burden, vaccine acceptability, and public health and economic impact. CDC is also developing communication materials about vaccine development and immunization monitoring to address expected questions and concerns. In 2023, CDC established enhanced Lyme disease surveillance programs as a foundation for future vaccine effectiveness studies.

***Mosquito abatement and mosquito-borne disease response:*** CDC provides annual funding and technical support to states to ensure they have the staff, training, expertise, and equipment needed to monitor and respond to mosquito-borne disease outbreaks. Since 2018, CDC has doubled investments in state, city, and territorial vector-borne prevention and control through CDC’s ELC Program. These investments ensure that jurisdictions are prepared with resources and expertise to respond to vector-borne disease threats and stop or limit local transmission.

For example, in 2023, Florida, Texas, and Maryland were able to promptly respond to the threat of local transmissions of malaria, by interrupting transmission and protecting their citizens from further infections. This was the first documented spread of malaria from mosquitoes to humans inside the United States in 20 years. Further, in 2023 unprecedented patterns were seen in the transmission of West Nile virus in the United States., with cases emerging early and outbreaks occurring simultaneously across multiple states. With CDC investments, Arizona, Colorado, Texas, and California were able to respond promptly and limit local transmission of this deadly disease.

## **National Healthcare Safety Network (NHSN) Budget Request**

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CDC’s National Healthcare Safety Network (NHSN) is the nation’s most comprehensive and widely used system to identify emerging and enduring threats across healthcare, such as COVID-19, healthcare-associated infections (HAIs), and antimicrobial-resistant infections.

More than 38,300 U.S. healthcare facilities, including nearly every hospital (~7,100), ambulatory surgery center (~5,400), dialysis facility (~7,900), and CMS-certified nursing home (~15,400), participate in NHSN. The number of participating healthcare facilities has doubled since 2015. NHSN data and analytics help drive real-time quality improvement and patient safety by enabling healthcare facilities to track, report, assess gaps, and take actions related to a range of urgent health threats. Over the past eight years, the number of facilities reporting both voluntary and mandatory data to NHSN has tripled, and the number of conditions reported has expanded. To sustain and extend Healthcare-Associated Infections (HAI) surveillance and prevention progress, full engagement between local, state, and federal public health agencies and their partners in the healthcare sector is vital.

### **Budget Request**

CDC’s FY 2025 budget request of **\$24,000,000** for the National Healthcare Safety Network is level with the FY 2023 final level. With this funding, CDC will:

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<sup>52</sup> Lyme disease vaccine, Available at: <https://www.cdc.gov/lyme/prev/vaccine.html>

- Continue to increase the automation of data reporting to NHSN.
- Continue the integration of electronic healthcare records and other emerging data standards to NHSN.
- Continue to capture critical data to inform public health decision-making to identify and respond to emerging and enduring health threats in healthcare facilities, such as COVID-19 and influenza.
- Maintain current capabilities to address future health emergencies.
- Accelerate the adoption and improvement of measurements of patient safety, including sepsis, healthcare-associated conditions, and antimicrobial use and resistance to improve healthcare quality and safety.
- Continue to improve the provision of analytic reports and electronic data provided from NHSN to state and local health departments, other federal government agencies—such as CMS and ASPR—and public health partners to support their decisions.
- Work with health departments, hospitals, nursing homes, and other partners to increase the use of reporting pathways such as the NHSN Antimicrobial Use and Resistance (AUR) module<sup>53</sup> to assess antibiotic prescribing and antibiotic-resistant infections in hospitals in support of national HAI/AR prevention goals.
- Onboard facilities and partner with other state, local, and federal government agencies to help them meet new mandatory Centers for Medicare & Medicaid Services AUR Surveillance measure reporting requirements in NHSN.<sup>54</sup> This reporting is completely automated, with no manual data entry.
- Build upon COVID-19 and bed capacity data collection efforts from all hospitals and pilot the creation of an enduring domestic all-hazards data collection capability to contribute to national security needs for situational awareness of the healthcare system’s capacity to provide care during emergencies.
- Identify hotspots of infections within the healthcare system and disproportionately affected populations, respond to future emergencies, and aid other U.S. government agencies, state and local health departments, and individual healthcare facilities.

Technical assistance is a key component of the comprehensive NHSN quality improvement program. CDC continues to promote the use of the Targeted Assessment for Prevention (TAP) Strategy<sup>55</sup> to target and tailor prevention efforts alerting providers and public health professionals about facilities with more infections so they can immediately target prevention efforts.

### Program Accomplishments

**Emergency response:** Throughout the COVID-19 pandemic, CDC has leveraged NHSN to collect and analyze urgently needed information to drive key emergency response actions. In December 2022, for the first time, the U.S. federal government gained near-real-time insight into the hospital bed and ICU bed occupancy rates and availability rates for all ~5,300 acute care/critical access hospitals in the country after transferring data collection to CDC’s NHSN to inform the U.S. government’s response to COVID-19 and to prepare for future respiratory virus surges.

<sup>53</sup> Antimicrobial Use and Resistance (AUR) Module, Available at: <https://www.cdc.gov/nhsn/pdfs/pscmanual/11pscaurcurrent.pdf>, Last updated January 2023.

<sup>54</sup> Federal Register: Public Inspection: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates; etc., Available at: <https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>

<sup>55</sup> The Targeted Assessment for Prevention (TAP) Strategy, Available at: <https://www.cdc.gov/hai/prevent/tap.html#:~:text=The%20Targeted%20Assessment%20for%20Prevention%20%28TAP%29%20Strategy%20is,data%20for%20action%20to%20prevent%20healthcare-associated%20infections%20%28HAIs%29.>

***Preventing infections and death:*** Following the example of CDC’s successful *Core Elements of Hospital Antibiotic Stewardship Programs*,<sup>56</sup> CDC released the Hospital Sepsis Program Core Elements in August 2023<sup>57</sup> to help U.S. hospitals implement, monitor, and optimize institutional sepsis programs and sepsis outcomes. In a typical year, at least 1.7 million adults in America develop sepsis and at least 350,000 adults who develop sepsis die during their hospitalization or are discharged to hospice<sup>58</sup>; this guidance aims to help prevent infections and deaths. This release was developed and promoted in collaboration with key partners to encourage hospitals to do more to protect patients from sepsis. CDC will monitor updates and implementation using the NHSN annual facility survey of all hospitals in the country and revise the guidance based on feedback from healthcare partners.

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<sup>56</sup> Core Elements of Hospital Antibiotic Stewardship Programs, Available at: <https://www.cdc.gov/antibiotic-use/core-elements/hospital.html>

<sup>57</sup> Hospital Sepsis Program Core Elements, Available September 2023 at: <https://www.cdc.gov/sepsis/>

<sup>58</sup> What is sepsis, Available at: <https://www.cdc.gov/sepsis/what-is-sepsis.html>

## Healthcare-Associated Infections Budget Request

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Each day, approximately one in 31 U.S. hospital patients and one in 43 nursing home residents contracts at least one infection in association with their healthcare, underscoring the need for improvements in patient care practices in U.S. healthcare facilities<sup>59</sup>. CDC plays a critical role in preventing infections people get while receiving medical care, including those caused by antimicrobial-resistant pathogens, emerging pathogens, and infections leading to sepsis. While CDC has made great progress in preventing Healthcare-Associated Infections (HAIs) in the United States, data from CDC's National Healthcare Safety Network (NHSN) showed increases in certain HAIs during 2020 and 2021, a strong contrast to the consistent declines prior to the COVID-19 pandemic.<sup>60</sup> With ongoing support from CDC and implementation of infection prevention and control strategies in healthcare settings, 2022 NHSN data have shown a decrease in these infections<sup>61</sup>.

HAIs can lead to sepsis. To address sepsis, CDC focuses on four key areas: tracking sepsis, preventing infections that can lead to sepsis, early detection and diagnosis, and appropriate treatment. CDC defines the magnitude of the burden and the impact of interventions, prevents HAIs and infections caused by antimicrobial resistant pathogens that might lead to sepsis, educates clinicians and the public about the importance of early recognition and detection of sepsis through the *Get Ahead of Sepsis*<sup>62</sup> national education campaign; and preserves antibiotics as life-saving tools through antibiotic stewardship.

### Budget Request

CDC's FY 2025 budget request of **\$12,000,000** from the Prevention and Public Health Fund (PPHF) for Healthcare-Associated Infections is level with the FY 2023 final level. CDC continues to provide national leadership in Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) prevention, emerging threat identification, and patient protection, including working with health departments and healthcare facilities when problems arise, engaging other health partners to prevent HAIs, and supporting other federal agencies through the provision of data and technical expertise. This funding will support CDC's delivery of tools and expertise provided during COVID-19, including Tele-ICAR<sup>63</sup>. CDC will also continue its prevention, tracking, lab, and applied research activities to push the country further toward the goal of eliminating HAIs.

### Program Accomplishments

**Supporting preparedness and response:** In 2023, CDC directly assisted and responded to more than 200 healthcare-related outbreaks across 49 state and local health jurisdictions (including six multistate investigations) and three non-US locations. CDC also published a *Viral Respiratory Pathogens Toolkit* for Nursing Homes<sup>64</sup> which includes resources to prepare for and respond to nursing home residents or healthcare personnel who develop signs or symptoms of a respiratory viral infection. CDC continues to improve infection prevention and control (IPC) across the spectrum of healthcare to identify infections early and limit transmission. CDC developed and implemented IPC guidance, tailored to specific healthcare settings; deployed staff to assist nursing homes and other healthcare facilities; provided remote technical assistance to complement in-person deployments; and supported CMS quality improvement programs. CDC continues strengthening the nation's public health infrastructure to prevent, detect, contain, and respond to infectious disease threats, including antibiotic resistance (AR).

<sup>59</sup> HAI and Antibiotic Use Prevalence Survey, Available at: <https://www.cdc.gov/hai/eip/antibiotic-use.html>

<sup>60</sup> COVID-19 Impact on HAIs, Available at: <https://www.cdc.gov/hai/data/portal/covid-impact-hai.html>

<sup>61</sup> 2022 CDC HAI Progress Report, Available at: <https://www.cdc.gov/hai/data/portal/progress-report.html>

<sup>62</sup> Educational Information "Get Ahead of Sepsis", Available at: <https://www.cdc.gov/sepsis/education/index.html>

<sup>63</sup> Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings, Available at: [https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhai%2Fprevent%2Finfection-control-assessment-tools%2Fnursing-homes.html](https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhai%2Fprevent%2Finfection-control-assessment-tools%2Fnursing-homes.html)

<sup>64</sup> Viral Respiratory Pathogens Toolkit for Nursing Homes, Available at: <https://www.cdc.gov/longtermcare/prevention/viral-respiratory-toolkit.html>



## **Advanced Molecular Detection (AMD) Budget Request**

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The Advanced Molecular Detection (AMD) program is a cross-cutting collaborative program, fostering biotechnology-focused laboratory and bioinformatic innovation and focusing on the integration of these technologies at CDC and across the U.S. public health system. Genomic sequencing and bioinformatics analysis form a powerful tool used to detect, characterize, and track infectious diseases, and these tools are becoming an essential function to address infectious disease threats in the United States and globally. The AMD program works with disease-specific programs across CDC and with public health, academic, and private partners, to expand the use of technologies in diseases as diverse as influenza, COVID-19, tuberculosis, salmonellosis, Valley fever, anthrax, West Nile virus, malaria, and mpox.

### **Budget Request**

CDC's FY 2025 budget request for **\$40,000,000** for Advanced Molecular Detection is level with the FY 2023 final level. In FY 2025, the AMD program will continue to focus on five key areas:

- **Innovating through research and development:** The AMD program serves as a model for how CDC can rapidly take advanced, complex technologies (e.g., next-generation sequencing and bioinformatics), adapt them to the needs of the U.S. public health system, and rapidly implement them to protect the health of Americans.
- **Deploying AMD technologies across a wider range of diseases:** The program has supported the adoption of AMD technologies at state and local health departments in many disease areas including foodborne illness, hepatitis C, influenza, meningitis, and Legionnaires' disease. However, there are many more areas where AMD technologies are applicable and could provide positive impacts on public health. CDC is increasingly focused on the pathogen-agnostic application of these technologies.
- **Enhancing technological investments:** The application of sequencing and related technologies requires access to high-performance computing and technical expertise in several specialized areas, including bioinformatics and genomic epidemiology. The rapid utilization of sequencing currently underway in many state and local health departments will require the modernization of existing services to maintain system reliability and rapid turnaround time.
- **Modernizing the workforce:** Although AMD technologies carry great potential; sufficient laboratory and bioinformatics capacity and a highly skilled workforce are essential to extract and interpret relevant information from the massive amount of sequencing data generated. To this end, CDC's AMD program offers molecular epidemiology training to state epidemiologists in addition to support for regional training programs and other technical resources.
- **Promoting collaboration:** During the COVID-19 pandemic, the AMD program implemented a collaborative initiative between universities/research institutions and state and local public health departments to improve public health capacity in the United States. With continued funding, AMD will build on the national and regional baselines established for sequence-based surveillance. In addition, AMD can continue to support competitive research awards to organizations including public health departments, academic institutions, and the private sector, to fill knowledge gaps and promote advancements in genomics for public health.

### **Program Accomplishments**

**Support to state, local, and territorial jurisdictions:** The AMD program helped jurisdictions rapidly scale up genomic sequencing for SARS-CoV-2 in U.S. public health laboratories and increase the sharing of sequence data in open, public databases for ongoing research. Through this effort, the United States has gone from 23 public health laboratories publishing around 17,000 COVID-19 sequences in 2020, to 68 labs publishing over 690,000 COVID-19 sequences in 2022.

**Pathogen Genomics Centers of Excellence:** In 2022, CDC launched the *Pathogen Genomics Centers of Excellence (PGCoE)*<sup>65</sup> to build on AMD’s foundational work translating genomic data into action. The network serves as an important model to foster innovation and technical capacity in pathogen genomics, and a new way to harness advances in genomic and bioinformatic technologies for public health impact. The PGCoE network allows CDC to maintain a pulse on the gaps, needs, and opportunities for use of pathogen genomics in public health through a landscape analysis approach. For example, the Northwest PGCoE in Washington state has created a landscape analysis toolkit for use by state and local public health departments to understand how genomic data are currently being used and future desired use cases, to inform training, strategic planning, and program development.

**Sequencing for Public Health Emergency Response, Epidemiology, and Surveillance (SPHERES):**<sup>66</sup> CDC continues to lead the *SPHERES* consortium, with more than 250 participating institutions (public, private, academic, and non-governmental organizations) coordinating to share information, foster collaboration and identify opportunities to enhance public health sequencing, COVID-19 variant surveillance, and other response activities across sectors. The consortium has expanded to share important information on topics such as wastewater surveillance and mpox sequencing. SPHERES builds on the AMD program’s previous collaborations with academic laboratories as well as with the private sector, and has become an important platform for public, private, and academic collaboration and engagement.

**Academic and private sector innovation:** During the COVID-19 response, the AMD program awarded 43 contracts for organizations—primarily university laboratories—to work with public health agencies around the United States. Recipients have used the funding for a wide variety of public health activities such as improving respiratory surveillance for communities, assessing vaccine efficacy, and investigating transmission in rural communities.

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<sup>65</sup> Funding opportunity announced for Pathogen Genomics Centers of Excellence, Available at: <https://www.cdc.gov/amd/whats-new/PGCOE-NOFO.html#:~:text=The%20Pathogen%20Genomics%20Centers%20of%20Excellence%20%28PGCoE%29%20network,respond%20to%20microbial%20threats%20of%20public%20health%20importance.>

<sup>66</sup> Spheres, Available at: <https://www.cdc.gov/coronavirus/2019-ncov/variants/spheres.html>

## Food Safety Budget Request

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CDC has a unique role in detecting and investigating foodborne illnesses and outbreaks and attributing them to specific foods and settings. CDC collaborates with FDA, USDA, state and local health departments, and food industries to protect Americans from food contaminated with dangerous pathogens.

CDC's goals for reducing foodborne illness include reducing the size, scope, and severity of foodborne outbreaks, including rapid detection of outbreaks caused by priority pathogens; improving molecular surveillance systems that rapidly detect and characterize foodborne pathogens and track progress; and increasing plans and actions from external partners that reflect CDC's scientific input and policy advice on major causes of foodborne illnesses and how to prevent and respond to them.

### Budget Request

CDC's FY 2025 budget request of **\$71,000,000** for Food Safety is level with the FY 2023 final level. CDC will continue supporting the nation's food safety system, focusing on disease detection, outbreak response, and prevention efforts. CDC will achieve these priorities through programs that enhance state and local public health capacity to support national surveillance, improve foodborne outbreak detection and investigations, enhance food safety prevention efforts, and maintain vigilance for emerging threats to our nation's food supply. In FY 2025, CDC will continue to:

- Use whole genome sequencing (WGS) in the PulseNet USA network (CDC's national laboratory network that connects foodborne, waterborne, and One Health–related illnesses) to identify outbreaks rapidly and better define the reservoirs of bacteria that make foods unsafe. CDC will also support expanded adoption of WGS methods in other countries through PulseNet International to improve detection and control before pathogens reach the United States.
- Assess trends in foodborne illness and associated disparities, identify high-risk foods, and evaluate the effectiveness of prevention strategies, through the FoodNet Surveillance and Interagency Food Safety Analytics Collaboration Programs.<sup>67</sup>
- Coordinate with FDA, USDA, and NIH for the application of laboratory technology including genomics, metagenomics, and bioinformatics for outbreak detection and characterization of foodborne bacteria in the genomics in PulseNet and the Food and Feed Safety workgroup.

### Program Accomplishments

**Rapid international outbreak detection:** Every year, PulseNet<sup>68</sup> prevents approximately 270,000 illnesses and saves at least \$500 million in medical costs and lost productivity. For every \$1 invested into PulseNet, an estimated \$70 is saved.<sup>69</sup> The use of WGS has improved CDC's ability to detect and investigate widespread problems in the food supply. In 2023, CDC worked with state, local, territorial, and federal regulatory partners to investigate *Salmonella* illnesses linked to cantaloupes imported from Mexico. CDC quickly identified the source of the outbreak and used WGS to link this outbreak to an outbreak in Canada, which helped identify additional cases. This investigation led to expanded recalls, limiting the number of illnesses in both countries, and demonstrating the value of international lab surveillance networks.

**Training to improve capacity for state, local, and territorial partners:** In FY 2023, CDC trained over 100 public health laboratory personnel in best practices for foodborne disease detection, surveillance, laboratory/whole genome sequencing, pathogen identification, and outbreak investigation and control. The investment in

<sup>67</sup> FoodNet Surveillance, Available at: <https://www.cdc.gov/foodnet/surveillance.html>

<sup>68</sup> PulseNet compares the DNA fingerprints of bacteria from patients to find clusters of disease that represent unrecognized outbreaks.

<sup>69</sup> An Economic Evaluation of PulseNet: A Network for Foodborne Disease Surveillance, Available at: <http://www.sciencedirect.com/science/article/pii/S0749379715006108>

laboratory capacity building for food safety is key to preparedness and allows the CDC to better protect people and reduce foodborne illnesses in America.

## Chronic Fatigue Syndrome Budget Request

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Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) is a serious, long-term illness that affects many body systems. People who experience ME/CFS often have challenges with being diagnosed and receiving care due to the nature of the symptoms and limited scientific understanding. CDC's ME/CFS program works to understand this illness better, as well as other Infection Associated Chronic Conditions (IACC). This program conducts and supports innovative research to improve understanding of the clinical presentation of ME/CFS and to advance patient care. CDC tracks the prevalence of ME/CFS through large national systems, such as the *Behavioral Risk Factor Surveillance System*<sup>70</sup> and the *National Health Interview Survey*.<sup>71</sup> CDC also works closely with partners to gather syndromic surveillance on risk factors, characteristics of the disease (including onset), and management strategies that favor improvement through the CDC Emerging Infections Program.

### Budget Request

CDC's FY 2025 budget request of \$5,400,000 for ME/CFS is level with the **FY 2023 final level**. In FY 2025, CDC will invest these resources in critical research to understand ME/CFS disease burden and approaches to care and to conduct surveillance to better understand the prevalence, onset, and course of ME/CFS and associated disparities. CDC will also continue to work with public health and medical organizations to improve clinical care of persons living with ME/CFS and to address the critical shortage of healthcare providers familiar with the diagnosis and management of the disease. In coordination with federal partners, CDC will work toward cross-agency alignment of initiatives to improve access to care and conduct research to advance knowledge of ME/CFS.

## Epidemiological and Laboratory Capacity Program Budget Request

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The *Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC)*<sup>72</sup> cooperative agreement provides support to all 50 states, six large localities, and eight U.S. territories to prevent, detect, respond to, and control the growing threats posed by infectious diseases. This program affords recipients the flexibility to meet program goals and milestones while allowing them to find approaches that incorporate unique jurisdictional needs.

The ELC program awards more than \$200 million each year from across a variety of CDC programs and serves as the primary mechanism to support emerging infectious disease epidemiology and laboratory capacity in the United States. These funds support more than 3,000 infectious disease staff across the nation, providing state and local jurisdictions with a critical workforce and leadership.

### Budget Request

CDC's FY 2025 budget request of **\$40,000,000** from the Prevention and Public Health Fund (PPHF) for the Epidemiological and Laboratory Capacity Program is level with the FY 2023 final level. This flexible funding allows CDC to provide support and technical assistance to all jurisdictions specifically to help strengthen cross-cutting surveillance and health information systems. This includes support for a skilled public health workforce and systems that can maintain critical flexibility to address emergent infectious disease threats and outbreaks.

<sup>70</sup> Behavioral Risk Factor Surveillance System, Available at: <https://www.cdc.gov/brfss/index.html>

<sup>71</sup> National Center for Health Statistics, National Health Interview Survey, Available at: <https://www.cdc.gov/nchs/nhis/index.htm>

<sup>72</sup> Epidemiology and Laboratory Capacity, Available at: <https://www.cdc.gov/elc/>

## Program Accomplishments

**Support to state and local health departments:** ELC investments for health departments ensure robust fiscal oversight, and improved coordination among laboratory, epidemiology, and health information systems through dedicated staff that provide leadership, management, and fiscal accountability for the complex ELC portfolio. These investments also mean that health departments have experienced staff to quickly identify an outbreak or the emergence of a new infectious disease threat through effective monitoring, quick epidemiologic investigations, and advanced laboratory testing.

**RSV in Missouri:** For example, in the United States, respiratory syncytial virus (RSV) is a major respiratory pathogen leading to 58,000 hospitalizations and up to 500 deaths among young children, as well as 177,000 hospitalizations, and 14,000 deaths among adults 65 years or older, annually. In 2022, Missouri experienced an increase in RSV and investigated 10 outbreaks of the virus in daycares, long-term care facilities, and a school from October – December. ELC investments allowed the Missouri Department of Health and Senior Services to enhance surveillance activities, such as supporting epidemiologists and laboratorians who could rapidly test and investigate cases. State health officials worked with local health departments and high-risk facilities to provide test kits and offer results at no cost and issued a health advisory providing recommendations for medical providers. These actions allowed health officials to promptly notify families with children in daycare or loved ones in long-term care facilities and offer guidance for control measures to prevent additional illnesses.

**Blastomycosis in Wisconsin:** ELC investments in Wisconsin ensured that public health epidemiologists, veterinarians, and laboratorians were prepared to respond and lead a multi-agency cluster investigation of blastomycosis first identified in dogs. CDC, state, and local public health authorities surveyed residents and tested specimens to better understand the prevalence in the community. A review of surveillance data identified two human cases reported in the same area within three weeks of the canine cases. Both patients experienced severe disease; one patient died and the other required extracorporeal membrane oxygenation.<sup>73</sup> Public health officials used data gleaned from the investigation to educate residents, medical providers, and veterinarians on how to prevent future cases. Results were also published in a CDC MMWR.<sup>74</sup>

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<sup>73</sup> This is a technique of providing prolonged cardiac and respiratory support to a person whose heart and lungs are unable to provide an adequate amount of gas exchange or perfusion to sustain life.

<sup>74</sup> Notes from the Field article titled Cluster of Blastomycosis among Neighborhood Residents — St. Croix County, Wisconsin, 2022, Available at: <https://www.cdc.gov/mmwr/volumes/72/wr/mm7213a5.htm>

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## CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$1,175.464	\$1,175.464	\$1,304.464	+\$129.000
PPHF	\$254.950	\$254.950	\$254.950	\$0
<b>Total Request</b>	<b>\$1,430.414</b>	<b>\$1,430.414</b>	<b>\$1,559.414</b>	<b>+\$129.000</b>
FTEs	876	927	949	73
-- Tobacco <sup>1</sup>	\$120.650	\$120.650	\$130.650	+\$10.000
-- Tobacco (PPHF)	\$125.850	\$125.850	\$125.850	\$0
-- Nutrition Physical Activity and Obesity	\$58.420	\$58.420	\$58.420	\$0
-- School Health	\$19.400	\$19.400	\$38.400	+\$19.000
-- Health Promotion	\$62.600	\$62.600	\$62.600	\$0
-- Glaucoma	\$4.000	\$4.000	\$4.000	\$0
-- Vision and Eye Health	\$2.500	\$2.500	\$2.500	\$0
-- Alzheimer's Disease	\$38.500	\$38.500	\$38.500	\$0
-- Inflammatory Bowel Disease	\$1.500	\$1.500	\$1.500	\$0
-- Interstitial Cystitis	\$1.100	\$1.100	\$1.100	\$0
-- Excessive Alcohol Use	\$6.000	\$6.000	\$6.000	\$0
-- Chronic Kidney Disease	\$4.500	\$4.500	\$4.500	\$0
-- Chronic Disease Education and Awareness	\$4.500	\$4.500	\$4.500	\$0
-- Prevention Research Centers	\$28.961	\$28.961	\$28.961	\$0
-- Heart Disease and Stroke	\$98.030	\$98.030	\$98.030	\$0
-- Heart Disease and Stroke (PPHF)	\$57.075	\$57.075	\$57.075	\$0
-- Diabetes	\$102.854	\$102.854	\$102.854	\$0
-- Diabetes (PPHF)	\$52.275	\$52.275	\$52.275	\$0
-- National Diabetes Prevention Program	\$37.300	\$37.300	\$37.300	\$0
-- Cancer Prevention and Control <sup>1</sup>	\$409.549	\$409.549	\$499.549	+\$90.000
-- Breast and Cervical Cancer	\$235.500	\$235.500	\$280.500	+\$45.000
-- Breast Cancer Awareness for Young Women	\$6.960	\$6.960	\$6.960	\$0
-- WISEWOMAN (non-add)	\$34.620	\$34.620	\$34.620	\$0
-- Cancer Registries	\$53.440	\$53.440	\$78.440	+\$25.000
-- Colorectal Cancer	\$44.294	\$44.294	\$64.294	+\$20.000
-- Comprehensive Cancer	\$22.425	\$22.425	\$22.425	\$0
-- Johanna's Law	\$11.500	\$11.500	\$11.500	\$0
-- Ovarian Cancer	\$14.500	\$14.500	\$14.500	\$0
-- Prostate Cancer	\$15,205	\$15,205	\$15,205	\$0
-- Skin Cancer	\$5.000	\$5.000	\$5.000	\$0
-- Cancer Survivorship Resource Center	\$725	\$725	\$725	\$0
-- Oral Health	\$20.250	\$20.250	\$20.250	\$0
-- Safe Motherhood/ Infant Health	\$108.000	\$108.000	\$118.000	+\$10.000
-- Arthritis	\$11.000	\$11.000	\$11.000	\$0
-- Epilepsy	\$11.500	\$11.500	\$11.500	\$0
-- National Lupus Patient Registry	\$10.000	\$10.000	\$10.000	\$0
-- Racial and Ethnic Approach to Community Health	\$68.950	\$68.950	\$68.950	\$0
-- Good Health and Wellness in Indian Country (non-add)	\$24.000	\$24.000	\$24.000	\$0
-- Social Determinants of Health	\$8.000	\$8.000	\$8.000	\$0
-- Million Hearts (PPHF)	\$5.000	\$5.000	\$5.000	\$0
-- National Early Child Care Collaboratives (PPHF)	\$5.000	\$5.000	\$5.000	\$0
-- Hospitals Promoting Breastfeeding (PPHF)	\$9.750	\$9.750	\$9.750	\$0

<sup>1</sup> FY 2025 level for Chronic Disease Prevention and Health Promotion account includes an increase of \$100 million for Cancer Moonshot priorities.

**Enabling Legislation Citation:** PHS A § 301, PHS A § 307, PHS A § 310, PHS A § 311, PHS A § 317, PHS A § 317D\*, PHS A § 317H\*, PHS A § 317K, PHS A § 317L, PHS A § 317M\*, PHS A § 317P\*, PHS A § 330E\*, PHS A § 398B, PHS A § 399B-F\*, PHS A § 399Q\*, PHS A § 399R, PHS A § 399V-3\*, PHS A § 399V-6, PHS A §§ 399W-Z\*, PHS A §§ 399LL-399LL-2\*, PHS A § 399NN, PHS A § 417E, PHS A § 1501–1510\*, PHS A § 1706\*, Comprehensive Smoking Education

Act of 1984, Comprehensive Smokeless Tobacco Health Education Act of 1986, Federal Cigarette Labeling and Advertising Act, Fertility Clinic Success Rate And Certification Act of 1992 (P. L. 102-493), Firefighter Cancer Registry Act of 2018 (Pub. L. 115-194)\*

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/expiring noted with \*

**Allocation Methods:** Direct Federal Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; and Competitive Contracts

#### Program Description

Chronic diseases—such as heart disease, cancer, chronic lung diseases, stroke, and diabetes—account for most deaths in the United States and globally and are the major drivers of sickness, disability, and health care costs in the nation. They are responsible for seven out of 10 deaths among Americans each year, and they are the leading drivers of the nation’s \$4.1 trillion in annual health care costs. CDC’s chronic disease prevention efforts contribute to CDC’s goals of preventing and reducing chronic diseases, conditions, and associated risk factors; promoting health; and eliminating health disparities. In FY 2025, CDC will continue to provide national leadership and technical assistance to prevent and control chronic diseases and associated risk factors.

While chronic diseases affect all populations, they are not evenly distributed. Disease rates vary by race, ethnicity, education, and income level, with the most disadvantaged Americans often suffering the highest burden of disease. For example, African American women had a 37 percent higher rate of breast cancer deaths than White women in 2020. Diagnosed diabetes prevalence is 75 percent higher among non-Hispanic Black adults, 70 percent higher among Hispanic adults, and nearly twice as high among American Indians and Alaska Native adults than non-Hispanic White adults in 2021. In 2021, 30.7 percent of adults with a general education development diploma (GED) currently smoked cigarettes, compared to 5.3 percent of adults with a bachelor’s degree. The COVID-19 pandemic further underscored the importance of addressing chronic diseases and underlying factors. During public health emergencies people with chronic diseases are often most at-risk for negative health outcomes. CDC’s mission of protecting the public’s health is only achievable when reducing chronic disease is a key focus.

#### Budget Request

CDC’s FY 2025 budget request of **\$1,559,414,000** for the Chronic Disease Prevention and Health Promotion program is **\$129,000,000** above the FY 2023 final level and includes **\$254,950,000** from the Prevention and Public Health Fund (PPHF), which is level with the FY 2023 final level.



## CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

### BY THE NUMBERS

Chronic diseases are the leading causes of death and disability, and a major driver of healthcare costs in the United States. Over half of adults have a chronic disease and 33.8 percent of adults have two or more chronic diseases. \* CDC programs produce lasting change to address these costly conditions. Based on the most recent data:

- **1.5 million**—women received breast and cervical cancer services through the National Breast and Cervical Cancer Early Detection Program from 2017-2022 which led to detection of 13,784 breast cancers and 26,702 precancerous cervical lesions potentially preventing progression to invasive cervical cancer.
- **5 percent** —Improvement in blood pressure control rates among partner health systems from 2018-2021. Improving control of risk factors like hypertension prevents heart attacks and strokes and their associated medical costs of \$23,500 and \$17,500 per event, respectively.
- **1 million**—People with diabetes receiving diabetes self-management education and support services annually supported by CDC-funded state programs, reducing risk for diabetes complications.
- **1 million**—Number of U.S. adults that quit smoking because of CDC’s *Tips From Former Smokers*® Campaign (2012-2018)<sup>1</sup>

References:

<sup>1</sup>Murphy-Hoefer R, Davis KC, King BA, Beistle D, Rodes R, Graffunder C. Association between the Tips From Former Smokers Campaign and Smoking Cessation Among Adults, United States, 2012–2018. *Preventing Chronic Disease* 2020; 17:200052

\*Unless otherwise noted, all information and calculations are from CDC program data

Chronic Disease Prevention and Health Promotion Funding History	
Fiscal Year	Dollars (in millions)
FY 2021 (BA)	\$1,018.578
FY 2021 (PPHF)	\$254.950
FY 2022 (BA)	\$1,083.174
FY 2022 (PPHF)	\$254.950
FY 2023 (BA)	\$1,175.464
FY 2023 (PPHF)	\$254.950
FY 2024 CR (BA)	\$1,175.464
FY 2024 CR (PPHF)	\$254.950
FY 2025 President’s Budget (BA)	\$1,559.414
FY 2025 President’s Budget (PPHF)	\$254.950

## Program Accomplishments

In 2023, CDC's Tips From Former Smokers (*Tips*®) campaign celebrated its 12th campaign; it continues to run new compelling ads to raise awareness about the health effects caused by smoking and promote resources to help people quit smoking. For the 2023 campaign, call volume to 1-800-QUIT-NOW was over 40 percent above the baseline measurement three weeks prior to the launch of the campaign. Call volume to the Spanish quitline, 1-855-DÉJELO-YA (1-855-335-3569), was 63 percent higher compared to the baseline; opt-ins to the National Texting Portal had a 32% increase compared to baseline. Year after year, the *Tips*® campaign has had a significant and sustained impact, helping more than 1 million U.S. adults quit smoking and inspiring millions more to try.

CDC funds state-based Perinatal Quality Collaboratives (PQCs) to disseminate best practices and implement initiatives to improve outcomes for pregnant persons and newborns. PQCs have contributed to measurable improvements in postpartum outcomes. For example, the Illinois PQC made progress in eliminating racial disparities in care for mothers with opioid use disorder (OUD). At baseline, Black women with OUD were less likely to be on Medication-Assisted Treatment (MAT) than White women with OUD (24 percent vs 45 percent), however across the initiative, improvements in MAT rates were seen for all patients with the greatest improvements for Black patients (60 percent Black patients vs 58 percent for White patients).

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) helps those with low incomes who do not have adequate insurance gain access to timely breast and cervical cancer screening, diagnostic, and treatment services. Between 2017 and 2022, the NBCCEDP provided breast and cervical cancer services to more than 1.5 million people. Screening can detect cancer early when treatment is more effective and for cervical cancer, screening can also prevent cancer by removing precancerous lesions. During this time, the NBCCEDP screenings led to detection of 26,702 high-grade premalignant cervical lesions, potentially preventing progression to invasive cervical cancer. In addition, NBCCEDP screenings led to detection of 13,784 breast cancers.

Approximately, 725,000 people participated in CDC's National Diabetes Prevention Program. Fifty-three percent of evaluated participants reduced their risk of developing type 2 diabetes by achieving: at least 5 percent weight loss (49 percent); at least 4 percent weight loss combined with an average of 150 minutes/week of physical activity (35 percent); or a minimum of 0.2 percent reduction in A1C (0.7 percent). By covering the program, payers can avoid the high cost of diabetes—approximately \$19,736 per person annually for medical expenses or 2.6 times higher than someone without diabetes—by delaying or preventing the onset of type 2 diabetes among covered individuals.<sup>75</sup>

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<sup>75</sup> Parker ED, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care*. November 2023; dci230085. <https://doi.org/10.2337/dci23-0085>.

## Social Determinants of Health Budget Request

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Social determinants of health (SDOH) are factors in the places where people live, learn, work, and play and can affect a wide range of health risks and outcomes. Differences in SDOH contribute to the stark and persistent chronic disease rates, as well as health disparities in the United States among racial, ethnic, and low socioeconomic groups, systematically affecting health and limiting opportunities for members of some groups to be healthy.

### Budget Request

CDC's FY 2025 budget request of **\$8,000,000** for Social Determinants of Health is level with the FY 2023 final level. In FY 2025, CDC will continue support for communities to implement SDOH plans through community ACTION (Addressing Conditions to Improve Population Health) funding and continue to build the evidence base through applied research, data collection, and evaluation.

CDC invests directly in communities to reduce chronic diseases among groups affected by health disparities. From FY 2021 to FY 2023, CDC awarded funds to 71 communities to develop accelerator plans to improve health among disproportionately affected populations by addressing challenges related to the built environment, food and nutrition security, clinical-community linkages, social connectedness, and tobacco-free policies. Recipients were geographically diverse and focused on various populations, including African American, Hispanic/Latino, Asian American and Pacific Islander, Native Americans, rural, and lower income. For example, St. Louis County in Duluth, Minnesota, developed a plan that engages the health sector and other partners to strengthen community-clinical linkages, reinforce social connectedness, and improve food and nutrition security to improve chronic disease disparities that disproportionately impact residents living below 200 percent of the federal poverty line. The multisector collaboration involved more than 17 local organizations, including public health, city government, and over 500 residents. Activities in the plan included establishing a neighborhood grocery store and updating the Lincoln Park Community Resilience Hub community center to provide services such as telemedicine and tele-mental health support.

In FY 2024, CDC began its initial work in developing a model to explore the impacts of SDOH factors on chronic disease incidence, mortality, and disparities. CDC will use a systems science approach to create a mathematical simulation model that integrates risk with various SDOH factors to determine the effect on the incidence of heart disease, stroke, diabetes, chronic kidney disease, cancer, and Alzheimer's disease. This model will assess—on a scale of years to decades—the long-term effectiveness and cost-effectiveness of programs, policies, or practices that address SDOH with a focus on five priority areas: the built environment, community-clinical linkages, food and nutrition security, tobacco-free policy, and social connectedness.

CDC will continue to focus its resources where public health investments can accelerate progress and complement other investments; CDC will coordinate efforts across the agency and federal government to ensure that drivers of health are addressed in our scientific and intervention planning, implementation, and evaluation activities. Research indicates chronic disease rates will increase over the next few decades. Without addressing factors outside of healthcare, such as SDOH, the burden of associated physical and economic costs of chronic conditions will worsen and disparities will continue to widen.

## Safe Motherhood and Infant Health Budget Request

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For over 50 years, CDC has been dedicated to promoting optimal, equitable, and safe maternal and infant health, and improving the lives of women, children, and families through surveillance, science, and partnerships.

### Program Accomplishment

In November 2022, CDC in partnership with the HHS Office of Minority Health released a [segment](#)<sup>76</sup> of the *Hear Her*<sup>™</sup> campaign to amplify the [stories](#)<sup>77</sup> of American Indian and Alaska Native (AI/AN) women who have experienced pregnancy-related complications. Through August 2023, there have been almost 100,000 views of the new *Hear Her*<sup>™</sup> pages with resources for AI/AN communities. Digital and social media aimed at promoting these resources garnered over 16.5 million impressions.

### Budget Request

CDC's FY 2025 request of **\$118,000,000** for Safe Motherhood and Infant Health is \$10,000,000 above the FY 2023 final level. Funding will support CDC activities related to building the national infrastructure for maternal mortality prevention, including Maternal Mortality Review Committees (MMRCs), Perinatal Quality Collaboratives (PQCs), CDC Levels of Care Assessment Tool (LOCATe), and the Hear Her Campaign. Funding will support implementation of multi-level maternal mortality prevention activities in communities with a focus on individuals' first postpartum year. Funding will also support states in leveraging public health infrastructure to ensure pregnant and postpartum women get the right care, in the right place and at the right time.

**Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)**<sup>78</sup>: CDC supports 46 states and jurisdictions to coordinate and manage Maternal Mortality Review Committees (MMRCs) to identify, review, and characterize pregnancy-related deaths and identify prevention opportunities. In FY 2023, CDC expanded the ERASE MM program to fund 7 additional states. Additionally, funding increases were provided for existing ERASE MM Program recipients to better support informant interviews and data quality assurance.

ERASE MM has supported states in improving their MMRC processes. Since program roll out, recipients have developed 177 total MMRC analyses and had 587 total data dissemination activities. With the National Association of Public Health Statistics and Information Systems, CDC piloted real-time transfer of vital records from states to CDC. This has improved the timeliness and completeness of identifying pregnancy-related deaths in the pilot states, while also dramatically reducing state-level data entry burden, saving up to 40 hours a year on average per jurisdiction. CDC has provided focused technical assistance to ensure that MMRCs have both clinical and non-clinical members to strengthen an MMRC's ability to fully understand the circumstances of a woman's life and death. CDC also partners with the HHS Office of Minority Health and others to build a health equity framework for maternal mortality review and prevention. CDC is supporting the implementation of MMRC processes by tribes and tribal serving organizations that reflect tribal values, culture, and sovereignty.

**Perinatal Quality Collaboratives (PQC)**<sup>79</sup>: In 2023, CDC expanded support to 9 additional state PQCs, now supporting 36 PQCs and the National Network of PQCs to improve quality of care and health outcomes around pregnancy and childbirth and to increase equity in care and outcomes. State-based PQCs are networks of hospitals, patients, public health, and other stakeholders providing opportunities for collaborative learning and quality improvement science to achieve systems-level change. As state MMRCs identify recommendations to improve maternal outcomes, PQCs are a key partner in implementing these recommendations more broadly across health facility networks and creating strong clinical-community linkages. With CDC support, PQCs have

<sup>76</sup> <https://www.cdc.gov/hearher/aian/>

<sup>77</sup> <https://www.cdc.gov/hearher/aian/stories.html>

<sup>78</sup> <https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html>

<sup>79</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm>

contributed to measurable improvements in postpartum outcomes. For example, in two years, the Louisiana PQC achieved a 49 percent reduction in severe maternal morbidity from hemorrhage among Black women and a 35 percent reduction overall.

**Hear Her**<sup>80</sup>: CDC’s *Hear Her*™ campaign is a national effort to raise awareness on the urgent maternal warning signs during and after pregnancy and to improve communication between patients and their providers. Since its launch in August 2020, CDC’s *Hear Her*™ campaign has received over two million unique visitors to its website, with over 2.3 million page views. In addition, the campaign has garnered over 259 million impressions from digital ads and social media, and over 1,000 earned media mentions. In FY 2022, *Hear Her*™ released a new suite of materials for healthcare professionals. In FY 2023, CDC in partnership with HHS Office of Minority Health, released a new segment of the campaign to amplify the voices of AI/AN people to improve maternal health outcomes. Evaluation of the campaign overall demonstrates it is raising awareness of urgent maternal warning signs and encouraging people to seek more information and talk to their healthcare providers about concerns.

**SUID and SDY Case Registry**<sup>81</sup>: About 3,400 babies in the United States die suddenly and unexpectedly each year. In FY 2023, CDC published a new five-year Notice of Funding Opportunity (NOFO) providing support to 32 states and jurisdictions for their Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry monitoring programs. Participating states and jurisdictions use data about SUID trends and circumstances to develop strategies to reduce future deaths.

**Monitor Assisted Reproductive Technology (ART)**<sup>82</sup>: While ART relieves the burden of infertility for many couples, it presents a significant public health challenge due to the substantial risk for multiple birth delivery, which is associated with poor maternal and infant health outcomes. To monitor the safety and effectiveness of procedures in the United States, through the National ART Surveillance System, CDC collects data from every fertility clinic in the US that performs ART and calculates standardized pregnancy success rates for each clinic.

**Pregnancy Risk Assessment Monitoring System (PRAMS)**<sup>83</sup>: CDC supports 46 states, the District of Columbia, New York City, Northern Mariana Islands, and Puerto Rico participating in PRAMS, representing approximately 81 percent of all U.S. live births. PRAMS provides data not available from other sources and is used to measure progress towards goals in improving the health of mothers and infants. Researchers use PRAMS data to investigate emerging issues in the field of reproductive health. State, territory, and local governments use PRAMS data to plan and review programs and policies aimed at reducing health problems among mothers and babies. PRAMS identifies behavioral and health status trends and risk factors for adverse outcomes, monitors access to care and services, and measures progress in reducing pregnancy- and childbirth-associated health problems.

**Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Awards**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President’s Budget
Number of Awards	46	46	59
- New Awards	7	0	13
- Continuing Awards	39	46	46
Average Award	\$0.448	\$0.448	\$0.504
Range of Awards	\$0.295-\$0.860	\$0.295-\$0.860	\$0.345-\$0.910
<b>Total Awards</b>	<b>\$20.6</b>	<b>\$20.6</b>	<b>\$29.8</b>

<sup>80</sup> <https://www.cdc.gov/hearher/>

<sup>81</sup> <https://www.cdc.gov/sids/case-registry.htm>

<sup>82</sup> <https://www.cdc.gov/art/key-findings/>

<sup>83</sup> <https://www.cdc.gov/prams/index.htm>

## Cancer Prevention and Control Budget Request

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Cancer affects every age group and is responsible for more years of life lost than all other causes of death combined. Early cancer detection and advances in treatment help reduce deaths, but disparities in prevention, screening, early detection, and quality of care persist. As the U.S. population ages, more people will be at risk for cancer. CDC works with state, tribal, and territorial health departments, and nongovernmental organizations to improve prevention and early detection, including access to screenings and other services.

### Budget Request

CDC's FY 2025 request of **\$499,549,000** for Cancer Prevention and Control is **\$90,000,000** above the FY 2023 final level. Resources will also support CDC activities that are part of the Administration's Cancer Moonshot Initiative. In FY 2025, CDC will continue cancer prevention and control efforts, including funding cooperative agreements with states, territories, tribes or tribal organizations, and other eligible organizations to implement four major cancer control programs; funds will also continue to support surveillance, education, awareness, and applied research related to breast cancer in young women, cancer survivors, and prostate, ovarian, skin, and gynecologic cancers.

### **National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides screening and diagnostic services to uninsured and underinsured women in 50 States, Washington, D.C., 13 tribes/tribal organizations, Puerto Rico, U.S. Virgin Islands, and five U.S. Affiliated Pacific Islands. Since 1991, NBCCEDP has served over 6.2 million women and diagnosed 77,968 cases of invasive breast cancer, 5,220 cases of invasive cervical cancer, and 242,261 premalignant cervical lesions. Funded programs implement strategies to increase the number of individuals completing screening processes, particularly among people never or rarely screened or who are in a higher-risk age bracket. For example, the Alabama Breast and Cervical Cancer Program noted that cervical cancer screening rates were stagnant at 79 percent and that Alabama cervical cancer incidence and death rates are higher than the U.S. rates. The program increased their reach for those most at risk. In FY 2021, they screened 3,723 women for cervical cancer (up from 2,957 the prior year); 70 percent of these women had never been screened before. To further solidify their commitment to improving cervical cancer outcomes, in Fall of 2022, the program held a statewide cervical cancer summit and developed a statewide action plan to eliminate cervical cancer in Alabama by 2033 through human papillomavirus (HPV) vaccination, cervical cancer screening, and treatment. With an additional \$45 million requested for FY 2025, CDC can increase funding to all 70 programs recipients by an average of approximately \$515,000 per recipient. With this investment CDC estimates the program can serve an additional 99,000 women and detect an additional 1,769 invasive breast and cervical cancers, including precancerous cervical lesions. In FY 2025, CDC will continue to support the Cancer Moonshot Initiative and provide funding and technical assistance to NBCCEDP recipients to further improve breast and cervical cancer screening prevalence for uninsured women with low incomes.

### **Colorectal Cancer Control Program (CRCCP)**

CDC's Colorectal Cancer Control Program ([CRCCP](https://www.cdc.gov/cancer/crccp/index.htm))<sup>84</sup> funds 35 recipients: 20 states, eight universities, two tribal organizations, and five other organizations to implement evidence-based interventions in primary care clinics to increase colorectal cancer (CRC) screening rates. In 2020, the median CRCCP screening rate fell to 50 percent due to COVID-19 pandemic-related challenges, but some CRCCP recipients continued showing improvements in screening rates. For example, the New York State Department of Health partnered with two clinics from a Federally Qualified Health Center on a project to increase CRC screening rates in clinics serving low-income populations who bear a disproportionately high burden of CRC. By implementing new evidence-based interventions, both clinics saw increased monthly screening rates and sustained increases in annual screening rates, with Clinic 1 increasing from 39 percent in June 2020 to 58 percent in June 2022 and Clinic 2 from 43

<sup>84</sup> <https://www.cdc.gov/cancer/crccp/index.htm>

percent to 51 percent over the same period. In program year 2 (July 2021 – June 2022), CRCCP partner clinics screened almost 198,000 people for colorectal cancer. This was a 35 percent increase (51,084 more screenings) from the previous 12-month period. With an additional \$20 million requested for FY 2025, CDC can expand the CRCCP nationwide to fund a recipient in every state at approximately \$800,000 per award. With this investment, CDC estimates the program could screen up to an additional 310,000 people for colorectal cancer over 5 years. In FY 2025, CDC will continue to support the Cancer Moonshot Initiative and provide funding and technical assistance to CRCCP recipients to continue implementing interventions that have been shown to improve CRC screening rates. CDC will also support the Cancer Moonshot Initiative, through its *Screen for Life: National Colorectal Cancer Action* campaign, which informs men and women who are 45 and older about the importance of getting screened for colorectal cancer regularly.

### **National Program of Cancer Registries**

CDC's National Program of Cancer Registries ([NPCR](#))<sup>85</sup> funds 46 states, Washington, D.C., Puerto Rico, the U.S. Pacific Island jurisdictions, and the U.S. Virgin Islands to collect data about cancer cases and deaths for 97 percent of the population.<sup>86</sup> In FY 2025, in support of the Cancer Moonshot Initiative, the additional \$25 million requested will be used to increase funding to all 50 recipients by an average of approximately \$500,000 per award. With this investment CDC can fully implement the Cancer Surveillance Cloud-Based Computing Platform and enable real-time reporting of cancer cases in all 50 central cancer registries.

NPCR coordinates with the National Cancer Institute (NCI) to produce the U.S. Cancer Statistics (USCS), which provides cancer data on almost 100 percent of the U.S. population. CDC provides USCS data through a public use database and a data visualization tool allowing users to customize cancer statistics at national, state, county, and smaller geographic levels. NPCR is developing a single cloud-based computing platform shared by all central cancer registries to improve efficiency, reduce costs, and deliver more accurate, comprehensive cancer statistics in real time. Real-time access to accurate and comprehensive data will improve the ability to define and monitor burden; identify incidence trends, investigate cancer treatment patterns, and evaluate cancer prevention effectiveness. As of July 2023, 100 percent of central cancer registries are receiving daily reporting of cancer pathology reports in a cloud-based platform from at least one national pathology laboratory - an increase from 90 percent in 2022. Data received in real-time through this mechanism allows cancer registries to focus on the type of cancers with increasing incidence, and the specific geographic areas for further investigation.

**National Comprehensive Cancer Control Program** CDC's National Comprehensive Cancer Control Program ([NCCCP](#))<sup>87</sup> funds 50 states, Washington, D.C., seven tribal organizations, and eight U.S. territories and Pacific Island Jurisdictions. NCCCP supports policy and system improvements advancing cancer prevention, early detection and treatment, survivor support, and health equity. Recipients convene coalitions to create jurisdiction-specific plans supporting cancer prevention and reduction strategies. Each year, NCCCP recipients collaborate with over 2000 partners (with a median of 27 partners per award) to promote healthy behaviors, increase cancer screening, enhance cancer survivor support, and more. Recipients work with government, health care, and nonprofit organizations. For example, the North Carolina Comprehensive Cancer Control Program worked with the North Carolina Radon Program to educate people about radon, so fewer people in the state would get lung cancer. Both programs worked together to develop a new continuing education course for real estate agents to learn how radon can enter a home and how homes can be tested for radon. The course launched in 2021 and hundreds of real estate agents have completed it over the past three years. In FY 2025, in support of the Cancer Moonshot Initiative, CDC will continue to provide funding and technical assistance to NCCCP recipients to identify and implement policy, systems, and environmental changes that improve cancer prevention, screening, and survivor support. This will include a continued emphasis on patient navigation activities and support groups

<sup>85</sup> <https://www.cdc.gov/cancer/npcr/index.htm>

<sup>86</sup> The remaining states participate in the NIH National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program to ensure that the official U.S. cancer statistics cover the whole country.

<sup>87</sup> <https://www.cdc.gov/cancer/ncccp/index.htm>

for cancer survivors; and activities to advance health equity by addressing the factors that influence health and well-being through meaningful partnerships and collaboration.

### **Breast Cancer Awareness for Young Women**

While breast cancer mainly affects older women, nine percent of all breast cancers in the United States are reported in women younger than age 45. CDC's *Bring Your Brave* [campaign](#)<sup>88</sup> is a digital advertising and social media campaign that shares the stories of young women affected by breast cancer, prevention information, importance of family history of cancer, and healthcare professionals' guidance on understanding and managing breast cancer risk in young women. The *Bring Your Brave* campaign has resulted in 194.3 million impressions across social media, blogs, search engines, digital display, and earned media; nearly 9.5 million video views, nearly 1.8 million social media engagements and nearly 2.1 million visits to *Bring Your Brave* web pages. In partnership with the American College of Obstetricians and Gynecologists, CDC also provides free online continuing medical education (CME) courses educating healthcare providers on breast cancer diagnosis frequency in women under age 45. As of September 2023, healthcare providers have completed 2,640 courses since the online learning platform was launched in 2020. In FY 2025, CDC will continue to develop and improve communication strategies and materials to support young breast cancer survivors and promote prevention and early detection for young women with an increased risk of breast cancer.

### **Johanna's Law (Gynecologic Cancer Education and Awareness Act of 2005)**

CDC's *Inside Knowledge: About Gynecologic Cancer*<sup>89</sup> campaign educates healthcare providers and women on the five main types of gynecologic cancer: cervical, ovarian, uterine, vaginal, and vulvar, through free videos, graphics, and printed materials for public use. *Inside Knowledge (IK)* has generated more than 9 billion impressions across search engines, social media, digital display, paid digital advertising, and earned media. The ads have amassed over 32 million clicks to CDC resources. In FY 2025, CDC will continue to develop and improve communication strategies and materials to increase awareness of the risk factors, signs, and symptoms of gynecologic cancers.

### **Ovarian Cancer**

Ovarian cancer is the second most common gynecologic cancer and the leading cause of death among cancers of the female reproductive system in the United States. Each year, about 18,500 new cases of ovarian cancer and over 13,400 deaths are reported. CDC conducts research and surveillance related to ovarian cancer, such as studies to better understand geographic patterns of care and disparities among women with ovarian cancer by age, race, and urbanicity/rurality. In FY 2025, in support of the Cancer Moonshot Initiative, CDC will support NPCR recipients to conduct feasibility assessments exploring prognostic factors specific to ovarian cancer, genetic testing, or treatment-related data; and conduct a pilot study on data capture for genetic testing of Hereditary Breast and Ovarian Cancer Syndrome.

### **Prostate Cancer**

CDC works to improve prostate cancer data quality in cancer registries, especially information about the grade and stage at the time of diagnosis, patterns of care, and race and ethnicity of affected men. CDC also sponsors measures of prostate cancer testing on national surveys, funds research on patient and provider knowledge and awareness of prostate cancer and monitors prostate cancer activities in local cancer control plans. CDC developed interactive decision aids featuring virtual human simulation (*Talk to Nathan*)<sup>90</sup> to help patients navigate cancer screening and treatment options, and to help healthcare providers aid patients with these decisions.<sup>91,92</sup> In FY 2025, in support of the Cancer Moonshot Initiative, CDC will disseminate education materials and tools to men eligible for prostate cancer screening, prostate cancer patients, survivors, and their caregivers;

<sup>88</sup> [https://www.cdc.gov/cancer/breast/young\\_women/bringyourbrave/about.htm](https://www.cdc.gov/cancer/breast/young_women/bringyourbrave/about.htm)

<sup>89</sup> <https://www.cdc.gov/cancer/gynecologic/knowledge/index.htm>

<sup>90</sup> <https://www.cdc.gov/cancer/prostate/talk-to-nathan/>

<sup>91</sup> <https://simulations.kognito.com/PROS/PatientScreening/>

<sup>92</sup> <https://simulations.kognito.com/PROS/PatientTreatment/>



fund support groups and a resource center for men with prostate cancer and prostate cancer survivors; and support studies to better understand decision-making and disparities related to prostate cancer risk, screening and treatment.

### **Skin Cancer**

Skin cancer is the most common cancer in the United States. CDC uses data, science, and public health programs—including a visualization tool, the *Melanoma Dashboard*<sup>93</sup>—to empower individuals and communities to adopt best practices to reduce cancer risk. In FY 2025, in support of the Cancer Moonshot Initiative, CDC will maintain communication materials on how different community sectors can support sun safety in outdoor community spaces; and continue data collection on sunburn, sunscreen use, and indoor and outdoor tanning to inform skin cancer prevention efforts at the state and local level.

### **Cancer Survivorship Resource Center**

As of January 2022, there were an estimated 18.1 million cancer survivors in the United States. The number of cancer survivors is projected to increase to 22.5 million by 2032. CDC prioritizes health needs of cancer survivors by conducting epidemiologic and applied research and surveillance and supporting programs for survivors. An evaluation of the Resource Center led to the development of *Healthy Living Guides and Survivor Stories*<sup>94</sup> by connecting survivors to informative and inspirational resources. It also showed the need for specific and tailored resources on patient physical and mental health, navigating cancer care, and care coordination. Over 80 percent of National Comprehensive Cancer Control Program (NCCCP) survey respondents indicated the importance of providing their partners and constituents with these resources. In FY 2025, in support of the Cancer Moonshot Initiative, CDC will continue to develop and disseminate resources that provide strategies focused on improving the quality of life for cancer survivors and their caregivers.

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<sup>93</sup> <https://ephtracking.cdc.gov/Applications/melanomadashboard/>

<sup>94</sup> <https://www.cdc.gov/cancer/survivors/healthy-living-guides/index.htm>

## School Health Budget Request

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CDC's Division of Adolescent and School Health includes CDC's [Healthy Schools Program](#)<sup>95</sup> which plays a unique role in bringing together the education and public health sectors to support physical education, physical activity and healthy nutrition, and management of chronic conditions.

### Program Accomplishments

Healthy Schools Program is in the first year of its new five-year cooperative agreement. In the fourth year of the last cooperative agreement, 56 percent of Healthy School Program grantees promoted, expanded, or convened statewide school health coalitions, and 69 percent of grantees reported an increase in the number of functional school health councils or teams. These coalitions and councils promote the implementation of evidence-based strategies that support healthy eating, physical activity, and management of chronic conditions in schools.

CDC's Leadership Exchange for Adolescent Health Promotion (LEAHP) initiative created multi-sector state teams to successfully connect leaders in 13 states from state education agencies, state health departments, and others interested in school health to build their capacity to collaborate, review policies and data related to school health, and improve health education, health services, and safe and supportive environments in schools. This learning collaborative enabled state officials to work across sectors and cultivate much needed relationships with the common goal to improve adolescent health in their state.

### Budget Request

CDC's FY 2025 budget request of **\$38,400,000** for School Health is **\$19,000,000** above the FY 2023 final level.

CDC's Healthy Schools program funds education and health agencies who work with local communities to implement evidence-based, comprehensive school health policies, practices, and programs designed to improve the health of students and staff and advance equity. For example, Oklahoma implemented Painted Play Spaces at recess to increase physical activity resulting in a 66 percent increase in adults playing games and being engaged with students. There was also a 27 percent increase in the percentage of students who are physically active. Healthy Schools also funds six national non-governmental organizations to support state education agencies, local school districts, schools, parents, and community partners. Each of these national organizations have specialized knowledge and skills and provide professional development and technical assistance to improve the health and wellbeing of students and staff. CDC tools and programs help 132,000 schools in the United States, reaching 78 million students. In addition, CDC tools and training currently reach approximately 40,000 school staff annually with education and resources that promote and support the health and wellbeing of both staff and students.

In FY 2025, in addition to continuing to fund the existing Healthy Schools Program, CDC will fund 57 state, tribal and territorial education agencies to implement CDC's Leadership Exchange for Adolescent Health Promotion (LEAHP) initiative. This initiative, building upon a smaller, 13-recipient cooperative agreement cycle with an end date in mid-FY 2024, will support state education and public health agency teams to assess state-level school health organizational policies and practices and develop and implement action plans of model school-based policies and practices that enhance youth mental and behavioral health. State teams will work to improve the effectiveness of local education agencies to implement activities related to improving student mental health through improved school connectedness, student, parental and community engagement, and increased access to mental health services.

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<sup>95</sup> <https://www.cdc.gov/healthyschools/index.htm>

## Tobacco Prevention and Control Budget Request

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Commercial tobacco<sup>96</sup> use is the leading cause of preventable disease, disability, and death in the United States. Each year, nearly half a million U.S. adults die prematurely due to smoking-related disease, including exposure to secondhand smoke. In addition, over 16 million U.S. adults live with a serious illness caused by smoking. Smoking harms nearly every organ of the body and compromises the immune system. Further, cigarette smoking cost the United States more than \$600 billion in 2018. In 2021, an estimated 46 million U.S. adults (18.7 percent) reported currently using any tobacco product. Progress in prevention and control efforts is challenged by the continued diversification of the tobacco product landscape, including e-cigarettes, and other emerging flavored tobacco products. In 2023, an estimated 2.8 million U.S. middle and high school students (10.0 percent) reported currently using any tobacco product; 2.13 million of these middle and high school students (7.7 percent) reported currently using e-cigarettes.<sup>97</sup>

### Budget Request

CDC's FY 2025 budget request of **\$256,500,000** for Tobacco Prevention and Control is **\$10,000,000** above the FY 2023 final level. The total request includes **\$125,850,000** from the Prevention and Public Health Fund (PPHF), which is level with FY 2023 final. In FY 2025, in alignment with the Cancer Moonshot Initiative, CDC will continue tobacco prevention, control, and surveillance efforts, including addressing tobacco use among youth, and the successful *Tips From Former Smokers (Tips®)* campaign, which helps adults who smoke quit. In FY 2025, CDC will place additional Tips ads on platforms that reach populations with the highest smoking prevalence, increase support to the National Tobacco Control Programs to expand Tobacco Quitline services, and will enhance community-based program efforts to increase awareness of cessation services and coverage options among populations experiencing health disparities.

### National Tobacco Control Program

CDC's [National Tobacco Control Program](#)<sup>98</sup> is the only nationwide investment that provides funding and technical support to all 50 states, plus Washington, D.C., eight U.S. territories, nine national networks, and 26 tribal organizations to implement efforts that reduce tobacco-related diseases, disabilities, and deaths. CDC works with grantees to address youth e-cigarette use and tobacco-related disparities. This includes supporting and implementing policies to reduce tobacco use initiation and collaborating with organizations, healthcare systems, and networks reinforcing tobacco-free norms among youth and young adults. Recipients also emphasize strategies to advance health equity by focusing on communities with the highest burden of tobacco use, identifying and reducing statewide and community-based disparities, implementing commercial tobacco control policies, and evaluating their impact. The program has achieved many successes, for example, in 2022, Florida's *TheFactsNow* tobacco prevention media campaign shared stories with youth and young adults about the effects of nicotine addiction and e-cigarettes. The campaign has over 600,000 website users and over 187 million social media impressions.

### National Tobacco Education Campaign

Seven out of 10 U.S. adults who smoke cigarettes want to quit smoking.<sup>99</sup> CDC's *Tips From Former Smokers® (Tips®)* campaign, the first federally funded national tobacco education campaign celebrated its 12<sup>th</sup> year on air in 2023. The *Tips* campaign profiles real people living with serious long-term health effects due to smoking and

<sup>96</sup> References to tobacco refer to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

<sup>97</sup> Birdsey J, Cornelius M, Jamal A, et al. Tobacco Product Use Among U.S. Middle and High School Students — National Youth Tobacco Survey, 2023. *MMWR Morb Mortal Wkly Rep* 2023;72:1173–1182.

<sup>98</sup> <https://www.cdc.gov/tobacco/stateandcommunity/tobacco-control/program-funding/index.htm>

<sup>99</sup> Babb S, Malarcher A, Schauer G, et al. Quitting Smoking Among Adults — United States, 2000–2015. *MMWR Morb Mortal Wkly Rep* 2017;65:1457–1464.

secondhand smoke exposure. Between 2012-2018, approximately one million adults who smoked cigarettes quit because of CDC's *Tips* campaign; *Tips* also helped prevent an estimated 129,000 early deaths and save \$7.3 billion in healthcare sector costs.<sup>100</sup> The *Tips* campaign was also associated with healthcare cost savings of \$11,400 per lifetime quit, and \$5,300 per quality-adjusted life year gained. For every \$3,800 spent on the *Tips* campaign between 2012-2018, CDC prevented an early death. In 2023, the *Tips* campaign placed additional media on a variety of focused channels, including TV, print, and digital to reach African American, Hispanic, Asian, American Indian/Alaska Native, and LGBTQ+ audiences. CDC also periodically ran promotions for free nicotine replacement therapy (NRT) on TV ads as part of the campaign. The 2024 *Tips* campaign will feature new people living with serious, long-term health effects from smoking, including several new ads focused on the harms of smoking menthol cigarettes. Year after year, the *Tips* campaign has proven its effectiveness while promoting a range of cessation services, in multiple languages, including 1-800-QUIT-NOW, which links callers to their state quitline, as well as web-based, text-based, and app-based cessation support resources.

### **Youth Tobacco Product Use**

CDC conducts and coordinates surveillance, laboratory, and evaluation activities related to tobacco product use, including e-cigarette use, among youth. For example, CDC implements the National Youth Tobacco Survey (NYTS), in collaboration with FDA, to provide national data on youth tobacco product use. These data are key to designing, implementing, and evaluating youth tobacco prevention and control programs.

CDC placed digital and social media ads about the risks of youth e-cigarette use from February 2023 through the end of 2023. These ads aim to empower U.S. middle and high school educators, including teachers, coaches, school counselors, and on-site administrators to speak with youth about the risks of e-cigarettes and nicotine addiction and to encourage them to avoid and/or quit vaping. The placements include search ads and social media ads on Facebook, Instagram, Twitter, Pinterest, and LinkedIn. In 2023, CDC also added new animated videos as part of the [Empower Vape-Free Youth™](#) campaign, building on the *Emerging Tobacco Products* and the *Protecting Young People from E-cigarettes* communication initiatives.

In addition, CDC in partnership with the American Academy of Pediatrics (AAP) is working to support the development of youth cessation resources and the creation of digital tools geared toward pediatric clinicians. In 2023, AAP with support from CDC, integrated the "Ask – Counsel – Treat" (A.C.T.) cessation counseling model into a clinical decision support tool to provide real-time decision support during clinical encounters.

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<sup>100</sup> Murphy-Hoefer R, Davis KC, King BA, et. al. Association between the Tips from Former Smokers Campaign and Smoking Cessation Among Adults, United States, 2012–2018. *Preventing Chronic Disease* 2020;17:200052.

## Diabetes Budget Request

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Diabetes affects about 38.4 million Americans, including 352,000 children and adolescents. Each year 1.2 million Americans aged 18 or older are newly diagnosed. CDC estimates that 97.6 million American adults—more than one in three—have prediabetes, a serious health condition that increases the risk of developing type 2 diabetes, heart disease, and stroke. In addition, medical costs are twice as high and productivity costs are 13 percent higher in people with diabetes compared to those without.<sup>101</sup> In 2022, the cost of diabetes was approximately \$413 billion due to medical costs and reduced productivity.<sup>102</sup>

### Program Accomplishment

As of August 2023, National Diabetes Prevention Program participant organizations developed 195 culturally and linguistically adapted curricula and materials; established 42 CDC-recognized organizations as Medicare DPP suppliers in underserved areas; created 120 reimbursement agreements with employers and payers, reaching over 6 million people; and implemented 507 advanced trainings for Lifestyle Coaches helping participants achieve their goals.

### Budget Request

CDC's FY 2025 budget request of **\$155,129,000** for Diabetes is level with the FY 2023 final level. The total request includes **\$52,275,000** from the Prevention and Public Health Fund (PPHF). In addition, the FY 2025 request includes **\$37,300,000** for the National Diabetes Prevention Program, which is level with the FY 2023 final level. In FY 2025, CDC will continue to fund a diverse group of national, state, local organizations, and tribes to prevent or delay onset of type 2 diabetes among adults at high risk and to improve self-care practices, quality of care, and early detection of complications among people with diabetes. CDC will also conduct surveillance, applied research, and modeling and economics studies to develop and apply sound science to reduce the burden of diabetes and inform long-term health cost outcomes of diabetes interventions.

### **National Diabetes Prevention Program (National DPP)**

CDC implements the National Diabetes Prevention Program (National DPP),<sup>103</sup> a scientifically proven lifestyle change program to prevent or delay the onset of type 2 diabetes in adults at high risk. National DPP is a partnership of public and private organizations working to build a nationwide delivery system focused on healthy eating, physical activity, and stress management. According to CDC estimates, administering the National DPP lifestyle change program to a participant who completes all 22 sessions of the year-long program costs an average of \$500. By covering the program, payers can reduce the high cost of type 2 diabetes through delaying or preventing the onset of type 2 diabetes among covered individuals.<sup>104</sup> CDC continues to expand the reach and coverage of the program to include all payers. For example, Medicare started covering the program in 2018. A growing number of state Medicaid agencies and commercial and employer payers also offer coverage as well. CDC works with the Centers for Medicare & Medicaid Services (CMS) to support Medicare coverage for the National DPP lifestyle change program, and data show that adults aged 65 years or older participating in the National DPP lifestyle change program achieve the 5 percent weight loss goal at a higher rate than the population under age 65. In FY 2025, CDC will continue to provide technical assistance and training for over 1,500 CDC-recognized program delivery organizations, employers, and other stakeholders. CDC will also monitor National DPP delivery organizations through the CDC Diabetes Prevention Recognition Program and support continued CMS expansion of the Medicare Diabetes Prevention Program as a covered service for Medicare

<sup>101</sup> Park J, Bigman E, and Zhang P. [Productivity Loss and Medical Costs Associated With Type 2 Diabetes Among Employees Aged 18–64 Years With Large Employer-Sponsored Insurance](#). *Diabetes Care*. November 2022; 45 (11): 2553–2560.

<sup>102</sup> Parker ED, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care*. November 2023; dci230085. <https://doi.org/10.2337/dci23-0085>.

<sup>103</sup> <https://www.cdc.gov/diabetes/prevention/index.html>

<sup>104</sup> <https://coveragetoolkit.org/cost-value-elements/>

beneficiaries with prediabetes. In addition, CDC launched the National DPP Operations Center, a web-based application that combines data from multiple sources into a common information hub for the National DPP, enabling data-driven decision-making and equipping CDC and partners to better support the National DPP's growth and long-term sustainability.

### **Cross-Cutting Cooperative Agreements to Prevent Diabetes and Reduce Diabetes-Related Complications**

In FY 2023, CDC funded seven cooperative agreements to support type 2 diabetes prevention and diabetes management and reduce diabetes-related complications.<sup>105,106</sup> These programs develop, implement, and evaluate evidence-based strategies to manage diabetes; prevent or delay type 2 diabetes in populations with high rates of diabetes; and build the National DPP infrastructure in communities needing it most.

Since 2017, CDC has awarded over \$84 million to 10 national organizations to expand access to the National DPP lifestyle change program.<sup>107</sup> As of August 2023, these organizations were working with over 164 affiliated sites to deliver the National DPP lifestyle change program in 34 states, Washington, D.C., and four U.S. Affiliated Pacific Islands. These sites enrolled over 28,233 eligible participants, including Hispanic/Latino, African American, American Indian/Alaska Native, Asian American, Pacific Islander individuals; Medicare beneficiaries; and noninstitutionalized people with visual impairments or physical disabilities. Participants who attended eight or more sessions in the first six months and stayed in the program for at least nine full months had an average weight loss of 6.2 percent – greater than the desired program goal.

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<sup>105</sup> <https://www.cdc.gov/diabetes/programs/stateandlocal/funded-programs/dp18-1815.html>

<sup>106</sup> <https://www.cdc.gov/diabetes/programs/stateandlocal/funded-programs/dp18-1817.html>

<sup>107</sup> <https://www.cdc.gov/diabetes/prevention/index.html>

## Oral Health Budget Request

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Oral health is essential to overall health and well-being<sup>108</sup>. Oral health affects the ability to eat, speak, smile, and show emotions, as well as impacts self-esteem, school performance, and attendance at work or school. Oral diseases can lead to pain, inflammation, and infections that can spread in the body.

### Budget Request

CDC's FY 2025 budget request of **\$20,250,000** for Oral Health is level with the FY 2023 final level. In FY 2025, CDC will continue to support states and territories to implement proven interventions to reduce cavity and oral disease rates and to integrate oral health into chronic disease prevention programs and medical care services.

Cavities are one of the greatest unmet health treatment needs among all age groups. Among children aged six to eight years, over half (52 percent) have had a cavity in their primary (baby) teeth. Children from low-income households are twice as likely to have untreated cavities as children from higher-income households.<sup>109</sup> In adults aged 20 to 64, one in four currently has at least one untreated cavity; for those aged 65 or older, the ratio is one in six.<sup>34,35</sup>

In FY 2024, CDC funded 20 state health departments to assist their efforts to decrease dental caries, oral health disparities, and other chronic diseases co-morbid with poor oral health. CDC encourages the use of community water fluoridation to benefit all community members, regardless of age, education, or income by reducing the rates of cavities and improving oral health. CDC also promotes greater use of school dental sealant programs targeted toward schools with children less likely to receive private dental care, an intervention shown to decrease disparity in access to care among children from low-income households.<sup>110</sup>

CDC serves as the national leader in infection prevention and control for the dental community, developing and promoting guidelines, as well as tools, resources, and trainings, to increase adherence to guidelines. CDC also conducts surveillance activities that include research and translation of national and state data on oral disease burden, access to dental care, preventive services, and cost-effectiveness of preventive interventions. Additionally, CDC hosts a dental public health specialty residency program, which produces skilled dental public health specialists who can work in various health settings.

One third of adults had a past-year medical visit and no dental visit.<sup>111</sup> Medical visits may be the only opportunity to provide oral health education and referrals to adults. To address this, CDC is working to develop a national action framework to outline opportunities to integrate medical and dental services in different healthcare settings at the local, state, national, and healthcare system level.

As part of efforts to further integrate the nation's medical and dental care systems, CDC will continue its partnership with the American Academy of Pediatrics (AAP) to test and promote *Protect Tiny Teeth*, an oral health toolkit for medical providers to raise awareness about the importance of oral health as part of prenatal care. AAP has developed implementation guides for using these resources in maternity and pediatric care settings.

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<sup>108</sup> National Institutes of Health. Oral Health in America: Advances and Challenges. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2021.

<sup>109</sup> Centers for Disease Control and Prevention. Oral Health Surveillance Report: Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999–2004 to 2011–2016. US Dept of Health and Human Services; 2019.

<sup>110</sup> Centers for Disease Control and Prevention. Vital signs: dental sealant use and untreated tooth decay among US school-aged children. MMWR. 2016;65(41):1141-1145.

<sup>111</sup> Manski, R., Rohde, F., Ricks T., and Chalmers, N. Trends in the Number and Percentage of the Population with Any Dental or Medical Visits, 2019. Statistical Brief #544. October 2022. Agency for Healthcare Research and Quality, Rockville, MD.

## Heart Disease and Stroke Budget Request

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In 2021, over 934,000 people died of cardiovascular diseases (CVD), which include heart disease and stroke. CVD deaths account for one-third of all U.S. deaths—more than COVID-19, cancer, and unintentional injuries combined. Hypertension, or high blood pressure, is a major cause of CVD, putting 120 million or nearly 1 in 2 adults in the United States at risk for largely preventable heart attacks, strokes, heart failure, kidney disease, and pregnancy complications. The United States loses around \$407 billion annually in healthcare costs, productivity, and premature death due to CVD; \$1 of each \$8 in healthcare costs is spent on CVD. The cost could reach \$1.1 trillion per year by 2035.

### Program Accomplishment

From 2022 – 2023, CDC’s *Live to the Beat* campaign had tremendous reach, with 473 million media impressions in the first year. The campaign is a public-private partnership communications campaign to help adults take steps to live a heart-healthy lifestyle and prevent heart attacks and strokes.

### Budget Request

CDC’s FY 2025 budget request of **\$155,105,000** for heart disease and stroke is level with the FY 2023 final level. The total request includes **\$57,075,000** from the Prevention and Public Health Fund (PPHF). In FY 2025, CDC will support states, localities, tribes, and territories use of interventions to control risk factors and prevent and manage heart disease and stroke. CDC will also build out its portfolio of work to improve women’s cardiovascular health, with an initial focus on improving detection and control of hypertension in women across the life course, including during and after pregnancy. CDC will also conduct surveillance and applied research to understand how best to reduce the burden and risk factors for heart disease and stroke. In addition, CDC will continue leading Million Hearts® to prevent cardiovascular events in five-year intervals.

### **State and Local Heart Disease and Stroke Cooperative Agreements**

CDC funds 50 states, Washington, D.C., and some large cities to prevent, detect, and treat high blood pressure and high cholesterol. CDC works with recipients and their partners to improve the quality of care for people with these risk factors and to provide access to heart-healthy lifestyle resources. Lowering blood pressure, even if control is not achieved, lowers the risk of heart attacks and stroke. Just a 5-point reduction in systolic blood pressure reduces the risk of a major cardiac event by 10 percent. The interventions promoted by CDC are cost-effective and can help prevent incurring the significant costs of cardiac events, as the average hospital costs for a heart attack and stroke are estimated at \$23,500 and \$17,500, respectively.

CDC’s National Cardiovascular Health Program is improving blood pressure control in participating health systems. These health systems have reached tens of millions of people and have seen a blood pressure control rate improvement of 6 percent from 2013 to 2018 and a 5 percent improvement in blood pressure control from 2018 to 2022, even while the COVID-19 pandemic worsened overall CVD mortality. As an example, Hawaii partnered with healthcare clinics to use electronic health records to identify patients with undiagnosed high blood pressure and improve treatment. Overall, in partner health systems implementing this and other CDC-recommended interventions, 65 percent of patients have achieved blood pressure control, up from 52 percent in 2018.

Every year, more than 795,000 Americans have a stroke; and more than 162,000 of them will die. Strokes are the leading cause of long-term disability in the United States, generating over \$56 billion in costs annually. CDC’s Paul Coverdell National Acute Stroke Program funds states to implement comprehensive stroke systems for individuals at highest risk. Recipients use data to improve action across the continuum of care, from stroke symptom onset through emergency transport, hospitalization, and discharge. Improvements in the rapid



administration of the drug tissue plasminogen activator (tPA) increases the likelihood of recovery for patients with the most common kind of stroke. Among Coverdell Program recipients, the percentage of patients receiving tPA within the national standard of 60 minutes rose from 26 percent in 2008 to 71 percent in 2021. From 2012 to June 2021, the program reached 797 hospitals in 13 states, with nearly 1.1 million stroke patients benefiting from quality care improvement efforts.

In FY 2024, CDC will continue funding a pilot project to use de-identified and aggregated electronic health record (EHR) clinical data on chronic disease indicators, including heart disease and stroke which will improve access to more timely data. An EHR-based surveillance system could help CDC programs improve blood pressure control and cholesterol management and direct resources where they matter most by providing near real-time, local-level data that would better identify places with high burden of CVD and risk factors and enable better targeting of interventions.

### **Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)**

Heart disease is the number one killer of women; more than 310,000 women died from it in 2021, incurring losses to families and communities and costs in the tens of billions of dollars. CDC's WISEWOMAN program assesses risk for CVD among low-income, uninsured, and underinsured women aged 35 to 64 who are participants of the CDC-funded National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The WISEWOMAN program connects participants to healthy behavior support services (HBSS) such as evidence-based lifestyle programs, health coaching, and other resources that support improved diet, physical activity, tobacco cessation, and medication adherence. From 2008 to 2022, WISEWOMAN provided 365,440 screenings to 256,442 participants and provided nearly 502,000 HBSS to reduce CVD risk; currently, 82 percent of WISEWOMAN participants receive at least one HBSS. In FY 2025, CDC will continue funding states, territories, and tribal-serving entities for screenings and referrals to HBSS to reduce CVD risk factors in participants.

### **Million Hearts<sup>®112</sup>**

Million Hearts 2027 is a national initiative co-led by CDC and the Center for Medicare & Medicaid Services to prevent one million heart attacks and strokes in five years.

#### Budget Request

CDC's FY 2025 budget request for Million Hearts includes **\$5,000,000** from the Prevention and Public Health Fund (PPHF), which is level with the FY 2023 final level.

In FY 2025, Million Hearts will be in its third five-year cycle and will continue to leverage its network of over 300 partners to build healthy communities, optimize care and improve cardiovascular health for all, with a deliberate emphasis on populations experiencing inequities, such as pregnant and postpartum women. In its first five-year cycle from 2012-2016, Million Hearts prevented an estimated 135,000 heart attacks, strokes, and related cardiovascular events, and saved \$5.6 billion in direct medical costs – a substantial portion of which was saved by public insurance programs like Medicare and Medicaid. Evaluations of the second five-year cycle are underway. Through a partnership with the National Association of Community Health Centers (NACHC), Million Hearts<sup>®</sup> has directly improved the quality of care for more than 700,000 at-risk patients in community health centers across the nation for an extremely low cost of about \$14 per person. In addition, as part of a public-private partnership, CDC continues to lead the “Live to the Beat,” campaign to support African American adults ages 35 to 54 adopt heart-healthy habits, as well as a second public campaign directed at all adults ages 55 to 64 who have at least one risk factor for a heart attack or stroke. The campaign has had tremendous reach, producing more than 473 million media impressions in its first year.

<sup>112</sup> <https://millionhearts.hhs.gov/index.html>

## **Nutrition, Physical Activity, and Obesity Budget Request**

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In the United States, poor diet and inactivity contribute to the leading causes of disease and death. Good nutrition, starting with breastfeeding, and regular physical activity improve health and well-being. Twenty six percent of adults are inactive; over 42 percent of adults (age 20 years and older) and 19.7 percent of children (ages two to 19) have obesity, increasing their risk for type 2 diabetes, heart disease, stroke, certain cancers, depression, and early death. Poor diet, inactivity, obesity affect overall health, increase healthcare costs, and harm worker productivity. U.S. military readiness is affected: just over one in three (37 percent) young adults aged 17 – 24 exceed the military’s weight and body fat limits.

### **Budget Request**

CDC’s FY 2025 budget request of **\$58,420,000** for Nutrition, Physical Activity, and Obesity is level with the FY 2023 final level. In FY 2025, CDC will continue to fund and provide technical assistance to recipients and partners to implement, evaluate, and translate, program activities at state and local levels. CDC works with partners to develop evidence-based interventions, surveillance, and research to inform policies, programs, and guidelines. CDC’s FY 2025 request of **\$9,750,000** for Hospitals Promoting Breastfeeding and **\$5,000,000** for National Child Care Collaboratives from the PPHF are level with the FY 2023 Final level. CDC will continue to support breastfeeding in birthing hospitals, worksites, and communities while addressing related racial disparities.

### **Cross-Cutting Cooperative Agreements to Enhance Nutrition and Physical Activity and Prevent Obesity**

In FY 2025, CDC will continue to fund 17 states through the [State Physical Activity and Nutrition Program](#) (SPAN)<sup>113</sup> to increase access to safe places for physical activity and healthier foods; implement interventions supportive of breastfeeding; and embed nutrition and physical activity standards into statewide early care and education (ECE) systems with a focus on health equity across all strategies. CDC will also continue to fund 16 land grant universities through the [High Obesity Program](#) (HOP)<sup>114</sup> to work with community extension services to increase access to healthier foods and safe and convenient places for physical activity in counties where over 40 percent of adults have obesity. In addition to continuing critical nutrition and physical activity strategies from past HOP cycles, eight HOP recipients (2023 – 2028) are working on implementing Family Healthy Weight Programs (FHWP). These comprehensive, evidence-based, family lifestyle change programs can help children with overweight or obesity make progress toward a healthier weight through positive behavior changes.

SPAN and HOP 2018 recipients had significant accomplishments over their 5-year funding period. SPAN recipients helped over 1.4 million people through community support to start and continue breastfeeding and reached over 18 million people through increased access to places where they can be physically active. HOP recipients increased access to healthier foods for over 385,000 people. New SPAN and HOP recipients for the 2023 – 2028 funding period are laying the groundwork for similar accomplishments, including deploying food-is-medicine strategies such as fruit and vegetable incentives and produce prescriptions.

In FY 2025, CDC will continue to expand Active People, Healthy Nation<sup>SM</sup>, an initiative to help 27 million people become more physically active by 2027. Physical activity is important for short-term and long-term health outcomes. One brisk walk can improve sleep quality, reduce anxiety, and blood pressure. Adults who meet aerobic and muscle-strengthening physical activity guidelines are about half as likely to die from flu and pneumonia as adults who meet neither guideline and physical activity is associated with a decrease in risk of COVID-19 hospitalizations and deaths. Physical activity can also improve social connections, mental health, and

<sup>113</sup> <https://www.cdc.gov/nccdphp/dnpao/state-local-programs/span/span-2023.html>

<sup>114</sup> <https://www.cdc.gov/nccdphp/dnpao/state-local-programs/hop/high-obesity-program-2023-2028.html>

cognitive function, and reduce the risk of chronic diseases such as type 2 diabetes, heart disease, and some types of cancer.

### **Nutrition, Physical Activity, and Obesity Prevention**

CDC focuses on several nutrition and obesity prevention efforts. CDC supports state farm-to-early to care (ECE) policies and practices which promote local food purchasing and increased access to healthy, local foods in ECE settings. From 2018 – 2022, CDC worked with partners to fund and support these efforts in ten states and Washington, D.C., reaching 220,000 children in approximately 4,000 ECE sites and reaching 254 U.S. counties. In FY 2025, all [State Physical Activity and Nutrition Program](#) (SPAN) recipients will support Farm to ECE to assist state and community-level nutrition experts in expanding and continuing their work focusing on health equity. CDC also supports strategies to increase access to healthy food and beverages such as Federal Food Service Guidelines (FSGs). FSGs are voluntary standards developed by CDC and federal partners for sustainable, healthier food and beverage service operations in settings such as worksites, hospitals, recreation centers, and food banks. CDC funds states and communities to adopt and implement FSGs. From 2018 - 2022, this work helped up to 4 million people have healthier food options. In addition, CDC monitors state policies to support healthy food service and procurement. Since 2007, 11 states and D.C. have adopted 20 state-level FSG policies. In FY 2025, CDC will continue promoting FSGs to increase availability of healthier food options.

CDC will continue its investment to improve equitable access to safe and convenient places for physical activity. CDC has trained over 2,300 community leaders to develop action plans expanding opportunities for physical activity through community design. CDC supported recipients to leverage resources to create almost 2,600 new linear miles of pedestrian and bicycle infrastructure. CDC also worked with national partners to support community implementation of safe routes to schools, access to parks, and more walkable neighborhoods. This work has led to the implementation of Complete Street Policies in over 1,500 jurisdictions, reaching an estimate of nearly 50 percent of the U.S. population.

Since 2000, CDC's International Micronutrient Malnutrition Prevention and Control (IMMPaCt) program has contributed to global nutrition guidance development and provided technical assistance, training, and/or funding to about 60 countries to monitor vitamin and mineral status and deliver and evaluate interventions. In FY 2025, CDC will continue strengthening these efforts domestically and globally.

### **Hospitals Promoting Breastfeeding**

Infants who are breastfed have reduced risks of asthma, obesity, type 1 diabetes, sudden infant death syndrome, and certain infections. Breastfeeding also helps lower postpartum risk of high blood pressure, type 2 diabetes, and breast and ovarian cancer. A CDC study of U.S. births found that breastfeeding initiation reduced the risk of post-perinatal (between seven and 364 days after birth) infant deaths by 26 percent. CDC reports annual breastfeeding rates, among infants born in 2019 and over half were breastfed at age six months (55.8 percent). In the last five years, breastfeeding rates at age six months have improved from 41.5 percent in 2014 to 44 percent in 2019 among non-Hispanic black infants. With continued CDC investments in breastfeeding support, almost one million babies per year (29 percent) are born in hospitals with supportive breastfeeding practices.

### **National Early Child Care Collaboratives**

Children with obesity face an increased risk of high blood pressure, high cholesterol, type 2 diabetes, asthma, joint problems, and fatty liver disease. They also may have higher rates of depression, low self-esteem, and bullying. CDC funding helps children up to five years old develop healthy eating and physical activity behaviors for healthy growth, and brain development, while decreasing later in life risk for obesity. CDC funds, assists, and monitors state level obesity prevention efforts in ECE settings using CDC's ECE framework<sup>115</sup> which outlines how

<sup>115</sup> [Spectrum of Opportunities for Obesity Prevention in the Early Care and Education Setting \(ECE\). \(cdc.gov\)](#)

states can embed obesity prevention standards to ensure healthy eating, breastfeeding support, and physical activity. CDC has assisted 22 states to use an evidence-based intervention with 9,600 registered ECE programs reaching 485,000 children. CDC funding has also contributed to 44 states updating ECE state licensing regulations to incorporate obesity prevention standards.

## **Racial and Ethnic Approaches to Community Health (REACH) Budget Request**

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Health disparities continue to affect people with lower income and less education, rural populations, and racial and ethnic minority populations. The Racial and Ethnic Approaches to Community Health (REACH) budget line funds two initiatives, the REACH Program, and the Healthy Tribes program. Since 1999, REACH<sup>116</sup> has been at the forefront of CDC's efforts to reduce health disparities, and has increased opportunities for physical activity, healthier food options, and living smoke-free/tobacco-free for millions of Americans. CDC's Healthy Tribes program partners with Tribal communities to strengthen cultural connectedness and support traditional practices to improve health and promote wellness.

### **Budget Request**

CDC's FY 2025 budget request of **\$68,950,000** for the REACH program is level with the FY 2023 final level. At this funding level, CDC will continue to support up to 50 recipients to implement culturally tailored interventions to address preventable risk behaviors, including poor nutrition, physical inactivity, and tobacco use, and increase referral and access to community health programs for chronic disease prevention and treatment. This request also includes **\$24,000,000** for the Healthy Tribes program to invest in advancing in the health and wellbeing of American Indians and Alaska Natives (AI/AN).

### **Racial and Ethnic Approaches to Community Health (REACH)**

CDC's REACH program works to end disparities by partnering with racial and ethnic communities with the highest risk or rates of chronic disease to make healthy choices easier. Through REACH, funded organizations plan and carry out local, evidence-based, and culturally appropriate programs including Food is Medicine strategies and Family Health Weight Program implementation to address a wide range of health issues among Black or African American, Hispanic, or Latino, Asian, American Indian, Native Hawaiian, Pacific Islander, and Alaska Native persons. REACH 2018 recipients had significant accomplishments during their 5-year funding period. In the first four years of the program, they implemented nutrition standards in 222 community settings, established or improved breastfeeding supports across 452 sites or programs, helped communities create 1,377 linear miles of activity friendly routes, and more. 50 new recipients received funding for year 1 of the 2023 – 2028 REACH program. In FY 2025, CDC's REACH program will continue to support rural, urban, and tribal communities to improve health among racial and ethnic minority populations.

Among the program's many recent successes, in 2022, the Greater Flint Health Coalition of Michigan REACH program partnered with Freedom Temple Outreach (FTO), a local temple and food bank, to transition some of the charitable food operations to a full-service indoor food pantry. Due to these efforts, FTO provides bi-weekly food distribution coupled with an indoor food pantry to support families and community members in Flint. In a year-span from 2022 to 2023, FTO served over 1,000 families, seniors, and individuals in need of fresh produce and non-perishable food items. Similar successes continue in REACH programs benefiting communities across the nation.

### **Healthy Tribes Program**

American Indians and Alaskan Natives (AI/AN) have higher rates of disease, disability, injury, and early death compared to other racial and ethnic groups in the United States. CDC supports AI/AN communities to promote

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<sup>116</sup> <https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/>

health, prevent disease, address social determinants of health and reduce health disparities, and build public health capacity and infrastructure to improve health and well-being in Indian Country.

Good Health and Wellness in Indian Country (GHWIC) is a program supporting a holistic approach to chronic disease prevention through community-chosen, culturally adapted policies, systems, and environmental improvements to achieve long-term goals of reducing rates of death and disability from commercial tobacco use, diabetes, heart disease and stroke, and reducing the prevalence of obesity. From FY2019 - 2022 GHWIC activities reached over 285,000 AI/AN community members with nutrition, physical activity, breastfeeding support, and obesity prevention programs. In FY 2025, CDC will continue to fund GHWIC<sup>117</sup> recipients to implement cross-cutting activities with support from other NCCDPHP programs.

Tribal Epidemiology Centers Public Health Infrastructure<sup>118</sup> (TECPHI) supports Tribal Epidemiology Centers (TECs) to improve the delivery of public health functions to and with Tribes and Urban Indian Organizations (UIOs). From FY 2017 to FY 2022, TECs established over 300 new or updated data sharing agreements that enhanced their health data monitoring and evaluation capacity to provide AI/AN communities and partners with accessible, up-to-date health data. Tribes use this data to inform decision-making and responses to public health challenges and emergencies. In FY 2025, CDC will continue to fund 12 TECs and one Network Coordinating Center to strengthen public health capacity and infrastructure among Tribes and UIOs served.

Tribal Practices for Wellness in Indian Country<sup>119</sup> (TPWIC) is an innovative program that funds Tribes, Tribal organizations, and UIOs to implement cultural practices to promote cultural connectedness as a pathway to wellness. Engaging in cultural activities and practices is a protective factor for health and well-being. It builds resilience and connections to community, family, and culture, which can reduce risk factors for chronic disease and promote health and wellness. During the first iteration of TPWIC (FY 2018 – FY 2022), more than 775,500 individuals engaged in cultural activities to improve health and wellness. Over 206,600 community members participated in nutrition, physical activity, and gardening activities that promoted healthy living practices, and almost 45,000 community members participated in activities to increase traditional foods in diets, such as community gardens and cooking demonstrations. In FY 2025, CDC will continue to fund 36 recipients to promote traditional foods, physical activity, and healthy practices as a path to chronic disease prevention and wellness promotion in AI/AN communities.

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<sup>117</sup> <https://www.cdc.gov/healthytribes/ghwic.htm>

<sup>118</sup> <https://www.cdc.gov/healthytribes/tecphi.htm>

<sup>119</sup> <https://www.cdc.gov/healthytribes/tribalpractices.htm>

## Health Promotion Budget Request

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CDC collects and studies health data to define the public health impact of key risk factors and chronic conditions and identify effective prevention strategies to reduce chronic disease and promote health.

### Budget Request

CDC's FY 2025 budget request of **\$62,600,000** for Health Promotion is level with the FY 2023 final level. In FY 2025, CDC will continue to assess disease and risk factor trends and strengthen the science base for preventing leading causes of disease, disability, and death, enabling the public health community to anticipate and effectively plan for future chronic disease burdens in the following programs.

### **Alzheimer's Disease**

Alzheimer's disease seriously impairs a person's ability to carry out activities of daily living and to live independently. In 2023, approximately 6.7 million Americans were living with Alzheimer's and this number is expected to increase to nearly 14 million by 2060. In FY 2024, CDC increased the number of public health departments funded through the Building our Largest Dementia Infrastructure (BOLD) program from 23 to 43. BOLD recipients bolster the public health infrastructure by improving early detection, risk reduction, hospitalization prevention, and caregiving support. To support their efforts, CDC also funds three organizations through the BOLD Public Health Centers of Excellence (PHCOE) to identify, translate, and disseminate promising research findings and evidence-informed best practices. CDC's work supports the new goal in the National Plan to Address Alzheimer's Disease; goal 6 emphasizes risk reduction for Alzheimer's disease and related dementias. The new goal builds on the CDC's National Healthy Brain Initiative, which focuses on promoting brain health in populations with the highest prevalence of Alzheimer's disease and related dementias including African American, Hispanic, American Indian, and Alaskan Native populations and those who have intellectual and developmental disabilities. CDC funds four organizations through the National Healthy Brain Initiative to implement and evaluate the updated Healthy Brain Initiative (HBI) Road Map. The HBI road map actions provide a guide for state, local and tribal public health practitioners to address brain health in communities.

In FY 2025, CDC will continue to support funded programs and update its [Alzheimer's Disease and Healthy Aging Data Portal](#),<sup>120</sup> infographic series, and [Healthy Brain Resource Center](#)<sup>121</sup> to share up-to-date data for public health action.

### **Excessive Alcohol Use Prevention**

Excessive alcohol use,<sup>122</sup> including binge and underage drinking, is responsible for more than 140,000 deaths in the United States each year, or more than 380 deaths per day. One in five deaths among people aged 20 to 49 years is from excessive alcohol use. In FY 2024, CDC continued its support for alcohol epidemiology in 12 states and through the Center for Advancing Alcohol Science to Practice, which delivers evidence-based technical assistance and training. This support improved state surveillance on excessive drinking and alcohol-related harms and facilitated the integration of excessive alcohol use prevention into a range of other topic areas to leverage resources and amplify prevention efforts. In FY 2025, CDC will continue to strengthen state capacity to prevent excessive drinking and alcohol-related disease, injury, and death, including supporting innovative research on youth exposure to digital alcohol marketing and research translation tools to measure the concentration of alcohol outlets to improve the alcohol environment and address alcohol-related health disparities.

<sup>120</sup> <https://www.cdc.gov/aging/agingdata/index.html>

<sup>121</sup> <https://www.cdc.gov/aging/healthy-brain-resource-center/index.html>

<sup>122</sup> <http://www.cdc.gov/alcohol/>

## **Chronic Kidney Disease, Inflammatory Bowel Disease (IBD), and Interstitial Cystitis (IC)**

About 35.5 million Americans have chronic kidney disease (CKD), with most unaware of their condition. In 2021, treating Medicare beneficiaries with CKD cost nearly \$77 billion, and treating people with end-stage kidney disease or kidney failure cost \$52.3 billion. Diabetes and high blood pressure account for two in three new cases of kidney failure. CDC's CKD Initiative<sup>123</sup> provides strategies for kidney health promotion. In FY 2025, CDC will continue working with partners to strengthen and update the Kidney Disease Surveillance System; prevent and control risk factors for CKD; increase public awareness; and promote early diagnosis and treatment.

CDC supports research on inflammatory bowel disease (IBD),<sup>124</sup> a disease that CDC estimates to affect over 3 million U.S. adults. IBD is associated with poor quality of life, substantial illness, and complications requiring costly hospitalizations and surgical procedures. In FY 2025, CDC will continue to support epidemiologic research to study IBD's natural history, social and psychological factors, health disparities, and effective management strategies. CDC will also continue to support activities to translate scientific findings to support public health and healthcare practice.

CDC also supports an epidemiologic study on interstitial cystitis (IC),<sup>125</sup> a chronic condition that results in recurring pain in the bladder or surrounding pelvic region. In FY 2025, CDC will support an IC epidemiologic cohort study to examine the incidence of co-occurring conditions; demographic, clinical, and treatment patterns; health disparities; and impact on health and quality of life over time. Findings support health provider awareness and education, and medical and self-management strategies to reduce pain and improve quality of life for people living with IC.

## **Vision Health and Glaucoma**

Vision impairment is one of the top 10 leading causes of disability among US adults. An estimated 7.7 million Americans have vision impairment, including 1 million who are blind. Vision impairment is also a disabling condition among children, with approximately 7 percent of the children in the United States having diagnosed eye and vision conditions. CDC's Vision Health Initiative (VHI)<sup>126</sup> invests in national, state, and community public health infrastructure and developed the Vision and Eye Health Surveillance System (VEHSS) to assess related population trends and health disparities. In FY 2025, CDC's VHI will continue to enhance and update the VEHSS to integrate vision and eye health promotion into public health infrastructure, and support research to improve glaucoma detection, management, referral, and treatment for high-risk populations.

## **Chronic Disease Education and Awareness**

Chronic diseases are conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Advancing CDC's work with partners on chronic diseases demonstrating clear disparities in public and professional awareness is critical to advancing public health action. In FY 2025, CDC will continue administering two competitive grants to fund partners to develop and implement education and awareness activities for chronic diseases that do not otherwise receive dedicated CDC appropriated resources. For example, through this program, CDC is funding two recipients who focus on Chronic Obstructive Pulmonary Disease (COPD), which is a leading cause of death in the United States.

<sup>123</sup> <https://www.cdc.gov/kidneydisease/index.html>

<sup>124</sup> <https://www.cdc.gov/ibd/index.htm>

<sup>125</sup> <http://www.cdc.gov/ic/>

<sup>126</sup> <https://www.cdc.gov/visionhealth/vehss/index.html>

## Prevention Research Centers Budget Request

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CDC provides leadership, technical assistance, and oversight to a network of academic Prevention Research Centers<sup>127</sup> (PRCs) to conduct innovative public health research at the community level to develop, test, and evaluate interventions that can be disseminated to address chronic diseases and leading causes of death and disability in the United States.<sup>128</sup>

### Budget Request

CDC's FY 2025 budget request of **\$28,961,000** for Prevention Research Centers is level with the FY 2023 final level. In FY 2025, CDC will continue to leverage the PRC Network to conduct applied prevention research and increase the translation, dissemination, and uptake of evidence-based interventions into practice by public health practitioners to improve population health and advance health equity.

In FY 2024, CDC will fund a new five-year cooperative agreement cycle for PRCs to conduct dissemination and implementation research projects that utilize an evidence-based intervention and a community-engaged approach to address a leading cause of chronic disease illness and death in a population experiencing high levels of health disparities. The 2024 - 2029 cycle will build on the 2019 - 2024 cycle to increase public health impact. PRCs in the 2019 - 2024 funding cycle trained nearly 14,000 persons through almost 300 PRC-hosted trainings and developed over 230 research and practice tools to help public health practitioners adopt and implement evidence-based practices.

CDC also funds PRCs to conduct Special Interest Projects (SIPs) that enable all CDC Centers, Institutes, and Offices (CIOs) to leverage PRC expertise and their established relationships with community partners to conduct additional applied research projects. In the 2019 - 2024 funding cycle, CDC awarded 54 SIPs, including five thematic research networks that focused on cancer, epilepsy, nutrition and obesity, physical activity, and dementia risk reduction. Thematic research networks fund multiple PRCs to work together to conduct research to advance a specific health issue. In 2022, the Cancer Prevention and Control Research Network (CPCRN) celebrated its 20<sup>th</sup> anniversary. With CDC support, the CPCRN has published over 2,000 CPCRN-related papers in peer-reviewed journals, delivered more than 2,000 presentations to external organizations, and awarded over 682 grants to further public health work.

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<sup>127</sup> <http://www.cdc.gov/prc/>

<sup>128</sup> Authorized under Public Health Service Act, Section 1706 (42 U.S.C. § 300u-5).



## Arthritis, Lupus, and Epilepsy Budget Request

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Arthritis is a leading cause of disability; with over 53.2 million adults reporting an arthritis diagnosis and over 25.7 million reporting activity limitations due to their arthritis. One in 5 U.S. adults have arthritis and almost all of them are aged 45 and older. The number of adults diagnosed with arthritis is expected to grow to 78.4 million by 2040. Lupus is a rheumatic autoimmune disease that can cause inflammation and tissue damage, resulting in disability, pain, and premature death. Epilepsy, a chronic neurological condition, affects about 3.4 million people in the United States. People with epilepsy often have higher healthcare costs than those without the disorder. From 2010-2018, \$24.5 billion direct U.S. healthcare spending was attributed to seizures or epilepsy.

### Budget Request

CDC's FY 2025 budget request of **\$32,500,000** for Arthritis, Lupus, and Epilepsy is level with the FY 2023 final level.

CDC's [Arthritis](#) program<sup>129</sup> promotes lifestyle management interventions such as physical activity and self-management education programs that have been effective in improving arthritis symptoms, and quality of life in people with arthritis. In FY 2024, CDC continued funding 12 state health departments and 5 national organizations to promote cost-effective, arthritis-appropriate, evidence-based interventions (AAEBIs) that facilitate physical activity and chronic disease self-management behaviors among adults with arthritis. Funded partners also continued to collaborate with healthcare providers to increase physical activity counseling and AAEBI referrals, and collect data to inform priorities, decisions, and access to evidence-based health communications campaigns. AAEBIs are now available in all 50 states, D.C., Puerto Rico, and American Samoa. In FY 2025 CDC will continue to support funded partners to promote healthcare provider physical activity counseling for arthritis, implement innovative strategies to overcome challenges and barriers to counseling and referrals, and expand the reach of proven physical activity and self-management education programs.

Guided by the [National Public Health Agenda for Lupus](#),<sup>130</sup> CDC funds population registries and cohort studies to increase public health knowledge about lupus. In FY 2024, CDC funded five registry studies, including one focused on pediatric lupus. These studies improved the understanding of lupus diagnoses, disease burden, natural history, and intervention efforts. In FY 2025, CDC will continue to support research on treatment patterns and impacts, health care access, and disparities to fill gaps in knowledge regarding long-term lupus in adult and pediatric populations. CDC also funds The Lupus Foundation and the American College of Rheumatology to develop and disseminate strategies for sustainable lupus awareness, knowledge, skills, and partnerships.

CDC's Epilepsy Program<sup>131</sup> funds five organizations to increase awareness, reduce stigma, and enhance care and safety for people with epilepsy. For example, with CDC support, the Epilepsy Foundation's (EF) anti-stigma campaign "Change Our Epilepsy Story" focused on reducing stigma among Black, African American, and Hispanic American people with epilepsy, reaching over 25 million impressions. In addition, EF trained 179,900 school professionals on epilepsy and first aid. As of March 2023, CDC recipients have referred close to 8,000 people with epilepsy to community-based services, and recipients reported 14 health systems that are monitoring and tracking epilepsy clinical data to improve outcomes. In addition, CDC funds four organizations to implement self-management programs in clinical settings. In FY 2025, CDC will continue surveillance and prevention research, program implementation, and provider education in more communities to improve epilepsy diagnosis and management.

<sup>129</sup> <https://www.cdc.gov/arthritis/about/index.html>

<sup>130</sup> <https://stacks.cdc.gov/view/cdc/78565>

<sup>131</sup> <https://www.cdc.gov/epilepsy/index.html>

**State Table: Grant Funding<sup>1</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$10,321,999	TBD	TBD	TBD
Alaska	\$7,109,573	TBD	TBD	TBD
Arizona	\$8,571,887	TBD	TBD	TBD
Arkansas	\$8,107,063	TBD	TBD	TBD
California	\$19,972,139	TBD	TBD	TBD
Colorado	\$10,362,467	TBD	TBD	TBD
Connecticut	\$6,220,438	TBD	TBD	TBD
Delaware	\$4,887,547	TBD	TBD	TBD
District of Columbia	\$6,878,369	TBD	TBD	TBD
Florida	\$12,068,103	TBD	TBD	TBD
Georgia	\$15,647,181	TBD	TBD	TBD
Hawaii	\$5,667,532	TBD	TBD	TBD
Idaho	\$4,130,572	TBD	TBD	TBD
Illinois	\$17,116,307	TBD	TBD	TBD
Indiana	\$8,244,902	TBD	TBD	TBD
Iowa	\$6,048,962	TBD	TBD	TBD
Kansas	\$9,571,514	TBD	TBD	TBD
Kentucky	\$7,448,526	TBD	TBD	TBD
Louisiana	\$7,375,611	TBD	TBD	TBD
Maine	\$4,970,005	TBD	TBD	TBD
Maryland	\$7,650,749	TBD	TBD	TBD
Massachusetts	\$7,891,392	TBD	TBD	TBD
Michigan	\$12,309,522	TBD	TBD	TBD
Minnesota	\$11,912,413	TBD	TBD	TBD
Mississippi	\$7,459,884	TBD	TBD	TBD
Missouri	\$10,327,691	TBD	TBD	TBD
Montana	\$6,206,210	TBD	TBD	TBD
Nebraska	\$6,440,891	TBD	TBD	TBD
Nevada	\$8,135,591	TBD	TBD	TBD
New Hampshire	\$6,091,705	TBD	TBD	TBD
New Jersey	\$9,313,389	TBD	TBD	TBD
New Mexico	\$7,072,741	TBD	TBD	TBD
New York	\$17,188,931	TBD	TBD	TBD
North Carolina	\$12,027,759	TBD	TBD	TBD
North Dakota	\$5,070,531	TBD	TBD	TBD
Ohio	\$11,127,434	TBD	TBD	TBD
Oklahoma	\$5,115,955	TBD	TBD	TBD
Oregon	\$8,451,633	TBD	TBD	TBD
Pennsylvania	\$11,783,338	TBD	TBD	TBD
Rhode Island	\$7,322,288	TBD	TBD	TBD
South Carolina	\$12,431,918	TBD	TBD	TBD
South Dakota	\$4,732,844	TBD	TBD	TBD
Tennessee	\$8,632,613	TBD	TBD	TBD

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Texas	\$18,018,789	TBD	TBD	TBD
Utah	\$8,588,156	TBD	TBD	TBD
Vermont	\$5,143,819	TBD	TBD	TBD
Virginia	\$9,942,426	TBD	TBD	TBD
Washington	\$11,976,992	TBD	TBD	TBD
West Virginia	\$6,568,736	TBD	TBD	TBD
Wisconsin	\$7,381,028	TBD	TBD	TBD
Wyoming	\$4,034,358	TBD	TBD	TBD
<b>Other Awardees</b>				
Indian Tribes	\$54,834,653	TBD	TBD	TBD
American Samoa	\$902,176	TBD	TBD	TBD
Guam	\$1,547,955	TBD	TBD	TBD
Northern Mariana Islands	\$1,197,973	TBD	TBD	TBD
Puerto Rico	\$2,199,639	TBD	TBD	TBD
Virgin Islands	\$1,026,082	TBD	TBD	TBD
<b>Subtotal, States</b>	<b>\$457,072,423</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal, Other Awardees</b>	<b>\$61,708,478</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Total Resources</b>	<b>\$518,780,901</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup>This state table is a summary of NCCDPHP programs that fund states and Washington, D.C., tribal, and territorial awardees. For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>. Relevant CFDA numbers are 93.334 (DP 20-2004 BOLD Public Health Centers of Excellence to Address Alzheimer’s Disease and Related Dementias; DP20-2003 The National Healthy Brain Initiative), 93.336 (DP20-2007 Behavioral Risk Factor Surveillance System), 93.898 (DP22-2202 Cancer Prevention and Control Programs), 93.387 (DP20-2001 National and State Tobacco Control Program), 93.426 (DP23-0004 The National Cardiovascular Health Program), 93.431 (DP23-0015 National Networks Driving Action), 93.436 (DP18-1816 Well-Integrated Screening and Evaluation for Women Across the Nation), 93.479 (DP19-1903 Good Health and Wellness in Indian Country), 93.304 (DP23-0014 Racial and Ethnic Approaches to Community Health), 93.800 (DP20-2002 Public Health and Health Systems Partnerships to Increase CRC Screening), 93.762 (DP22-2206 Tribal Epidemiology Centers Public Health Infrastructure ), and 93.762 (DP22-2201 Tribal Practices for Wellness in Indian Country).

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## BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$205.560	\$205.560	\$205.560	\$0
<b>Total Request</b>	<b>\$205.560</b>	<b>\$205.560</b>	<b>\$205.560</b>	<b>\$0</b>
FTEs	209	222	222	14
-- Child Health and Development	\$71.300	\$71.300	\$71.300	\$0
-- Birth Defects	\$19.000	\$19.000	\$19.000	\$0
-- Fetal Death	\$0.900	\$0.900	\$0.900	\$0
-- Fetal Alcohol Syndrome	\$11.500	\$11.500	\$11.500	\$0
-- Folic Acid	\$3.150	\$3.150	\$3.150	\$0
-- Infant Health	\$8.650	\$8.650	\$8.650	\$0
-- Autism	\$28.100	\$28.100	\$28.100	\$0
-- Health and Development for People with Disabilities	<u>\$85.910</u>	<u>\$85.910</u>	<u>\$85.910</u>	<u>\$0</u>
-- Disability and Health	\$45.500	\$45.500	\$45.500	\$0
-- Tourette Syndrome	\$2.500	\$2.500	\$2.500	\$0
-- Early Hearing Detection and Intervention	\$10.760	\$10.760	\$10.760	\$0
-- Muscular Dystrophy	\$7.500	\$7.500	\$7.500	\$0
-- Attention Deficit Hyperactivity Disorder	\$1.900	\$1.900	\$1.900	\$0
-- Fragile X	\$2.000	\$2.000	\$2.000	\$0
-- Spina Bifida	\$7.500	\$7.500	\$7.500	\$0
-- Congenital Heart Failure	\$8.250	\$8.250	\$8.250	\$0
-- Public Health Approach to Blood Disorders	\$10.400	\$10.400	\$10.400	\$0
-- <i>Sickle Cell Research (non-add)</i>	<i>\$3.000</i>	<i>\$3.000</i>	<i>\$6.000</i>	<i>\$0</i>
-- Hemophilia CDC Activities	\$3.500	\$3.500	\$3.500	\$0
-- Hemophilia Treatment Centers	\$5.100	\$5.100	\$5.100	\$0
-- Thalassemia	\$2.100	\$2.100	\$2.100	\$0
-- Neonatal Abstinence Syndrome	\$4.250	\$4.250	\$4.250	\$0
-- Surveillance for Emerging Threats to Mothers and Babies	\$23.000	\$23.000	\$23.000	\$0

**Enabling Legislation Citation:** PHSA § 301, PHSA § 304, PHSA § 307, PHSA § 308(d), PHSA § 310, PHSA § 311, PHSA § 317, PHSA § 317C\*, PHSA § 317J\*, PHSA § 317K, PHSA § 317L, PHSA § 317Q, PHSA § 327, PHSA § 352, PHSA § 399M\*, PHSA § 399Q\*, PHSA § 399S, PHSA § 399S-1\*, PHSA § 399T, PHSA § 399V-2, PHSA § 399AA, PHSA § 399BB, PHSA § 399CC, PHSA § 1102, PHSA § 1106, PHSA § 1107, PHSA § 1108\*, PHSA § 1110, PHSA § 1113, PHSA § 1114, PHSA § 1115, PHSA § 1132\*, PHSA § 1706\*, The Prematurity Research Expansion And Education For Mothers Who Deliver Infants Early Act § 2\* (42 U.S.C. 247b-4f\*)

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural, Competitive Grants, Cooperative Agreements and Contracts

## Program Description

CDC's birth defects, developmental disabilities, blood disorders, and disability and health programs promote optimal health across the lifespan among populations by advancing science, leadership, research, tools, and surveillance. These programs aim to improve the well-being of populations that have been disproportionately impacted in the United States and advance the science to support those that have been historically marginalized. CDC identifies and addresses health inequities by:

- Linking birth defects and other data such as Critical Congenital Heart Defect (CCHD) newborn screening data to determine the method and timing of detection and disparities in timing of diagnosis.
- Improving access to timely screenings and quality health care for children with developmental disabilities including those with hearing loss.
- Expanding surveillance and strengthening reporting of disability status and gender identity for persons with bleeding disorders.
- Building the evidence base to understand the needs of people with, or at risk of disabilities to improve health and development outcomes.

## Budget Request

CDC's FY 2025 budget request of **\$205,560,000** for Birth Defects, Developmental Disabilities, Disabilities and Health is level with the FY 2023 final level. CDC will continue to modernize and expand its surveillance efforts to address birth defects and developmental disabilities. To achieve this, CDC is committed to recruiting, retaining, and increasing the number of public health professionals with epidemiology and laboratory expertise to provide critical support needed to address the needs of vulnerable populations. A diversified and experienced workforce will also help identify a more detailed picture of the impact that public health emergencies have on Americans, leading to enhanced public health responses for infants, pregnant people, people with disabilities, and people with blood disorders.

The COVID-19 pandemic highlighted critical and systemic factors contributing to health disparities, especially for children at risk for or with developmental disabilities and people with disabilities. For example, COVID-19 has a disproportionate impact on people with disabilities, who experience barriers to accessing COVID-19 testing and vaccines. To reduce health inequities, CDC worked with partners including the Association of University Centers on Disability to promote equitable access to COVID-19 preventative measures for people with disabilities; CDC also worked with the National Academies of Science, Engineering, and Medicine (NAEM) to design free online tools to support coping skills and resilience among those disproportionately affected. CDC also issued specific and relevant guidance for people with disabilities using a variety of communication formats, including [American Sign Language](#)<sup>132</sup> and extreme low literacy tools, to ensure accessible messaging about how to stay well during the COVID-19 pandemic. CDC partnered with the Administration on Community Living on the Disability Information and Access Line (DIAL) to help people with disabilities get vaccinated and has begun to monitor COVID-19 vaccination by disability status. These efforts helped improve inclusion for people with disabilities, but gaps remain.

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<sup>132</sup> <https://www.youtube.com/watch?v=XdLviGpW-DM>

## BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH

### BY THE NUMBERS<sup>1</sup>

CDC’s birth defects, developmental disabilities, and blood disorders programs have successfully supported states, territories, and communities:

- **31 jurisdictions** and clinical sites are addressing COVID-19, hepatitis C, syphilis, and congenital cytomegalovirus (cCMV) as part of the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET). Data collected through SET-NET directly influenced clinical decisions and public health policy amid the COVID-19 pandemic, including vaccine prioritization for pregnant people, and will inform decision making for a potential CMV vaccine.
- **16 sites** monitoring the prevalence and early identification of autism spectrum disorder (ASD) across the Autism and Developmental Disabilities Monitoring (ADDM) Network, with 9 sites monitoring transition planning and outcomes among 16-year-olds helping communities identify healthcare needs and gaps in planning for transition to adulthood among youth with ASD.
- **39 jurisdictions** are funded to enhance data systems to ensure all infants in the United States are screened for hearing loss and receive the essential follow-up diagnostic and intervention services.
- **2 national programs** focusing on adapting evidence-based health promotion programs to the unique needs of individuals with intellectual and developmental disabilities and mobility limitations in community settings.
- **16 states** funded to expand the Sickle Cell Data Collection program by gathering health data about people with sickle cell disease (SCD) to inform policy and practice that impact health. Early data indicates that historical prevalence estimates of the SCD population are an underestimate.

<sup>1</sup>Unless otherwise noted, all information and calculations are from CDC program data.

Birth Defects, Developmental Disabilities, Disabilities and Health Funding History	
Fiscal Year	Dollars (in millions)
FY 2021	\$167.294
FY 2022	\$177.060
FY 2023 Final	\$205.560
FY 2024 CR	\$205.560
FY 2025 President’s Budget	\$205.560

## Program Accomplishments

### ***Saving Babies through surveillance, research, and prevention of birth defects and infant disorders***

In 2022, CDC funded 40 jurisdictions and clinical sites to conduct maternal-infant surveillance through the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) to examine hepatitis C, syphilis, Zika, congenital cytomegalovirus (cCMV). SET-NET data have been used to inform clinical and public health guidance for pregnant people and their infants and will continue to provide timely data for action. Further, establishing cCMV surveillance efforts will be helpful to heighten awareness and inform prevention strategies as new vaccines are developed.

### ***Helping Children live to the fullest by understanding developmental disabilities***

CDC implemented a new case definition and data system for tracking autism allowing for the most recent results to be published in March 2023, a full year faster than the previous method allowed. In 2023, CDC also expanded the Autism and Developmental Disabilities Monitoring (ADDM) Network from 11 to 16 sites across the United States and released the first ADDM report on children aged 16 years with autism, helping communities identify healthcare needs and gaps in planning for transition to adulthood among youth with autism. Additionally, CDC has re-established monitoring prevalence and early identification of cerebral palsy across multiple ADDM sites.

### ***Protecting People by preventing the complications of blood disorders***

CDC's Sickle Cell Data Collection (SCDC) program supports 16 states to better understand the health and healthcare needs of people with sickle cell disease (SCD). SCDC California uses findings to identify unaffiliated patients and help connect them to SCD specialists. SCDC Michigan uses data to identify individuals eligible for new programs, therapies, and clinical trials. SCDC Georgia uses data to plot new locations for mobile clinic services in rural areas, and for supporting new mental health services. SCDC North Carolina uses data to inform provider and health system education efforts designed to improve patient experiences and quality measures for SCD. Additionally, this data program is attracting a new cohort of public health and medical professionals and researchers working to better understand SCD and the collaboration needed to achieve progress for a historically marginalized population.

### ***Improving Health of people with disabilities***

CDC led efforts to increase inclusion of people with disabilities in public health data to learn more about health disparities, focus disease prevention and health promotion activities, and evaluate outcomes. Efforts focus on increasing the use of standard disability questions in data collection systems. Collaborations also help enhance the use of administrative and survey data in identifying people with disabilities.



## Saving Babies Budget Request

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### Program Description

Birth defects and infant disorders are common, costly, and critical. CDC identifies causes of these conditions, finds opportunities for prevention, and improves the health of those living with them.

### **Birth Defects**

CDC's FY 2025 budget request of **\$19,000,000** for Birth Defects is level with the FY 2023 final level.

Every year, 3.6 million babies are conceived in the United States. For 1 in every 33 of these pregnancies, parents will receive news that their baby has a birth defect. Babies born with a birth defect are more likely to die before their first birthday, while those who survive may face lifelong challenges, such as mobility issues, urinary and bowel problems, and learning disabilities. Furthermore, in the United States, more than \$22 billion per year is spent on medical costs associated with birth defects.

In FY 2025, CDC will continue to work to detect trends in birth defects and who is affected by them, understand the impact of new exposures such as medications or infectious disease, identify causes and opportunities for prevention, and improve the health of people living with these conditions.

### **Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET)**

CDC's FY 2025 budget request of **\$23,000,000** for Surveillance for Emerging Threats to Mothers and Babies is level with the FY 2023 final level.

CDC's SET-NET program is a multi-faceted program to detect, understand, and prevent or reduce threats to mothers and babies. This effort identifies and addresses the impact of infectious diseases, other exposures, and diseases on pregnant individuals, their babies and families. CDC currently funds health departments and geographically diverse clinical sites with the proven ability to collect and link population-based, high-quality mother-infant data.

### Helping State, Local, and Territorial Health Agencies Address Emerging Issues in Their Communities

Health departments funded for SET-NET use the data and the approach to increase surveillance capacity, bridge data silos, create new data linkages within their jurisdictions, and take public health action within their jurisdictions in conjunction with the clinical and local community.<sup>133</sup>

### Expanding to Address New Threats

- **Establishing surveillance for congenital cytomegalovirus (cCMV):** cCMV is one of the most common causes of congenital infection, which can lead to microcephaly, hearing loss, and developmental delays in children. CDC is expanding a pilot project to explore the feasibility of leveraging the jurisdictional network to conduct surveillance for cCMV. In FY 2024, the original five sites were joined by seven additional jurisdictions and clinical sites.
- **Identifying need for integrating substance use screening into prenatal and other obstetrical care services:** An analysis of SET-NET data found that one fifth of people with hepatitis C virus (HCV) infection during pregnancy first tested positive for HCV before they became pregnant, indicating a missed opportunity to provide curative treatment before pregnancy. Eighty percent of pregnant people with

<sup>133</sup> <https://www.cdc.gov/ncbddd/set-net/success-stories.html#:~:text=%20SET-NET%20Success%20Stories%20%201%20Increasing%20Surveillance,used%20SET-NET%20to%20help%20understand%20how...%20More%20>

HCV reported substance use during pregnancy. These findings highlight the need for integration of substance use screening and services into prenatal and other obstetrical care services.<sup>134</sup>

- **Identifying need for syphilis screening into substance use treatment and emergency use and urgent care medical encounters:** An analysis found that substance use among persons with syphilis during pregnancy in Arizona and Georgia was nearly twice as high among those with a congenital syphilis pregnancy outcome as among those without.

### Modernizing Data Collection

CDC is enhancing SET-NET’s data collection and approach to improve data sharing by standardizing data collection, reducing redundancy, and supporting multi-directional data flows among state, local, and territorial partners and CDC. CDC is also leveraging hospitals and clinical sites to monitor maternal, infant, and child health outcomes.

In FY 2025, CDC will continue to:

- Support health departments and clinical sites to conduct and improve mother-infant linked longitudinal surveillance and disseminate findings for clinical and public health action;
- Support public health and health care professional organizations’ use of SET-NET to inform clinical and public health recommendations to improve maternal and infant health; and
- Pilot innovative approaches to mother-infant linked longitudinal surveillance.

### **Neonatal Abstinence Syndrome (NAS)**

CDC’s FY 2025 budget request of **\$4,250,000** for Neonatal Abstinence Syndrome (NAS) is level with the FY 2023 final level.

NAS is a withdrawal syndrome that can occur in newborns after exposure to opioids during pregnancy. To better understand the effects of multiple substances and their links to NAS, CDC is focused on surveillance and communication with providers to increase NAS reporting. In FY 2025, CDC will work with partners to strengthen surveillance for and advance the understanding of NAS as well as maternal, infant, and child health outcomes associated with opioid and other substance use during pregnancy and identify best practices for care, evaluation, and management of NAS.

### **Infant Health**

CDC’s FY 2025 budget request of **\$8,650,000** for Fetal Infant Health is level with the FY 2023 final level.

CDC supports infant health by promoting and improving the health of people living with birth defects, infant disorders, and related conditions, and works to identify and address preventable causes of such conditions. In FY 2025, CDC will use these funds to support internal maternal child health subject matter experts on fetal death, birth defects, and emerging threats along with activities to rapidly translate emerging data from surveillance to action for parents and health care providers.

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<sup>134</sup> Woodworth, Kate R. MD, MPH; Newton, Suzanne M. MPH; Olsen, Emily O. PhD, MSPH; Tannis, Ayzsa MPH; Sizemore, Lindsey MPH; Wingate, Heather MPH; Orkis, Lauren DrPH; Reynolds, Bethany MPH; Longcore, Nicole MPH; Thomas, Nadia MS, RN; Bocour, Angelica MPH; Wills, Aprielle MPH; Kim, Shin Y. MPH; Panagiotakopoulos, Lakshmi MD, MPH; Wester, Carolyn MD, MPH; Delman Meaney, Dana MD, MPH; Gilboa, Suzanne M. PhD; Tong, Van T. MPH. Timing of Positive Hepatitis C Virus Test Results During and 1 Year Before Pregnancy. *Obstetrics & Gynecology* 140(6):p 997-999, December 2022. | DOI: [10.1097/AOG.0000000000004980](https://doi.org/10.1097/AOG.0000000000004980)

## Fetal Alcohol Syndrome

CDC's FY 2025 budget request of **\$11,500,000** for Fetal Alcohol Syndrome is level with the FY 2023 final level.

Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person who was exposed to alcohol before birth. While population-based estimates are not yet available, a recent study indicates that one in twenty U.S. children may have FASDs.<sup>135</sup> Despite the [known adverse effects](#)<sup>136</sup> of FASD, alcohol use during pregnancy remains a critical public health issue, and polysubstance use is increasingly common. In FY 2025, CDC will continue working to strengthen partnerships in preventing alcohol use during pregnancy, improve support services and access to care, and improve identification and health of children with FASD and their families.

## Folic Acid

CDC's FY 2025 budget request of **\$3,150,000** for Folic Acid is level with the FY 2023 final level.

Neural tube defects (NTDs) are severe birth defects of the brain or spine and a major cause of infant death and lifelong disability worldwide. Despite the success of folic acid fortification in the United States, about 23 percent of women remain at elevated risk for NTDs. Although strides have been made in preventing NTDs, ethnic disparities remain. Hispanic women in the United States have the highest risk of having a child affected by a NTD, with birth prevalence of approximately seven NTDs per 10,000 live births.<sup>137</sup> In FY 2023, CDC conducted formative research with less acculturated Hispanic women to better understand knowledge, attitudes, and practices related to folic acid. In FY 2025, CDC will continue efforts to reduce morbidity and mortality related to folic acid preventable NTDs, monitor folate levels, examine risk factors for NTDs, and provide education on NTD prevention.

## Fetal Death (Stillbirth)

CDC's FY 2025 budget request of **\$900,000** for Fetal Death is level with the FY 2023 final level.

Stillbirth, the loss of a baby at or after 20 weeks of pregnancy, is one of the most common adverse pregnancy outcomes. CDC participates in the Stillbirth Task Force and is committed to implementing as many of the March 2023 Stillbirth Task Force report recommendations as possible. CDC supports two research centers in Arkansas and Massachusetts for the Birth Defects Study to Evaluate Pregnancy exposureS (BD-STEPS) to better understand factors that might impact the risk for stillbirth. A recent CDC analysis identified disparities in stillbirth; Black people were more than twice as likely to experience a stillbirth compared to White and Hispanic people. In FY 2025, CDC will continue to collect and analyze data and publish findings to build the science base to develop stillbirth prevention strategies.

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<sup>135</sup> Prevalence of Fetal Alcohol Spectrum Disorders in 4 US Communities - PubMed (nih.gov): <https://pubmed.ncbi.nlm.nih.gov/29411031/>

<sup>136</sup> <https://www.cdc.gov/ncbddd/fasd/facts.html>

<sup>137</sup> <https://pubmed.ncbi.nlm.nih.gov/31504109/>

## Helping Children Budget Request

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### Program Description

Developmental disabilities are among the most significant child health issues facing American families. They include conditions like autism spectrum disorder (ASD), congenital hearing loss, attention-deficit/hyperactivity disorder (ADHD), Tourette syndrome and other tic disorders, and fragile X syndrome. These conditions typically appear by early childhood, may impact day-to-day functioning, and usually last throughout a person's lifetime.

Children with developmental disabilities are at significantly greater risk for other co-occurring mental, emotional, and behavioral disorders that often cause additional challenges for these children and their families. CDC helps children with developmental disabilities reach their full potential by providing families, educators, health care providers, and community leaders with essential data on these conditions. CDC collects and analyzes data to inform policies and health promotion programs, develops resources that help identify children early, promotes equitable access to services, and supports across the lifespan so that all children with developmental disabilities and their families get the support they need.

### **Autism Spectrum Disorder**

CDC's FY 2025 budget request of **\$28,100,000** for Autism Spectrum Disorder is level with the FY 2023 final level.

#### ***Autism and Developmental Disability Monitoring Network (ADDM)***

Through ADDM, CDC tracks and monitors prevalence and early identification of ASD among children 4 and 8 years old across 16 ADDM Network sites. CDC also monitors co-occurring conditions and educational transition planning among adolescents with ASD aged 16 years at nine ADDM Network sites.<sup>138</sup> ADDM data provide important information over time about racial and socioeconomic disparities in identification, co-occurring conditions, educational services, and transition planning. The ADDM Network will also continue surveillance of cerebral palsy (CP) at five ADDM Network sites. The ADDM Network provides the only population-based surveillance of CP and will report information about how prevalent the condition is, how early children are being identified, and whether there are disparities by race or socioeconomic status.

The ADDM Network is informing data system enhancements that could be applied more broadly across CDC programs. And through improvements in methodology, CDC has reduced ADDM data reporting time by one year.

#### ***Study to Explore Early Development (SEED)***

CDC's [SEED study](https://www.cdc.gov/ncbddd/autism/seed.html)<sup>139</sup> contributes to knowledge about risk factors for ASD and describes the behavioral phenotypes, co-occurring health conditions, and healthcare services and needs of children with ASD or with other developmental disabilities. With the release of data from the final phase of SEED, data are now available for over 6,000 children, including over 1,800 children with ASD.<sup>140</sup>

In FY 2023, CDC applied the results of the completed [SEED Teen study](https://www.cdc.gov/ncbddd/autism/seed-teen.html)<sup>141</sup> and lessons learned to develop a new study called SEED Follow-up, which will provide an opportunity for CDC to learn more about early adult outcomes of individuals with ASD (e.g., health, functioning, service use, and needs) and factors associated with developmental trajectories. Young adults with ASD often experience a precipitous loss of access to well-

<sup>138</sup> <https://www.cdc.gov/ncbddd/autism/addm-network-sites.html>

<sup>139</sup> <https://www.cdc.gov/ncbddd/autism/seed.html>

<sup>140</sup> <https://www.cdc.gov/ncbddd/autism/seed-phase3.html>

<sup>141</sup> <https://www.cdc.gov/mmwr/volumes/70/wr/mm7017a1.htm>

integrated school-based health and mental healthcare and have limited employment and educational opportunities. Surveying young adults will provide critical information from their perspective on topics such as anxiety and depression symptoms, substance abuse, suicidality, social camouflaging, and quality of life. Data collection for SEED Follow-Up is now underway with plans to invite over 6,000 families to participate.

***Learn the Signs. Act Early (LTSAE)***

CDC’s LTSAE program encourages family and professional engagement in monitoring early development and acting early on concerns. Sixty-three [Act Early Ambassadors](#)<sup>142</sup> are working in nearly all states and territories to improve early identification of developmental delays and disabilities. The program plans to intensify collaboration with Federally Qualified Health Centers. Recently, CDC’s LTSAE program team provided technical assistance to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics in 21 states and increased family-engaged developmental monitoring in conjunction with WIC services.

CDC continues to improve its [Milestone Tracker app](#)<sup>143</sup> to help parents and other caregivers track their children’s early development and take action on possible developmental concerns. Early identification of developmental concerns can help parents and caregivers take action during early onset, and work with providers to establish a plan to address the concerns. The app has been downloaded over 1.9 million times with over 4.3 million uses. CDC launched a survey of app users to evaluate the impact of the app on knowledge and behaviors related to early identification of developmental delay and disability. Preliminary results are expected in the coming year, with data collection continuing over the next 3 years.

In FY 2025, along with programs to promote early identification of developmental delays and disabilities, CDC will continue to support the tracking and research that help us better understand ASD, how children and families are affected, and how we can best address health inequities and support this population during and after public health emergencies.

**Early Hearing Detection and Intervention**

CDC’s FY 2025 budget request of **\$10,760,000** for Early Hearing Detection and Intervention is level with the FY 2023 final level.

Nearly one out of every 500 infants in the United States are born deaf or hard of hearing. Undiagnosed hearing loss can result in serious and long-term consequences by affecting a child’s ability to develop speech, language, and social skills. Early identification and intervention of hearing loss can significantly improve developmental outcomes for children. From 2019-2023, CDC supported 38 states and Puerto Rico to optimize their Early Hearing Detection and Intervention Information Systems (EHDI-IS).<sup>144</sup>

In FY 2025, CDC will continue to support states and jurisdictions in analyzing EHDI data for improved tracking and informed decision making. CDC will support increasing the number of infants who receive a diagnosis before three months of age and who are enrolled in intervention services before six months of age. In partnership with the Health Resources Services Administration (HRSA), CDC will leverage EHDI-IS data to continue assessing and supporting optimal developmental outcomes for infants born deaf or hard of hearing.

<sup>142</sup> <https://www.cdc.gov/ncbddd/actearly/ambassadors-list.html>

<sup>143</sup> <https://www.cdc.gov/ncbddd/actearly/milestones-app.html>

<sup>144</sup> <https://www.cdc.gov/ncbddd/hearingloss/maps/funding-map-FOA-1701.html>

## Attention-Deficit/Hyperactivity Disorder

CDC's FY 2025 budget request of **\$1,900,000** for Attention-Deficit/Hyperactivity Disorder (ADHD) is level with the FY 2023 Final level. Early and effective treatment of ADHD is the key to children's success at home, in school, in the community, and as they transition into adulthood.

ADHD is one of the most common neurodevelopmental disorders of childhood affecting nearly one in 10 children aged 3 through 17 years.<sup>145</sup> Children with ADHD are at significantly greater risk for other co-occurring mental, developmental, and behavioral disorders. Excess expenses related to childhood ADHD cost Americans up to \$124.5 billion per year.<sup>146</sup> In FY 2025, CDC will continue to work with partners to promote optimal health and development among children and adolescents with ADHD and describe the public health impact of ADHD.

## Tourette Syndrome (TS)

CDC's FY 2025 budget request of **\$2,500,000** for Tourette Syndrome is level with the FY 2023 final level.

CDC works with partners to conduct research on the nearly one in 50 children aged 5 to 14 years with persistent tic disorders, including TS, to better understand prevalence, risk and protective factors, and health risk behaviors.<sup>147</sup> TS data are used to improve identification of tic disorders in community and clinical settings, treatment of TS, and to address racial and ethnic disparities in identification and diagnosis. CDC has funded a study to develop and evaluate diagnostic and screening tools for tic disorders. In addition, CDC is examining healthcare expenditures related to tic disorders using claims data. CDC also supported the Tourette Association of America's Centers of Excellence to expand the reach of healthcare provider and educator trainings.

In FY 2025, CDC will lead research efforts to better understand the prevalence and impact of TS and co-occurring conditions. Using data from the National Survey of Children's Health and working with the Tourette Association of America, CDC will support outreach to children, families, and young adults with TS and tic disorders and linkages to professionals who support them.

## Fragile X Syndrome (FXS)

CDC's FY 2025 budget request of **\$2,000,000** for Fragile X Syndrome is level with the FY 2023 final level.

FXS is the most common inherited cause of intellectual disability. FORWARD-MARCH is the latest CDC-funded research study designed to learn more about FXS.<sup>148</sup> It builds on an earlier study, the National Fragile X Foundation's Fragile X Online Registry with Accessible Research Database (FORWARD) which helps researchers and health care providers learn more about co-occurring conditions among individuals with FXS, the impact of FXS on daily living, short-term and long-term outcomes, and effective interventions and support. More than 600 children and adolescents with FXS and their families from across 22 FXS clinics throughout the United States are participating in the study.

In FY 2025, CDC will continue to lead research efforts to learn more about individuals with FXS, including their co-occurring conditions, short-term, and long-term outcomes so better approaches to intervention, clinical care, and family support can be developed.

<sup>145</sup> <https://www.cdc.gov/mmwr/volumes/71/su/su7102a1.htm#:~:text=months%E2%80%9317%20years,-,Attention%20Deficit/Hyperactivity%20Disorder,-ADHD%20is%20a>

<sup>146</sup> <https://link.springer.com/article/10.1007/s10802-019-00518-5>

<sup>147</sup> <https://www.cdc.gov/ncbddd/tourette/data.html>

<sup>148</sup> <https://www.cdc.gov/ncbddd/fxs/features/moving-research-forward.html>

## Protecting People Budget Request

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### Program Description

About one in 76 Americans are affected by a blood disorder. CDC continues to address the needs of Americans with blood disorders by gathering data on patient outcomes over time, targeting education campaigns to improve understanding of how to be healthy while living with blood disorders, and working with partners to ensure doctors and patients know how to prevent complications from both heritable and acquired blood disorders.

CDC's FY 2025 budget request of **\$10,400,000** for Public Health Approach to Blood Disorders is level with the FY 2023 final level. In addition to supporting sickle cell disease capacity building, CDC works to address other blood disorders like blood clots.

### ***Venous Thromboembolism (VTE)***

CDC works to prevent medical complications, such as venous thromboembolism, or blood clots in the veins. VTE affects as many as 900,000 American patients each year; one in 10 of whom die from VTE (many without ever being diagnosed), and costs the health care system an estimated \$10 billion annually. CDC funds a national campaign to promote the awareness of the signs, symptoms, and risk factors for VTE.<sup>149,150</sup> The campaign achieved over 800 million media impressions and an advertising value-added return on investment of up to 178 percent, providing a comprehensive toolkit, and helping families, caregivers, and providers obtain important information about blood clots and how to best act early to address them.

In FY 2025, CDC will continue to build the inventory for best practices in VTE prevention, work closely with partner institutions to improve and tailor pilot VTE surveillance mechanisms at healthcare institutions, and increase patient and provider awareness of the signs and symptoms of VTE.

### **Sickle Cell Disease**

CDC's FY 2025 budget request of **\$10,400,000** for Public Health Approach to Blood Disorders, including **\$6,000,000** for Sickle Cell Disease, is level with the FY 2023 final level.

Sickle Cell Disease (SCD) is the most common inherited blood disorder in the United States, and the third most common disorder identified by newborn screening. Complications of SCD, including multi-organ damage and failure, debilitating pain, infection, and anemia, can cause life-long physical and mental disabilities. People with SCD experience 20-to-30-year shorter life expectancy compared to people without SCD, and the rate of stroke among African American people with SCD is three-fold higher than rates in African Americans without SCD. Risks for poor health outcomes in people with SCD are compounded by racial, socioeconomic, and healthcare disparities. Most people with SCD in the United States are Black or African American, and Hispanics comprise a notable proportion.

CDC's Sickle Cell Data Collection (SCDC) program studies long-term trends in diagnosis, treatment, and healthcare access to help inform policy and healthcare standards that improve and extend the lives of people with SCD. Data indicates that individuals living with SCD are seeing disease specialists at a lower rate than

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<sup>149</sup> <https://www.stoptheclot.org/spreadtheword/>

<sup>150</sup> <https://www.cdc.gov/ncbddd/dvt/stop-the-clot-resource-toolkit.html>

people with other chronic genetic diseases.<sup>151</sup> Individuals with SCD are at increased risk of hospitalization and mortality due to COVID-19, even when accounting for race.<sup>152</sup>

To continue this important work CDC funds a five-year cooperative agreement (FY 2023 – FY 2027) with 16 states to collect and link data from multiple sources to paint a comprehensive picture of where people with SCD live, how they access healthcare, and other important health information. In FY 2025, CDC will:

- Continue to collect data and conduct surveillance activities in states with significant numbers of people with SCD;
- Provide guidance for important analyses such as SCD and COVID-19 causes and measures of mortality, reproductive health, access to specialty care, the Hispanic population, and social vulnerability; and
- Educate patients, families, providers, and other stakeholders through topic-focused data briefs, fact sheets, and reports.

## Hemophilia

CDC’s FY 2025 budget request of **\$3,500,000** for Hemophilia CDC Activities is level with the FY 2023 final level. In addition, the FY 2025 request of **\$5,100,000** for Hemophilia Treatment Centers is level with the FY 2023 final level. CDC works closely with Hemophilia Treatment Centers (HTC) across the country to monitor the health of people with hemophilia, an inherited bleeding disorder that can cause damage to internal organs, chronic joint disease, and pain. [Community Counts](#)<sup>153</sup> is CDC’s surveillance system that gathers individual and population-level data to help physicians and scientists improve the lives of people with hemophilia. CDC’s data visualization tool<sup>154</sup> for Community Counts represents the largest U.S. publicly accessible database with over 88,000 individuals with bleeding disorders receiving care at HTCs. CDC continues to add new features making more data available to the patients, providers, and public.

In FY 2025, CDC will:

- Continue to enhance laboratory safety, quality, and excellence in science while improving early detection of inhibitors in people with bleeding disorders;
- Continue developing an internal data tracking system accessible to regional coordinators;
- Continue the public health education campaign to increase awareness about the signs, symptoms, and diagnosis of bleeding disorders among women and healthcare providers;
- Work to enroll 6,000 people annually in the Community Counts surveillance system through federally funded HTCs; and
- Work toward reporting disability status and gender identity of people with bleeding disorders to inform their healthcare needs and reduce stigmatization.

## Thalassemia

CDC’s FY 2025 budget request of **\$2,100,000** for Thalassemia is level with the FY 2023 final level.

Thalassemia is a group of genetic red blood cell disorders that cause anemia beginning at birth and lasting throughout life. People with thalassemia require blood transfusions to live, which places them at higher risk for transfusion-related infections and complications that can result in organ failure and early death. CDC funds the Transfusions Complications Monitoring project to learn more about treatment complications associated with blood transfusions for thalassemia and SCD. The goal of the project is to improve access to, coordination of, and

<sup>151</sup> <https://ashpublications.org/bloodadvances/article/6/17/5128/485873/Hematologist-encounters-among-Medicaid-patients>

<sup>152</sup> [https://journals.lww.com/jpho-online/Fulltext/2023/05000/COVID\\_19\\_Infection\\_and\\_Outcomes\\_in\\_Newborn.2.aspx](https://journals.lww.com/jpho-online/Fulltext/2023/05000/COVID_19_Infection_and_Outcomes_in_Newborn.2.aspx)

<sup>153</sup> <https://www.cdc.gov/ncbddd/hemophilia/communitycounts/about.html>

<sup>154</sup> <https://www.cdc.gov/ncbddd/hemophilia/communitycounts/data-viz.html>.



continuity of healthcare for people with thalassemia or SCD, leading to fewer transfusion-related complications and improved quality and increased lifespan.

In FY 2025, CDC will continue efforts to learn more about treatment complications associated with blood transfusions for thalassemia. Funding also will also support development of communication strategies and educational tools that improve consumer and provider awareness and knowledge about thalassemia complication prevention and treatment practices.

## Improving Health Budget Request

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### Program Description

Up to 27 percent of American adults have at least one disability. This includes both people with lifelong, developmental disabilities and disabilities that may have a later onset as a result of injury, illness, or aging. Annual healthcare costs associated with disabilities are nearly \$868 billion, which is over 36 percent of all healthcare expenditures for adults residing in the United States.<sup>155</sup>

### **Disability and Health**

CDC's FY 2025 budget request of **\$45,500,000** for Disability and Health is level with the FY 2023 final level.

CDC works to support state disability and health programs to address health disparities among adults with disabilities, the disability and health data system, and the development of an implementation science model to improve health and wellbeing among people with disabilities. CDC maintains critical partnerships with the National Center on Health, Physical Activity and Disability (NCHPAD), and Special Olympics to reduce health disparities and support healthy athletes.

CDC is working to ensure that people with disabilities are included in public health monitoring and disease prevention and health promotion efforts. This includes addressing multiple areas where people with disabilities are not included or are underrepresented in public health data. These data are essential for identifying targeted support and interventions in the community to address significant disparities and enhance quality of life with people with disabilities across the lifespan.

### **Improving the Health of People with Mobility Limitations**

CDC funds the National Center on Health, Physical Activity and Disability (NCHPAD) to reduce health disparities and improve the health of people with mobility limitations (ML) by delivering health promotion programs and expanding healthcare and community-based providers' capacity for serving the health needs of people with ML.

NCHPAD developed a comprehensive, evidence-based set of wellness modules that help tailor health promotion programs to the unique needs of people with a range of disability and mobility issues. NCHPAD has built an extensive infrastructure to support a growing national network of providers, partners, and people with mobility disabilities, each of whom play a role in expanding healthcare screening/referral, health promotion programs, and capacity to address unique and complex health needs.

In FY 2025, CDC will continue to support work to improve the mental and physical health of Americans with mobility limitations across the lifespan through evidence-based health promotion programs.

### **Improving the Health of People with Intellectual and Developmental Disabilities**

Special Olympics provides year-round sports training and athletic competition in a variety of Olympic-type sports for children and adults with intellectual and developmental disabilities (IDD). CDC funds the Special Olympics Healthy Athletes® and Healthy Communities Programs to provide Special Olympics athletes with increased access to free health screenings, education, services, and referrals for follow-up healthcare as well as year-round health promotion and disease prevention programs.

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<sup>155</sup> Khavjou OA, Anderson WL, Honeycutt AA, Bates LG, Razzaghi H, Hollis ND, Grosse SD. National Health Care Expenditures Associated With Disability. *Med Care.* 2020 Sep;58(9):826-832. doi: [10.1097/MLR.0000000000001371](https://doi.org/10.1097/MLR.0000000000001371). PMID: [32826747](https://pubmed.ncbi.nlm.nih.gov/32826747/); PMCID: [PMC7505687](https://pubmed.ncbi.nlm.nih.gov/PMC7505687/)

CDC's partnership with Special Olympics focuses on reducing barriers to inclusive health services and programs, challenging misperceptions, eliminating stigma, and improving the health of people with ID by:

- Training health care professionals to conduct and support Healthy Athletes® screening events throughout the United States.
- Increasing the availability of data during and after screening events using digital health technology to evaluate effectiveness and provide critical health information on this population.
- Providing disability awareness training to health care professionals, community wellness partners, schools, and other collaborators who have limited or no experience working with people with intellectual disabilities.

In FY 2025, CDC will continue to work with Special Olympics to screen and connect athletes with healthcare resources in their communities and to promote best practices for health promotion and follow-up care.

### State Disability and Health Programs

CDC invests in 10 State Disability and Health Programs to improve engagement with high-quality routine preventive healthcare, adoption of healthy lifestyle behaviors, and early identification, management, and control of chronic disease and mental health conditions among people with intellectual and developmental disabilities and people with mobility limitations. These programs have reached over 3.2 million people nationwide through the implementation of 39 evidence-based strategies<sup>156</sup> and interventions on physical activity, nutrition, diabetes, and other topics significant to this population.

CDC's [Disability and Health Data System \(DHDS\)](https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/),<sup>157</sup> an online interactive source for state, regional, and national data on the health and demographics of adults with disabilities, provides states with information on 30 measures of health of their population with disabilities and tailor health protection programs for them.

In FY 2025, CDC will continue to fund State Disability and Health Programs and provide subject matter expertise to assist federal, tribal, local governments, and nonprofit organizations to identify unmet preventive healthcare needs of people with disabilities—and to adapt and improve public health programs and services to be more inclusive of people with disabilities.

### Muscular Dystrophy

CDC's FY 2025 budget request of **\$7,500,000** for Muscular Dystrophy is level with the FY 2023 final level.

[Muscular dystrophies \(MDs\)](https://www.cdc.gov/ncbddd/muscular-dystrophy/)<sup>158</sup> are a group of genetic muscle diseases that, over time, cause muscle weakness and wasting, leading to decreased mobility, making the tasks of daily living difficult. There are many muscular dystrophies that vary in age of onset, severity, and patterns of inheritance. Through public health research and collaboration with partners, CDC aims to improve the health and quality of life for people with MDs by understanding the impact of living with these complex conditions, promoting early diagnosis, and improving care and services.

CDC funds and manages the only population-based surveillance system for muscular dystrophy in the United States, the [Muscular Dystrophy Surveillance Tracking and Research Network \(MD STARnet\)](https://www.cdc.gov/ncbddd/muscular-dystrophy/research.html).<sup>159</sup> CDC researchers found it takes 2.3 years longer for families of non-Hispanic Black males to receive their initial evaluation for Duchenne muscular dystrophy (DMD) when compared to both non-Hispanic White and Hispanic males. These delays prevent children and families from getting the services and support they need as soon as possible. CDC

<sup>156</sup> <https://www.cdc.gov/ncbddd/disabilityandhealth/programs.html>.

<sup>157</sup> <https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/index.html>

<sup>158</sup> <https://www.cdc.gov/ncbddd/muscular-dystrophy/index.html>

<sup>159</sup> <http://www.cdc.gov/ncbddd/muscular-dystrophy/research.html>

supported the American Academy of Pediatrics (AAP) through a cooperative agreement to implement a five-part webinar series focused on primary and specialty care for patients with DMD.

In FY 2025, CDC will continue to utilize MD STARnet data to estimate prevalence, describe care and services, and assess health disparities and mental health needs. CDC is committed to population-based estimates to understand disparities and guide efforts to improve health equity. CDC will continue to promote early identification and earlier access to care and services of MDs.

## Spina Bifida

CDC's FY 2025 budget request of **\$7,500,000** for Spina Bifida is level with the FY 2023 final level.

Approximately 1,400 babies born in the United States each year are affected by spina bifida (SB), a complex, disabling condition that affects the spine and is usually apparent at birth. SB, a neural tube defect, has a tremendous impact on individuals and families, including high healthcare costs associated with frequent surgeries and hospitalizations. The lifetime direct costs to treat just one child with SB are estimated at \$790,000.

In 2008, CDC established the [National Spina Bifida Patient Registry \(NSBPR\)](#)<sup>160</sup> which is now the largest SB patient registry in the United States. Findings from NSBPR found specific sociodemographic, medical, and functional factors are associated with the likelihood of employment for young adults living with SB. Some employment-associated factors, such as continence and self-management skills, are modifiable and are important for clinicians to consider when facilitating transition for patients into adulthood. CDC is currently analyzing data from NSBPR to better understand health disparities for infants living with SB by race/ethnicity. In FY 2025, CDC is committed to expanding population-based estimates to inform improved care and services for individuals of all ages living with SB and efforts to improve quality of life across the lifespan.

## Congenital Heart Defects

CDC's FY 2025 budget request of **\$8,250,000** for Congenital Heart Defects is level with the FY 2023 final level.

[Congenital heart defects \(CHDs\)](#)<sup>161</sup> affect the structure of the heart and the way it functions. Collectively, CHDs are the most common type of birth defect. Thanks to advancements in medical care and treatment, infants with CHDs are living longer and healthier lives. However, children with CHDs face new challenges as they transition into adulthood, including increased risk of pregnancy complications and longer-term co-morbidities. CDC funds the Congenital Heart Defects Surveillance across Time And Regions (CHD STAR) project to examine the health of children and adults with heart defects over a 10-year period. To modernize CHD surveillance, CDC funds a site to examine whether machine learning can improve the quality of CHD surveillance data. Additionally, eight states are working to better understand when and how critical CHDs are detected, racial and ethnic groups most at risk for late detection, and other barriers to timely detection and intervention.

Congenital Heart Survey To Recognize Outcomes, Needs, and well-being (CH STRONG)<sup>162</sup> gathers information to improve the lives of people living with heart defects. CH STRONG found that many of the estimated 1.4 million adults with congenital heart defects in the United States may not be receiving specific care for their heart, despite recommendations for ongoing cardiology care. CH STRONG-KIDS surveys parents and caregivers of children with CHDs about their child's healthcare utilization, barriers to care, quality of life, social and educational outcomes, and transition of care from childhood to adulthood as well as needs and experiences of the caregiver.

<sup>160</sup> <https://www.cdc.gov/ncbddd/spinabifida/nsbprregistry.html>

<sup>161</sup> <https://www.cdc.gov/ncbddd/heartdefects/index.html>

<sup>162</sup> <http://www.chstrong.org/#:~:text=CH%20STRONG%20stands%20for%20Congenital%20Heart%20Survey%20To,receive%20better%20care%20and%20plan%20for%20their%20future.>

In FY 2025, CDC will continue to support surveillance of healthcare utilization and health outcomes among children, adolescents, and adults with CHD, and continue a survey to understand health, educational, and social outcomes among children and adolescents with heart defects.

**State Table: Early Hearing Detection and Intervention<sup>1, 2, 3</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$166,000	\$160,000	\$160,000	-\$6,000
Alaska	\$166,000	\$160,000	\$160,000	-\$6,000
Arizona	-	-	-	-
Arkansas	\$166,000	\$160,000	\$160,000	-\$6,000
California	-	-	-	-
Colorado	\$600,000	-	-	-\$600,000
Connecticut	-	-	-	-
Delaware	-	-	-	-
Florida	\$166,000	\$160,000	\$160,000	-\$6,000
Georgia	\$166,000	\$160,000	\$160,000	-\$6,000
Hawaii	\$166,000	\$160,000	\$160,000	-\$6,000
Idaho	\$166,000	\$160,000	\$160,000	-\$6,000
Illinois	\$166,000	\$160,000	\$160,000	-\$6,000
Indiana	\$166,000	\$160,000	\$160,000	-\$6,000
Iowa	\$166,000	\$160,000	\$160,000	-\$6,000
Kansas	\$106,000	\$95,000	\$160,000	\$54,000
Kentucky	\$160,000	\$160,000	\$160,000	\$0
Louisiana	\$165,998	\$159,998	\$160,000	-\$5,998
Maine	\$160,000	\$160,000	\$160,000	\$0
Maryland	\$166,000	\$160,000	\$160,000	-\$6,000
Massachusetts	\$166,000	\$160,000	\$160,000	-\$6,000
Michigan	\$166,000	\$160,000	\$160,000	-\$6,000
Minnesota	\$166,000	\$160,000	\$160,000	-\$6,000
Mississippi	-	-	-	-
Missouri	\$166,000	\$160,000	\$160,000	-\$6,000
Montana	-	-	-	-
Nebraska	\$166,000	\$160,000	\$160,000	-\$6,000
Nevada	\$166,000	\$160,000	\$160,000	-\$6,000
New Hampshire	\$160,000	\$160,000	\$160,000	\$0
New Jersey	\$160,000	\$160,000	\$160,000	\$0
New Mexico	\$160,000	\$160,000	\$160,000	\$0
New York	\$166,000	\$160,000	\$160,000	-\$6,000
North Carolina	\$166,000	\$150,000	\$150,000	-\$16,000
North Dakota	\$166,000	\$160,000	\$160,000	-\$6,000
Ohio	-	-	-	-
Oklahoma	\$160,000	\$160,000	\$160,000	\$0
Oregon	\$166,000	\$160,000	\$160,000	-\$6,000
Pennsylvania	-	-	-	-
Rhode Island	\$166,000	\$160,000	\$160,000	-\$6,000
South Carolina	\$166,000	\$160,000	\$160,000	-\$6,000
South Dakota	-	-	-	-
Tennessee	\$166,000	\$160,000	\$160,000	-\$6,000
Texas	\$160,000	\$160,000	\$160,000	\$0
Utah	\$166,000	\$160,000	\$160,000	-\$6,000
Vermont	\$166,000	\$160,000	\$160,000	-\$6,000
Virginia	\$166,000	\$160,000	\$160,000	-\$6,000
Washington	\$166,000	\$160,000	\$160,000	-\$6,000
Washington, D.C.	-	-	-	-
West Virginia	-	-	-	-
Wisconsin	-	-	-	-

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Wyoming	\$166,000	\$160,000	\$160,000	-\$6,000
<b>Territories</b>				\$0
America Samoa	-	-	-	-
Guam	-	-	-	-
Marshall Islands	-	-	-	-
Micronesia	-	-	-	-
Northern Marianas	-	-	-	-
Puerto Rico	\$160,000	\$160,000	\$160,000	\$0
Palau	-	-	-	-
Virgin Islands	-	-	-	-
<b>Subtotal, States</b>	<b>\$6,805,998</b>	<b>\$6,004,998</b>	<b>\$6,070,000</b>	<b>-\$735,998</b>
<b>Subtotal, Territories</b>	<b>\$160,000</b>	<b>\$160,000</b>	<b>\$160,000</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$6,965,998</b>	<b>\$6,164,998</b>	<b>\$6,230,000</b>	<b>-\$735,998</b>

<sup>1</sup>This State Table is a snapshot of selected programs that fund states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <https://www.cdc.gov/funding/funding-profiles/>

<sup>2</sup>CFDA number 93.314

<sup>3</sup>FY 2023 included a one-time increase for most, not all, recipients. Any difference in funding amounts across states is the result of some states requesting lower than the full increase amount available.

**State Table: Disability and Health Grants<sup>1,2,3,4</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	-	-	-	-
Alaska	-	-	-	-
Arizona	-	-	-	-
Arkansas	-	-	-	-
California	-	-	-	-
Colorado	-	-	-	-
Connecticut	-	-	-	-
Delaware	-	-	-	-
Florida	-	-	-	-
Georgia	\$585,494	\$584,494	\$584,349	-\$1,145
Hawaii	-	-	-	-
Idaho	-	-	-	-
Illinois	-	-	-	-
Indiana	-	-	-	-
Iowa	-	-	-	-
Kansas	-	-	-	-
Kentucky	-	-	-	-
Louisiana	-	-	-	-
Maine	-	-	-	-
Maryland	-	-	-	-
Massachusetts	\$585,000	\$585,000	\$585,000	\$0
Michigan	\$585,000	\$585,000	\$585,000	\$0
Minnesota	-	-	-	-
Mississippi	-	-	-	-
Missouri	\$585,000	\$585,000	\$585,000	\$0
Montana	\$572,500	\$572,500	\$585,000	\$12,500
Nebraska	-	-	-	-
Nevada	-	-	-	-
New Hampshire	\$572,500	\$572,500	\$585,000	\$12,500
New Jersey	-	-	-	-
New Mexico	-	-	-	-
New York	\$585,000	\$585,000	\$585,000	\$0
North Carolina	-	-	-	-
North Dakota	-	-	-	-
Ohio	\$572,500	\$572,500	\$585,000	\$12,500
Oklahoma	-	-	-	-
Oregon	\$585,000	\$585,000	\$585,000	\$0
Pennsylvania	-	-	-	-
Rhode Island	-	-	-	-
South Carolina	-	-	-	-
South Dakota	-	-	-	-
Tennessee	-	-	-	-
Texas	-	-	-	-
Utah	\$585,000	\$585,000	\$585,000	\$0
Vermont	-	-	-	-
Virginia	-	-	-	-
Washington	-	-	-	-
West Virginia	-	-	-	-
Wisconsin	-	-	-	-



CDC FY 2025 Congressional Justification

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Wyoming	-	-	-	-
<b>Territories</b>	-	-	-	-
America Samoa	-	-	-	-
Guam	-	-	-	-
Marshall Islands	-	-	-	-
Micronesia	-	-	-	-
Northern Marianas	-	-	-	-
Puerto Rico	-	-	-	-
Palau	-	-	-	-
Virgin Islands	-	-	-	-
<b>Subtotal, States</b>	<b>\$5,802,676</b>	<b>\$5, 802,676</b>	<b>\$5,849,349</b>	<b>\$47,324</b>
<b>Subtotal, Territories</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$5,802,676</b>	<b>\$5,802,676</b>	<b>\$5,849,349</b>	<b>\$47,324</b>

<sup>1</sup>This State Table is a snapshot of selected programs that fund states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

<sup>2</sup> <http://www.cdc.gov/ncbddd/disabilityandhealth/programs.html>

<sup>3</sup> CFDA number 93.184

<sup>4</sup> The difference in funding amounts across states is the result of some states requesting lower than the full award amount available.

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## PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$754.497	\$754.497	\$621.197	-\$133.300
Prevention and Public Health Fund	\$0	\$0	\$182.900	+\$182.900
<b>Total Request</b>	<b>\$754.497</b>	<b>\$754.497</b>	<b>\$804.097</b>	<b>+\$49.600</b>
FTEs	1,601	1,550	1,570	-31
-- Health Statistics	\$187.397	\$187.397	\$187.397	\$0
-- Surveillance, Epidemiology, and Informatics	\$298.100	\$298.100	\$298.100	\$0
-- Advancing Laboratory Science	\$23.000	\$23.000	\$23.000	\$0
--Public Health Data Modernization	<u>\$175.000</u>	<u>\$175.000</u>	<u>\$224.600</u>	<u>+\$49.600</u>
--Public Health Data Modernization	\$175.000	\$175.000	\$41.700	-\$133.300
--Public Health Data Modernization (PPHF)	\$0	\$0	\$182.900	+\$182.900
-- Public Health Workforce	\$71.000	\$71.000	\$71.000	\$0

**Enabling Legislation Citation:** PHSA § 241, PHSA § 301, PHSA § 304, PHSA § 306,\* PHSA § 307, PHSA § 308, PHSA § 310, PHSA § 317, PHSA § 317F,\* PHSA § 317G, PHSA § 318,\* PHSA § 319, PHSA § 319A, PHSA § 319D, PHSA § 353, PHSA § 391\*, PHSA § 399S-1,\* PHSA § 768, PHSA § 778,\* PHSA § 1102, PHSA § 2315, PHSA § 2341, 44 U.S.C. §3581, E-Government Act of 2002 (P. L. 107-347), Food, Conservation, and Energy Act of 2008 § 4403 (7 U.S.C. 5311a), Intelligence Reform and Terrorism Prevention Act of 2004 § 7211,\* National Nutrition Monitoring and Related Research Act of 1990 (P. L. 101-445 § 5341), Title V (44 U.S.C. 3501 note)

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Contracts

Program Description

CDC’s Public Health Scientific Services (PHSS) budget supports the agency’s activities to lead, promote, and facilitate scientific standards and policies to protect the health of Americans here and abroad:

- Providing leadership and training for a diverse, competent, sustainable, and empowered public health workforce;
- Modernizing public health surveillance systems and infrastructure; and
- Improving access to information needed by public health professionals who monitor and respond to disease outbreaks and other threats.

Budget Request

CDC’s FY 2025 budget request of **\$804,097,000** for Public Health Scientific Services, including **\$182,900,000** from the Prevention and Public Health Fund (PPHF) is **\$49,600,000** above the FY 2023 final level to fund state, tribal, local, and territorial health departments to build sustainable infrastructure so that they can receive and share data across systems and use it to inform public health actions.

## **Program Accomplishments**

CDC collects, analyzes, and reports scientific data to inform policies and practices to protect the health of all Americans through its Public Health Scientific Services (PHSS) activities. CDC has made substantial progress in modernizing the data ecosystem used for gathering, analyzing, and sharing data across public and private health care systems. Making data available for more rapid decision making is a monumental effort requiring upgrades to hundreds of individual systems that were operating independently. U.S. investment is aligning systems to seamlessly share data across public and private sector health systems. For example, modernization of vital records has yielded faster overdose death data, new data on excess deaths, and expanded life expectancy reporting by race and Hispanic origin. CDC has reduced the time it takes to publish provisional death data from months to just weeks. Nearly 70% of deaths are now reported electronically within 10 days, and preliminary estimates are accessible on CDC WONDER. Modernized public health data infrastructure also enables more complete data on race, ethnicity, gender, sexual orientation, disability, and urban versus rural status. In addition to characterizing the disparate impact of diseases and conditions among different communities, this data informs policies, practices, and guidance that promote equity among groups that have historically been economically and socially marginalized. Key activities include:

- Enhancing and modernizing CDC and state, territorial, local, and tribal data, surveillance, and analytics capabilities to provide more complete, higher quality data that better illuminate health disparities.
- Releasing additional estimates on drivers of health disparities, including occupation, gender identity, environmental exposures, geographic location, and nonfinancial barriers to care.
- Facilitating more effective action to address health disparities by generating more complete, representative, and specific information via new and non-traditional data sources and methods.
- Expanding data linkages between CDC health data and datasets from other federal agencies to identify and analyze health disparities driven by social determinants of health.
- Increasing laboratory data exchange with an emphasis on facilities that serve medically underserved individuals to ensure access to quality diagnostics and care.
- Reducing the incidence of diagnostic errors for conditions frequently misdiagnosed among ethnic, racial, or other disproportionately affected groups.
- Strengthening and supporting a diverse public health workforce. Increasing and strengthening pathways to public health careers, including from under-represented groups and communities.

## PUBLIC HEALTH SCIENTIFIC SERVICES

### BY THE NUMBERS

- **146**—Number of statistical products and releases produced by the National Center for Health Statistics in 2023 on diverse public health topics and sub-populations, including 86 reports, a handbook for physicians, web tables, and dashboards.
- **6,529**—Number of healthcare facilities across the 50 states, Washington, D.C., and Guam that contribute data to the National Syndromic Surveillance Program's BioSense Platform.
- **2,202**—CDC campus laboratory spaces receiving onsite, in-person safety inspections in a typical year from CDC laboratory safety officials.
- **409**—Number of CDC fellows and trainees, in FY 2023, assigned to positions in a state, local, tribal, or territorial public health agency.<sup>1</sup>

\*Unless otherwise noted, all information and calculations are from CDC program data.

<sup>1</sup> In FY 2023, this includes ALL (new and continuing) full-time trainees at least partially funded by CDC PHSS, in the CDC Epidemic Intelligence Service, Laboratory Leadership Service, Preventive Medicine Residency and Fellowship, and the Public Health Associate Program. It also includes full-time trainees in the CDC/CSTE Applied Epidemiology Fellowship and the CDC/CSTE Applied Public Health Informatics Fellowship.

<b>Public Health Scientific Services Funding History</b>	
Fiscal Year	Dollars (in millions)
FY 2021 (BA)	\$590.181
FY 2022 (BA)	\$651.997
FY 2023 Final (BA)	\$754.497
FY 2024 CR (BA)	\$754.497
FY 2025 President's Budget (BA)	\$621.197
FY 2025 President's Budget (PPHF)	\$182.900

## Health Statistics Budget Request

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CDC's National Center for Health Statistics (NCHS) is the nation's principal health statistics agency, designated by the Office of Management and Budget (OMB) to produce official health statistics for the nation. These statistics provide critical evidence to inform policies, monitor programs, track progress, and measure change. Through foundational health statistics systems that gather data from vital records and a suite of surveys, NCHS tracks detailed and diverse demographic information about the U.S. population, providing policymakers with the information needed to support evidence-based decision-making. For example, CDC uses suicide, homicide, and drug overdose mortality statistics from NCHS to develop guidance and programs and monitor progress in prevention and treatment.

Innovations in health statistics at CDC help modernize the entire public health data system, harness new data, expand the scope and capacity for statistical analysis, and link data across the statistical system. CDC is leading innovations in methods development, data integration, and emerging approaches in data science and modeling to embrace new technology and approaches for managing data. NCHS drives these efforts through its longstanding relationships with other federal entities, experience in data access and data use agreements, and expertise in record matching, data linkage, and analytic methods.

### Budget Request

CDC's FY 2025 budget request of **\$187,397,000** for the National Center for Health Statistics is level with the FY 2023 final level.

FY 2025 resources will be used to invest in ongoing statistical agency activities:

- Providing high-quality health statistics to inform decisions by maintaining existing health data systems at current functionality.
- Maintaining baseline sample sizes for surveys to produce estimates on key health indicators.
- Ensuring maximum efficiency of efforts through statistical agency coordination and alignment of data collection activities across agencies and programs.
- Advancing work on equity analysis through data collection.
- Evaluating the use of electronic health records (EHRs) to better understand how the data capture health equity variables.
- Evaluating misclassification of race and ethnicity in vital records, develop and implement methodologies to adjust for misclassification in published statistics, and develop training materials and targeted outreach to data providers on proper classification.

NCHS will maintain its existing data collection and dissemination activities while absorbing increased survey deployment and personnel costs. CDC will continue to prioritize its major data collection activities, described below, that allow policymakers and the public to understand the health of the U.S. population.

### **National Vital Statistics System (NVSS)**

The NVSS provides key information on approximately 3.8 million births and 2.8 million deaths annually in the United States. This system produces information on birth rates, infant and maternal mortality, life expectancy, mortality, and the leading causes of death. The quality, timeliness, and utility of NVSS data have significantly improved in the last decade due to the successful long-standing collaboration with vital registration jurisdictions, consisting of U.S. states, territories, New York City, and Washington, D.C.

CDC staff have also worked with medical examiners and coroners to improve the quality of mortality data, including the creation of a new office within NCHS in 2022 dedicated to this effort: the Collaborating Office for Medical Examiners and Coroners (COMEC). NVSS's monthly release of [Provisional Drug Overdose Death](#)

[Counts](#),<sup>163</sup> launched in 2017, provides access to the timeliest information on drug overdose deaths. Since its launch, the number of jurisdictions reporting overdose death counts with drug specificity has more than doubled. As of July 2023, 42 jurisdictions made such reports. These data guide overdose prevention programs and have been crucial in identifying the rapid rise of fentanyl-related overdose deaths in the United States. Through these improvements, CDC has accelerated the reporting of mortality data. Since 2011, there has been a 52-percentage-point improvement in mortality records received within 10 days of the event, enabling more detailed analysis and faster publication of findings. For example, CDC now reports provisional overdose mortality four months after the date of death versus the previous norm of a six-months.

Since the beginning of the COVID-19 pandemic, CDC has provided timely and relevant data and tools to support decision making and response efforts. CDC published weekly updates on [COVID-19 mortality counts](#),<sup>164</sup> stratified by geographic region, age, sex, race and ethnicity, and educational status, to inform policymakers on the different effects of COVID-19 on various sub-populations. In December 2022, NCHS published the first federal [report](#)<sup>165</sup> identifying deaths due to long COVID. NVSS mortality data are over 99 percent complete for race and ethnicity fields.

CDC also publishes monthly estimates of [excess deaths](#),<sup>166</sup> including deaths directly or indirectly attributed to COVID-19, to provide information about the total burden of mortality due to the pandemic. Published data on excess deaths are available by age group, race and Hispanic origin, and for select causes of death. Information on excess deaths allows public health experts and policymakers to identify where and when mortality increases. These data exposed elevated mortality due to heart disease, hypertension, dementia, and other ailments during the pandemic within weeks of the deaths occurring.

### **National Health Interview Survey (NHIS)**

For more than 60 years, the NHIS has served as the nation’s principal health survey and has provided invaluable information on the state of health and wellbeing in the U.S. population. The NHIS collects data through personal household interviews focusing on critical public health topics, including mental health, prescription opioid use, long-COVID symptoms, and vaccination status. Data collected also cover health status, risk factors, health conditions, health insurance coverage, and access to care. NHIS data reveal how respondents’ health impacts their daily lives, something that cannot be done via medical and case records or insurance claim reviews. NHIS data are crucial for crafting policies that support the health and well-being of all Americans.

Many states benchmark health surveys to the NHIS, allowing CDC and HHS to use the NHIS to compare the effectiveness of state and local public health programs. Private sector health surveys also rely on the NHIS for national population health estimates. NHIS data have become the linchpin for modeling access to care and estimating the impact of changes in national policy on various segments of the U.S. population. For example, quarterly health insurance estimates from NHIS allow policymakers to track health insurance coverage by age group, family income, race and ethnicity, and geographic region within four months of data collection.

### **National Health and Nutrition Examination Survey (NHANES)**

The NHANES is the only federal survey that combines household interviews with physical examinations and laboratory tests. These unique methods allow NHANES to collect objective, nationally representative data on the prevalence of diagnosed and undiagnosed conditions in the population, including diabetes, hypertension, environmental exposures, high cholesterol, and obesity. NHANES also provides information summarizing

<sup>163</sup> <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

<sup>164</sup> <https://www.cdc.gov/nchs/nvss/covid-19.htm/>

<sup>165</sup> <https://www.cdc.gov/nchs/data/nvsr/nvsr71/nvsr71-06.pdf>

<sup>166</sup> [https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess\\_deaths.htm](https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm)

national height, weight, and blood pressure distributions, as well as the only nationally representative data on topics such as respiratory health, oral health, and vision.

CDC and other federal agencies, including the National Institutes of Health (NIH) and the U.S. Department of Agriculture (USDA), rely on NHANES to provide insights for public health program resource allocation, planning, and evaluation. NHANES is the primary source of data for many reports and guidance, including CDC's growth charts for children, the Dietary Guidelines for Americans, the National Report on Human Exposure to Environmental Chemicals, and the Healthy People 2030 objectives. NHANES data are also heavily referenced in academic literature: From August 2021 to August 2023 nearly 4,000 published articles used NHANES data.

### **National Health Care Surveys**

The National Health Care Surveys are provider-based surveys that cover a broad spectrum of healthcare settings. Inpatient hospital units, emergency departments (EDs), physician offices, and long-term care facilities provide information on their practices, the delivery of services and care, and individual patient encounters. CDC recently developed methods to identify co-occurring disorders among opioid users using linked hospital-care and mortality data, leading to a report published in July 2022 which found 7.8 percent of opioid-involved ED visits and 15 percent of opioid-involved hospitalizations were among patients diagnosed with both a substance use disorder and a selected mental health issue<sup>167</sup>. Additional updates are underway, which include adding variables on disparities in healthcare settings and expanding use of electronic health record (EHR) data.

### **Health Equity Analysis**

NCHS's data reveal racial and ethnic disparities on a wide range of health indicators, including life expectancy; infant and maternal mortality; risk factors like smoking, physical activity, and alcohol use; and access to care. In FY 2023, CDC supported efforts to accelerate equity analysis by evaluating EHRs to ensure that race, ethnicity, and language variables are updated and standardized.

At the FY 2025 requested level, CDC will evaluate EHRs from hospitals and federally qualified health centers for use in equity analyses. CDC will also work to improve the reporting of race and ethnicity with evaluations linking death records to data from the Census Bureau. Beyond race and ethnicity analyses, NCHS will continue to collect data on other health equity factors, including occupation, gender identity, environmental exposures, geographic location, and financial and nonfinancial barriers to care.

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<sup>167</sup> <https://www.cdc.gov/nchs/data/nhsr/nhsr173.pdf>



## **Data Access**

CDC provides access to health statistics from its suite of data collection systems to policymakers, researchers, and the public. The NCHS Research Data Center (RDC) provides researchers access to restricted public health data in an ethical manner to inform evidence-based policymaking while protecting the confidentiality of survey respondents, study subjects, and institutions. CDC is also developing a more efficient means to conduct research through a Virtual Data Enclave (VDE) to increase access and lower costs for researchers using restricted data.

The NCHS Data Linkage Program connects health-related data sources to help answer complex policy questions. Linked data resources reduce costs associated with recontacting survey participants for follow-up information and connect historical and social context to survey data on major diseases, risk factors, and health services utilization. Data linkage maximizes the value of CDC's health surveys by integrating data from the National Death Index, Centers for Medicare and Medicaid enrollment and claims, the U.S. Department of Housing and Urban Development, and the U.S. Department of Veterans Affairs (VA). Linked data have helped evaluate the effectiveness of policies to lower lead exposure in children living in public housing and enabled analyses comparing Veterans receiving VA health care with those not enrolled in VA care.

## **Surveillance, Epidemiology, and Informatics Budget Request**

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Surveillance, Epidemiology, and Informatics serve as the foundation for the nation’s ability to identify and respond to health threats. The public health surveillance systems, laboratory exchange between public health and clinical laboratories, and high-quality scientific publications supported by this line provide vital insights into the nation’s health, health disparities, and useful public health recommendations. The COVID-19 pandemic demonstrated how essential a comprehensive picture of public health data—from case reporting to emergency department visits to laboratory result data—is to our ability to understand and respond to health threats. Continued investment is needed to support and maintain platforms for syndromic data and case reporting. Simultaneously, CDC continues to make progress in modernizing those systems at the federal, state, and local level to ensure that data can move faster than the spread of disease.

CDC supports a national network of strong health departments, which work to provide accessible, timely, quality, and sustainable public health services, underpinned by strong surveillance and epidemiology, to protect Americans’ health and safety. These essential components of the nation’s front line of public health defense require tools, resources, and a sustainable, well-trained workforce to work better, faster, and smarter. CDC works with executive-level partners in health departments throughout the public health system and provides services tailored to state, tribal, local, and territorial health officials—including targeted communications, consultations, and site visits—that will improve community health outcomes.

### **Budget Request**

CDC’s FY 2025 budget request of **\$298,100,000** for Surveillance, Epidemiology, and Informatics is level with the FY 2023 final level.

CDC will continue to build the agency’s scientific integrity and quality infrastructure; support clinical and public health laboratory activities; support the National Syndromic Surveillance Program as the nation’s early warning system to detect and monitor health threats; support the National Notifiable Disease Surveillance System to provide comprehensive national surveillance for diseases and conditions that present a potential threat to the health of a community; and support the Behavioral Risk Factor Surveillance System to collect data on health-related behaviors across the nation.

In FY 2025, the following priority activities will enhance the agency’s **scientific integrity and quality infrastructure** to support public health by:

- Modernizing policies, practices, and training in scientific integrity in alignment with federal regulations and ensure that its activities meet the highest standards of scientific integrity, quality, ethics, and transparency.
- Building capacity through scientific integrity experts and a trained, diverse scientific workforce.
- Advancing health equity science and interventions by expanding the evidence-base for effective approaches that reduce health disparities, improve health outcomes, and advance health equity.
- Modernizing data and leveraging innovation and emerging technology to advance scientific methods, systems, research processes, and analytics capabilities across the agency.
- Developing systems, infrastructure, and knowledge management to increase public access to CDC science, data, and surveillance and ensure that systems evaluate impact, relevance, credibility, and transparency.

FY 2025 priorities for **clinical and public health laboratory activities** include the following areas:

- Improving the quality and safety of clinical and public health testing and practice.
- Providing technical expertise to the federally mandated CLIA program in partnership with CMS and FDA.

- Developing resources, tools, and guidelines for next-generation sequencing and other emerging technologies.
- Advancing laboratory-focused activities to reduce the incidence of diagnostic errors, focusing on health conditions that disproportionately affect medically underserved populations.
- Enhancing laboratory preparedness of clinical and public health laboratories during emergency response.
- Strengthening the laboratory testing community through expanded access to innovative training methods and platforms that facilitate remote collaboration and real-time virtual training.
- Maintaining operation of biorepository services to include enhancing the stewardship of collections and expanding the repository of isolates and human specimens needed for assay validation, particularly during public health emergencies.

### **National Syndromic Surveillance Program (NSSP)**

CDC's NSSP provides local, state, and federal health officials with a near-real time situational awareness system for detecting and monitoring health events. NSSP integrates electronic healthcare data from emergency departments, commercial laboratories, Veterans Affairs, air quality, the Department of Defense, and, during deployments, Administration for Strategic Preparedness and Response Disaster Medical Assistance Teams.

By tracking symptoms and diagnoses of patients across electronic health data sources, analysts can detect unusual levels or changing patterns of illness. Every day, more than 2,000 users across local, state, and federal health government conduct 4,000 searches of these data to inform public health response, decision-making, and action. Public health practitioners at all levels of government, including 73 state and local health departments, collaborate through a Slack site, regular calls, and annual conference with more than 900 participants in 2023.

Through 2023, across all levels of government, NSSP data were used to provide critical insights for more than 40 responses addressing infectious diseases (e.g., pneumonia, COVID-19, RSV, domestic polio), disasters (e.g., extreme heat and cold, flooding, chemical exposure), injuries (e.g., overdose, poisonings, child abuse and elder abuse), and for mental health, mass gatherings and other conditions. These data provide a public health situational awareness, supporting a common understanding of health threats over time and across regional boundaries.

### **National Notifiable Diseases Surveillance System (NNDSS)**

Across the U.S., more than 3,000 state, tribal, local, and territorial health departments collect data about diseases and conditions that pose a risk to their communities. CDC reports weekly and annual data on 120 diseases and conditions and provides crucial support for health departments so that they can receive disease data, track cases, identify outbreaks, and prevent disease spread.

Data Modernization is improving every aspect of public health data gathering and reporting so that all levels of government have faster, actionable insights for decision-making. CDC provides essential funding and support for collection and analyses, system modernization (e.g., cloud services), and capacity building at public health departments to implement new technological innovations, such as electronic case reporting (eCR), which makes richer data available sooner and with less manual effort. For example, electronic lab reporting enabled epidemiologists in the District of Columbia to stop manually standardizing information faxed to them in spreadsheets. They also used DMI funds to hire dedicated informaticians and automate test ordering systems, reducing a 48-hour process to 12 hours in this jurisdiction alone. Nationally, public health information can now move at a far greater pace thanks to use of electronic lab and electronic case reporting.

**Behavioral Risk Factor Surveillance System (BRFSS)**

BRFSS is a state-based system of health surveys that collects data from non-institutionalized adults, ages 18 years and older, about a wide range of behaviors that affect their health, including health risk behaviors, chronic health conditions, and use of preventive services. BRFSS participation includes all 50 states, the District of Columbia, and five territories (Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, and the Federated States of Micronesia), and each year about 450,000 U.S. adults are interviewed by the BRFSS, making it the world's largest continuously conducted telephone health survey.

As the only source of state-based data on adult health and health risk behaviors for most states, BRFSS gives communities and states, as well as the CDC and other federal agencies, information they need to collect and analyze surveillance data to monitor the prevalence of health risk behaviors that are associated with chronic health problems, and preventable injuries. Annual survey data are publicly available within eight months and assist in planning public health programs at the local, state, and national levels.

**National Neurological Conditions Surveillance System (NNCSS)**

The NNCSS harnesses the power of multiple data sources to produce robust national surveillance estimates, identify populations that are at higher risk or underserved, monitor trends, inform public health and healthcare action, and catalyze further research into causes, diagnostics, prevention, and treatments for two key neurological conditions: multiple sclerosis (MS) and Parkinson’s disease (PD). In FY 2023, CDC solicited input from external subject matter experts and partner organizations on NNCSS’s initial surveillance estimates and how they might be used. CDC also initiated work to validate its methods and completed a preliminary assessment of the burden placed on patients and their caregivers by MS, PD, and related neurological conditions.

**Standards and Services in Public Health and Clinical Laboratories**

CDC provides critical support to the dynamic network of clinical and public health laboratories across the country, including those responsible for performing routine clinical testing, detecting biothreats, and preparing for and responding to public health emergencies.

In 2022, over 14.6 billion diagnostic laboratory tests were conducted in the more than 320,000 clinical and public health laboratories and testing locations that are certified under Clinical Laboratory Improvement Amendments of 1988 (CLIA) requirements. CDC develops and disseminates free and accessible data-driven laboratory guidance documents and trainings available to broad audiences, including under-resourced laboratories and those providing diagnostic services to populations that have been marginalized. CDC also works with commercial laboratories to enhance the preparedness and response capabilities and capacities of the clinical and public health testing community.

CDC employs a multifaceted approach to improve public health, patient outcomes, and health equity by advancing laboratory systems:

- CDC’s Laboratory Outreach Communication System (LOCS) creates a direct line of communication and source of technical support to clinical laboratories nationwide which is comprised of nearly 100,000 clinical laboratory professionals. CDC, other federal partners, and professional organizations collaborate to present LOCS webinars that deliver updates and answer questions from the laboratory and testing community. Each monthly call reaches an average of 700 attendees.
- CDC OneLab™ is building a training community of practice among US laboratory and testing professionals through innovative tools and courses, live monthly training events, regular community of practice meetings, and a virtual reality training facility for laboratory professionals that is accessible online from anywhere.

- The CDC Biorepository (CBR) is the nation’s largest accredited federal biorepository which houses and provides scientific samples that are used in research to advance scientific knowledge, characterize new etiologic agents, investigate the cause of diseases, and develop new tests, vaccines, and treatments.

### **Morbidity and Mortality Weekly Report (MMWR) and CDC Vital Signs**

CDC’s mission is not only to conduct high-quality science, but to share that information with the public in an actionable way. Publications such as the MMWR, often referred to as “the Voice of CDC,” and CDC Vital Signs are the agency’s primary vehicles for scientific publication of timely, reliable, authoritative, accurate, and objective scientific findings. Major news media outlets, medical societies, and scholarly medical journals extensively redistribute MMWR and CDC Vital Signs content, amplifying CDC’s ability to get public health information into the hands of people who need it.

The MMWR’s relentless focus on scientific quality, timeliness, and impact has resulted in a steady stream of scientific reports that have shaped the national understanding of COVID-19. COVID-19-related MMWR reports have resulted in more than 935,000 social media impressions and more than 30,000 total citations. During the first two and a half years of the pandemic, MMWR published a COVID-19 report an average of every 48 hours, increasing our release of content from once per week to three times per week. These reports have become touchpoints in the public understanding of the pandemic: the effectiveness of face masks and respirators for preventing infections, the initial detection of the Omicron variant in the United States, ventilation improvement strategies in K-12 schools, post-COVID conditions among adults, and racial and ethnic disparities in outpatient treatment of COVID-19. MMWR reports have also shone a light on the collateral effects of the pandemic, such as the mental health impact on public health workers and caregivers. MMWR has also played a crucial role in disseminating information about the 2022 mpox outbreak, publishing reports about the epidemiologic and clinical features of mpox and mpox vaccine effectiveness. Overall, CDC’s Moving Forward initiative is streamlining publication of information so that it reaches decisionmakers and the public more rapidly.

### **Scientific Integrity and Quality**

CDC ensures the highest standards of scientific integrity, relevance, credibility, and transparency for any data, publications, research, and communication materials. CDC scientific services include training, guidance, consultations, library resources, science dissemination, extramural research coordination, and technology transfer facilitation for over 14,000 scientists across the agency. In FY 2021, CDC’s scientific leadership began incorporating its [CORE Health Equity Science and Intervention Strategy](#)<sup>168</sup> throughout the agency’s scientific and research programs to ensure that health equity principles and criteria are routinely considered in the early stages of CDC’s work and drive progress in ensuring all people have an opportunity to live as healthy as possible.

CDC’s investments in data science and modernization also promote data sharing, public access, and alignment with federal data initiatives and privacy, ethics, and confidentiality principles. In FY 2023, CDC executed 400 technology transfer agreements, in which CDC partners with industry, academia, non-profits, and other government agencies to transfer CDC’s research portfolio, including diagnostics assays, early therapeutics, vaccine candidates, and software, into products and services to improve public health. These agreements foster dissemination and application of CDC science and technology innovations, enabling rapid prevention, detection, and treatment of public health threats. In FY 2022, CDC also executed 496 technology transfer agreements, of which 28 were COVID-related. CDC has worked to increase fair and timely access to scientific publications by reducing our scientific review clearance time by 50 percent and providing access to more than 22,300 peer-reviewed scholarly publications through our repository or the NIH PMC since January 2013.

<sup>168</sup> <https://www.cdc.gov/healthequity/core/index.html>

**NSSP Awards<sup>1,2</sup>**

(Dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President's Budget
Number of Awards	51	51	51
- New Awards	0	0	0
- Continuing Awards	51	51	51
<b>Total Awards</b>	<b>\$6.000</b>	<b>\$6.000</b>	<b>\$6.000</b>

<sup>1</sup> Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs.

<sup>2</sup> These funds are not awarded by formula.

**NNDSS Awards<sup>1</sup>**

(Dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President's Budget
Number of Awards	64	64	64
- New Awards	0	0	0
- Continuing Awards	64	64	64
Average Award	\$0.172	\$0.172	\$0.172
Range of Awards	\$0.003 - \$0.342	\$0.003 - \$0.342	\$0.003 - \$0.342
<b>Total Awards</b>	<b>\$11.035</b>	<b>\$11.035</b>	<b>\$11.035</b>

<sup>1</sup> These funds are not awarded by formula.

**BRFSS Awards<sup>1,2</sup>**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President's Budget
Number of Awards	56	56	56
- New Awards	0	0	0
- Continuing Awards	56	56	56
Average Award	\$0.400	\$0.400	\$0.400
Range of Awards	\$0.125 - \$0.405	\$0.125 - \$0.405	\$0.125 - \$0.405
<b>Total Awards</b>	<b>\$24.600</b>	<b>\$24.600</b>	<b>\$24.600</b>

<sup>1</sup> Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs.

<sup>2</sup> These funds are not awarded by formula.

## **Advancing Laboratory Science Budget Request**

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High-quality, timely, and affordable laboratory test results are essential for the effective detection, diagnosis, treatment, and prevention of infectious disease, chronic disease, and harmful exposures. For CDC laboratories to provide these critical functions, they must:

- 1) Provide high-quality and timely test results, including during emergencies, that identify new and dangerous pathogens, as well as surveillance test results that detect the incidence and prevalence of disease in affected populations.
- 2) Be at the cutting edge of advances in laboratory science to develop – independently and in collaboration with public and private partners--unique, new, faster, less expensive, and better in vitro diagnostic tests that can be used in both public health and private facilities.
- 3) Provide state-of-the-art laboratory technology, expertise, and high-quality products and services to advance public health and preparedness, including management of CDC’s Laboratory Response Network and promotion of the national laboratory preparedness and response system through effective integration and collaboration with public health and private sector laboratories and diagnostic testing facilities.
- 4) Ensure the safety of laboratory personnel, appropriate laboratory protocols, and compliance with all applicable regulatory requirements.
- 5) Advance laboratory information systems at CDC and across the public and private sectors to improve the timeliness, quality, and efficiency of laboratory data exchange, especially during public health outbreaks and emergencies.
- 6) Develop and disseminate cutting-edge laboratory quality, safety, informatics, and diagnostics training, guidance, and technology transfer to CDC and private partner laboratory professionals and scientists.

### Budget Request

CDC’s FY 2025 budget request of **\$23,000,000** for Advancing Laboratory Science is level with the FY 2023 final level.

### **Strengthening Laboratory Safety, Quality, and Training at CDC**

CDC has pledged to base public health decisions on the highest quality scientific data derived openly and objectively by continually improving laboratory quality and safety. More than 1,700 laboratory scientists at CDC’s 200 laboratories detect and diagnose infectious diseases, respond to foodborne outbreaks, evaluate effectiveness of treatments and vaccines against high-consequence infectious diseases, investigate disease and death of unknown cause, evaluate biosecurity threats, protect America’s blood supply, screen for genetic and other health risk factors, monitor the health of communities, and identify harmful exposures.

CDC continues to advance laboratory science to run unique tests, provide exceptional quality, and offer methodologically well-characterized and validated clinical diagnostic test results. CDC ensures scientifically excellent, timely, and efficient laboratory support for an emergency response that is integrated well with the overall CDC response and the response efforts of private and public laboratories and health partners. Additionally, CDC develops a comprehensive training curriculum, including laboratory safety and quality courses, to ensure CDC’s laboratory scientists are equipped to meet public health challenges.

In FY 2023, CDC began implementing the Quality Manual for Microbiological Laboratories, which specifies quality standards and practices for all clinical, surveillance, and research infectious disease laboratories. CDC’s method expert groups developed new method validation standards and documentation requirements for tests based on polymerase chain reactions (PCR) tests that are frequently used in CDC infectious disease laboratories. CDC also developed electronic Quality Management Systems (eQMS) for CDC laboratories, configuring six

modules that were deployed within 15 pilot laboratories to facilitate management of documents, equipment, training, and nonconforming events.

Activities in FY 2025 will build on expected progress during FY 2024:

- Promoting cutting-edge laboratory science to develop unique, new, faster, and less expensive diagnostic tests that are instrumental for pandemic preparedness.
- Delivering specific training programs that meet the unique needs of CDC laboratory scientists.
- Maximizing safety by increasing on-the-ground inspections and continued process improvement.

### **Strengthening the Workforce in Public Health and Clinical Laboratories**

The Government Accountability Office identified the availability of a sufficient public health workforce as a key concern of officials interviewed from selected jurisdictions and stakeholder groups. CDC provides critical preparedness and response support to the dynamic network of clinical, commercial, and public health laboratories across the country, including those responsible for performing routine clinical testing, detecting biothreats, and preparing for and responding to public health emergencies.

In FY 2023, the more than 320,000 clinical and public health laboratories and testing locations that are certified under Clinical Laboratory Improvement Amendments of 1988 (CLIA) requirements conducted nearly 14.7 billion diagnostic laboratory tests. CDC develops and disseminates free and accessible data-driven laboratory guidance and trainings available to broad audiences, including under-resourced laboratories and those providing diagnostic services to populations that historically have been marginalized.

CDC employs a multifaceted approach to improve public health, patient outcomes, and health equity by advancing communications and training among laboratory systems:

- CDC's Laboratory Outreach Communication System (LOCS), which serves as a direct line of communication and source of technical support to clinical laboratories in the United States. During FY 2023 CDC used this system to send more than 100,000 health alerts and laboratory testing guidance notifications for Marburg, mpox, fungal meningitis, measles, and malaria outbreaks to clinical staff. CDC also uses this system for presenting monthly webinars, reaching an average of 700 trainees per month.
- CDC's OneLab™ platform, which supports CDC's free online training resources, courses, webinars, and tools, the clinical laboratory community of practice, and worldwide access to virtual reality training.



## Public Health Data Modernization Budget Request

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Modernizing public health data is a fundamental component of response readiness. Americans rely on CDC data on health threats to make day-to-day decisions on how to best protect themselves, their families, and communities from public health challenges, including seasonal respiratory viruses. Widespread transmission of respiratory syncytial virus and influenza could affect nearly every aspect of family life—from keeping children in school to planning holidays. While the U.S. invested tens of billions of dollars in interoperable health data exchange in the healthcare delivery system<sup>169</sup>, no comparable long-term national financial investment exists for public health.

Two major gaps exist across the nationwide public health system: the lack of standardization and interoperability; and the limitations of the core infrastructure. Data hasn't moved quickly because our systems do not use consistent standards. For example, if cellular phone companies hadn't created standards for exchanging phone calls, these calls could not be connected. The same is true for data exchange. To enable near real time core data exchange, we must invest in secure, standardized data and systems.

CDC will fund state, local, tribal, and territorial jurisdictions to build sustainable infrastructure so that they can receive and share data across systems and use it to inform public health actions. CDC will provide technical assistance and deploy CDC-developed tools to health departments to support necessary enhancements and avoid unnecessary modernization costs.

CDC will also upgrade its core data systems, which are leveraged across public health and require continuous modernization to benefit the nationwide ecosystem.

### Budget Request

CDC's FY 2025 budget request of **\$224,600,000** for the Public Health Data Modernization, including **\$182,900,000** from the Prevention and Public Health Fund (PPHF), is **\$49,600,000** above the FY 2023 final level.

Funding at this level will allow CDC to invest in more comprehensive real-time situational awareness capabilities for CDC, health departments, and other public health agencies. These resources will be used to improve shared core infrastructure, to provide continued support for data modernization to 64 directly funded STLT recipients of the Public Health Infrastructure Grant, and to provide larger awards and an increased number of recipients in the Strengthening Public Health Systems and Services in Indian Country program.

### **Funding for State, Local, Tribal, and Territorial Jurisdictions**

CDC will enhance the shared data infrastructure that CDC and state and local health departments rely on for real-time situational awareness and early warning of public health threats. CDC will also improve public health data systems that health departments depend on to manage and use data to understand and respond to public health needs in their communities. CDC will provide technical assistance to health departments for implementation of modernization efforts and harmonization across activities. CDC and its partners recognize the potential for capitalizing on improved collection and transmission of data within and across healthcare and public health systems. Ingestion, integration, and analysis of diverse and emerging data sources are giving decisionmakers vastly improved insight into major public health threats facing Americans today. These efforts align with the HHS Data Strategy priorities, including improving access to data, increasing data linkage, ensuring privacy protections, improving interagency information sharing, and enhancing the data workforce. The nation is at a critical turning point—an “all hands-on deck” moment with the opportunity to transform how we collect, use, and share data.

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<sup>169</sup> <https://cdo.hhs.gov/s/hhs-data-strategy>

## Improving Systems that Benefit All of Public Health

Because of modernization efforts, CDC has more data for decision-making, particularly across the core surveillance systems used by many CDC programs and public health partners, including the following examples:

- Using eCR reduces the clinical and administrative burden on healthcare providers when they switch from manual case reporting to electronic case reporting using eCR. The Oregon Community Health Information Network implemented eCR for 985 healthcare facilities, saving them approximately 145,000 staff hours or \$4.3 million over a one-year period.
- CDC built a new electronic pathway for COVID-19 laboratory-based diagnostic tests that has handled over one billion diagnostic test reports, reaching over 1.5 million per day, and is supporting reporting for mpox, allowing CDC to evaluate testing practices, assess percent positivity, and inform response.
- Advancements in interoperability of immunization information systems have improved national situational awareness. Data pipelines have allowed for aggregate reporting of over one billion COVID-19 vaccine doses and more than one million mpox vaccine doses.
- Modernization of vital records has yielded faster access to provisional birth and death data. For death data this includes high profile causes of death like drug overdoses, influenza, and COVID, allowing rapid data access for critical public health needs. Reports on excess deaths and life expectancy by race and Hispanic origin have been expanded and enhanced. CDC reduced lag time to releasing provisional death data to the public from months to days for many causes of death. Nearly 70 percent of deaths are reported electronically to CDC within 10 days. CDC is supporting states to implement bi-directional interoperability of electronic death registration systems with CDC to improve information exchange.
- CDC and the U.S. Digital Service developed SimpleReport early in the COVID-19 pandemic as a fast, easy, and free way to record COVID-19 test results and report them to state, tribal, local, and territorial public health jurisdictions. Since 2020, over 16,400 testing sites have registered and used SimpleReport to submit 7,862,797 COVID-19 test results to 37 state and local health departments.

## Bolstering CDC's Capabilities to Protect Health

Modernization efforts have bolstered CDC programs' capabilities to protect health through the migration to cloud-based storage and services, including increased use of enterprise-wide tools and services. The Enterprise Data, Analytics, and Visualization (EDAV) platform, a collection of cloud-based tools and services that enable in-depth data analysis and data visualization, is allowing CDC's scientists to catalog, analyze, and communicate findings faster, improving preparedness and response for conditions such as pertussis, influenza, tuberculosis, Lyme disease, drug overdose, suicide, cancer, and hazardous environmental exposures. CDC scientists use EDAV to model novel and emerging threats, such as the recent Ebola and mpox outbreaks.

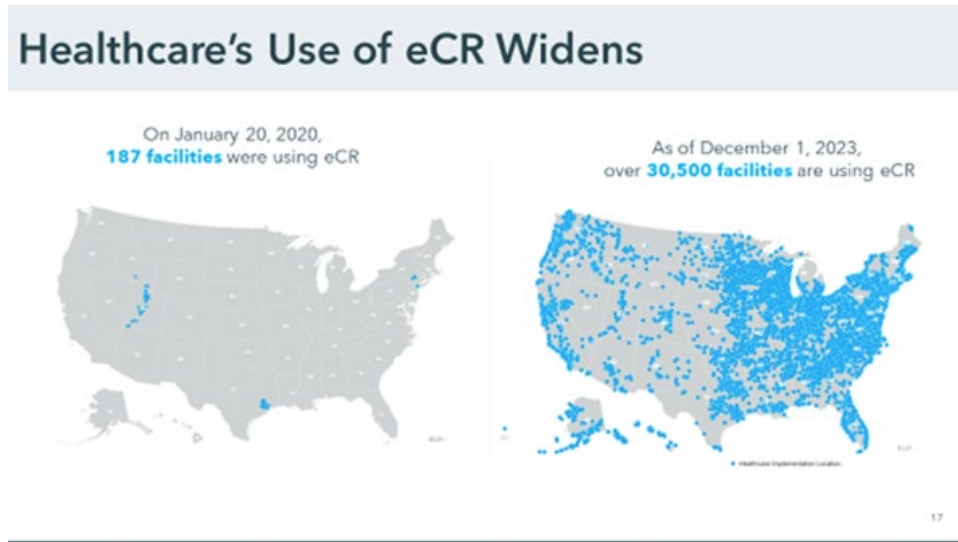
### Data Modernization Spotlight: Electronic Case Reporting

CDC has filled substantial data reporting and technology gaps through electronic case reporting (eCR) from healthcare providers to public health departments. As of December 1, 2023, there was a 163-fold increase in healthcare facilities (187 in 2020 to 30,500 in 2023) sending electronic case reports to public health departments in 50 states, DC, Puerto Rico, Guam, 15 locals, and one tribal public health agency using eCR. In 2023 alone, there was a 38 percent increase in healthcare facilities using eCR (22,000 to 30,500 facilities).

eCR reduces the clinical and administrative burden on both healthcare providers and health departments. For example, early industry analysis performed by one healthcare organization showed that using eCR saved an

average of \$660,000 in health care provider time over a one-year period compared with manually reporting cases for similar smaller-sized health care organizations (50-130 facilities).<sup>170</sup>

eCR also produces timelier, richer, and more complete data than traditional case reporting. One study showed that eCR improved data completeness from 45 percent for both race and ethnicity to 99 percent for race and 92 percent for ethnicity. The timeliness of eCR was less than one minute, whereas the median timeliness of health care provider report submissions to public health departments using manual case reporting was 5 days.<sup>171</sup>



eCR advances health equity by enabling public health departments to make timely data-driven decisions in under-resourced and socially marginalized communities. The number of tribal healthcare facilities reporting electronically through eCR increased 6.5-fold in 2023 from 45 to 291. Importantly, the first ever tribal public health authority was connected in 2023 and began receiving case reports electronically using eCR. Additionally, 27 percent of rural Critical Access Hospitals and 10 percent of Federally Qualified Health Center service sites, including look-alike sites, are using eCR. Continued investment will increase capacity and reduce burden in these communities.

The nationwide expansion of eCR use is improving the quality of public health data, reducing the clinical and administrative burden on healthcare and public health, and providing pandemic readiness for all Americans. Additional work remains to connect more health care organizations and public health departments to eCR infrastructure. Public health departments benefit from ongoing technical assistance to help maximize use their eCR data, and eCR can scale to efficiently include more reportable conditions.

Data modernization ensures public health gets the information needed to ensure that all people have an equal opportunity to attain the best health possible. To better serve Americans, CDC is making demographic data, such as race and ethnicity data, more complete and representative. CDC is addressing social and structural determinants of health by making geographic-linked data on causes of poor health outcomes available, better directing resources to address barriers to achieving the highest level of health. As CDC transforms public health data, advancements in analytics allow for real-time insights, enhancing capabilities to detect public health threats before they become emergencies. Through modernization, CDC envisions a future in which public health is response-ready, more equitable, and better at promoting wellness for all Americans.

<sup>170</sup> Industry data, unpublished.

<sup>171</sup> *Ibid.*

## Public Health Workforce Budget Request

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Public health agencies at all levels of the government, including federal, state, tribal, local, and territorial (STLT), understand that the workforce needs substantial changes to address long-standing vulnerabilities. Public health agencies and related organizations have lost thousands of jobs in the past decade. Between 2017 and 2021, a large proportion of the workforce left their positions in public health, including three-quarters of workers thirty-five and younger. If this trend holds, by 2025 more than 100,000 staff will leave their organizations—half of the U.S. governmental public health workforce.<sup>172</sup>

Losing the very people who led the way through several outbreaks and emergency responses, including the COVID pandemic, and who would lead the way through the next public health threat represents an incalculable loss in institutional knowledge and future leadership that would leave the nation vulnerable to public health threats large and small. [CDC fellowship and training programs](#) serve a pivotal role in training the public health leaders of today and tomorrow. A robust public health workforce is essential to responding to outbreaks and emergencies. Actions taken now to invest in developing the next generation of essential public health workers will better position our communities and the nation to safeguard Americans' health.

CDC strengthens the U.S. public health workforce through world-class public health fellowship and training programs like the [Epidemic Intelligence Service](#) (EIS), [Laboratory Leadership Service](#) (LLS), [Public Health Associate Program](#) (PHAP), and the [Public Health Informatics Fellowship Program](#) (PHIFP). These programs ensure broad access to training and educational resources for students and professionals, help identify and address workforce and recruitment gaps, and build foundational workforce capacity to prepare public health for future threats.

### Budget Request

CDC's FY 2025 budget request of **\$71,000,000** for Public Health Workforce is level with the FY 2023 final level. Funding will support current EIS, PHAP, and other CDC trainees to complete fellowship training.

In FY 2025, CDC will support STLT health departments through CDC fellowships, training programs, and technical guidance to assist in hiring and recruitment, identify and address public health workforce barriers and gaps, and build capacity to respond to current and future public health threats. CDC will continue to build a pathway for epidemiologists, laboratorians, data scientists, evaluators, prevention effectiveness specialists, and other public health professionals and leaders; increase the diversity of training program participants; and expand training-in-place programs for the existing public health workforce, such as the [CDC Data Science Upskilling program](#), to provide existing CDC staff a team-based foundation in data science.

As STLT health departments hire and onboard staff and achieve more sufficient staffing levels, the nation's public health system faces the critical task of training these public health professionals, so they are most effective. CDC provides training, including fellowship programs, and other resources broadly to public health professionals at no cost to STLT public health departments. CDC will maintain multi-disciplinary pathways into public health careers, including exploring strategies to increase and sustain the demographic diversity of CDC fellowship participants, and publishing training materials and STEM resources highlighting pathways to careers in public health. CDC will also continue to modernize public health workforce development data and analytics capacity, working with partners to access and facilitate rotation opportunities for university students at STLT public health agencies.

### **Support for State, Tribal, Local, and Territorial Health Departments**

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<sup>172</sup> Leider, J.P., et al. 2022. The Exodus of State and Local Public Health Employees: Separations Started Before And Continued Throughout COVID-19. *Health Affairs* 42(3); pp. 338-348. doi: 10.1377/hlthaff.2022.01251

CDC supports a national network of health departments, which work to provide accessible, timely, quality, and sustainable public health services that protect Americans' health and safety. These essential components of the nation's forefront of public health defense require tools, resources, and a sustainable, well-trained workforce to work better, faster, and smarter. CDC partners with STLT health departments throughout the country to build this workforce.

In FY 2023, 409 field trainees across six full-time fellowship programs were hosted in STLT health agencies. These public health trainees fill workforce gaps at STLT agencies, provide valuable clinical and scientific skills, and foster long-term relationships between the STLT agencies and CDC at minimal to no financial cost to the host site. These trainees support public health departments throughout the nation to investigate urgent public health problems, such as infectious or non-communicable disease outbreaks, unexplained illnesses, or natural or manmade disasters through on-site technical assistance by CDC trainees and subject matter experts.

CDC also bolsters the STLT public health workforce by providing continuing education and accredited learning opportunities to health professionals at no cost to them. In FY 2023, nearly 232,000 unique health professionals earned free continuing education close to 635,000 times, valued at an estimated \$10 million. CDC continues to offer training plans in [CDC TRAIN](#), an on-demand resource covering topics including health equity, communication skills, and data analytics, to build the proficiencies of new and current public health professionals using quality training standards.

### **Building Pathways to Careers in Public Health**

A [robust public health workforce](#)<sup>173</sup> ensures CDC has the capacity to address complex diseases and swiftly respond to new threats. To accomplish this, CDC must maintain and build a highly trained, cutting-edge, and flexible scientific and programmatic workforce, and support the development of such a workforce at every level of government. CDC provides pathways to long-term careers in public health at the federal level and among STLT jurisdictions. To build pathways into public health, CDC develops educational resources to teach science, technology, engineering, and math (STEM) students about public health, epidemiology, and related careers and offers dynamic educational development opportunities and resources to help STEM teachers and other educators bring public health sciences into middle- and high-school classrooms (STEM@CDC). Using COVID supplemental appropriations, CDC funded the Public Health AmeriCorps as part of a historic partnership with AmeriCorps to build the capacity of a strained public health system and create entry-level pathways into public health. By the end of 2023, the Public Health AmeriCorps program had enrolled 3,600 members in 104 organizations across the country.

CDC also works to upskill its current workforce and drive innovation by training leaders to use applied modeling and analytics to translate data into evidence and support public health decision-making at STLT health departments. For example, among those who graduated from one of CDC's seven career fellowship programs (EIS, Laboratory Leadership Service, PHAP, Public Health Informatics Fellowship Program, the [Presidential Management Fellowship](#), [Prevention Effectiveness Fellowship](#), and [Future Leaders in Global Health Threats Fellowship](#)) in 2023, 81.6 percent continued with public health employment or training, demonstrating strong retention in their fields. These graduates are uniquely prepared to integrate non-infectious diseases, injuries, birth defects and disabilities, and environmental health data into science, policies, and programs across CDC and within the broader STLT public health communities to build health security, reduce health disparities, and create better health for all.

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<sup>173</sup> <https://www.cdc.gov/workforce/>

**State Table: National Notifiable Diseases Surveillance System (NNDSS) Grants<sup>1,2</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$248,435	\$248,435	TBD	TBD
Alaska	\$174,546	\$174,546	TBD	TBD
Arizona	\$236,114	\$236,114	TBD	TBD
Arkansas	\$121,446	\$121,446	TBD	TBD
California	\$280,265	\$280,265	TBD	TBD
Colorado	\$184,081	\$184,081	TBD	TBD
Connecticut	\$202,137	\$202,137	TBD	TBD
Delaware	\$104,503	\$104,503	TBD	TBD
District of Columbia	\$131,457	\$131,457	TBD	TBD
Florida	\$259,419	\$259,419	TBD	TBD
Georgia	\$150,846	\$150,846	TBD	TBD
Hawaii	\$189,694	\$189,694	TBD	TBD
Idaho	\$84,595	\$84,595	TBD	TBD
Illinois	\$319,188	\$319,188	TBD	TBD
Indiana	\$224,009	\$224,009	TBD	TBD
Iowa	\$297,924	\$297,924	TBD	TBD
Kansas	\$292,293	\$292,293	TBD	TBD
Kentucky	\$106,407	\$106,407	TBD	TBD
Louisiana	\$123,538	\$123,538	TBD	TBD
Maine	\$143,341	\$143,341	TBD	TBD
Maryland	\$211,582	\$211,582	TBD	TBD
Massachusetts	\$299,581	\$299,581	TBD	TBD
Michigan	\$200,298	\$200,298	TBD	TBD
Minnesota	\$256,004	\$256,004	TBD	TBD
Mississippi	\$103,291	\$103,291	TBD	TBD
Missouri	\$100,756	\$100,756	TBD	TBD
Montana	\$172,176	\$172,176	TBD	TBD
Nebraska	\$154,650	\$154,650	TBD	TBD
Nevada	\$199,003	\$199,003	TBD	TBD
New Hampshire	\$155,255	\$155,255	TBD	TBD
New Jersey	\$233,366	\$233,366	TBD	TBD
New Mexico	\$182,685	\$182,685	TBD	TBD
New York	\$293,330	\$293,330	TBD	TBD
North Carolina	\$219,807	\$219,807	TBD	TBD
North Dakota	\$109,492	\$109,492	TBD	TBD
Ohio	\$303,425	\$303,425	TBD	TBD
Oklahoma	\$147,862	\$147,862	TBD	TBD
Oregon	\$210,332	\$210,332	TBD	TBD
Pennsylvania	\$316,380	\$316,380	TBD	TBD
Rhode Island	\$166,005	\$166,005	TBD	TBD
South Carolina	\$169,739	\$169,739	TBD	TBD
South Dakota	\$127,434	\$127,434	TBD	TBD
Tennessee	\$177,742	\$177,742	TBD	TBD
Texas	\$60,324	\$60,324	TBD	TBD
Utah	\$342,218	\$342,218	TBD	TBD
Vermont	\$119,774	\$119,774	TBD	TBD
Virginia	\$299,574	\$299,574	TBD	TBD
Washington	\$248,426	\$248,426	TBD	TBD
West Virginia	\$127,458	\$127,458	TBD	TBD
Wisconsin	\$223,622	\$223,622	TBD	TBD

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
<b>Territories</b>				
Guam	\$78,866	\$78,866	TBD	TBD
Marshall Islands	\$39,376	\$39,376	TBD	TBD
Micronesia	\$12,305	\$12,305	TBD	TBD
Northern Mariana Islands	\$123,779	\$123,779	TBD	TBD
Palau	\$3,445	\$3,445	TBD	TBD
Puerto Rico	\$37,524	\$37,524	TBD	TBD
Virgin Islands	\$23,564	\$23,564	TBD	TBD
American Samoa	\$3,445	\$3,445	TBD	TBD
<b>Cities</b>				
Chicago	\$9,672	\$9,672	TBD	TBD
Houston	\$159,719	\$159,719	TBD	TBD
Los Angeles	\$171,627	\$171,627	TBD	TBD
New York City	\$302,813	\$302,813	TBD	TBD
Philadelphia	\$155,877	\$155,877	TBD	TBD
<b>Subtotal States</b>	<b>\$9,757,615</b>	<b>\$9,757,615</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Territories</b>	<b>\$347,169</b>	<b>\$347,169</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Cities</b>	<b>\$931,165</b>	<b>\$931,165</b>	<b>TBD</b>	<b>TBD</b>
<b>Total Resources</b>	<b>\$11,035,949</b>	<b>\$11,035,949</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup>This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <https://www.cdc.gov/funding/funding-profiles/>.

<sup>2</sup> CFDA Number:93.323 [Discretionary]

**State Table: Behavioral Risk Factor Surveillance System (BRFSS) Grants<sup>1,2,3</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$370,500	\$370,500	TBD	TBD
Alaska	\$437,885	\$437,885	TBD	TBD
Arizona	\$411,000	\$411,000	TBD	TBD
Arkansas	\$362,976	\$362,976	TBD	TBD
California	\$609,282	\$609,282	TBD	TBD
Colorado	\$421,479	\$421,479	TBD	TBD
Connecticut	\$441,566	\$441,566	TBD	TBD
Delaware	\$474,954	\$474,954	TBD	TBD
District of Columbia	\$451,479	\$451,479	TBD	TBD
Florida	\$460,000	\$460,000	TBD	TBD
Georgia	\$433,232	\$433,232	TBD	TBD
Hawaii	\$432,744	\$432,744	TBD	TBD
Idaho	\$413,962	\$413,962	TBD	TBD
Illinois	\$455,000	\$455,000	TBD	TBD
Indiana	\$689,051	\$689,051	TBD	TBD
Iowa	\$361,244	\$361,244	TBD	TBD
Kansas	\$442,290	\$442,290	TBD	TBD
Kentucky	\$385,236	\$385,236	TBD	TBD
Louisiana	\$253,488	\$253,488	TBD	TBD
Maine	\$412,047	\$412,047	TBD	TBD
Maryland	\$590,089	\$590,089	TBD	TBD
Massachusetts	\$441,380	\$441,380	TBD	TBD
Michigan	\$625,544	\$625,544	TBD	TBD
Minnesota	\$445,439	\$445,439	TBD	TBD
Mississippi	\$396,479	\$396,479	TBD	TBD
Missouri	\$440,000	\$440,000	TBD	TBD
Montana	\$387,452	\$387,452	TBD	TBD
Nebraska	\$390,000	\$390,000	TBD	TBD
Nevada	\$442,000	\$442,000	TBD	TBD
New Hampshire	\$680,343	\$680,343	TBD	TBD
New Jersey	\$582,500	\$582,500	TBD	TBD
New Mexico	\$614,104	\$614,104	TBD	TBD
New York	\$540,000	\$540,000	TBD	TBD
North Carolina	\$372,566	\$372,566	TBD	TBD
North Dakota	\$441,479	\$441,479	TBD	TBD
Ohio	\$427,336	\$427,336	TBD	TBD
Oklahoma	\$314,886	\$314,886	TBD	TBD
Oregon	\$499,907	\$499,907	TBD	TBD
Pennsylvania	\$450,000	\$450,000	TBD	TBD
Rhode Island	\$487,533	\$487,533	TBD	TBD
South Carolina	\$534,968	\$534,968	TBD	TBD
South Dakota	\$434,606	\$434,606	TBD	TBD
Tennessee	\$301,568	\$301,568	TBD	TBD
Texas	\$430,000	\$430,000	TBD	TBD
Utah	\$541,879	\$541,879	TBD	TBD
Vermont	\$444,433	\$444,433	TBD	TBD
Virginia	\$425,979	\$425,979	TBD	TBD
Washington	\$420,000	\$420,000	TBD	TBD
West Virginia	\$467,979	\$467,979	TBD	TBD
Wisconsin	\$550,100	\$550,100	TBD	TBD



	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Wyoming	\$368,775	\$368,775	TBD	TBD
<b>Territories</b>				
America Samoa	\$252,676	\$252,676	TBD	TBD
Guam	\$405,425	\$405,425	TBD	TBD
Micronesia	\$125,500	\$125,500	TBD	TBD
Puerto Rico	\$432,049	\$432,049	TBD	TBD
Virgin Islands	\$201,447	\$201,447	TBD	TBD
<b>Subtotal States</b>	<b>\$23,208,739</b>	<b>\$23,208,739</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Territories</b>	<b>\$1,417,097</b>	<b>\$1,417,097</b>	<b>TBD</b>	<b>TBD</b>
<b>Total Resources</b>	<b>\$24,625,836</b>	<b>\$24,625,836</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup>This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

<sup>2</sup>Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs. These funds are not awarded by formula.

<sup>3</sup>CFDA Number: 93-336 [Discretionary]

**Behavioral Risk Factor Surveillance System (BRFSS) Grants<sup>1,2,3</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$316,380	\$370,000	\$370,000	\$0
Alaska	\$435,000	\$385,000	\$385,000	\$0
Arizona	\$430,000	\$386,000	\$386,000	\$0
Arkansas	\$355,500	\$335,000	\$335,000	\$0
California	\$425,000	\$390,000	\$390,000	\$0
Colorado	\$430,000	\$395,000	\$395,000	\$0
Connecticut	\$450,087	\$392,000	\$392,000	\$0
Delaware	\$425,496	\$370,000	\$370,000	\$0
District of Columbia	\$440,000	\$385,000	\$385,000	\$0
Florida	\$425,000	\$395,000	\$395,000	\$0
Georgia	\$455,610	\$350,000	\$350,000	\$0
Hawaii	\$425,468	\$370,000	\$370,000	\$0
Idaho	\$423,994	\$390,000	\$390,000	\$0
Illinois	\$435,760	\$350,000	\$350,000	\$0
Indiana	\$425,000	\$390,000	\$390,000	\$0
Iowa	\$402,997	\$380,000	\$380,000	\$0
Kansas	\$430,811	\$390,000	\$390,000	\$0
Kentucky	\$403,757	\$390,000	\$390,000	\$0
Louisiana	\$430,731	\$390,000	\$390,000	\$0
Maine	\$405,568	\$335,000	\$335,000	\$0
Maryland	\$429,946	\$390,000	\$390,000	\$0
Massachusetts	\$429,901	\$390,000	\$390,000	\$0
Michigan	\$421,836	\$375,272	\$375,272	\$0
Minnesota	\$445,439	\$385,000	\$385,000	\$0
Mississippi	\$431,000	\$390,000	\$390,000	\$0
Missouri	\$431,000	\$390,000	\$390,000	\$0
Montana	\$431,000	\$390,000	\$390,000	\$0
Nebraska	\$430,982	\$390,000	\$390,000	\$0
Nevada	\$400,000	\$405,000	\$405,000	\$0
New Hampshire	\$450,382	\$392,001	\$392,001	\$0
New Jersey	\$430,000	\$390,000	\$390,000	\$0
New Mexico	\$430,962	\$390,000	\$390,000	\$0
New York	\$430,000	\$405,000	\$405,000	\$0
North Carolina	\$431,566	\$390,000	\$390,000	\$0
North Dakota	\$430,000	\$390,000	\$390,000	\$0
Ohio	\$425,990	\$390,000	\$390,000	\$0
Oklahoma	\$410,451	\$380,629	\$380,629	\$0
Oregon	\$470,339	\$392,000	\$392,000	\$0
Pennsylvania	\$415,000	\$390,000	\$390,000	\$0
Rhode Island	\$377,054	\$340,000	\$340,000	\$0
South Carolina	\$430,000	\$390,000	\$390,000	\$0
South Dakota	\$325,738	\$296,346	\$296,346	\$0
Tennessee	\$421,063	\$299,419	\$299,419	\$0
Texas	\$430,000	\$390,000	\$390,000	\$0
Utah	\$425,000	\$335,000	\$335,000	\$0
Vermont	\$462,954	\$385,000	\$385,000	\$0
Virginia	\$370,000	\$370,000	\$370,000	\$0
Washington	\$420,000	\$390,000	\$390,000	\$0
West Virginia	\$415,000	\$390,000	\$390,000	\$0
Wisconsin	\$440,100	\$390,000	\$390,000	\$0
Wyoming	\$349,382	\$290,330	\$290,330	\$0

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
<b>Territories</b>				
America Samoa	\$80,000	\$125,000	\$125,000	\$0
Guam	\$345,243	\$270,000	\$270,000	\$0
Micronesia	\$70,000	\$125,000	\$125,000	\$0
Puerto Rico	\$425,068	\$360,000	\$360,000	\$0
Virgin Islands	\$150,080	\$125,000	\$125,000	\$0
<b>Subtotal States</b>	<b>\$21,414,244</b>	<b>\$19,218,997</b>	<b>\$19,218,997</b>	<b>\$0</b>
<b>Subtotal Territories</b>	<b>\$1,070,391</b>	<b>\$1,005,000</b>	<b>\$1,005,000</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$22,484,635</b>	<b>\$20,223,997</b>	<b>\$20,223,997</b>	<b>\$0</b>

<sup>1</sup>This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

<sup>2</sup>Table includes core funding from the Surveillance, Epidemiology, and Public Health Informatics budget activity and other CDC programs. These funds are not awarded by formula.

<sup>3</sup>CFDA Number: 93-336 [Discretionary]

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## ENVIRONMENTAL HEALTH

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$229.850	\$229.850	\$249.850	+\$20.000
Prevention and Public Health Fund	\$17.000	\$17.000	\$17.000	\$0
<b>Total Request</b>	<b>\$246.850</b>	<b>\$246.850</b>	<b>\$266.850</b>	<b>+\$20.000</b>
FTEs	483	510	517	34
-- Environmental Health Laboratory	\$70.750	\$70.750	\$70.750	\$0
-- <i>Newborn Screening Quality Assurance Program (non-add)</i>	\$21.000	\$21.000	\$21.000	\$0
-- <i>Newborn Screening for Severe Combined Immuno. Diseases (non-add)</i>	\$1.250	\$1.250	\$1.250	\$0
-- Environmental Health Activities	<u>\$52.600</u>	<u>\$52.600</u>	<u>\$62.600</u>	<u>+\$10.000</u>
-- Environmental Health Capacity <sup>1</sup>	\$39.600	\$39.600	\$49.600	+\$10.000
-- <i>Climate and Health (non-add)</i>	\$10.000	\$10.000	\$20.000	+\$10.000
-- Amyotrophic Lateral Sclerosis Registry (ALS)	\$10.000	\$10.000	\$10.000	\$0
-- Trevor's Law	\$3.000	\$3.000	\$3.000	\$0
-- Environmental and Health Outcome Tracking Network	\$34.000	\$34.000	\$34.000	\$0
-- Asthma	\$33.500	\$33.500	\$33.500	\$0
-- Lead Exposure Registry	\$5.000	\$5.000	\$5.000	\$0
-- Childhood Lead Poisoning Prevention	<u>\$51.000</u>	<u>\$51.000</u>	<u>\$61.000</u>	<u>+\$10.000</u>
-- Childhood Lead Poisoning Prevention - BA	\$34.000	\$34.000	\$44.000	+\$10.000
-- <i>Childhood Lead Poisoning Prevention (PPHF)</i>	<u>\$17.000</u>	<u>\$17.000</u>	<u>\$17.000</u>	<u>\$0</u>

<sup>1</sup> FY 2023 and FY 2024 Levels are comparably adjusted to reflect proposed realignment of All Other Environmental Health and Safe Water into Environmental Health Capacity and to display Climate and Health as a non-add line under Environmental Health Capacity.

**Enabling Legislation Citation:** PHSA § 301, PHSA § 307, PHSA § 310, PHSA § 311, PHSA § 317, PHSA § 317A\*, PHSA § 317B, PHSA § 317I\*, PHSA § 317O\*, PHSA § 327, PHSA § 352, PHSA § 361, PHSA § 366, PHSA § 399S, PHSA § 399V-6 (42 U.S. Code § 280g–17), PHSA § 1102, PHSA § 1706\*, 42 U.S.C. Section 300j-27(b)\*, 42 U.S.C. Section 300u-11.

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural, Contracts, Competitive Grants/Cooperative Agreements

CDC helps protect Americans from health effects resulting from environmental hazards in air, water, food, and soil. The World Health Organization (WHO) estimates that, overall, 13 percent of the disease burden in the United States is due to environmental factors. The WHO also estimates that 5.6 million disability-adjusted life years and 398,000 deaths annually can be attributed to environmental factors in the United States.<sup>174</sup>

CDC prevents health effects from exposure to environmental hazards through four core strategies:

1. Partnering with state, local, territorial health departments, tribal nations, and national and local organizations to provide expertise, guidance, and support aimed at increasing environmental public health capacity to reduce harmful environmental exposures and implement effective environmental public health prevention programs and interventions.
2. Monitoring and investigating environmental public health threats and their health effects through public health data surveillance and analytics; conducting laboratory analyses and environmental exposure and health studies; and championing informatics for data-driven decisions to improve health outcomes.
3. Monitoring and responding to extreme weather events—from hurricanes and floods to wildfires and extreme heat—and building appropriate public health response capacity within state, local, territorial, and tribal communities.

<sup>174</sup> Pugh, KH and Zarus, GM. (2012). The Burden of Environmental Disease in the United States. Journal of Env. Health. Volume 74, Number 9.

4. Improving guidance, education, and implementation of best practices to prevent and reduce the effects of the environment on health through research, evaluation, and translation of the highest quality scientific findings into an expanded environmental health evidence base.

CDC's FY 2025 budget request of **\$266,850,000** for Environmental Health is **\$20,000,000** above the FY 2023 final level and includes **\$17,000,000** from the Prevention and Public Health Fund, which is level with the FY 2023 final level. This request includes resources for the Childhood Lead Poisoning Prevention Program to improve blood lead level surveillance and reporting, which will support the early detection of childhood lead exposures, and for the Lead-Free Communities initiative to eliminate lead exposure and its associated negative health effects in communities across the United States. The FY 2025 request also provides resources to fund a pilot program to provide portable High Efficiency Particulate Air (HEPA) filtration units for socially vulnerable homes in communities most affected by exposure to wildfire smoke, and to better understand the feasibility and health impact of providing such units.

## ENVIRONMENTAL HEALTH

### BY THE NUMBERS

- **37**—Number of states (including DC and Puerto Rico) that have implemented CDC’s updated blood reference value, published in October 2021, allowing health departments to focus resources on children with higher levels of lead in their blood compared to most children.
- **46%**—Reduction in emergency department visits since 2015 for children with asthma in the southeast region of New Mexico, where the CDC-funded New Mexico Asthma Control Program (NMACP) has partnered with a hospital to provide an Asthma Self-Management Education referral program.
- **701**—Laboratories in 50 states and 88 countries that are directly benefiting from CDC’s newborn screening quality assurance activities. These services are vital to ensuring the early and accurate identification of babies born with life-threatening or disabling conditions.
- **100%**—As of July 2023, elimination of the U.S. weapons stockpile and a major public health threat for communities, the United States, and the world. CDC’s Chemical Demilitarization Program helped the Department of Defense safely destruct 33,000 tons of chemical weapons.
- **6**—Types of cancer that CDC’s Environmental Public Health Tracking Network created cancer indicators for using population-based geographies. This is the first federal release of cancer incidence data at this geographic level and allows public health practitioners and others to identify areas with elevated cancer rates at geographies smaller than the county level, improving the targeting of public health interventions such as cancer screenings.

<b>Environmental Health Funding History</b>	
Fiscal Year	Dollars (in millions)
FY 2021 (BA)	\$205.218
FY 2021 (PPHF)	\$17.000
FY 2022 (BA)	\$209.850
FY 2022 (PPHF)	\$17.000
FY 2023 Final (BA)	\$229.850
FY 2023 Final (PPHF)	\$17.000
FY 2024 CR (BA)	\$229.850
FY 2024 CR (PPHF)	\$17.000
FY 2025 President’s Budget (BA)	\$249.850
FY 2025 President’s Budget (PPHF)	\$17.000

## Childhood Lead Poisoning Prevention Budget Request

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Lead exposure can cause adverse effects in nearly every system in the body and seriously harm a child's health. Even at low levels, lead exposure has the potential to affect growth and development, hearing and speech, IQ, academic achievement, and behavior. Public health initiatives to reduce environmental exposures to lead have caused steady blood lead level (BLL) decreases among the U.S. population, including children. Average BLLs in children less than six have decreased approximately 94 percent from the late 1970s. However, nearly 29 million U.S. homes contain at least one lead hazard, and over 10 million U.S. homes rely on lead-containing service lines to carry water from municipal sources into family dwellings, putting large numbers of children at risk for lead exposure. Risk varies greatly due to the distribution of lead hazards in the environment and other risk factors in the population, with children from lower income and racial and ethnic minority households experiencing higher risk. An analysis from the Health Impact Project estimates that eliminating lead hazards from the places where children live, learn, and play could generate approximately \$84 billion in long-term benefits per birth cohort. Additionally, permanently removing lead hazards from the environment would benefit future birth cohorts, compounding savings over time.

### Budget Request

CDC's FY 2025 budget request of **\$61,000,000** for Childhood Lead Poisoning Prevention is **\$10,000,000** above the FY 2023 final level. This request includes **\$17,000,000** from the Prevention and Public Health Fund (PPHF).

In FY 2025, CDC will continue to support childhood lead poisoning prevention activities in state, local, tribal, and affiliated territorial jurisdictions and continue expanding opportunities for capacity building. CDC will use part of the FY 2025 increase of \$10 million to provide additional resources for childhood lead poisoning surveillance and reporting. CDC will also use up to \$4.6 million of the increase to expand its Lead-Free Communities (LFC) initiative, a community-based effort to further support communities with the highest need to an additional 23 community recipients. LFC provides funds directly to underserved communities with a higher proportion of older housing and other risk factors for lead exposure to effectively conduct lead poisoning prevention education and outreach.

### Program Accomplishments

- The CDC-funded North Carolina Childhood Lead Poisoning Surveillance Program discovered the cause of a nationwide lead poisoning outbreak linked to cinnamon applesauce pouches. Their work began the chain of events that has led to the removal of the product from retailers around the world and the identification of more than 300 cases from 38 states.
- The Colorado CLPPP developed a statistical tool in 2020 to detect changes in the rates of higher BLLs in children. In April 2022, the tool helped the Colorado CLPPP detect a cluster of 38 children with BLLs at or above CDC's blood lead reference value among refugees/newcomers. The Colorado CLPPP worked quickly to connect with the state refugee health program to ensure the appropriate steps were taken for follow-up care.
- To increase the number of children tested for lead poisoning, the Salt Lake County Health Department provided participating clinics with a point of care analyzer, education, and help with creating and implementing policies and workflows. As a result, three participating clinics had a 260 percent increase in capillary blood tests and a 405 percent increase in venous testing.
- New Hampshire developed a children's board book, [Happy, Healthy, Lead-Free Me!](#) to educate families on lead poisoning prevention and the importance of blood lead testing in children, distributing 13,000 books to pediatricians statewide for them to provide to children at the 9-month well child checkup appointments. New Hampshire's Women, Infant and Children program and Maternal and Child Health Program also purchased 14,000 books for distribution to young children through their community-based programs. The book is available to download from the webpage in seven additional languages.



CDC’s Childhood Lead Poisoning Prevention Program (CLPPP) reduces the number of children exposed to lead and eliminates BLL disparities. Currently, CDC funds 62 states and localities to address critical gaps in services. CDC funding and guidance have enabled substantial local interventions, ultimately improving the physical and socioeconomic health of communities. All funding recipients support blood lead testing and reporting, analyzing and disseminating data to track trends and identify risk hot spots, linking lead-exposed children to services, and implementing tailored, community-based interventions.

CDC’s CLPPP also conducts research to identify and evaluate best practices in lead poisoning prevention; develops case management guidelines and other documents to assist health departments and healthcare providers; provides technical assistance to states to develop, implement, and evaluate local lead poisoning prevention activities; provides training and education materials for public health professionals, providers, and others; and maintains the Childhood Blood Lead Surveillance System used by state and local health departments for blood lead surveillance, case management activities, and reporting data to CDC. These activities are essential for an evidence-based and coordinated approach for eliminating childhood lead poisoning within the United States.

In FY 2023, CDC initiated The Lead Detect Prize on challenge.gov to develop a portable, simple-to-use, and affordable point-of-care system to detect very low concentrations of lead in blood to address the need for reliable and effective technology for blood lead sampling and analyses. This innovation challenge will award prizes to researchers and innovators who submit concepts and development plans for advanced point-of-care blood lead tests.

CDC is also supporting the Lead-Free Communities (LFC) Initiative, an effort to eliminate lead exposure and its associated negative health effects in communities across the United States. In FY 2023, CDC funded 11 community-based organizations to help families avoid the dangers of lead in their homes through community engagement, prevention education, and family support. The LFC Initiative offers a unique, comprehensive, multi-sector approach for encouraging and supporting communities to collaboratively develop and implement a customized plan to become lead-free and provides communities access to a national network of resources and subject matter experts. CDC expects to launch an interactive toolkit to help communities develop action plans and budgets for becoming lead free.

CDC supports the Flint Lead Exposure Registry, a model for the nation’s first lead-free city and support for the Flint community. In FY 2022, CDC awarded Michigan State University a second five-year grant to continue community, tribal, and stakeholder outreach and training; registrant enrollment via targeted outreach; data collection; referral of registrants to services to reduce or control lead exposure effects; measurement of registrants’ exposure, health, developmental milestones with their interventions, services, and enrichment activities; cohort maintenance of enrolled participants; and evaluation and dissemination of findings to share best practices. As of October 2023, over 21,600 people had been fully enrolled in the Flint Registry.

**Childhood Lead Poisoning Prevention Grants<sup>1</sup>**

(dollars in millions)	<b>FY 2023</b>	<b>FY 2024</b>	<b>FY 2025</b>
	<b>Final</b>	<b>CR</b>	<b>President’s Budget</b>
Number of Awards	73	73	96
- New Awards	11	0	23
- Continuing Awards	62	73	73
Average Award	\$0.500	\$0.500	\$0.500
Range of Awards	\$0.200-0.750	\$0.200-0.750	\$0.200-0.750
<b>Total Awards</b>	<b>\$36.000</b>	<b>\$36.000</b>	<b>\$40.600</b>

<sup>1</sup> These funds are not awarded by formula.

## **Environmental and Health Outcome Tracking Network Budget Request**

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CDC's National Environmental and Health Outcome Tracking Network (Tracking Network) provides innovative programs and solutions that empower people to make information-driven decisions to protect and improve health. By providing timely, accurate, standardized, and accessible data through a Web-based system that delivers data in a variety of ways, the Tracking Network serves different needs of users and informs decision making at local, state, and national levels.

The Tracking Network's interactive Data Explorer has over 770 environmental and health measures that users can utilize to create maps, charts, and tables. For example, data are available regarding air quality, radon, asthma, and birth defects. The Tracking Network also has a data visualization embedding feature, which allows anyone to embed a fully interactive map, chart, or table into their own website.

CDC collaborates with other federal agencies and state and local health departments to increase the quality and availability of data sources; improve the utilization of Tracking Network data to protect the health of Americans; and address data gaps in the areas of environmental health. By allowing users to seamlessly pair disparate data sources to identify communities that are disproportionately affected by environmental factors, the Tracking Network enables public health professionals to discover environmental health trends that may otherwise go unnoticed.

The Tracking Network data science experts has prepared the public health workforce of the future by expanding health departments' capacity in data collection, analytics, reporting, and dissemination. The Tracking Network experts have developed innovative analytic methods that facilitate broad visibility into public health insights and trends at the census tract level that were previously only accessible to a few data scientists and researchers.

### Budget Request

CDC's FY 2025 budget request of **\$34,000,000** for CDC's Environmental and Health Outcome Tracking Network is level with the FY 2023 final level. CDC's Tracking Network will continue to focus on capacity building for current state/local tracking recipients to improve public health data infrastructure, and ensure that data science, tools, and expertise are used across the United States to drive public health action. The Tracking Network will also continue to advance CDC's data modernization priorities by partnering with other agency programs to enhance disease surveillance by incorporating environmental health data; making practical advancements in data science to provide better and more efficient methods to improve public health; collaborating with non-traditional partners to uncover new insights and drive environmental health decision-making in new sectors; and using cutting edge data visualization tools and products to address and respond to existing and emerging public health crises.

### Program Accomplishments

- CDC created cancer indicators that use its Environmental Public Health Tracking Network's new population-based geographies—the first federal release of cancer incidence data at this geographic level. This allows public health practitioners and others to identify areas with elevated cancer rates at geographies smaller than the county level, improving the targeting of public health interventions such as cancer screenings. Data are currently available on six cancer types (lung, female breast, prostate, colorectal, kidney, and melanoma) from 27 cancer registries. Additional cancer types (kidney, pancreatic, thyroid, bladder, leukemia, and oral and pharynx) will be added soon.
- To help address the issues with national radon data, the Tracking Network developed indicators and measures to track, visualize, and monitor radon levels across the country. Radon is the second leading cause of lung cancer in the United States and is present in every state. Knowing where radon levels are high can help public health professionals' direct resources to people most at risk for radon exposure. However, radon data is often limited, outdated, or not easily accessible. The Tracking Network continues

to expand their collection of radon data and makes the data publicly available through their Data Explorer. Today, the Tracking Network hosts the most comprehensive radon testing dataset in the nation.

**Responding to Public Health Crises**

Access to timely, accurate data is vital to making decisions quickly during an emergency. The number of reported heat-related deaths in the United States has been increasing. The Tracking Network powers CDC’s Heat and Health Tracker which delivers user-friendly, real-time local-level heat and health data that can be used to inform decisions and public health actions related to heat. For example, county-level information on expected number of days at or above a dangerous heat level for public health can help health departments and emergency planners identify the needs of disproportionately affected populations and take appropriate actions. During ongoing heatwaves, this timely health information provides critical situational awareness to deploy resources and supports communities most impacted by extreme heat.

**Capacity Building: Improving State/Local Public Health Infrastructure**

CDC funds 33 state or local tracking programs through competitive cooperative agreements to create, maintain, and add to their own local tracking networks, as well as to contribute to and receive data from the national Tracking Network. According to the Council for State and Territorial Epidemiologists, less than half of all states report having adequate environmental epidemiology capacity. CDC helps maintain vital environmental health surveillance and epidemiology capacity—saving time, money, and resources—by supporting over 250 state personnel and facilitating a mentoring program with current and potential recipients. For example, Minnesota’s Tracking Program estimates that its public health data website saves the state \$3.6 million per year in staff time by making data publicly available and reducing the number of public data inquiries the state must process. Additionally, the infrastructure and expertise developed by the Tracking Program has enabled CDC’s Tracking Network to serve as the primary surveillance data platform in 17 state health departments.

**Tracking Network Grants<sup>1</sup>**

(dollars in millions)	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President’s Budget</b>
Number of Awards	33	33	33
- New Awards	33	0	0
- Continuing Awards	0	33	33
Average Award	\$0.606	\$0.606	\$0.606
Range of Awards	\$0.300-0.710	\$0.300-0.710	\$0.300-0.710
Total Awards	\$19.998	\$19.998	\$19.998

<sup>1</sup>These funds are not awarded by formula.

## Environmental Health Laboratory Budget Request

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CDC's Environmental Health Laboratory improves the detection, diagnosis, treatment, and prevention of diseases resulting from exposure to harmful environmental chemicals and diseases needing advanced laboratory measurement for accurate diagnosis. The lab is recognized worldwide for its expertise in measurement science. It develops and applies innovative techniques to assess disease risk, determines exposure levels among the U.S. population, and responds rapidly to public health emergencies. It also supports state public health laboratories in assessing harmful exposures in their communities and works directly with state newborn screening programs to implement and ensure accurate tests for early detection of diseases that cause severe disability or death when untreated. In addition, the lab harmonizes tests for chronic diseases to ensure results are accurate and precise for diagnosing disease, guiding treatment and prevention, and supporting high-quality health research.

### Budget Request

CDC's FY 2025 budget request of **\$70,750,000** for the Environmental Health Laboratory is level with the FY 2023 final level. The total request includes **\$21,000,000** for the Newborn Screening Quality Assurance Program and **\$1,250,000** for the Newborn Screening for Severe Combined Immunodeficiency Diseases. In FY 2025, CDC will continue to maintain its state-of-the-art public health laboratory—delivering the unique diagnostic methods, profiles of measurements, and measurement quality needed for public health decisions.

### Program Accomplishments

- CDC provided dried blood spot quality assurance materials to 701 newborn screening laboratories in 88 countries worldwide, covering the core and secondary conditions on the Recommended Uniform Screening Panel (RUSP). These services are vital to ensuring the early and accurate identification of babies born with life-threatening or disabling conditions.
- CDC analyzed nearly 5,000 samples for per- and polyfluoroalkyl substances (PFAS) in 2023 for the PFAS Multi-site Health Study (MSS). The study provides information to communities about the health effects of exposure to PFAS. Information learned from the MSS will help all communities in the United States who have been exposed to PFAS through drinking water. Over 1,300 of these samples were received in October or later, with analyses completed by mid-December.
- As part of the newly modernized National Report on Human Exposure to Environmental Chemicals, CDC published the first nationally representative exposure data for glyphosate, the most widely used herbicide in the world, and made substantial updates to data for ethylene oxide, a chemical sterilizer.
- CDC developed a new sensitive method for measuring biotin in human serum that will allow for the assessment of biotin status in the U.S. population and will provide new insights on how biotin levels affect the reliability of certain clinical immunoassays, like COVID-19 antibody tests.

### **Using Biomonitoring to Assess Americans' Exposure to Harmful Chemicals and Their Nutrition Status**

CDC uses biomonitoring—measurements of chemicals or their metabolites in human blood and urine—to help identify harmful environmental exposures or nutrition deficiencies among the U.S. population. The Environmental Health Laboratory measures more than 400 chemical biomarkers, including a subset of PFAS compounds, and nutrition indicators in samples from participants in the National Health and Nutrition Examination Survey (NHANES) and other national studies. CDC regularly publishes findings in the *National Report on Human Exposure to Environmental Chemicals* and *National Report on Biochemical Indicators of Diet and Nutrition in the U.S. Population*. These reports are the most comprehensive assessments of Americans' exposure to environmental chemicals and Americans' nutrition status—providing national reference data that helps physicians, scientists, and public health officials identify harmful exposures and adequate nutrition levels.

In FY 2025, CDC will continue to release more biomonitoring data faster and with greater accuracy through its modernized web interface. CDC also intends to collaborate on more than 90 studies that assess environmental exposures in high-risk population groups or investigate the relationship between environmental exposures and adverse health effects.

In FY 2024, CDC expects to award a new cooperative agreement funding cycle to six states to expand nationwide capacity to measure priority environmental chemicals in human samples. The cooperative agreement will continue through FY 2025. Funding supports population-based studies at the state level and targeted investigations of groups at higher risk for exposure or consequences of exposure—including individuals who are pregnant, children, and firefighters.

### State Biomonitoring Cooperative Agreements

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
Number of Awards	6	7	7
- New Awards	0	7	0
- Continuing Awards	6	0	7
Average Award	\$0.833	\$0.700	\$0.700
Range of Awards	\$0.728-0.900	\$0.350-1.100	\$0.350-1.100
Total Awards	\$5.00	\$5.00	\$5.00

### Providing Critical Laboratory Expertise in Public Health Emergencies

CDC’s Environmental Health Laboratory uses its expertise in measurement science to support emergency investigations of potentially harmful exposures and disease. For example, CDC continues to improve quality assurance materials and online resources that helps clinical laboratories identify more than 250 synthetic opioid-related compounds. In FY 2023, CDC measurements supported studies of harmful algal bloom-related exposures in Florida, including an investigation of the association between marine toxin exposures and cognitive dysfunction.

CDC’s Environmental Health Laboratory also coordinates and provides technical expertise to the Laboratory Response Network for Chemical Threats (LRN-C) and pilot Laboratory Response Network for Radiologic Threats (LRN-R) programs. In FY 2025, CDC’s Environmental Health Laboratory will continue in-house response readiness and support for LRN-C member laboratories by providing surge capacity, sample logistics support, coordination with local, state, and federal partners, and sentinel surveillance support.

### Harmonizing Laboratory Tests for Better Disease Diagnosis and Treatment

Accurate and precise laboratory measurements are essential for correct diagnosis and treatment of disease. CDC uses expert measurement science to improve the accuracy, precision, and cost effectiveness of laboratory tests for environmental chemicals, nutrition indicators, heart disease, chronic diseases, and newborn screening. The lab develops reference methods and materials and provides quality assurance programs and trainings to assure the quality of tests in state, clinical, research, and academic laboratories. CDC’s efforts reach over one thousand domestic and international laboratories, helping reduce diagnosis and treatment errors, unnecessary medical procedures, and repeat laboratory tests. CDC uses its unique, reference-quality methods to assist other federal agencies as they address emerging issues, such as ensuring the quality of blood lead measurements.

CDC continues to expand its Clinical Standardization Programs to reach more manufacturers, hospital laboratories, and commercial laboratories—and harmonize measurements for new biomarkers. Recently, CDC identified and addressed a critical need for better thyroid biomarker measurements in clinical care by conducting a study that revealed potential patient misclassifications and launching a standardization program.

Additionally, in FY 2022, CDC identified problems with current pediatric reference intervals that may lead to misclassifications of children’s health status. Accurate pediatric reference intervals are critical for assessing health, correctly diagnosing disease, and establishing treatment efficacy in pediatric patients. CDC is currently working with stakeholders to develop innovative approaches to address this problem.

In FY 2023, CDC provided standardization programs for 45 chronic disease biomarkers, adding new priority biomarkers of bone disease and heart disease. In FY 2025, CDC will add another chronic disease biomarker to the Clinical Standardization Programs. CDC will develop or improve reference methods by assigning target levels to reference materials for cholesterol or other priority hormones. CDC will further expand harmonization and standardization programs to reach additional laboratories and manufacturers for harmonization of high priority clinical laboratory test results. These activities will improve the diagnosis, treatment, and prevention of chronic kidney diseases, diabetes, certain cancers, osteoporosis, developmental diseases, and thyroid diseases.

**Earlier Identification of Diseases in Newborns by Supporting State Screening**

CDC helps assure comprehensive and accurate newborn screening test results in the United States by providing training, technical assistance, quality assurance materials, and funding to state newborn screening programs. CDC supports states as they implement testing for all conditions on the HHS Recommended Uniform Screening Panel (RUSP). CDC develops and evaluates test methods for conditions on the RUSP, transfers technology to state laboratories, implements advanced technology for data analytics, supports expert workforce in state newborn screening programs, and works directly with states to overcome testing issues to accelerate nationwide adoption of screening for priority conditions. CDC is working to improve newborn screening test performance and streamline interpretation of complex data for better detection of newborn disorders.

CDC developed innovative processes for its newborn screening quality assurance program that ensure a sustainable supply for producing reference materials for spinal muscular atrophy (SMA), severe combined immunodeficiency (SCID), and cystic fibrosis. In FY 2024, CDC started a new four-year cooperative agreement with a single state newborn screening program. This program serves as a newborn screening Center of Excellence to strategically help state newborn screening programs implement testing for conditions on the RUSP and work with CDC on newborn screening quality improvement activities. In FY 2025, CDC will continue funding for the Center of Excellence.

**Newborn Screening Cooperative Agreements**

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President’s Budget
Number of Awards	5	1	1
- New Awards	0	1	0
- Continuing Awards	5	0	1
Average Award	\$0.397	\$1.000	\$1.000
Range of Awards	\$0.348-0.445	\$1.000	\$1.000
<b>Total Awards</b>	<b>\$1.987</b>	<b>\$1.000</b>	<b>\$1.000</b>

## Asthma Budget Request

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Nearly 25 million Americans suffer from asthma today, including over four million children. Asthma takes almost 4,000 lives and causes 1.6 million emergency department visits per year. The disease also costs the nation \$81.9 billion annually.<sup>175</sup> Asthma disproportionately affects Black or African American children, who are twice as likely to be hospitalized and more than four times more likely to die from asthma than White children. CDC's National Asthma Control Program (NACP) recipients conduct significant work in communities with lower incomes, among populations without access to services, and in areas disproportionately impacted by negative environmental effects (e.g., communities affected by transportation or industrial air pollution) and other outdoor air quality concerns to help address health disparities at the local level.

### Budget Request

CDC's FY 2025 budget request of **\$33,500,000** for the National Asthma Control Program is level with the FY 2023 final level. In FY 2025, CDC will continue to offer education and expertise, quantify risks and vulnerabilities to asthma control, and fund state and territorial health departments to implement comprehensive asthma control programs. CDC will prioritize proven prevention and control efforts that reduce the number of asthma hospitalizations and emergency department visits.

### Program Accomplishments

- The Maine Asthma Program worked with a certified asthma educator to develop the Asthma Self-Management Education Program (ASMEP), which offers asthma education in clinics and in homes. Evaluations of the precursor program revealed 69 percent fewer missed school days (from 141 to 24 school days), 79 percent of participants reporting well-controlled asthma (compared to 30 percent at initiation of the program), and a 60 percent decrease in hospitalizations due to asthma after completion of the program. Additionally, an economic evaluation of the program has shown that for every dollar invested in the program, \$1.80 (at seven months' follow-up) and \$3.09 (at 12 months' follow-up) is saved in averted healthcare costs and lost productivity.
- A 2022 evaluation of clinics recruited to a six-month learning collaborative by the CDC-supported Utah Asthma Program and the Utah Pediatric Partnership to Improve Healthcare Quality showed that participating clinics improved in many areas, including an increase in asthma assessments using a standardized tool from 38 to 90 percent and an increase in patients with a current asthma action plan/self-management plan on file from 55 to 100 percent.
- In May 2022, the Wisconsin Asthma Program completed an air monitoring and anti-idling pilot project at two Milwaukee public schools near heavy traffic corridors and with high asthma burden. This work informed the new 3-year, U.S. Environmental Protection Agency-funded project "Breathe S.M.A.R.T.," which aims to expand project implementation through the creation of a community-based network of neighborhood-level air quality monitoring stations in Milwaukee, Wisconsin, focusing on neighborhoods with high asthma burden.

### **Comprehensive Asthma Control Programs**

In FY 2020, NACP launched Controlling Childhood Asthma and Reducing Emergencies (CCARE), an initiative with the goal of preventing 500,000 emergency department visits and hospitalizations due to asthma by August 31, 2024. CCARE is supported by the EXHALE technical package, a set of six strategies that CDC and partners are using to reduce the burden of asthma in children:

- Education on asthma self-management
- Extinguishing smoking and exposure to second-hand smoke

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<sup>175</sup> <https://www.atsjournals.org/doi/full/10.1513/AnnalsATS.201703-259OC>

- Home visits for trigger reduction and asthma self-management education
- Achievement of guidelines-based medical management
- Linkages and coordination of care across settings
- Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources.

CDC funds 25 state, city, and territorial health departments to implement the EXHALE technical package. These programs focus their efforts on geographic areas or communities with a high or disproportionate burden of asthma. CDC funds have helped many asthma funding recipients achieve success in improving asthma control and decreasing emergency department visits and asthma-related hospitalizations.

CDC also funds four non-governmental organizations (NGOs) to develop communication, education, or policy strategies to enhance the management of asthma and indoor and outdoor air quality, aimed at individuals with asthma, their caretakers, clinicians, and other stakeholders. This partnership allows CDC’s NACP to reach a national audience in a coordinated manner.

**Asthma Surveillance**

State and local health departments rely on asthma surveillance to accurately direct their efforts to reduce the burden of asthma. CDC provides state-specific asthma prevalence data and important measures of asthma control through existing data systems. The Behavioral Risk Factor Surveillance System administers an in-depth Asthma Call-Back Survey (ACBS), and the National Health Interview Survey publishes national estimates of asthma burden. In FY 2025, CDC will continue to support the use of ACBS and publish national estimates of asthma burden. CDC is also focused on data modernization initiatives with the goal of improving asthma surveillance data, technology, and workforce capacity. NACP recipients use surveillance data to focus their efforts on populations with a disproportionate burden of asthma within their jurisdictions and address health disparities locally.

**Asthma Grants to Health Departments<sup>1</sup>**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President’s Budget
Number of Awards	25	25	25
- New Awards	0	0	0
- Continuing Awards	25	25	25
Average Award	\$0.604	\$0.604	\$0.604
Range of Awards	\$0.450-\$0.800	\$0.450-\$0.800	\$0.450-\$0.800
<b>Total Awards</b>	<b>\$15.704</b>	<b>\$15.704</b>	<b>\$15.704</b>

<sup>1</sup>These funds are not awarded by formula.



## **Environmental Health Activities Budget Request**

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CDC programs funded under Environmental Health Activities support the growing need for environmental health capacity at the state, tribal, local, and territorial level to prepare for, respond to, and recover from growing and emerging environmental health hazards. Health departments and communities are faced with an expanding array of challenges, from more frequent and severe natural disasters like wildfires, flooding, and extreme heat events; increasing concerns about cancers caused by environmental exposures; and concerns about chemical exposure from events like the train derailment in East Palestine, Ohio. Preparedness for and response to these events is critical, but underlying capacity or resource constraints pose a challenge for many state, tribal, local, and territorial public health departments. CDC builds capacity to address environmental health concerns by providing foundational support to health departments through CDC's tools, training, guidance, and subject matter expertise to rapidly coordinate effective evidence-based interventions, investigations, and responses.

### **Budget Request**

CDC's FY 2025 budget request of **\$62,600,000** for Environmental Health Activities is **\$10,000,000** above the FY 2023 final level. In FY 2025, CDC will use the \$10 million increase for Environmental Health Capacity to support jurisdictions to pilot the provision of portable High Efficiency Particulate Air (HEPA) filtration systems in homes and communities most affected by wildfire smoke, and to better understand the feasibility and health impact of installing such systems. Program outcomes (e.g., health impact of providing HEPA filters) will inform federal policies aimed at implementing the intervention in the future and help federal programs make decisions about wider implementation. CDC will also continue to build capacity to address emerging environmental health risks and respond to environmental health emergencies by developing tools, guidance, and trainings; disseminating best practices; and providing expertise and requested technical assistance on environmental health concerns.

### **Program Accomplishments**

- On July 7, 2023, CDC, with Department of Defense (DoD) and the Program Executive Office Assembled Chemical Weapons Alternatives (PEO ACWA), celebrated the safe and complete destruction of 100 percent of the United States chemical weapons stockpile, over 30,000 tons of chemical weapons. CDC's Chemical Demilitarization Program provides recommendations to DoD on plans for the destruction of stockpiled chemical weapons, protecting the health of the public and workers. On the 40<sup>th</sup> anniversary of CDC's involvement in the process, CDC helped to successfully eliminate a major public health threat for communities, the United States, and the world.
- CDC has a unique staff of subject matter experts in environmental epidemiology to rapidly investigate domestic and international non-infectious disease outbreaks. In at least three recent investigations, CDC quickly identified the source as a consumer product, informing actions that led to rapid product removal and prevention of further sale in the United States and internationally. A 2023 investigation prevented over half of the approximately 700 consumers of a subscription-based food product from exposure to a potentially toxic ingredient.
- CDC responded to the Canadian Wildfire Smoke event in June 2023 by providing health messaging for the public, public health professionals, and healthcare clinicians; surveillance of air quality and health effects; and coordination with federal, state, tribal, and territorial partners. CDC is also working with other federal agencies, including the Department of the Interior, U.S. Department of Agriculture, and U.S. Environmental Protection Agency (EPA), to integrate public health considerations into their wildfire activities and guidance documents.

### **Environmental Health Capacity**

CDC's Environmental Health Capacity (EHC) Program, initiated in FY 2021, funds 50 recipients to strengthen the capacity of health department environmental health programs. As of December 2023, recipients are

implementing 94 separate projects to detect, prevent, and control environmental health hazards and to build core capacity around data and evidence-based interventions.

Recipients have the flexibility to build capacity by focusing on environmental hazards that are a priority for their jurisdiction. For example, one EHC recipient conducted school-based outreach to encourage well testing for elevated levels of gross alpha, a measure of radioactivity in water. This led to testing of 260 wells and identification of 36 wells with potential exposure risks. The recipient held five outreach events to present findings and increase awareness of the issue to address the risk. Other EHC recipients’ activities include helping reduce risk of wildfire smoke exposure; wastewater surveillance; using electronic health record data to identify unusual occurrences of pediatric cancer and potential environmental exposures; and environmental health response, recovery, and mitigation efforts related to covered disasters or emergencies. In FY 2025, CDC will continue this work by funding state, territorial, local, and tribal governments to build environmental health capacity that suits their specific jurisdiction.

**Environmental Health Capacity Cooperative Agreement<sup>1</sup>**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President’s Budget
Number of Awards	29	29	29
- New Awards	0	0	0
- Continuing Awards	29	29	29
Average Award	\$0.085	\$0.085	\$0.085
Range of Awards	\$0.049–\$0.249	\$0.049–\$0.249	\$0.049–\$0.249
Total Awards	\$2.458	\$2.458	\$2.458

<sup>1</sup>These funds are not awarded by formula.

CDC provides critical subject matter expertise and funding to health departments to reduce morbidity and mortality from emerging environmental exposures and threats, including natural disasters, chemicals, radiation, toxins, and non-infectious disease outbreaks. Many jurisdictions are unable to maintain specific or rare subject matter expertise for the entire range of potential environmental hazards. CDC serves as a clearinghouse for expertise and guidance that other federal state, tribal, local, and territorial partners rely upon. In the past year alone, CDC’s subject matter experts have been consulted on topics ranging from wildfires and hurricanes; cancer cluster investigations; chemical exposures related to the train derailment in East Palestine, Ohio; and potential mass casualty events stemming from chemical, radiological, nuclear or explosive events in Ukraine. CDC’s experts develop trainings, tools, and guidance to improve the effectiveness and efficiency of state and local environmental health programs when they encounter emerging environmental health hazards. CDC’s experts also provide technical assistance to partners on request and provide surge capacity for investigations and emergencies on a wide variety of environmental health topics. For example:

- Everyone in the United States relies on our nation’s water supply for drinking, recreation, sanitation, and hygiene. Environmental contamination and waterborne illness occur naturally, as well as through industrial processes and accidents, water system failure, and changing environmental conditions, including storms and floods. Overall, water-related illness, such as Legionnaires’ disease, results in an estimated 40,000 hospitalizations and \$970 million in healthcare costs each year.<sup>176</sup> More than 2 million Americans lack access to safe drinking water and sanitation, with some communities bearing disproportionate impacts, including limited access to running water. Currently, 29 health departments use Environmental Health Capacity (EHC) cooperative agreement funding to strengthen programs and services for drinking water and recreational water within their jurisdiction. CDC’s Safe Water program provides expertise to assist during water emergencies, such as addressing the cause of waterborne illness outbreaks, including response to legionellosis outbreaks and other contaminants found in

<sup>176</sup> Adam, EA et al. 2017. “Prevalence and direct costs of emergency department visits and hospitalizations for selected diseases that can be transmitted by water, United States,” J. Water Health. 15(5):673-83.

building plumbing systems, and prioritizing efforts to keep small drinking water systems free from contamination.

- Extreme weather events, including drought, wildfires, heat waves, floods, and storms, are increasing in intensity and frequency. These events can exacerbate existing medical conditions, lead to adverse mental health effects, and disrupt public health and healthcare systems, creating long-term impacts on health.<sup>177</sup> As the only federal program that directly funds health departments to address the health impacts of climate-related extreme events, CDC's Climate and Health program is building capacity throughout the nation to prepare for and respond to weather-related health risks. In FY 2023, CDC funded 11 health departments and three tribes to prepare for and respond to extreme weather health impacts by following CDC's Building Resilience Against Climate Effects (BRACE) Framework. The BRACE framework helps communities anticipate weather impacts, assess vulnerabilities, project disease burden, assess public health interventions, develop adaptation plans, and evaluate the impact and quality of health interventions.
  - New Hampshire's health department used the BRACE Framework to study associations between heat index and all-cause hospital admissions and found that moderate heat events (85-95°F heat index) were associated with a rise in hospital admissions that equaled or exceeded the impacts from extreme heat events alone (over 95°F). This information will allow them to better plan interventions to protect people during heat events.
  - The Wisconsin Department of Health Services collaborated with health departments in Michigan, Minnesota, Illinois, North Carolina, and Florida to identify the best interventions for different weather-related impacts. Using insights from the collaborative and climate data projections, Wisconsin created online toolkits for weather-related emergencies to help local governments, local health departments, and residents prepare for or respond to extreme heat, flood, winter weather, wildfire, chemical releases, harmful algal blooms, drought, thunderstorms and tornadoes, and vector-borne disease.
- CDC also develops tools that jurisdictions can use to inform decisions about how to protect people from weather-related health impacts, such as CDC's [Heat & Health Tracker](#).<sup>178</sup> Through a collaboration with CDC's National Environmental Public Health Tracking Program, the tracker provides real-time local-level heat and health data that can be used to inform decisions and public health actions related to heat.
- CDC provides expertise in addressing harmful algal blooms (HABs), events that are increasing in frequency, geographic extent, and severity. In addition to supporting state and local health departments as they conduct activities to address HABs, CDC has developed a vulnerability index for HABs, updated the interagency HAB event surveillance system, and created an internship program for HABs surveillance and investigation. CDC is currently conducting a study in and around Lake Okeechobee, Florida, to assess human exposures and health effects associated with exposure to cyanobacterial HABs in order to provide insights on public health actions that can be taken to reduce exposures.
- Environmental factors are responsible for many foodborne diseases, from which one in six Americans get sick and 3,000 die every year, resulting in the United States spending approximately \$78 billion per year on healthcare, workplace, and other related costs.<sup>179</sup> CDC supports state and local environmental health programs in the identification and prevention of environmental factors that contribute to foodborne illness outbreaks. CDC's program and two major surveillance systems have helped identify and stop foodborne outbreaks; advanced research on food safety prevention practices, policies, and training; and informed significant, national food safety policy and practice guidelines that helps keep people safe. CDC also collaborates with the Food and Drug Administration (FDA) to reduce the occurrence of foodborne illness risk factors in retail food service establishments.

<sup>177</sup> <https://nca2018.globalchange.gov/chapter/14/>

<sup>178</sup> <https://ephtracking.cdc.gov/Applications/heatTracker/>

<sup>179</sup> Scharff, R. (2012). Economic burden from health losses due to foodborne illness in the United States. *Journal of Food Protection*, 75(1), 123–131.

- The public health response to radiological and nuclear incidents is uniquely challenging and requires specific skill sets not readily available within state and local public health communities. CDC’s radiation protection experts develop evidence-based environmental public health strategies and interventions to protect the public from radiation-related hazards and disseminate best practices guidance, training, tools, and information to professional and lay audiences. In the past decade, CDC has provided more than 21,000 emergency radiation preparedness toolkits to clinicians, state and local public health professionals, and other national and international partners. CDC provides expertise and assistance to federal, state, and local partners in exercising preparedness plans to enhance effective public health response to a radiation emergency.
- CDC maintains expertise to help communities prepare for, respond to, and recover from wildfires and wildfire smoke events. As the wildfire crisis continues to increase in size, duration, and intensity, millions of people are at increasing risk from wildfire and wildfire smoke. Smoke inhalation following a wildfire is linked to increases in respiratory conditions like asthma, heart disease, and cancer. Additionally, higher levels of dissolved organic matter, volatile organic compounds, and heavy metals in community water systems following wildfires can overwhelm traditional water treatment capabilities and reduce access to safe drinking water. CDC experts develop guidance and communication materials for public health departments and others and conduct research about the public health impacts of wildfire smoke exposure that are used to develop evidence-based strategies to reduce wildfire smoke exposures. CDC activated an emergency response unit to assist the Hawaii Department of Health following the August wildfires on the island of Maui and provided technical assistance on a range of environmental health issues related to the wildfires.

**Building Resilience Against Climate Effects (BRACE) Cooperative Agreement**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President’s Budget
Number of Awards	11	11	11
- New Awards	0	0	0
- Continuing Awards	11	11	11
Average Award	\$0.400	\$0.400	\$0.400
Range of Awards	\$0.300 - \$0.500	\$0.300 - \$0.500	\$0.300 - \$0.500
Total Awards	\$4.300	\$4.300	\$4.300

**Cancer Activities and Trevor’s Law**

Health departments receive hundreds of inquiries about suspected cancer clusters within the United States each year from individual residents, healthcare providers, and community organizations. Although the specifics of each inquiry may vary, public health officials need to maintain capacity and expertise for these events to respond effectively when they do occur. In December 2022, CDC revised and released updated Guidelines for Examining Unusual Patterns of Cancer and Environmental Concerns to meet this need and advance the goals of the Cancer Moonshot. CDC will continue to provide enhanced technical assistance, develop additional training materials and tools, establish linkages with the pediatric oncology community, and develop systems to collect and disseminate information among states to protect individuals from cancers associated with environmental exposures.

**National Amyotrophic Lateral Sclerosis (ALS) Registry**

Launched in 2010, the National Amyotrophic Lateral Sclerosis Registry—a joint effort between CDC and the Agency for Toxic Substances and Disease Registry (ATSDR)—is an important resource for scientists to understand, prevent, and potentially cure the disease. Also known as Lou Gehrig’s disease, ALS is a progressive, fatal, neurodegenerative disorder that has no cure and the cause of which is not fully understood. The main

goals of the Registry are to determine the epidemiology of ALS in the United States, characterize the demographics of those living with ALS, and identify potential risk factors.

Because ALS is not a notifiable disease, CDC/ATSDR has developed novel approaches to identify ALS cases. The first approach identifies prevalence cases from existing national administrative databases—Medicare, Medicaid, Veterans Health Administration, and Veterans Benefits Administration. The second method uses a secure web portal to identify cases not included in the national administrative databases and offers persons with ALS the opportunity to take brief, online surveys to help researchers learn more about potential risk factors for the disease. Registry participants have the option to donate blood, urine, tissue, and other samples to a biorepository that researchers can use to help better understand the cause(s) of ALS. To date, patients in all 50 states have enrolled in the registry.

Another critical function of the ALS program is advancing the science through studies. As of 2023, the ALS registry has connected thousands of patients with more than 70 clinical trials and epidemiological studies, collected specimens from more than 2,000 patients nationally for the biorepository, disseminated risk factor data and biospecimens to over a dozen research institutions, and funded 26 research grants. The ALS program will continue these efforts to explore the epidemiology, demographics and risk factors of the disease. The National ALS Registry has also conducted listening sessions to hear stakeholder and partner ideas to enhance the Registry, created a public dashboard to display current national ALS data, and published a 12-year analysis on the National ALS Registry’s findings to-date.

**ALS Research Grants<sup>1</sup>**

(dollars in millions)	<b>FY 2023</b>	<b>FY 2024</b>	<b>FY 2025</b>
	<b>Final</b>	<b>CR</b>	<b>President’s Budget</b>
Number of Awards	8	8	8
- New Awards	3	0	0
- Continuing Awards	5	8	8
Average Award	\$0.400	\$0.400	\$0.400
Range of Awards	\$0.300-0.500	\$0.300-0.500	\$0.300-0.500
<b>Total Awards</b>	<b>\$3.200</b>	<b>\$3.200</b>	<b>\$3.200</b>

<sup>1</sup> These funds are not awarded by formula.

**State Table: Environmental Health Funding<sup>1</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$713,404	\$713,404	\$713,404	\$0
Alaska	\$464,963	\$464,963	\$464,963	\$0
Arizona	\$2,092,856	\$2,092,856	\$2,092,856	\$0
Arkansas	\$0	\$0	\$0	\$0
California	\$4,211,487	\$4,211,487	\$4,211,487	\$0
Colorado	\$1,426,082	\$1,426,082	\$1,426,082	\$0
Connecticut	\$2,127,000	\$2,127,000	\$2,127,000	\$0
Delaware	\$1,080,000	\$1,080,000	\$1,080,000	\$0
District of Columbia	\$665,000	\$665,000	\$665,000	\$0
Florida	\$3,816,959	\$3,816,959	\$3,816,959	\$0
Georgia	\$1,361,915	\$1,316,915	\$1,316,915	\$0
Hawaii	\$592,273	\$592,273	\$592,273	\$0
Idaho	\$512,000	\$512,000	\$512,000	\$0
Illinois	\$2,206,308	\$2,206,308	\$2,206,308	\$0
Indiana	\$1,920,217	\$1,920,217	\$1,920,217	\$0
Iowa	\$2,008,020	\$2,008,020	\$2,008,020	\$0
Kansas	\$1,211,885	\$1,211,885	\$1,211,885	\$0
Kentucky	\$2,061,925	\$2,061,925	\$2,061,925	\$0
Louisiana	\$1,323,694	\$1,323,694	\$1,323,694	\$0
Maine	\$2,012,000	\$2,012,000	\$2,012,000	\$0
Maryland	\$1,385,582	\$1,385,582	\$1,385,582	\$0
Massachusetts	\$1,902,000	\$1,902,000	\$1,902,000	\$0
Michigan	\$7,630,091	\$7,630,091	\$7,630,091	\$0
Minnesota	\$3,137,466	\$3,137,466	\$3,137,466	\$0
Mississippi	\$664,811	\$664,811	\$664,811	\$0
Missouri	\$2,036,412	\$2,036,412	\$2,036,412	\$0
Montana	\$965,000	\$965,000	\$965,000	\$0
Nebraska	\$1,085,000	\$1,085,000	\$1,085,000	\$0
Nevada	\$1,005,313	\$1,005,313	\$1,005,313	\$0
New Hampshire	\$2,510,730	\$2,510,730	\$2,510,730	\$0
New Jersey	\$2,277,477	\$2,277,477	\$2,277,477	\$0
New Mexico	\$1,833,121	\$1,833,121	\$1,833,121	\$0
New York	\$4,702,995	\$4,702,995	\$4,702,995	\$0
North Carolina	\$3,117,985	\$3,117,985	\$3,117,985	\$0
North Dakota	\$0	\$0	\$0	\$0
Ohio	\$1,712,000	\$1,712,000	\$1,712,000	\$0
Oklahoma	\$515,000	\$515,000	\$515,000	\$0
Oregon	\$1,719,037	\$1,719,037	\$1,719,037	\$0
Pennsylvania	\$2,697,485	\$2,697,485	\$2,697,485	\$0
Rhode Island	\$2,062,000	\$2,062,000	\$2,062,000	\$0
South Carolina	\$1,800,000	\$1,800,000	\$1,800,000	\$0
South Dakota	\$498,955	\$498,955	\$498,955	\$0
Tennessee	\$1,122,710	\$1,122,710	\$1,122,710	\$0
Texas	\$2,749,081	\$2,749,081	\$2,749,081	\$0
Utah	\$2,426,572	\$2,426,572	\$2,426,572	\$0
Vermont	\$1,892,037	\$1,892,037	\$1,892,037	\$0

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Virginia	\$4,972,459	\$4,972,459	\$4,972,459	\$0
Washington	\$2,252,571	\$2,252,571	\$2,252,571	\$0
West Virginia	\$664,491	\$664,491	\$664,491	\$0
Wisconsin	\$2,901,084	\$2,901,084	\$2,901,084	\$0
Wyoming	\$465,000	\$465,000	\$465,000	\$0
<b>Total Resources</b>	<b>\$96,512,453</b>	<b>\$96,512,453</b>	<b>\$96,512,453</b>	<b>\$0</b>

<sup>1</sup>This table is a compilation of NCEH grant programs Building Resilience Against Climate Effects: Implementing and Evaluating Adaptation Strategies that Protect and Promote Human Health, EH21-2101, 93.070; Radiation Health Protection Involving Ionizing and Non-Ionizing Radiation, EH21-2103, 93.070; Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children, EH21-2102, 93.197; Modernizing Environmental Public Health Tracking to Advance Environmental Health Surveillance, EH22-2202, 93.070; Lead Exposure Registry of Flint Residents – Michigan, EH22-2203, 93.197; Identifying Common and Unique Barriers to the Exchange of Hospital Inpatient and Emergency Department Data, EH18-1802, 93.070; Developing Standards and Principles to Effectively Administer and Integrate Public Health Statistics and Information Systems into the National Environmental Public Health Tracking Network, EH18-1801, 93.070; Radiation Protection of Workers and the Public by State and Local Radiation Control Programs; EH23-0004, 93.070; State-Based Public Health Laboratory Biomonitoring Programs, EH19-1901, 93.070; A Comprehensive Public Health Approach to Asthma Control Through Evidence-Based Interventions, EH19-1902, 93.070; Promoting Asthma Friendly Environments Through Partnerships and Collaborations, EH20-2002, 93.070; National Public Health Surveillance for Chemical and Radiologic Exposures and Emerging Drug Threats, EH20-2003, 93.070; Enhancing Disease Detection in Newborns: Building Capacity in Public Health Laboratories, EH22-2201, 93.065; Strengthening Environmental Health Capacity (EHC) to detect, prevent, and control environmental health hazards through data-driven, evidence-based approaches, EH20-2005, 93.070; Supporting Communities to Reduce Lead Poisoning, EH23-0005, 93.197 and represents all funding within a jurisdiction (including funding to local, tribal, and other grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

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## INJURY PREVENTION AND CONTROL

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$761.379	\$761.379	\$843.379	+ \$82.000
PHS Evaluation Funds	\$0	\$0	\$100.000	+ \$100.000
<b>Total Request</b>	<b>\$761.379</b>	<b>\$761.379</b>	<b>\$943.379</b>	<b>+ \$182.000</b>
FTEs	549	594	712	163
-- Intentional Injury	<u>\$164.550</u>	<u>\$164.550</u>	<u>\$323.550</u>	<u>+ \$159.000</u>
-- Domestic Violence and Sexual Violence	\$38.200	\$38.200	\$38.200	\$0
-- <i>Child Maltreatment (non-add)</i>	\$7.250	\$7.250	\$7.250	\$0
-- <i>Child Sexual Abuse Prevention (non-add)</i>	\$3.000	\$3.000	\$3.000	\$0
-- Youth and Community Violence Prevention <sup>1</sup>	\$18.100	\$18.100	\$118.100	+ \$100.000
-- <i>Community Violence Intervention Initiative (non-add) PHS Evaluation Transfer</i>	\$0	\$0	\$100.000	+ \$100.000
-- Domestic Violence Community Projects	\$7.500	\$7.500	\$7.500	\$0
-- Rape Prevention	\$61.750	\$61.750	\$61.750	\$0
-- Suicide Prevention	\$30.000	\$30.000	\$68.000	+ \$38.000
-- Adverse Childhood Experiences (ACEs)	\$9.000	\$9.000	\$30.000	+ \$21.000
-- NVDRS	\$24.500	\$24.500	\$24.500	\$0
-- Unintentional Injury	<u>\$13.300</u>	<u>\$13.300</u>	<u>\$13.300</u>	<u>\$0</u>
-- Traumatic Brain Injury (TBI)	\$8.250	\$8.250	\$8.250	\$0
-- Elderly Falls	\$3.050	\$3.050	\$3.050	\$0
-- Drowning Prevention	\$2.000	\$2.000	\$2.000	\$0
-- Injury Prevention Activities	\$29.950	\$29.950	\$29.950	\$0
-- Opioid Abuse and Overdose Prevention and Surveillance	\$505.579	\$505.079	\$506.079	+ \$0.500
-- Injury Control Research Centers	\$11.000	\$11.000	\$11.000	\$0
-- Firearm Injury and Mortality Prevention Research	\$12.500	\$12.500	\$35.000	+ \$22.500

<sup>1</sup> The FY 2025 PB proposes to fund CDC's Community Violence Intervention Initiative at a total of \$2.5 billion over ten years in mandatory and discretionary funds. The PB assumes \$100 million in discretionary PHS Evaluation funding, which is reflected in CDC's Injury Account totals, and \$150 million in mandatory funding for FY 2025.

**Enabling Legislation Citation:** PHSA § 203\*, PHSA § 214, PHSA § 301, PHSA § 304, PHSA § 307, PHSA § 308, PHSA § 310, PHSA § 311, PHSA § 317, PHSA § 317N, PHSA § 319, PHSA § 319D, PHSA § 327, PHSA § 352, PHSA § 391\*, PHSA § 392\*, PHSA § 392A, PHSA § 393\*, PHSA § 393A, PHSA § 393B, PHSA § 393C, PHSA § 393D\*, PHSA § 394\*, PHSA § 399\*, PHSA § 399O, PHSA § 399P\*, PHSA § 1102, PHSA § 1706\*, Bayh-Dole Act of 1980 (P. L. 96-517), Family Violence Prevention and Services Act §§ 314\*, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act §§ 7011 and 7131 (P. L. 115-271), Comprehensive Addiction and Recovery Act of 2016 § 102 (P. L. 115-271), Violence Against Women Act Reauthorization Act of 2022 § 301 (P.L. 117-103).

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; and Competitive Contracts

### Program Description

CDC is the nation's leading authority on violence and injury prevention, following the same public health methods used to prevent disease:

- Carefully defining the problem through data.
- Studying factors that increase or decrease risk.
- Designing and evaluating interventions that target these risk factors.

- Taking steps to ensure that proven strategies are implemented in communities nationwide.

In the United States, injury is the leading cause of death of children and adults ages one to 45. Many causes of injury are urgent and interrelated. Adverse Childhood Experiences (ACEs) are one such cause – they can impact how a child’s brain develops and functions, significantly affecting lifelong health and opportunities. ACEs are associated with increased risk for at least five of the 10 leading causes of death, including a significant relationship to future risk of suicide and mental health challenges. ACEs are also strongly linked to substance use initiation, including opioid initiation, at a younger age, as well as injection drug use, substance use disorders, and overdose. For children, losing a loved one to suicide or overdose is an ACE, which in turn, increases the child’s risk of future overdose or suicide. By understanding and addressing these urgent, related, and preventable issues, we can prevent harm today and for generations to come.

### Budget Request

CDC’s FY 2025 budget request of **\$943,379,000** for Injury Prevention and Control is **\$182,000,000** million above the FY 2023 final Level. This total includes \$100 million in PHS Evaluation Funds.

CDC will continue to protect Americans from injury and violence by:

- Researching and evaluating prevention strategies to better understand what works, why, and for whom.
- Executing impactful strategies and effectively translating them for populations most at risk.
- Mobilizing a diverse group of champions and change agents to enhance preventive measures within communities.
- Ensuring equitable policies, programs, and services that build on individual, family, and community strengths while reducing disparities that increase risk.

CDC is advancing [health equity](#) as a fundamental part of our injury and violence prevention work by:

1. Establishing and strengthening internal mechanisms for implementing and evaluating how health equity is incorporated into CDC’s work.
2. Prioritizing health equity as part of CDC funding opportunities.
3. Building and disseminating a broader evidence-base to advance health equity.
4. Cultivating and strengthening reciprocal partnerships to achieve health equity.

## INJURY PREVENTION AND CONTROL

### BY THE NUMBERS<sup>1</sup>

- **300**—Americans die each day from a drug overdose.<sup>2</sup>
- **66%**—Percentage of survey respondents exposed to the Rx Awareness campaign pilot who reported the campaign was effective or very effective at improving knowledge.
- **39%**—Percentage of youth with four or more ACEs that attempted suicide in the first half of 2021.
- **6.5%**—Reduction in suicide rates from 2019 to 2021 among veterans and service members served by Comprehensive Suicide Prevention Program recipients.
- **\$103,767**—Lifetime cost of intimate partner violence per female victim and \$23,414 per male victim.
- **93%** -- Percentage of respondents from the Still Going Strong campaign survey felt they can prevent common injuries.
- **180,000** – Number of visits to an online, interactive older-adult falls screening tool.

<sup>1</sup>Unless otherwise noted, all information and calculations are from CDC program data.

<sup>2</sup>Provisional drug overdose death counts 2023 | National Center for Health Statistics

<b>Injury Prevention and Control Funding History</b>	
FY 2021	\$680.783
FY 2022	\$714.879
FY 2023 Final	\$761.379
FY 2024 CR	\$761.379
FY 2025 President’s Budget	\$943.379

## National Violent Death Reporting System Budget Request

The [National Violent Death Reporting System \(NVDRS\)](#)<sup>180</sup> pools information from multiple data sources into a usable, anonymous database describing the circumstances of homicides and suicides (including opioid-related suicides). CDC supports NVDRS programs in all 50 states, Washington, D.C., and Puerto Rico.

NVDRS benefits from improvements made to information systems through CDC’s accelerated Data Modernization Initiative. As CDC continues transforming its approach to public health data, advancements in rapid data analysis give public health professionals and policymakers greater visibility into public health threats, allowing them to make decisions faster.

### Budget Request

CDC’s FY 2025 budget request of **\$24,500,000** for the National Violent Death Reporting System is level with the FY 2023 final level. In FY 2025, CDC will continue supporting the 52 NVDRS recipients to implement and maintain the system, monitor, and report data, and use these data to inform prevention efforts to save lives. CDC will continue to increase the use of NVDRS data by characterizing deaths collected (e.g., homicide, suicide, deaths of undetermined intent) among various populations (e.g., ethnic, racial, rural, sexual and gender minorities, military). CDC will also work with data providers to identify ways to improve data completeness, timeliness, and quality and continue to enhance system infrastructure with NVDRS web-based system refinements.

(dollars in millions)	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President’s Budget</b>
Number of Awards	52	TBD	TBD
- New Awards	0	TBD	TBD
- Continuing Awards	52	TBD	TBD
Average Award	\$0.323	TBD	TBD
Range of Awards	\$0.178–\$0.962	TBD	TBD
<b>Total Awards</b>	<b>\$16.833</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> These funds are awarded by formula.

<sup>180</sup> <https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html>

## **Unintentional Injury Prevention Budget Request**

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Unintentional injuries, like falls, motor vehicle crashes, and drowning, are the leading cause of death for people one to 44 years old in the United States and the fourth leading cause of death for all ages combined. Over one in four adults 65 and older fall each year, resulting in about 37 million falls and an estimated \$50 billion in medical costs. An average of 190 traumatic brain injury (TBI)-related deaths and 586 TBI-related hospitalizations occur each day, and Americans aged 75 years and older account for around one-third of both hospitalizations and deaths related to TBI. In addition, drowning is the leading cause of death among children ages one to four years.

### **Budget Request**

CDC's FY 2025 budget request of **\$13,300,000** for Unintentional Injury Prevention is level with the FY 2023 final Level. At this level, CDC will continue to prevent and minimize unintentional injury impacts. With these funds, CDC will create new [Still Going Strong](#) campaign assets to focus on differently abled older adults and American Indian/Alaska Native elders, to expand the campaign's reach, and to broaden the campaign focus to promote social connectedness. CDC will also continue to fund its Heads Up TBI campaign.

### **Falls**

CDC informs older adults and caregivers about fall prevention, provides state-level data on falls burden, and partners with doctors and other healthcare providers, state and local health departments, and tribes to develop fall prevention tools and resources and implement and evaluate effective fall prevention strategies. CDC's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative teaches clinicians to screen, assess, and intervene to reduce fall risks. CDC's *Still Going Strong* campaign empowers older adults to reduce their risk of common injuries like falls, motor vehicle crashes, and traumatic brain injury.

### **Program Accomplishments**

- CDC's *Still Going Strong* campaign launched in 2021 and has garnered millions of impressions. A 2022 evaluation survey found 91 percent of respondents strongly agreed the campaign made them feel they can prevent common injuries, and 92 percent strongly agreed that the campaign made them feel optimistic about living independently.
- CDC provided technical assistance to the CDC Foundation to develop an online, interactive falls screening tool released on the National Council on Aging website in August 2022. Since the release, there have been over 335,000 visits and over 50,000 screener completions.

### **Traumatic Brain Injury (TBI)**

There were 69,473 TBI-related deaths in 2021. American Indian/Alaska Native (AI/AN) children and adults have higher rates of TBI-related hospitalizations and deaths than other racial or ethnic groups. CDC is focused on preventing TBI, enhancing national TBI surveillance efforts, improving care for AI/AN with TBI, helping students return to school following a TBI, and improving the diagnosis and management of mild TBI, also called a concussion. CDC's Heads Up tools and resources help protect youth from TBI and its potentially devastating effects.

### **Program Accomplishments**

CDC partnered with more than 85 organizations across the fields of athletics, healthcare, public health, education, and scientific research to advance brain injury awareness and prevention efforts through the Heads-Up program. Since its inception 20 years ago, over 10 million participants have completed online training courses, and more than 200 million people have been reached through ad campaigns and educational materials.

## Drowning

Drowning is one of the three leading causes of unintentional injury and death among persons aged 29 years and younger. In 2021, 4,677 lives were lost to unintentional drowning, and drowning was the leading cause of death among children one to four years of age. Alarming, a 2022 CDC publication<sup>181</sup> revealed that although drowning death rates for people aged 29 years or younger in the United States decreased by two percent per year from 2010 to 2019, they increased by 17 percent from 2019 to 2020. The most significant increases from 2019 to 2020 occurred among young adults aged 20 to 24 years (44 percent), Black or African American persons (24 percent), and males (20 percent). In 2021, CDC released a study that found non-Hispanic AI/AN persons had two times higher drowning rates, and non-Hispanic African American or Black persons had 1.5 times higher rates than non-Hispanic White persons.

To address these disparities, CDC is funding partners to improve the quality of drowning data and surveillance, understand barriers that populations at higher risk of drowning may have in accessing effective interventions, and pilot basic swimming and water safety skills programs in communities at increased risk of drowning. CDC is also working with community-based organizations to understand how best to scale these programs nationally and to initiate the implementation of the U.S. National Water Safety Action Plan.

## Injury Prevention Activities Budget Request

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More than 245,000 people die from an injury every year. There are 11 hospitalizations and 109 emergency department visits for every one injury-related death. People who survive major injuries can have lifelong mental, physical, and financial problems. CDC developed the Core State Injury Prevention Program (Core SIPP) to support health department infrastructure and partnerships that identify and respond to existing and emerging injury threats with data-driven public health actions. This support increases protective factors and reduces risk factors using the best evidence to prevent injuries and death.

### Budget Request

CDC's FY 2025 budget request of **\$29,950,000** for Injury Prevention Activities is level with the FY 2023 final level. At this level, CDC will continue conducting prevention activities in areas of greatest need, including crosscutting programs such as Core SIPP and other critical activities such as providing public health leadership in motor vehicle crash injury prevention.

### Transportation Safety

In 2021, the United States had the highest number of motor vehicle traffic deaths in over a decade—over 45,000 people died. In the same year, crash deaths resulted in over \$480 billion in total costs (including medical costs and estimates for lives lost), in addition to the immeasurable burden on victims' families and friends. In 2022, CDC [released a study](#) revealing that the United States had the highest population-based crash death rate (11.1 per 100,000 population) out of 29 high-income countries in 2019.

Motor vehicle crashes are a leading cause of death for children. In 2022, CDC reported that combined child passenger death rates (from 2015–2019) were highest for non-Hispanic AI/AN children (2.67 per 100,000 population) and non-Hispanic Black children (1.96 per 100,000 population). Also, death rates among Hispanic children increased over seven-fold from the most urban counties to the most rural counties, while those for non-Hispanic White and Black children increased over five-fold. Older adults are more likely to experience serious injury or death in a crash than younger adults.

CDC provides public health leadership to enhance the implementation of proven prevention strategies by:

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<sup>181</sup> [Increased unintentional drowning deaths in 2020 by age, race/ethnicity, sex, and location, United States - PubMed \(nih.gov\)](#)

- Working with partners to gather data and provide guidance on effective transportation safety interventions that identify and reduce motor vehicle crash deaths and injuries among disproportionately affected populations.
- Addressing disparities in child passenger death rates by promoting its Booster Seat Planning Guide to assist states, tribes, localities, and territories with assessing, planning, and implementing improved booster seat laws to reduce crash injuries and deaths among children.
- Expanding its *MyMobility Plan*,<sup>182</sup> which helps older adults stay mobile and independent as they age, prevent or reduce the effects of mobility changes, and review their medicines to reduce their risk of falls and car crashes. Updates to the *MyMobility Plan* include developing materials for AI/AN and rural populations, two groups disproportionately affected by crashes, and producing materials for Spanish-speaking populations.

**Core State Injury Prevention Program Grants<sup>1,2</sup>**

(dollars in millions)	<b>FY 2023</b>	<b>FY 2024</b>	<b>FY 2025</b>
	<b>Final</b>	<b>CR</b>	<b>President’s Budget</b>
Number of Awards	26	TBD	TBD
- New Awards	3	TBD	TBD
- Continuing Awards	0	TBD	TBD
Average Award	\$0.292	TBD	TBD
Range of Awards	\$0.248–\$0.475	TBD	TBD
<b>Total Awards</b>	<b>\$7.395</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> All Core SIPP states receive approximately \$250,000 in base funding. Select states are funded for enhanced components above their base funding.

<sup>2</sup> These funds are not awarded by formula.

<sup>182</sup> [https://www.cdc.gov/transportationsafety/older\\_adult\\_drivers/mymobility/index.html](https://www.cdc.gov/transportationsafety/older_adult_drivers/mymobility/index.html)

## Opioid Overdose Prevention and Surveillance Budget Request

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The drug overdose epidemic continues to evolve and become more complex due to an increasing array of potential substances and exposures, such as synthetic opioids (e.g., illicitly manufactured fentanyl) and stimulants, and an increase in polysubstance use (i.e., use of more than one substance). In the United States, drug overdoses have claimed over 932,000 lives over the past 21 years and the drug overdose crisis continues to worsen. Overdose deaths remained high in 2022 with an estimated 110,511 drug overdose deaths, 83,695 of which involved opioids. Opioids, mainly synthetic opioids (other than methadone), are currently the main driver of drug overdose deaths, with the age-adjusted rate of synthetic drug overdose deaths increasing from 1.0 per 100,000 in 2013 to 21.8 in 2021. From 2012 through 2021, the rate of drug overdose deaths involving cocaine increased by more than 420 percent (from 1.4 to 7.3), while those involving psychostimulants with abuse potential (e.g., methamphetamine) increased by 1150 percent (from 0.8 to 10.0).

CDC's drug overdose prevention work encompasses the foundational pillars highlighted below, all of which align with the HHS Overdose Prevention Strategy as well as the Office of National Drug Control Policy (ONDCP) national drug control strategy and are implemented within a framework centering on health equity, reducing stigma, and improving linkage to care and treatment.

### Budget Request

CDC's FY 2025 request of **\$506,079,000** for Opioid Overdose Prevention and Surveillance is **\$500,000** above the FY 2023 final Level. With increased funding, CDC will continue to meet the evolving needs of the overdose crisis by investing in communities heavily impacted by this crisis while supporting all states, territories, and tribes to track and prevent overdose deaths. CDC will support the collection and reporting of real-time, robust overdose data, building upon the work of Overdose Data to Action (OD2A) programs. CDC will partner with state, local, and territorial health departments to implement actionable data collection that include contextual and toxicological information that can identify emerging drug threats, such as xylazine and fentanyl analogs, and prevent overdose and negative health outcomes in communities.

Recognizing the associations between ACEs, suicide, and substance use disorders, CDC will continue supporting upstream prevention programs, such as expanding ACEs data collection in communities experiencing high rates of drug overdoses and leveraging ongoing comprehensive suicide prevention approaches to test a community approach for the primary and secondary prevention of ACEs.

### **Surveillance and Research**

CDC's surveillance efforts help states adapt to the rapidly changing overdose epidemic and implement more tailored strategies in communities. Data have also equipped communities to help save lives and link people to care and treatment in cases of nonfatal overdose.

CDC's State Unintentional Drug Overdose Reporting System (SUDORS) supports states in collecting data on all unintentional or undetermined intent drug overdose deaths. As a result, states can spot substance use trends and understand factors leading to overdose deaths. Data collected by SUDORS includes:

- Valuable information from death scene investigations.
- Detailed information on toxicology and drugs contributing to death.
- The route of administration.
- Other risk factors associated with fatal overdose.

These data make SUDORS an essential tool to identify and track changes in the landscape of illicitly manufactured fentanyl (IMF) analogs, which have similar chemical structures to fentanyl but with varying potency.



CDC collects ACEs data in its Behavioral Risk Factor Surveillance System (BRFSS) to gain better insight into trends in ACEs and their connection to opioid misuse over time. Once CDC experts identify essential trends or successful strategies, they work to understand how the insights and interventions can inform action in other jurisdictions and continuously evaluate and refine them.

### Program Accomplishments

- Chicago converted data from their opioid overdose alert system into an actionable response plan, advancing outreach efforts in persistent overdose hotspots. There are now teams and processes to respond to overdose spikes with Narcan, education, and linkages to additional resources via outreach events.
- In New Hampshire, monthly state- and county-level non-fatal drug overdose information was distributed to decision-makers, enabling response teams to make timely decisions regarding outreach and other prevention strategies.

### **Build State, Local, and Tribal Capacity**

CDC's [Overdose Data to Action \(OD2A\) program](#) supports states, localities, and territories to advance understanding of the drug overdose epidemic and to scale up surveillance and prevention strategies. This overarching support is made up of two distinct cooperative agreements: Overdose Data to Action in States (OD2A-S), which supports 49 state health departments and the District of Columbia, and Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL), which supports 40 local and territorial health departments.

Both OD2A-S and OD2A: LOCAL strengthen overdose data efforts, support tailoring and scaling evidence-based prevention and response efforts to reduce overdose deaths and focus on groups disproportionately affected by the overdose epidemic. Through the OD2A initiative, CDC supports a robust menu of strategies at state, local, and territorial levels, including linkage to evidence-based treatment and innovative surveillance activities that can assist in evaluating linkage to care efforts.

CDC funds tribal partners to improve overdose surveillance and data infrastructure, as well as culturally appropriate prevention strategies. In partnership across the agency, CDC provides \$13 million to 11 Tribal Epidemiology Centers and 15 tribes or tribal-serving organizations to support data collection improvements and regional overdose prevention strategic planning.

CDC also works with public safety and harm reduction organizations that serve people from racial and ethnic minority groups to develop, disseminate, and evaluate educational and communications materials to reduce adverse health outcomes related to opioid use disorder. These tools use a trauma-informed, recovery-oriented approach to address the social determinants of health and incorporate real-world “how to” steps to implement the recommendations.

### **Empower Consumers to Make Safe Choices**

CDC prioritizes raising awareness about the risks of overdose and providing individuals, as well as their employers, the resources and information they need to make informed choices. CDC's four evidence-based campaigns, known together as *Stop Overdose*,<sup>183</sup> focus on preventing and reducing drug overdose in young adults ages 18 to 34. The campaigns address the risks of polysubstance use, the dangers of fentanyl, the life-saving power of naloxone, and the stigma around treatment and recovery for substance use disorder.

<sup>183</sup> <https://www.cdc.gov/stopoverdose/index.html>

**Support Providers, Health Systems, and Payers**

CDC supports providers and healthcare systems with resources to support and increase safe and effective pain care, maximize the use of prescription drug monitoring programs, and advance insurer and health systems interventions at the federal, state, and local levels. Pain, particularly chronic pain, can lead to impaired physical functioning, poor mental health, and reduced quality of life. It contributes to substantial morbidity and mortality in the United States each year. Chronic pain is the leading cause of disability in the United States, and the economic costs are staggering—between \$560 billion and \$635 billion dollars annually.

- CDC conducts research on chronic pain and treatments using nationally representative population-based survey data (such as the *Medical Expenditure Panel Survey* and the *National Ambulatory Medical Care Survey*) and administrative claims data from commercially and publicly insured patients.
- CDC provides recommendations for clinicians to provide evidence-based treatment for pain care for patients in its 2022 *Clinical Practice Guideline for Prescribing Opioids for Pain* (Clinical Practice Guideline). The Clinical Practice Guideline promotes a multimodal and multidisciplinary approach to pain management and implementation strategies to reduce disparities and improve pain care.<sup>184</sup>

**Public Health—Public Safety Partnerships**

CDC continues to build partnerships through public health and public safety collaborations to strengthen and improve efforts to reduce drug overdoses. These partnerships allow for effective implementation of programs and help advance promising strategies that address the overdose epidemic. For example, CDC is collaborating with the Drug Enforcement Agency’s High-Intensity Drug Trafficking Areas program to implement the Overdose Response Strategy (ORS). ORS helps communities reduce fatal and non-fatal drug overdoses by connecting public health and public safety agencies, sharing information, and supporting evidence-based interventions.

**Overdose Data to Action: State and OD2A: Local Grants<sup>1,2</sup>**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President’s Budget
Number of Awards	90	TBD	TBD
- New Awards	--	--	--
- OD2A: State	50	TBD	TBD
- OD2A: Local	40	TBD	TBD
	--	--	--
	90	TBD	
Average Award			--
			--
- OD2A: State	\$3.105	TBD	TBD
- OD2A: Local	\$2.200	TBD	TBD
Range of Awards			
- OD2A: State	\$1.866-5.474	TBD	TBD
- OD2A: Local	\$0.824-3.743	TBD	TBD
<b>Total Awards</b>	<b>\$279,499</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> These funds are not awarded by formula.

<sup>2</sup> Estimated funding may shift if jurisdictions adjust budgets.

<sup>184</sup> <https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm>

## Firearm Injury and Mortality Prevention Research Budget Request

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Firearm-related injuries are among the five leading causes of death for people ages one to 44 in the United States. In 2021, there were 48,830 firearm-related deaths in the United States. The 2021 firearm homicide rate is the highest in more than 25 years. Long-standing systemic inequities and structural racism contribute to avoidable firearm-related health disparities among some racial and ethnic groups. In 2021, the rate of firearm homicide for Black boys and young Black men aged 10-24 was 29 times higher than the rate for White boys and young White men in the same age group. Addressing the gaps in knowledge around firearm violence and identifying effective prevention strategies are critical in keeping people, families, schools, and communities safe from firearm injury and death.

CDC supports prevention researchers and foundational surveillance activities and data analysis to record the public health burden of firearm injuries and strengthen firearm-related data. The Firearm Injury Surveillance Through Emergency Rooms (FASTER) program funds 12 state health departments to collect data on nonfatal firearm injuries to provide near real-time, local data. Data collected through FASTER allow communities to identify patterns, respond to surges in gun violence, and know where to direct intervention efforts. These states have made progress in collecting and disseminating data and are leveraging partnerships to connect these data to inform action. CDC also supports 22 research grants to prevent firearm-related injuries, deaths, and crime; findings can inform the development and evaluation of promising prevention strategies to keep individuals, families, schools, and communities safe.

### Budget Request

CDC's FY 2025 budget request of **\$35,000,000** for firearm injury and mortality prevention research is **\$22,500,000** above the FY 2023 final Level. CDC will use these resources to continue funding research grants and improve the collection and dissemination of timely firearm-related data. Increased funding for firearm injury and mortality prevention will allow CDC to expand the very successful FASTER program to all 50 states, the District of Columbia, and the territories. This funding will also support additional research grants to improve understanding of firearm injury, inform the development of innovative and promising prevention strategies, and rigorously evaluate the effectiveness of existing and future prevention strategies.

### Program Accomplishments

- Utah used FASTER data to collaborate with community partners to plan, create, and implement a digital and social media campaign to prevent unintentional firearm injuries in their state.
- CDC-funded researchers at the University of Michigan and Virginia Commonwealth University study emergency department and hospital-based violence prevention programs. Preliminary analysis shows that many patients aged 18 to 24 in urban emergency departments reported recently carrying a firearm, with nearly half of these young adults reporting using alcohol or drugs while carrying a firearm. These early findings suggest that many young adults who carry firearms could benefit from firearm safety interventions such as gun safety training and education to promote safe storage.
- CDC-funded researchers at the University of California at Davis published findings that community firearm homicide exposure was associated with depression among youth with the highest risk of exposure and that boys in the most disadvantaged communities, particularly Black boys, were at greatest risk. These findings underscore the need for accessible and culturally responsive violence interventions and therapeutic services to reduce exposure to community firearm violence while mitigating negative mental health consequences.<sup>185</sup>

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<sup>185</sup> Buggs, S. A. L., Zhang, X., Aubel, A., Bruns, A., & Kravitz-Wirtz, N. (2022). Heterogeneous effects of spatially proximate firearm homicide exposure on anxiety and depression symptoms among U.S. youth. *Preventive medicine*, 165(Pt A), 107224. <https://doi.org/10.1016/j.ypmed.2022.107224>

## Injury Control Research Centers Budget Request

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Injuries are the leading cause of death and hospitalizations for children in the United States aged one to 18. Every day, more than 25 children die from preventable injuries, resulting in more deaths than all other causes combined. [Injury Control Research Centers](#) (ICRCs) study ways to prevent injuries and violence and work with community partners to put research findings into action. There are nine ICRCs conducting research, outreach, and training on motor vehicle injuries, interpersonal violence, suicide, overdoses, older adult falls, and traumatic brain injuries.

### Budget Request

CDC's FY 2025 budget request of **\$11,000,000** for the Injury Control Research Centers is level with the FY 2023 final level. In FY 2024, the new ICRC funding cycle will start, and CDC anticipates increasing the number of funded ICRCs from nine to eleven. With the \$2 million increase received in FY 2023, CDC will support two additional ICRCs in FY 2024, in alignment with Congressional direction. In the new five-year funding cycle, ICRCs will continue to implement high-quality research, training, and outreach activities, as well as effective translation of scientific discoveries into practice for the prevention and control of injuries and violence.

### Program Accomplishments

With support from CDC's ICRC program, Nationwide Children's Center for Injury Research and Policy developed Trainees for Child Injury Prevention (T4CIP) to promote interest and engagement in child injury prevention. Medical students, residents, and fellows interested in pediatrics, child injury prevention, health behavior change, and communication apply to become pediatric trainees in T4CIP. The program exposes them to public health approaches and community engagement to prevent child and teen injuries and violence. T4CIP trainees are using their new skills to engage in child injury prevention and build strong relationships with peers, mentors, and patient families.

The Johns Hopkins Center for Injury Research and Policy (JHCIRP) found that state laws mandating ignition interlock use for all drunk driving offenders reduced fatal alcohol-involved crashes by at least seven percent.

## Intentional Injury Prevention Budget Request

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Violence and suicide are serious public health challenges, affecting not only immediate victims but people close to them and often communities more broadly. Survivors of violence suffer from physical, mental, and emotional health problems throughout their lives. Communities affected by violence experience damage to local economies, increasing demand on law enforcement, and strained social services. In 2020, 24,576 people were victims of homicide. Over half of women and almost one in three men experience sexual violence (SV) involving physical contact during their lifetimes. At least one in seven children has experienced child abuse and neglect in the past year, and about one in 12 U.S. high school students experiences physical dating violence. In 2021, suicide was the second leading cause of death for people aged 10-14 and 25-34, responsible for 48,183 deaths.

To address these serious health concerns, CDC:

- Collects, analyzes, and shares critical data with state and local public health agencies, universities, and non-governmental organizations to implement and evaluate prevention programs.
- Publishes [Resources for Action](#), which are the scientific basis for CDC's programmatic violence prevention work with communities.<sup>186</sup> In FY 2024, CDC released the *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*.
- Produces training modules for professionals to learn about preventing adverse childhood experiences (ACEs). In 2023, CDC released an ACEs Training Module designed to help faith, spiritual, and religious

<sup>186</sup> <https://www.cdc.gov/violenceprevention/communicationresources/pub/resource-for-action.html>

leaders, staff members, volunteers, and others who serve children and families understand their role in preventing ACEs.

- Funds states tribes, territories, non-governmental organizations, and university research programs to track and monitor suicide-related outcomes, build implementation capacity, and implement and evaluate suicide prevention strategies and approaches with the best available evidence.

### Budget Request

CDC's FY 2025 budget request of **\$323,550,000** for Intentional Injury Prevention is **\$159,000,000** above the FY 2023 final level, which includes increased investments to scale up activities to prevent ACEs, community violence, and suicide. Level funding for Rape Prevention and Education will allow CDC to continue implementing the Violence Against Women Act (VAWA) 2022, funding Rape Prevention and Education Programs, and promoting the National Action Plan for Gender-Based Violence.

CDC will continue funding the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program to build the capacity to implement and evaluate proven intimate partner violence (IPV) prevention strategies in states.

The FY 2025 budget provides a total of \$2.5 billion over ten years in mandatory and discretionary funds for Youth and Community Violence Prevention. Of this total, the budget assumes \$100 million in discretionary funding per year and \$150 million in mandatory funding per year to support scaling up existing community violence prevention efforts and implementing and evaluating programs, policies, and practices based on the best available evidence for preventing community violence. With the total \$250.0 million investment, CDC will fund up to 75 cities and communities in geographic areas with the highest number of homicides or highest number of homicides per capita, to establish a collaborative, community driven public health approach to reduce community violence. Communities will select strategies based on their needs and priorities, using local data and experience. Funded communities will collaborate with local health departments, the health care sector, and law enforcement to use emergency department data to identify hot spots, understand trends, and link to CDC's Social Vulnerability Index to better understand community needs and risk and protective factors to inform prevention approaches. CDC would also support the recipients by providing training and technical assistance from organizations that are representative of communities most impacted by youth and community violence and have a proven track record of serving those communities.

Increased funding for youth and community violence prevention will also allow CDC to fund up to seven additional National Centers of Excellence in Youth Violence (YVPCs) beyond the currently funded five YVPCs to develop, implement, and rigorously evaluate innovative strategies to prevent violence and create safer, healthier family and community environments for youth. CDC will also fund research awards to both assist YVPC recipients with program evaluation and further build the evidence base for preventing violence in communities experiencing the greatest burden.

With the \$30 million investment in ACEs, CDC will use the proposed \$21 million increase to expand data-driven, evidence-based ACEs prevention and positive childhood experiences (PCEs) promotion strategies from the 12 currently funded entities to reach up to 30 states, territories, localities, and tribes. Funded recipients will improve the quality and consistency of data and use local data to identify and implement the most impactful prevention strategies and approaches in their communities. ACEs prevention and PCEs promotion improves the health and well-being of communities, families, and individuals and can reduce future risk for substance use, suicide, mental health problems, and a wide range of chronic diseases.

With the \$68 million investment in suicide prevention, CDC will leverage the proposed \$38 million increase to expand its Comprehensive Suicide Prevention (CSP) program to support recipients in up to 45 states or territories, an increase of 21 recipients. The CSP program supports recipients to implement and evaluate a comprehensive public health approach to suicide prevention, with a special focus on populations that are

disproportionately affected by suicide. This also includes supporting recipients to collect near real-time data to rapidly track and respond to changing patterns in suicidal behavior. CDC funds tribal organizations to increase capacity to adapt, implement, and evaluate suicide prevention programs to reduce suicide-related morbidity and mortality. With increased funds, CDC will expand funding to support up to four additional tribal organizations. CDC will also strengthen collaborations with funded jurisdictions and partners by building our knowledge in proven prevention strategies and broadening awareness of suicide while increasing accessibility to vital prevention resources.

**Rape Prevention and Education (RPE)**

FY 2024 is the first year of CDC’s newest five-year RPE cooperative agreement dedicated to preventing rape and other forms of sexual violence (SV), supporting health departments in all 50 states, the District of Columbia, and territories. FY 2024 is also the first year of a four-year grant program supporting prevention activities by state, territorial, and tribal sexual assault coalitions. RPE recipients’ efforts are informed by programs, practices, and policies identified within the *Violence Prevention Resource for Action*.<sup>187</sup> This resource for action shares evidence-based prevention strategies that include promoting positive social norms, providing opportunities to empower and support girls and women, teaching healthy relationship skills, and creating protective environments. CDC also supports six research awards to rigorously evaluate the effectiveness of primary prevention efforts implemented by RPE programs.

CDC continues to fund collaborative research projects between academic researchers and RPE-funded organizations to build evidence for sexual violence prevention approaches that are feasible for communities to implement.

Program Accomplishments:

- Illinois’ RPE program reviewed data from the 2019 Youth Risk Behavior Survey and found that 12 percent of girls and 7.5 percent of boys reported being physically forced to have sexual intercourse in grades 9-12. In response, the program provided comprehensive sex education focusing on consent, which can prevent SV among youth.

**Rape Prevention and Education Grants<sup>1</sup>**

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President’s Budget
<b>Number of Awards for State Health Departments</b>	53	TBD	TBD
- New Awards	0	TBD	TBD
- Continuing Awards	53	TBD	TBD
Average Award	\$0.771	TBD	TBD
Range of Awards	\$0.040–3.667	TBD	TBD
<b>Number of Awards for SV Coalitions</b>	49	TBD	TBD
- New Awards	49	TBD	TBD
- Continuing Awards	0	TBD	TBD
Average Award	\$0.124	TBD	TBD
Range of Awards	\$0.100-0.125	TBD	TBD
<b>Total Awards</b>	<b>\$46.384</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> Funding is awarded by formulas.

<sup>187</sup> [https://www.cdc.gov/violenceprevention/pdf/SV-Prevention-Resource\\_508.pdf](https://www.cdc.gov/violenceprevention/pdf/SV-Prevention-Resource_508.pdf)

## Intimate Partner Violence (IPV)

Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS), indicate that about 41 percent of women and 26 percent of men experienced contact sexual violence, physical violence, and/or stalking by an intimate partner and reported an intimate partner violence-related negative impact such as physical and mental health problems, fear, concern for safety, and missing work during their lifetime. NISVS data estimates that the lifetime cost of IPV is \$103,767 per female victim and \$23,414 per male victim.

In FY 2024, CDC continued funding 13 state domestic violence coalitions (SDVCs) under Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA). SDVCs establish, operate, and maintain local community projects to prevent family violence, domestic violence, and teen dating violence. SDVCs select and implement strategies from CDC's Intimate Partner Violence Resource for Action based on community needs.

## Child Abuse and Neglect

Child abuse and neglect are significant and preventable ACEs that have long-term repercussions for both the child and for society. In 2019, 1,840 children died of abuse and neglect in the United States. About one in four girls and one in 13 boys experience childhood sexual abuse. CDC published research in 2018 showing that, for each person in the United States who survives an experience of child abuse and neglect, the lifetime cost to society is more than \$830,000. The lifetime economic burden of child abuse and neglect in 2015 alone was estimated at \$428 billion,<sup>188</sup> rivaling the cost of stroke and type 2 diabetes.

With additional funding, CDC will support up to 30 states, territories, localities, and tribes to implement prevention strategies and approaches in their communities through the Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action (EfC: PACE D2A) cooperative agreement. EfC: PACE D2A is designed to support states in the prevention of ACEs, including child abuse and neglect, and promotion of positive childhood experiences (PCEs). Recipients leverage multi-sector partnerships and resources to improve ACE and PCE surveillance infrastructures and the coordination and implementation of ACE prevention strategies. This increases state capacity to develop and sustain a surveillance system that collects, uses, and disseminates data on ACEs and PCEs, including data used to identify health inequities and increases implementation and reach of ACE prevention strategies that help to promote safe, stable, nurturing relationships and environments where children live, learn, and play. With continued funding for child sexual abuse prevention, CDC will also continue to fund pioneering research to prevent child sexual abuse before it starts.

### Program Accomplishments:

- The California Essentials for Childhood Initiative educated community members, city staff, and elected officials about strategies in CDC's technical packages and provided guidance on implementing them locally. As a result, 17 separate evidence-based policies, programs, and practices are being implemented in communities across the state.
- The Georgia Department of Public Health PACE: D2A program created a publicly available resource that measures and tracks data to support ACEs prevention in Georgia. The state is using its data to inform practice by developing a mapping tool for regions across the state that provide local data on ACEs and the burden of ACEs on families and communities. These data are part of Georgia's [Child Abuse and Neglect Prevention Plan](#), and 14 regional committees are using the data to inform proven prevention strategies such as increasing implementation of early childhood home visitation to identify under-resourced regions and communities to better allocate resources to prevent ACEs.<sup>189</sup>

<sup>188</sup> <https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html>

<sup>189</sup> [Preventing Adverse Childhood Experiences: Data to Action | Emory University | Atlanta GA](#)

## Suicide Prevention

Suicide prevention has historically focused on crisis intervention and referring people to mental health treatment. However, CDC data have shown that about half of individuals who die by suicide do not have a known mental health condition. Multiple factors contribute to suicide at the individual, relationship, community, and societal levels. These can include issues related to substance misuse, physical health, jobs, money, interpersonal violence, stigma, and access to lethal means among people at risk.

CDC's Comprehensive Suicide Prevention Program (CSP) currently funds programs in 23 states and one territory to implement and evaluate a comprehensive public health approach to suicide prevention, with a particular focus on populations that are disproportionately affected by suicide, including youth, veterans, rural communities, LGBTQ+ individuals, and middle-aged adults. With increased funding, CDC would expand CSP to recipients in 45 states or territories and up to four tribal organizations. Funded entities use data to drive decision-making and apply the best available evidence to prevent suicide. CDC also funds tribal organizations to build capacity for comprehensive suicide prevention tailored to tribal communities.

CDC, in cooperation with the CDC Foundation, will also fund up to four veteran-serving organizations (VSOs) through its Veteran Suicide Prevention Evaluation program. This program increases VSOs' capacity to evaluate their suicide prevention programs focused on community connectedness and community integration among veterans. VSOs reported increased evaluation skills and numerous program and strategy improvements after just one year in the program. Input from these VSOs will be combined with those of future cohorts to develop an evaluation toolkit and increase the implementation of best practices.

### Program Accomplishments:

The Vermont Department of Health used CSP funding to create the Vermont Emergency Department Suicide Prevention Quality Improvement Initiative to improve hospitals' ability to screen, assess, and educate on how to reduce access to lethal means for persons at risk of suicide and support follow-up care for individuals at-risk for suicide. These activities are helping Vermont hospitals better care for the over 1,000 patients who visit hospital emergency departments for intentional self-harm and 4,000 patients who visit for suicidal ideation and self-directed violence each year. All Vermont hospitals completed a Zero Suicide Organizational Self Study, 86 percent participated in a Joint Commission Mock Survey focused on improving suicide care, 93 percent demonstrated improvement in their quality improvement goals, and over 300 hospital staff members completed training on Counseling on Access to Lethal Means.

## Youth and Community Violence Prevention

In the United States, 26,031 lives were lost to homicide in 2021. Homicide is the third leading cause of death among youth and young adults aged 10–34 and the leading cause of death among Black individuals in this age group. Youth who experience violence have experienced an ACE and so are more likely to have short-term and chronic physical and mental health conditions and behavioral difficulties, including future experiences with violence, smoking, substance use, obesity, high-risk sexual behavior, depression, academic difficulties, school dropout, and suicidal behavior. Youth violence prevention efforts are proven to reduce healthcare costs and reduce a myriad of future negative physical and mental health outcomes.

With increased funding for youth and community violence prevention, CDC will maintain current youth violence prevention activities with a focus on youth and young adults who experience violence to help stem the rise of the most lethal forms of violence in cities nationwide. CDC will support partnerships with community-based organizations and non-governmental organizations that serve hospital-based violence prevention and street outreach workers to increase the uptake of public health solutions such as using local data to guide action and building the necessary prevention infrastructure to support this emerging workforce. Community violence workers see trauma, violence, and death firsthand and can sometimes find themselves in the line of fire. Studies



show these workers experience symptoms of secondary traumatic stress and need support to reduce the negative health impacts of workplace exposure to violence.

The Youth and Community Violence Prevention program will focus on youth and young adults (aged 10-34) experiencing violence and will draw on CDC's more than 20 years of science-based youth violence prevention efforts. This program will fund up to 75 communities with high numbers of homicides and communities with high numbers of homicides per capita to establish a community-driven approaches to reducing violence. Communities will implement strategies best suited to their demographics and risk factors, including programs that complement law-enforcement activities, such as hospital-based violence intervention programs. Eligible recipients will include health departments, hospitals, and community-based organizations. Data will guide community decision making. Communities will be encouraged to use both death data and syndromic surveillance data on emergency department visits for firearm-related, other weapon-related, and physical assault injuries to understand local risks and identify patterns and trends. Communities will choose interventions, informed by the data, to prevent future injuries and deaths. Based on what they learn from these data, award recipients will work with partners across multiple sectors to implement strategies proven to reduce violence. Examples of proven approaches include built environment approaches like remediating vacant lots, adding green spaces, and enhancing safety in parks; school-based violence prevention programs, and provision of trauma informed mental health and trauma recovery services to survivors of gun violence. CDC will provide robust technical assistance to support anticipated varying and evolving community needs. Funds will go to organizations that are representative of communities most impacted by community violence and have a proven track record of serving those communities.

#### Program Accomplishments:

In FY 2024, CDC released the *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*, which is an update of the CDC's [Youth Violence Prevention Resource for Action](#)<sup>190</sup> that shows communities and states how to sharpen their focus on prevention activities and prioritize strategies with the greatest potential local benefit. Preventing Violence Affecting Young Lives (PREVAYL) recipients rely upon this resource and focus on sustaining the widespread impact and reach of proven violence prevention strategies and reducing high rates of violence in communities of color. CDC funds eight PREVAYL recipients to address social determinants of health such as concentrated poverty and limited educational or employment opportunities, which are associated with increased risk for violence. For example, the Monterey County Department of Health is working with student groups to identify and map unsafe areas in Salinas, California, and making recommendations to modify the physical environment to make their schools and communities safer.

CDC currently funds five Youth Violence Prevention Centers (YVPCs), which are academic-community collaborations that advance the science and practice of youth violence prevention research. For example, Michigan's YVPC adopted Crime Prevention Through Environmental Design (CPTED), promoting safety through cleaning up and improving vacant lots. Evaluation results showed that by beautifying and reinvigorating local neighborhoods, neighbors reported increased communication with one another, lower amounts of victimization, lower levels of fear and crime, and increased neighborhood satisfaction. Areas where this intervention was implemented witnessed a 38 percent decrease in youth seeking treatment for assault-related injuries and youth in the intervention area were 25 percent less likely to be victims of a violent assault than youth in a comparison area without the interventions.

#### **State Table: National Violent Death Reporting System<sup>1,2</sup>**

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<sup>190</sup> [https://www.cdc.gov/violenceprevention/pdf/YV-Prevention-Resource\\_508.pdf](https://www.cdc.gov/violenceprevention/pdf/YV-Prevention-Resource_508.pdf)

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Alabama	\$330,224	TBD	TBD	TBD
Alaska	\$204,513	TBD	TBD	TBD
Arizona	\$370,210	TBD	TBD	TBD
Arkansas	\$273,123	TBD	TBD	TBD
California	\$962,085	TBD	TBD	TBD
Colorado	\$333,405	TBD	TBD	TBD
Connecticut	\$234,676	TBD	TBD	TBD
District of Columbia	\$184,398	TBD	TBD	TBD
Delaware	\$183,314	TBD	TBD	TBD
Florida	\$709,468	TBD	TBD	TBD
Georgia	\$432,712	TBD	TBD	TBD
Hawaii	\$195,908	TBD	TBD	TBD
Idaho	\$212,021	TBD	TBD	TBD
Illinois	\$469,526	TBD	TBD	TBD
Indiana	\$352,671	TBD	TBD	TBD
Iowa	\$240,432	TBD	TBD	TBD
Kansas	\$254,240	TBD	TBD	TBD
Kentucky	\$288,180	TBD	TBD	TBD
Louisiana	\$330,086	TBD	TBD	TBD
Maine <sup>3</sup>	\$195,056	TBD	TBD	TBD
Maryland	\$459,044	TBD	TBD	TBD
Massachusetts	\$266,816	TBD	TBD	TBD
Michigan	\$434,523	TBD	TBD	TBD
Minnesota	\$279,049	TBD	TBD	TBD
Mississippi	\$265,229	TBD	TBD	TBD
Missouri	\$369,064	TBD	TBD	TBD
Montana	\$203,175	TBD	TBD	TBD
Nebraska	\$202,245	TBD	TBD	TBD
Nevada	\$277,984	TBD	TBD	TBD
New Hampshire	\$196,896	TBD	TBD	TBD
New Jersey	\$288,454	TBD	TBD	TBD
New Mexico	\$255,091	TBD	TBD	TBD
New York	\$469,614	TBD	TBD	TBD
North Carolina	\$423,840	TBD	TBD	TBD
North Dakota	\$182,151	TBD	TBD	TBD
Ohio	\$450,824	TBD	TBD	TBD
Oklahoma	\$312,737	TBD	TBD	TBD
Oregon	\$280,256	TBD	TBD	TBD
Pennsylvania	\$477,710	TBD	TBD	TBD
Puerto Rico	\$282,935	TBD	TBD	TBD
Rhode Island	\$180,387	TBD	TBD	TBD
South Carolina	\$319,523	TBD	TBD	TBD
South Dakota	\$192,173	TBD	TBD	TBD
Tennessee	\$363,681	TBD	TBD	TBD
Texas	\$780,508	TBD	TBD	TBD
Utah	\$265,822	TBD	TBD	TBD
Vermont <sup>3</sup>	\$178,505	TBD	TBD	TBD
Virginia	\$354,585	TBD	TBD	TBD
Washington	\$331,969	TBD	TBD	TBD
West Virginia	\$238,720	TBD	TBD	TBD
Wisconsin	\$311,848	TBD	TBD	TBD
Wyoming	\$181,687	TBD	TBD	TBD

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Total Resources</b>	<b>\$16,833,293</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> CFDA NUMBER: 93.136 Discretionary.

<sup>2</sup> This State Table is a snapshot of selected programs that fund states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <https://www.cdc.gov/fundingprofiles/>

<sup>3</sup> Maine and Vermont are funded together, with Maine as the lead state under the award.

**State Table: Rape Prevention and Education Funding to State Health Departments<sup>1,2</sup>**

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Alabama	\$628,809	TBD	TBD	TBD
Alaska	\$223,042	TBD	TBD	TBD
Arizona	\$832,388	TBD	TBD	TBD
Arkansas	\$412,627	TBD	TBD	TBD
California	\$3,599,548	TBD	TBD	TBD
Colorado	\$ 836,939	TBD	TBD	TBD
Connecticut	\$664,322	TBD	TBD	TBD
Delaware	\$243,734	TBD	TBD	TBD
District of Columbia	\$ 217,064	TBD	TBD	TBD
Florida	\$1,961,556	TBD	TBD	TBD
Georgia	\$1,056,143	TBD	TBD	TBD
Hawaii	\$290,646	TBD	TBD	TBD
Idaho	\$315,711	TBD	TBD	TBD
Illinois	\$1,275,083	TBD	TBD	TBD
Indiana	\$ 802,720	TBD	TBD	TBD
Iowa	\$658,621	TBD	TBD	TBD
Kansas	\$405,512	TBD	TBD	TBD
Kentucky	\$586,835	TBD	TBD	TBD
Louisiana	\$610,926	TBD	TBD	TBD
Maine	\$267,019	TBD	TBD	TBD
Maryland	\$742,340	TBD	TBD	TBD
Massachusetts	\$748,664	TBD	TBD	TBD
Michigan	\$1,127,476	TBD	TBD	TBD
Minnesota	\$893,458	TBD	TBD	TBD
Mississippi	\$444,251	TBD	TBD	TBD
Missouri	\$949,877	TBD	TBD	TBD
Montana	\$441,623	TBD	TBD	TBD
Nebraska	\$337,762	TBD	TBD	TBD
Nevada	\$439,459	TBD	TBD	TBD
New Hampshire	\$267,311	TBD	TBD	TBD
New Jersey	\$1,230,613	TBD	TBD	TBD
New Mexico	\$332,893	TBD	TBD	TBD
New York	\$2,093,992	TBD	TBD	TBD
North Carolina	\$1,148,986	TBD	TBD	TBD
North Dakota	\$224,623	TBD	TBD	TBD
Ohio	\$1,170,747	TBD	TBD	TBD
Oklahoma	\$494,828	TBD	TBD	TBD
Oregon	\$752,985	TBD	TBD	TBD
Pennsylvania	\$1,408,651	TBD	TBD	TBD
Rhode Island	\$442,846	TBD	TBD	TBD
South Carolina	\$638,440	TBD	TBD	TBD
South Dakota	\$235,207	TBD	TBD	TBD
Tennessee	\$804,833	TBD	TBD	TBD
Texas	\$2,598,747	TBD	TBD	TBD
Utah	\$650,403	TBD	TBD	TBD
Vermont	\$204,893	TBD	TBD	TBD
Virginia	\$978,172	TBD	TBD	TBD
Washington	\$867,529	TBD	TBD	TBD
West Virginia	\$330,278	TBD	TBD	TBD
Wisconsin	\$718,934	TBD	TBD	TBD
Wyoming	\$207,645	TBD	TBD	TBD

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Territories</b>				
American Samoa	\$0	TBD	TBD	TBD
Guam	\$0	TBD	TBD	TBD
Marshall Islands	\$0	TBD	TBD	TBD
Micronesia	\$0	TBD	TBD	TBD
Northern Mariana Islands	\$0	TBD	TBD	TBD
Puerto Rico	\$449,808	TBD	TBD	TBD
Republic of Palau	\$0	TBD	TBD	TBD
Virgin Islands	\$40,000	TBD	TBD	TBD
<b>Subtotal States</b>	<b>\$39,817,711</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Territories</b>	<b>\$489,808</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Total Resources</b>	<b>\$40,307,519</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> CFDA NUMBER: 93.136 Discretionary

<sup>2</sup> This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <https://www.cdc.gov/fundingprofiles/>

**State Table: Rape Prevention and Education Funding to State, Territorial and Tribal Sexual Assault Coalitions**

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Alabama	\$125,830	TBD	TBD	TBD
Alaska	\$0	TBD	TBD	TBD
Arizona	\$125,830	TBD	TBD	TBD
Arkansas	\$125,830	TBD	TBD	TBD
California	\$125,830	TBD	TBD	TBD
Colorado	\$125,830	TBD	TBD	TBD
Connecticut	\$115,641	TBD	TBD	TBD
Delaware	\$122,676	TBD	TBD	TBD
District of Columbia	\$125,443	TBD	TBD	TBD
Florida	\$125,830	TBD	TBD	TBD
Georgia	\$0	TBD	TBD	TBD
Hawaii	\$0	TBD	TBD	TBD
Idaho	\$125,000	TBD	TBD	TBD
Illinois	\$125,830	TBD	TBD	TBD
Indiana	\$125,830	TBD	TBD	TBD
Iowa	\$125,830	TBD	TBD	TBD
Kansas	\$125,830	TBD	TBD	TBD
Kentucky	\$125,830	TBD	TBD	TBD
Louisiana	\$125,830	TBD	TBD	TBD
Maine	\$125,830	TBD	TBD	TBD
Maryland	\$125,830	TBD	TBD	TBD
Massachusetts	\$125,830	TBD	TBD	TBD
Michigan	\$125,830	TBD	TBD	TBD
Minnesota	\$125,830	TBD	TBD	TBD
Mississippi	\$125,830	TBD	TBD	TBD
Missouri	\$125,830	TBD	TBD	TBD
Montana	\$125,830	TBD	TBD	TBD
Nebraska	\$125,830	TBD	TBD	TBD
Nevada	\$125,830	TBD	TBD	TBD
New Hampshire	\$125,830	TBD	TBD	TBD
New Jersey	\$125,830	TBD	TBD	TBD
New Mexico	\$125,000	TBD	TBD	TBD
New York	\$0	TBD	TBD	TBD
North Carolina	\$125,830	TBD	TBD	TBD
North Dakota	\$125,830	TBD	TBD	TBD
Ohio	\$125,830	TBD	TBD	TBD
Oklahoma	\$0	TBD	TBD	TBD
Oregon	\$125,000	TBD	TBD	TBD
Pennsylvania	\$125,830	TBD	TBD	TBD
Rhode Island	\$125,830	TBD	TBD	TBD
South Carolina	\$125,830	TBD	TBD	TBD
South Dakota	\$125,830	TBD	TBD	TBD
Tennessee	\$125,830	TBD	TBD	TBD
Texas	\$125,830	TBD	TBD	TBD
Utah	\$0	TBD	TBD	TBD
Vermont	\$125,830	TBD	TBD	TBD
Virginia	\$125,830	TBD	TBD	TBD
Washington	\$0	TBD	TBD	TBD
West Virginia	\$125,830	TBD	TBD	TBD

CDC FY 2025 Congressional Justification

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Wisconsin	\$125,830	TBD	TBD	TBD
Wyoming	\$115,641	TBD	TBD	TBD
<b>Territories</b>				
American Samoa	\$125,830	TBD	TBD	TBD
Guam	\$115,641	TBD	TBD	TBD
Puerto Rico	\$125,000	TBD	TBD	TBD
<b>Tribes</b>				
First Nations Women's Alliance Executive	\$100,000	TBD	TBD	TBD
Minnesota Indian Women's Sexual Assault Coalition	\$100,000	TBD	TBD	TBD
<b>Subtotal States</b>	<b>\$5,510,111</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Territories</b>	<b>\$366,471</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Tribes</b>	<b>\$200,000</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Total Resources</b>	<b>\$6,076,582</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

**State Table: Opioid Overdose Prevention and Surveillance Programs<sup>1,2</sup>**

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Alabama	\$3,519,072	TBD	TBD	TBD
Jefferson County	\$1,557,500	TBD	TBD	TBD
Alaska	\$2,692,878	TBD	TBD	TBD
Arizona	\$4,703,386	TBD	TBD	TBD
Maricopa County	\$2,892,500	TBD	TBD	TBD
Pima County	\$2,544,375	TBD	TBD	TBD
Arkansas	\$2,155,910	TBD	TBD	TBD
California	\$5,094,718	TBD	TBD	TBD
Riverside County	\$2,892,500	TBD	TBD	TBD
Alameda County	\$2,549,000	TBD	TBD	TBD
San Francisco	\$2,225,000	TBD	TBD	TBD
Los Angeles County	\$3,217,500	TBD	TBD	TBD
Santa Clara County	\$2,225,000	TBD	TBD	TBD
Colorado	\$4,307,579	TBD	TBD	TBD
Denver	\$1,807,494	TBD	TBD	TBD
Connecticut	\$4,452,788	TBD	TBD	TBD
City of New Haven	\$2,104,447	TBD	TBD	TBD
City of Hartford	\$1,090,000	TBD	TBD	TBD
Delaware	\$3,327,587	TBD	TBD	TBD
District of Columbia	\$3,945,761	TBD	TBD	TBD
Florida	\$5,823,539	TBD	TBD	TBD
Broward County	\$3,742,500	TBD	TBD	TBD
Duval County	\$2,550,000	TBD	TBD	TBD
Palm Beach County	\$3,075,000	TBD	TBD	TBD
Georgia	\$4,245,286	TBD	TBD	TBD
Hawaii	\$2,748,281	TBD	TBD	TBD
Idaho	\$2,041,935	TBD	TBD	TBD
Illinois	\$4,586,082	TBD	TBD	TBD
Chicago	\$3,417,500	TBD	TBD	TBD
Indiana	\$5,129,814	TBD	TBD	TBD
Marion County	\$2,750,000	TBD	TBD	TBD
Iowa	\$2,507,303	TBD	TBD	TBD
Kansas	\$2,685,279	TBD	TBD	TBD
Sedgwick County	\$1,140,000	TBD	TBD	TBD
Kentucky	\$5,407,419	TBD	TBD	TBD
Louisiana	\$4,688,805	TBD	TBD	TBD
Maine	\$2,920,497	TBD	TBD	TBD
City of Portland	\$823,799	TBD	TBD	TBD
Maryland	\$4,528,982	TBD	TBD	TBD
Baltimore County	\$2,550,000	TBD	TBD	TBD
Massachusetts	\$4,210,480	TBD	TBD	TBD
Boston	\$1,355,037	TBD	TBD	TBD
Michigan	\$4,261,805	TBD	TBD	TBD
Barry-Eaton	\$838,273	TBD	TBD	TBD
Minnesota	\$4,199,924	TBD	TBD	TBD
Mississippi	\$2,540,192	TBD	TBD	TBD
Missouri	\$4,394,497	TBD	TBD	TBD
St. Louis County	\$2,682,189	TBD	TBD	TBD
Montana	\$2,119,512	TBD	TBD	TBD
Nebraska	\$2,481,553	TBD	TBD	TBD



(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Douglas County	\$890,000			
Nevada	\$2,509,687	TBD	TBD	TBD
Clark County	\$2,550,000	TBD	TBD	TBD
New Hampshire	\$2,697,194	TBD	TBD	TBD
New Jersey	\$4,653,462	TBD	TBD	TBD
New Mexico	\$4,322,929	TBD	TBD	TBD
New York	\$5,017,294	TBD	TBD	TBD
New York City	\$3,401,911	TBD	TBD	TBD
Broome County	\$890,000	TBD	TBD	TBD
North Carolina	\$4,590,273	TBD	TBD	TBD
Mecklenburg County	\$837,708	TBD	TBD	TBD
North Dakota (did not apply for funding)	N/A	TBD	TBD	TBD
Ohio	\$5,256,430	TBD	TBD	TBD
Cuyahoga County	\$2,851,407	TBD	TBD	TBD
Franklin County	\$3,742,500	TBD	TBD	TBD
Hamilton County	\$3,075,000	TBD	TBD	TBD
Oklahoma	\$2,453,381	TBD	TBD	TBD
Oregon	\$3,854,849	TBD	TBD	TBD
Pennsylvania	\$5,310,740	TBD	TBD	TBD
Allegheny County	\$2,997,558	TBD	TBD	TBD
Philadelphia	\$3,742,500	TBD	TBD	TBD
Montgomery County	\$889,941	TBD	TBD	TBD
Rhode Island	\$3,453,142	TBD	TBD	TBD
South Carolina	\$4,587,985	TBD	TBD	TBD
South Dakota	\$1,865,943	TBD	TBD	TBD
Tennessee	\$5,343,696	TBD	TBD	TBD
Knox County	\$1,320,505	TBD	TBD	TBD
Texas	\$3,947,634	TBD	TBD	TBD
Harris County	\$2,231,063	TBD	TBD	TBD
Dallas County	\$2,225,000	TBD	TBD	TBD
Utah	\$2,710,977	TBD	TBD	TBD
Salt Lake County	\$2,550,000	TBD	TBD	TBD
Vermont	\$3,272,032	TBD	TBD	TBD
Virginia	\$4,066,658	TBD	TBD	TBD
Washington	\$4,193,955	TBD	TBD	TBD
Seattle & King County	\$3,075,000	TBD	TBD	TBD
Snohomish County	\$889,476	TBD	TBD	TBD
West Virginia	\$5,339,590	TBD	TBD	TBD
Wisconsin	\$4,483,777	TBD	TBD	TBD
Wyoming	1,952,553	TBD	TBD	TBD
<b>Territories</b>				
Puerto Rico	\$1,005,610	TBD	TBD	TBD
<b>Subtotal States</b>	<b>\$279,499,899</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Territories</b>	<b>\$1,005,640</b>	<b>TBD</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> CFDA NUMBER: 93.136 Discretionary.

<sup>2</sup> Estimated funding may shift if jurisdictions adjust budgets.

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## NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$362.800	\$362.800	\$363.200	+\$0.400
<b>Total Request</b>	<b>\$362.800</b>	<b>\$362.800</b>	<b>\$363.200</b>	<b>+\$0.400</b>
FTEs	1,047	1,063	1,065	18
-- National Occupational Research Agenda (NORA)	\$119.500	\$119.500	\$119.900	+\$0.400
-- <i>Agriculture, Forestry, Fishing (AgFF) (non-add)</i>	\$29.000	\$29.000	\$29.000	\$0
-- Education and Research Centers	\$32.000	\$32.000	\$32.000	\$0
-- Personal Protective Technology	\$23.000	\$23.000	\$23.000	\$0
-- Mining Research	\$66.500	\$66.500	\$66.500	\$0
-- Occupational Safety and Health Research and Services	\$115.100	\$115.100	\$115.100	\$0
-- National Mesothelioma Registry and Tissue Bank	\$1.200	\$1.200	\$1.200	\$0
-- National Firefighter Registry for Cancer	\$5.500	\$5.500	\$5.500	\$0
<b>Mandatory Programs Total</b>				
World Trade Center <sup>1</sup>	\$709.848	\$768.392	\$788.110	+\$78.262
Energy Employees Occupational Illness Compensation Program Act (EEOICPA) <sup>2</sup>	\$50.763	\$50.763	\$50.763	\$0

<sup>1</sup> Reflects the federal share of WTCHP only. These amounts are based on trend analysis and are the best estimates at the time but are subject to change. FY 2023 Final Level excludes supplemental funding of \$1 billion in the FY 2023 Appropriations Act (P.L. 117-328) and the FY 2024 amounts excludes supplemental funding of \$676 million in the FY 2024 National Defense Authorization Act (P.L.118-31).

<sup>2</sup> EEOICPA funds are subject to Defense sequestration amount of 8.6 percent. Levels reflect post-sequester amount.

**Enabling Legislation Citation:** PHS A § 301, PHS A § 304, PHS A § 306\*, PHS A § 307, PHS A § 308(d), PHS A § 310, PHS A § 311, PHS A § 317, PHS A § 317A\*, PHS A § 317B, PHS A § 319, PHS A § 327, PHS A § 352, PHS A §§ 399MM-399MM-3, PHS A § 399V-6, PHS A § 1102, PHS A § 2695, Bureau of Mine Act, as amended by Pub. L. 104-208; Energy Employees Occupational Illness Compensation Program Act of 2000; Federal Mine Safety and Health Act of 1977, Pub. L. 91-173 as amended by Pub. L. 95-164 and Pub. L. 109-236; Mine Improvement and New Emergency Response Act § 13, Firefighter Cancer Registry Act of 2018 (Pub. L. 115-194)\*, James Zadroga 9/11 Health and Compensation Act of 2010 (Pub. L. 111-347); Consolidated Appropriations Act, 2016 (Pub. L. 114-113); Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (Pub. L. 116-59); Consolidated Appropriations Act, 2023 (Pub. L. 117-328); Occupational Safety and Health Act of 1970 §§20–22, Pub. L. 91-596 as amended by Pub. L. 107-188 and 109-236 (29 U.S.C. 669–671); Radiation Exposure Compensation Act, §§ 6 and 12; Toxic Substances Control Act, Pub. L. 94-469 as amended by 102-550\*.

**Enabling Legislation Status:** Permanent Indefinite, Expired/Expiring noted with \*

**Authorization of Appropriations for FY 2023:** Indefinite

**Allocation Methods:** Direct Federal/Intramural, Competitive Grant/Cooperative Agreements, Contracts, Other

### Program Description

CDC's National Institute for Occupational Safety and Health (NIOSH) was established by the Occupational Safety and Health Act of 1970 to work cooperatively with employers and employees and adapt new knowledge from occupational health and safety research into workable solutions. NIOSH is the only dedicated federal investment for the research needed to prevent work-related injuries and illnesses among the nation's 164 million workers and is distinct from the regulatory function of the Occupational Safety and Health Administration. The economic impact of work-related injuries and illnesses in the states is estimated to be \$250 billion annually.<sup>191</sup>

NIOSH's research activities are aligned under the National Occupational Research Agenda (NORA), a public-private partnership that identifies critical needs. NIOSH prepares for, responds to, and studies chemical, biological, radiological, and natural disasters. NIOSH also administers the Energy Employees Occupational Illness

<sup>191</sup> Bureau of Labor Statistics. 2023. The Employment Situation – November 2023. <https://www.bls.gov/news.release/pdf/empsit.pdf>

Compensation Program and the World Trade Center Health Program, both supported by mandatory funding allocated to CDC.

### Program Accomplishments

In spring 2023, CDC launched its first Community of Practice (CoP) focused on developing cultural competence among internal staff and external partners to serve historically marginalized and underserved workers more effectively. The CoP has between 50-60 members and meets on a quarterly basis to discuss health disparities and inequities impacting these groups, and to help each other identify, develop, and implement culturally competent research and communication practices, methods, and approaches.

CDC provided over 70 trainings and other presentations to build foundational skills among intramural and extramural occupational safety and health professionals and trainees to enable them to competently advance equity work. Further, CDC established 21 new occupational safety and health equity research and intervention priorities across its diverse scientific agendas, implemented 14 new policies and procedures to better facilitate the conduct of occupational safety and health equity science and the development of interventions, and identified 97 occupational safety and health equity-related measures and methodologies to better capture data on the occupational safety and health status of historically marginalized and underserved sociodemographic populations.

Since 2021, CDC increased its occupational safety and health outreach and communication efforts to reach populations that historically have been marginalized and underserved through new partnerships and communication materials. For example, CDC launched an [initiative](#)<sup>192</sup> in collaboration with the National Aeronautics and Space Administration (NASA) and a crowdsourcing challenge hosting company to develop innovative solutions to problems (e.g., use, availability, accessibility, acceptability, and knowledge) related to offering personal protective technologies to all workers, including those belonging to sociodemographic groups that have been historically marginalized and underserved. CDC also generated 68 presentations, reports, publications, and other occupational safety and health equity-focused products.

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<sup>192</sup> NIOSH Protective Clothing Challenge. <https://www.herox.com/NIOSHProtectiveClothing/teams>

## NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

### BY THE NUMBERS

- **460**—Respirator approval decisions and 375 quality assurance audits completed in 2023, making more types of respirators available to workers.
- **132**—Health Hazard Evaluations (HHE) conducted in 37 states (including Washington DC and the U.S. Virgin Islands) since January 2023 addressing work-related health concerns of thousands of workers and managers.
- **1,475,894** —Downloads of the OSHA-NIOSH Heat Safety app over the past 12 months. The app serves as a useful resource for planning outdoor work activities based on how hot it feels throughout the day. It features real-time heat index and hourly forecasts as well as occupational safety and health recommendations from OSHA and NIOSH.
- **414,306** —Downloads of the NIOSH Ladder Safety Smartphone app over the past 12 months. The app provides graphical guidance on safe ladder use and includes a patented innovation that allows users to set safe ladder angles more accurately and quickly than other methods.
- **100,000,000+**—Number of records coded by the [NIOSH Industry and Occupation Computerized Coding System \(NIOCCS\)](#),<sup>193</sup> a free web application used to translate industry and occupation text found in surveys, death certificates, and medical records into standardized codes so that researchers can analyze their data. More than 50 million of these records were coded in fiscal year 2022 alone, when NIOSH moved NIOCCS to a new and improved learning-based system.

<b>National Institute for Occupational Safety and Health Discretionary Funding History</b>	
Fiscal Year	Dollars (in millions)
FY 2021	\$344.240
FY 2022	\$351.800
FY 2023 Final	\$362.800
FY 2024 CR	\$362.800
FY 2025 President’s Budget	\$363.200

<sup>193</sup> <https://csams.cdc.gov/nioccs/Default.aspx>

## Occupational Health and Safety Budget Request

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### Program Overview

CDC's occupational health and safety research reflects the economic and infrastructure needs of the American workforce as identified by employers and employees, data on occupational illness and injury, and the opportunities for making an impact. CDC conducts research to reduce worker illness and injury and advance worker wellbeing, recommends interventions and capacity building to keep workers safe, and enhances worker safety and health through global collaborations. This work addresses every segment of the American workforce.

### Budget Request

CDC's FY 2025 budget request of **\$363,200,000** for Occupational Health and Safety is **\$400,000** above the FY 2023 final level. In FY 2025, CDC will continue to support the [National Occupational Research Agenda](#)<sup>194</sup> (NORA). NORA is a partnership program that stimulates innovative research and improved workplace practices, while also addressing emerging issues. For example, the [Future of Work Initiative](#)<sup>195</sup> identifies new research solutions, practical approaches, and partnership opportunities to address the changing nature of work and the safety and health implications for the future workforce. Priority topics for intramural and extramural research in this area include work arrangements, artificial intelligence, demographics, worker skills, and innovative technologies such as additive and smart manufacturing. The request includes an increase of \$400,000 for the Firefighter Fatality Investigation Program to expand their ability to conduct research for the prevention of occupational related fatalities among firefighters.

CDC also evaluates emerging worker safety and health risks and develops evidence-based research solutions around new industries, organizational design, job arrangements, and ways to control risks that affect the future workforce. For example, CDC partnered with the National Science Foundation to fund studies on innovations in integration of robotics to improve worker safety through the [National Robotics Initiative 2.0](#).<sup>196</sup> In addition, CDC launched the [Center for Work and Fatigue Research \(CWFR\)](#),<sup>197</sup> to raise awareness of the various sources of worker fatigue, identify effective methods of assessing fatigue-risk in workplaces, and reduce health and safety risks associated with workplace fatigue. The Center published guidance for workers and employers to manage workplace fatigue and work safely.

Other examples of intramural and extramural NORA focus include:

- Increasing coordination and research activities that support the Agriculture, Forestry and Fishing (AgFF) program. Workers within the AgFF sector experience the highest fatal occupational injury rate at 21.5 deaths per 100,000 full-time workers.
- Continuing research to improve safety and health in maritime industries, which are found in every U.S. state and across multiple industry sectors and experience a higher risk of fatality, injury, and illness than most other American industries.
- Continuing research on PFAS exposure in firefighters and other industry sectors with high to moderate PFAS use, such as manufacturing, services, and public safety.
- Focusing on the use of robotics, exoskeletons, and other emerging technologies in construction to determine the impact on health and safety.
- Developing and making available new technologies and recommended practices in mining to reduce injuries and fatalities from machinery and rock falls, as well as exposures to harmful mine dusts, airborne pollutants, heat, and noise.

<sup>194</sup> <https://www.cdc.gov/nora/default.html>

<sup>195</sup> <https://www.cdc.gov/niosh/topics/future-of-work/default.html>

<sup>196</sup> <https://www.nsf.gov/pubs/2019/nsf19536/nsf19536.htm>

<sup>197</sup> <https://www.cdc.gov/niosh/programs/ppops/cwfr.html>

- Preventing workplace violence in the Wholesale and Retail Trade Sector.
- Assessing the relationship between truck driver working conditions and chronic diseases such as diabetes, obesity, and heart disease.

In FY 2025, CDC will continue its collaboration with the Indian Health Service to address occupational hazards with high public health burden, including disproportionately affected populations. For example, CDC will establish a tribal steering committee comprised of tribal members, tribal serving organizations, state and federal agencies, and other partners to prioritize and implement the activities contained in the [NIOSH American Indian and Alaska Native Worker Safety and Health Strategic Plan](#),<sup>198</sup> which was finalized in April 2023. This ten-year strategic plan outlines the research, information, and actions needed to help prevent occupational injuries, illnesses, and fatalities among American Indian and Alaska Native workers with a focus on research, practice, policy, and capacity building.

CDC will also continue supporting its Education and Research Centers (ERCs). CDC currently funds 18 ERCs to address the burden of occupational safety and health in the United States by providing state-of-the-art interdisciplinary training for the next generation of occupational safety and health practitioners and researchers.

### **Personal Protective Technology (PPT)**

CDC's [Respirator Approval Program \(RAP\)](#)<sup>199</sup> evaluates and approves all respirators used in American workplaces and is a critical asset within the U.S. public health infrastructure. The RAP completed 460 respirator approval decisions and 375 quality assurance audits in 2023. In addition, CDC continued to protect respirator users from purchasing products that may not provide the expected level of respiratory protection by obtaining distinct certification marks from the U.S. Patent and Trademark Office and U.S. Custom and Border Protection (11 distinct marks 2020-2022), as well as internationally with 14 countries. In 2023, two certification marks were registered in seven countries and 7,000 E-commerce listings were reviewed; 458 listings of fraudulent masks were identified through online marketplace monitoring and resulted in the removal of these product listings.

CDC is continuing research on respirator design, breathability, fit, comfort, and usability; this program also works to characterize source control effectiveness. For example, CDC is developing and evaluating better tools that the fire service can use to improve the ability to clean and decontaminate personal protective equipment (PPE), as well as to assess contamination risks from fireground-exposed PPE. Advanced robotic technologies are in development to help inform PPE standards and provide innovative conformity assessment advancements. To further foster innovation in respirator fit, NIOSH established a robust portfolio, including a mobile fit testing application, a web-based selection tool, research to advance sensor technology, and a crowdsourcing challenge to develop new technologies and approaches that provide feedback about respirator fit during use.

### **Improving the Safety and Health of Emergency Response Employees**

Emergency response employees (EREs) are essential workers, including firefighters, law enforcement officers, paramedics, emergency medical technicians, and funeral service practitioners. EREs are at risk of exposure to potentially life-threatening infectious diseases through interactions with victims during emergencies. [Part G of the Ryan White HIV/AIDS Treatment Extension Act of 2009](#)<sup>200</sup> requires medical facilities to notify EREs when they may have been exposed to potentially life-threatening infectious diseases while transporting or serving victims of an emergency. Such notification allows EREs to receive timely diagnosis and post-exposure medical treatment to prevent life-threatening diseases. Medical facilities failing to appropriately notify EREs of their exposures are violating their Part G responsibilities.

<sup>198</sup> <https://www.cdc.gov/niosh/docs/2023-123/default.html>

<sup>199</sup> <https://www.cdc.gov/niosh/npptl/respmanuf.html>

<sup>200</sup> <https://www.cdc.gov/niosh/topics/ryanwhite/default.html>

In 2022, CDC was delegated the authority, by the HHS Secretary, to establish an administrative process for encouraging EREs to report Part G violations. Accordingly, CDC is in the initial stages of developing a comprehensive program to receive and investigate reports of violations and educate state actors about the Part G requirements. CDC also plans to develop communication materials to educate state and local health departments, medical facilities, and employers, about their responsibilities under Part G. This will enable creation of reliable Part G infectious disease notification networks where they may not exist now to protect EREs from public health threats including the virus that causes COVID-19 and other pathogens.

### **Total Worker Health®**

The CDC/NIOSH Total Worker Health® program supports and conducts ground-breaking research in workplace safety, health, and wellbeing within the context of a changing economy and shifting workplace and population demographics.

As part of this program, ten funded Centers of Excellence (COE)—each with subject matter- and region-specific presence and expertise—play an important role in conducting novel research on the important connections between work arrangements, working conditions, and health. One such COE, launched in fall 2021, is specifically dedicated to workplace mental health as part of an expanded occupational safety and health mental health portfolio at CDC, including its research agenda, partners, and research-to-intervention strategies. Safeguarding and improving the mental health of workers, preventing work-related stress and burn-out are critical issues for employers and organizations as poor mental health outcomes and associated disability increase.

CDC's [Healthy Work Design](#)<sup>201</sup> and [Work Stress](#)<sup>202</sup> prevention programs examine the mental health impacts of work conditions such as non-standard work arrangements, work hours and fatigue, and occupational stress. These programs show that mental health issues permeate all industries. In addition, work-related factors increase critical risks for substance use disorders and suicide, two increasing causes of death among working age populations. Active Total Worker Health® research and interventions are offering timely solutions for these critical issues.

With funding from the American Rescue Plan Act of 2021, NIOSH collaborated with the Dr. Lorna Breen Heroes' Foundation to develop the [Impact Wellbeing](#) campaign,<sup>203</sup> which was launched in October 2023. The campaign gives hospital leaders, evidence-informed solutions to reduce healthcare worker burnout, sustain wellbeing, and build a system where healthcare workers thrive.

### **Work and Opioids**

CDC is also using Total Worker Health® principles to develop solutions to help workers and employers facing the opioid crisis in their communities. CDC examines opioid use in workers, from identifying workplace conditions and determining work-related risk factors, to protecting workers and developing methods for detection and decontamination. CDC identified elements of [Workplace Supported Recovery \(WSR\) Programs](#),<sup>204</sup> in which employers use evidence-based policies and programs to reduce multiple risk factors. These include helping prevent initial substance use to decrease the risk for substance misuse and its progression to a substance use disorder. WSR programs also take steps to help workers seek the care they need and assist with recovery, including staying at or returning to work.

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<sup>201</sup> <https://www.cdc.gov/niosh/programs/hwd/default.html>

<sup>202</sup> <https://www.cdc.gov/niosh/topics/healthcare/workstress.html>

<sup>203</sup> <https://www.cdc.gov/niosh/impactwellbeing/default.html>

<sup>204</sup> <https://www.cdc.gov/niosh/topics/opioids/wsrp/default.html>



## Occupational Climate Exposure

Climate-related hazards are an emerging worker safety health risk that can lead to adverse health effects and decreased worker productivity. Climate disproportionately affects workers, and they are likely to have more and greater exposure to climate-related hazards than the public. Examples of climate-related occupational hazards include increasing temperatures, air pollution, UV radiation, extreme weather, vector-borne diseases and expanding habitats, industrial transitions, and emerging industries. CDC takes a multi-disciplinary approach to address these critical and pressing public health problems. As participants in the CDC Climate and Health Task Force, participating staff are communicating with partners, including other federal agencies, about climate and work-related topics and activities; and establishing and implementing priorities for research and surveillance of climate-related hazards for workers in many industries across the country.



### [NIOSH Criteria for a Recommended Standard: Occupational Exposure to Heat and Hot Environments](#)<sup>205</sup>

is a well-recognized, often referenced source of information that includes scientific data on heat stress and hot environments. In 2023, CDC published an update to the climate and occupational safety and health framework in the *Journal of Occupational and Environmental Medicine*.<sup>206</sup> Another popular tool is the [OSHA-NIOSH Heat Safety app](#),<sup>207</sup> which helps users plan outdoor work activities based on how hot it feels throughout the day. It has been downloaded more than 2.5 million times and is routinely featured in news articles and trade magazines in the summer months. CDC is funding work on climate and occupational health through its Centers for Agriculture Safety and Health, including projects on heat stress in agriculture workers, measuring thermal load of personal floatation devices in fishermen, potential for respiratory problems in wildfire response workers, and preparedness and recovery for extreme weather events.

## Mining Research

CDC's [Mining Research Program](#)<sup>208</sup> addresses safety and health issues in both surface and underground mining within the coal, metal/nonmetal, and stone, sand, and gravel mining sectors. The Mining Research Program focuses on critical issues such as automation and emerging technologies, respirable mine dust including crystalline silica, ground control, ventilation, and the [Miner Health Program](#),<sup>209</sup> which was established to understand and improve the health and wellbeing of miners in all sectors through a focused integration of research, transfer of findings, evaluation, and community engagement. The Pittsburgh Mining Research Division (PMRD) conducts research on health hazards, safety hazards, and disaster survival and prevention in mining, as well as critical human factors issues relevant to research and system design. The Spokane Mining Research Division (SMRD) focuses on work-related illness, injury, and fatalities in the extractive industries with an emphasis on their unique needs throughout the western United States, including Alaska. Both PMRD and SMRD collaborate intramurally and with partners in industry, labor, academia, and government. In FY 2025, the mining research program will focus on key areas such as respirable crystalline silica, noise control, ground control at both surface and underground operations, lithium-ion battery safety, mine ventilation, and emergency disaster response and rescue.

The [Enhanced Coal Workers' Health Surveillance Program \(ECWHSP\)](#)<sup>210</sup> directly provides screening services via a mobile medical unit. During surveys, CDC staff provide medical testing and screening to coal miners at no cost to miners. Services include a chest radiograph, spirometry test, blood pressure screening, and respiratory

<sup>205</sup> <https://www.cdc.gov/niosh/docs/2016-106/default.html>

<sup>206</sup> <https://www.tandfonline.com/doi/full/10.1080/15459624.2023.2205468>

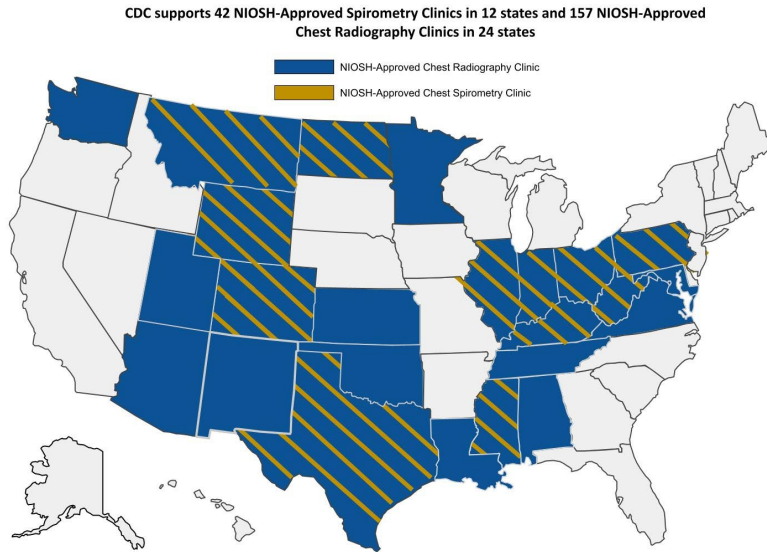
<sup>207</sup> <https://www.cdc.gov/niosh/topics/heatstress/heatapp.html>

<sup>208</sup> <https://www.cdc.gov/niosh/mining/researchprogram/index.html>

<sup>209</sup> [https://www.cdc.gov/niosh/mining/researchprogram/strategicplan/MHProgram\\_StrategicAgenda2020-2030.html](https://www.cdc.gov/niosh/mining/researchprogram/strategicplan/MHProgram_StrategicAgenda2020-2030.html)

<sup>210</sup> <https://www.cdc.gov/niosh/topics/cwhsp/ecwhsp.html>

assessment questionnaire at miners’ worksites or in their communities. In addition to the mobile medical unit, CDC also supports 42 NIOSH-Approved Spirometry Clinics in 12 states and 157 NIOSH-Approved Chest Radiography Clinics in 24 states.



### Firefighter Cancer Surveillance

The Firefighter Cancer Registry Act of 2018 required CDC to develop a [National Firefighter Registry \(NFR\) for Cancer](https://www.cdc.gov/niosh/firefighters/registry.html)<sup>211</sup> to collect relevant health and occupational information to better understand the link between workplace exposures and cancer. The registry is modeled after a landmark study in which CDC, with funding assistance from the U.S. Fire Administration, examined whether firefighters have a higher risk of cancer due to job exposures. The NFR for Cancer is now actively enrolling firefighters including career and volunteer, active and retired, and firefighters with and without cancer. The CDC is working with fire service organizations and other interested parties, to encourage firefighters throughout the country to enroll. Over time and with broad participation, the data will be used to better understand the types of cancer among firefighters; the prevalence of cancer risk factors and healthy behaviors among firefighters; and the relationship between firefighter cancer and workplace characteristics, exposures, and practices. The data will also be used to explore cancer risk among understudied firefighter groups including women, minorities, volunteers, and firefighters in sub-specialty assignments like wildland firefighters or fire-cause investigators. These analyses will help CDC identify the most important factors associated with firefighters’ risk of specific types of cancer, including rare forms of cancer.

Specific to wildland firefighters, CDC partnered with the United States Forest Service (USFS) and the Department of the Interior (DOI) on a multi-year study to better understand the potential chemical and physical hazards associated with wildland firefighting and how these exposures affect wildland firefighters’ health, especially after multiple fire seasons. CDC and research partners are analyzing and publishing the findings from this study and will continue close partnerships with USFS, DOI, and the National Wildfire Coordinating Group on research and outreach efforts.

<sup>211</sup> <https://www.cdc.gov/niosh/firefighters/registry.html>

In FY 2025, CDC will continue developing formal partnerships to conduct further outreach with fire services, conduct more in-depth data analysis, explore new data sources, conduct essential data linkages (e.g., with state cancer registries), and develop new follow-up questionnaires and resources for firefighters and fire service leaders. This will allow CDC to maximize the impact of its firefighting health surveillance data and its utility to scientific, public health, and fire service leaders.

### **Per- and Polyfluoroalkyl Substances (PFAS)**

CDC conducts research to learn more about the relationship between [exposure to per- and polyfluoroalkyl substances \(PFAS\)](#)<sup>212</sup> and human health effects. PFAS are a group of synthetic chemicals that have been integrated extensively into consumer products and industrial applications worldwide since the early 1950s. In occupational settings, workers may experience repeated and high levels of exposure to PFAS, and CDC's research is designed to assess the impacts on a variety of industries. CDC is conducting an occupational exposure and health indicator assessment of PFAS in industries with high to moderate PFAS use, such as manufacturing and services sector industries. This study focuses on ongoing exposure to PFAS and includes evaluation of PFAS in air, blood, and urine.

Additionally, as part of a collaboration with academic partners called the [Fire Fighter Cancer Cohort Study \(FFCCS\)](#),<sup>213</sup> CDC assesses acute exposure to PFAS through fireground response and turnout gear in airport, structural, and wildland-urban interface firefighters. This research study also includes toxicological assessments of aqueous film-forming foams (AFFF) and synthetic fluorine-free alternatives. CDC is also examining dermal absorption of PFAS, the PFAS contents of firefighter turnout gear, and the effects of wear and maintenance on exposures related to those turnout gear. The research being conducted by CDC will improve the understanding of who is exposed, how exposures occur, how much exposure individuals are having, and where interventions will be the most effective. CDC has also responded to multiple requests for technical assistance that include development of educational material and traditional exposure assessment evaluations.

### **Health Hazard Evaluation Program**

CDC field scientists conduct [Health Hazard Evaluations \(HHE\)](#),<sup>214</sup> a frontline service provided upon request, to determine if workers are being exposed to hazardous materials or harmful conditions and if these exposures affect employee health. Headquartered in Cincinnati, Ohio, the HHE program addresses the work-related health concerns of thousands of workers and managers. Since January 2023, HHE reports have been downloaded 14,397 times, and CDC has received 132 HHE requests in 37 states, plus Washington, D.C., and the U.S. Virgin Islands.

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<sup>212</sup> <https://www.cdc.gov/niosh/topics/pfas/default.html>

<sup>213</sup> <https://www.cdc.gov/niosh/firefighters/health.html>

<sup>214</sup> <https://www.cdc.gov/niosh/hhe/default.html>

**Occupational Safety and Health Research Grants<sup>1,2</sup>**

(dollars in millions)	FY 2023	FY 2024	FY 2025
	Final	CR	President's Budget
Number of Awards	145	145	145
- New Awards	39	TBD	TBD
- Continuing Awards	106	TBD	TBD
Average Award	\$0.67	\$0.67	\$0.67
Range of Awards	\$0.020-\$5.750	\$0.020-\$5.750	\$0.020-\$5.750
<b>Total Awards</b>	<b>\$97.34</b>	<b>\$97.34</b>	<b>\$97.34</b>

<sup>1</sup> These funds are not awarded by formula.

<sup>2</sup> FY2024 and FY2025 number of new and continuing awards are not yet determined.

**Respirator Approval Program and Health Hazard Evaluation Program Infrastructure Support**

Investments in physical infrastructure will also support NIOSH's core programs, as aging facilities, averaging 50 years old, result in frequent operational issues such as unexpected power outages, water shutdowns, and environmental control issues. In conjunction with annual appropriations, investments from the HHS Nonrecurring Expenses Fund (NEF) are being used to conduct renovations and upgrade systems that will prepare CDC's Human Performance and Physiology Research Branch laboratories, including the Respirator Approval Program (RAP), at NIOSH's Pittsburgh Facility for future infectious disease outbreaks and pandemics. CDC is also supporting its Health Hazard Evaluation (HHE) program facilities in Cincinnati, Ohio, through consolidating existing campuses into a new central facility through funding from the NEF. This consolidation will increase scientific collaboration, eliminate inefficiencies, and provide researchers with state-of-the-art laboratories and facilities.

## Energy Employees Occupational Illness Compensation Program Act (EEOICPA)

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Energy Employees Occupational Illness Compensation Program Act (EEOICPA) <sup>1</sup>	\$50.763	\$50.763	\$50.763	\$0

<sup>1</sup>EEOICPA reflects post-sequestered level.

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) is a mandatory federal program that provides compensation to U.S. Department of Energy employees or survivors of employees who have been diagnosed with a radiation-related cancer, beryllium-related disease, or chronic silicosis resulting from duties involving production or testing of nuclear weapons. CDC conducts dose reconstructions to estimate an employee's occupational radiation exposure for certain cancer cases, evaluates petitions for adding classes of workers to the Special Exposure Cohort (SEC), and provides administrative support to the Advisory Board on Radiation and Worker Health (Advisory Board). The U.S. Department of Labor uses CDC's estimates in making compensation determinations.

### Budget Request

CDC's FY 2025 estimate of **\$50,763,000** in mandatory funding for EEOICPA is level with the FY 2023 final level. As mandated by EEOICPA, CDC will use this funding to:

- Complete 2,400 radiation dose reconstructions to support the U.S. Department of Labor's adjudication of claims.
- Evaluate an estimated two petitions to add classes of employees to the Special Exposure Cohort (SEC).
- Provide administrative and technical support for the Advisory Board as it reviews technical documents and procedures used for dose reconstruction.
- Publicize acquired information related to radiation exposure at facilities involved with nuclear weapons production, testing, and disposal.

CDC will complete radiation dose reconstructions for all claims requiring such information to permit final adjudication. CDC will use radiation monitoring information provided by the U.S. Department of Energy and any relevant information provided by claimants to develop a dose reconstruction report. The number of dose reconstructions completed each year has stabilized at approximately 2,400 and is expected to return to this level following completion of a cybersecurity modernization initiative.

CDC will also evaluate petitions to add classes of employees to the SEC and present the evaluation reports to the Advisory Board, which makes recommendations to the HHS Secretary concerning whether a class of employees should be added to the SEC. SEC-related work has increased in response to the need to conduct more long-term evaluations, consider multiple classes of workers included in an individual petition, and re-evaluate previous petitions/reports as new information becomes available. CDC will engage the Advisory Board to assist in reviewing SEC evaluation reports and the scientific validity and quality of dose reconstruction efforts.

In FY 2023, CDC achieved the following occupational safety and health milestones:

- Completed 2,400 dose reconstructions.
- Received four SEC petitions.
- Supported 12 meetings of the Advisory Board, its Subcommittees, and Work Groups.
- Informed recommendations of the Advisory Board to the HHS Secretary concerning the addition of classes of employees to the SEC. No new classes were added to the SEC in FY 2023, thus the total number of classes added as of September 30, 2023, remains at 129.

**World Trade Center Health Program Budget Request<sup>1, 2</sup>**

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
World Trade Center	\$709.848	\$768.392	\$788.110	\$78.262

<sup>1</sup> The FY 2025 WTC Health Program amount is an estimate that may be revised during the FY 2024 planning process. Totals displayed for FY 2025 align with current projections.

<sup>2</sup> Reflects the federal share of WTCHP only. These amounts are based on trend analysis and are the best estimates at the time but are subject to change. FY 2023 Final Level excludes supplemental funding of \$1 billion in the FY 2023 Appropriations Act (P.L. 117-328) and the FY 2024 amounts excludes supplemental funding of \$676 million in the FY 2024 National Defense Authorization Act (P.L.118-31).

The September 11, 2001, terrorist attacks in New York City, at the Pentagon in Arlington, Virginia, and in Shanksville, Pennsylvania, required extensive response, recovery, and cleanup activities. Thousands of responders and survivors were exposed to toxic smoke, dust, debris, and psychological trauma. The James Zadroga 9/11 Health and Compensation Act of 2010 (P.L. 111-347 or Zadroga Act) created the World Trade Center (WTC) Health Program to provide healthcare benefits to eligible responders and survivors beginning on July 1, 2011. On December 18, 2015, the James Zadroga 9/11 Health and Compensation Reauthorization Act was enacted, extending the WTC Health Program through 2090. Additionally, on December 29, 2022, the Consolidated Appropriations Act, 2023, was enacted providing the WTC Health Program with \$1 billion in supplemental funding and requiring the Program to establish a Youth Research Cohort. Pursuant to the Zadroga Act, as amended, the WTC Health Program provides monitoring and treatment benefits to eligible responders and survivors, conducts research on WTC-related health conditions, and maintains a health registry to collect data on those affected by the September 11, 2001, terrorist attacks.

The FY 2024 National Defense Authorization Act (P.L. 118-31) modified the World Trade Center (WTC) Health Program’s eligibility criteria for responders to the crash sites at the Pentagon and Shanksville, Pennsylvania. The expanded eligibility criteria is intended to cover Federal employees and military who performed rescue, response, and/or cleanup at the Pentagon or Shanksville, Pennsylvania sites and do not meet the original eligibility criteria set forth in the James Zadroga 9/11 Health and Compensation Act of 2010. P.L. 118-31 also provides additional money available through FY 2033 to ensure the Program has sufficient funds in the short-term to continue to provide monitoring and treatment benefits for WTC-related health conditions to its more than 127,000 members, as well as providing for the monitoring and treatment of covered conditions for the responders enrolled under the expanded eligibility criteria.

In FY 2023, the WTC Health Program enrollment included almost 127,500 eligible responders and survivors. The Program has paid claims for eligible treatment, including medication, for almost 45,000 of these responders and survivors.

Budget Request

CDC’s FY 2025 estimate of **\$788,110,000** in mandatory Federal share funding for the WTC Health Program is **\$78,262,000** above the FY 2023 final level. Funds support the quality care, including treatment of covered WTC-related health conditions for enrolled responders and survivors. Including New York City’s required contribution of \$82,786,600, a total of \$864,931,600 in resources will support the WTC Health Program in FY 2025. Current estimates project that in FY 2030, the WTC Health Program will not have sufficient funds to fully support its statutorily required activities.

**WTC Health Program Enrollment**

	Sept. 30, 2022	Dec. 31, 2022	March 31, 2023	June 30, 2023	Sept. 30, 2023
New Members since July 2011 <sup>1</sup>	59,403	61,466	63,161	64,661	66,600

Total Members <sup>2</sup>	120,247	122,308	123,998	125,492	127,425
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<sup>1</sup>New members enrolled under the Zadroga Act requirements (adjustments are made each quarter to account for member records changes), including Pentagon and Shanksville, PA.

<sup>2</sup>New members and members enrolled prior to 7/1/2011 (adjustments are made each quarter to account for member records changes).

**WTC Health Program Paid Claims**

Healthcare Services as of Date <sup>1</sup>	Sept. 30, 2022	Dec. 31, 2022	Mar. 31, 2023	June 30, 2023	Sept. 30, 2023
Members who had monitoring or screening exams	49,877	49,900	49,468	49,098	48,212
Members who had diagnostic evaluations <sup>2</sup>	20,698	20,919	21,350	22,558	24,085
Members who had out-patient treatment	32,248	33,854	34,363	35,477	35,832
Members who had in-patient treatment	1,033	1,044	1,060	1,131	1,192
Members who received medications	31,264	32,536	33,618	33,459	35,182

<sup>1</sup>Based on claims for services that were paid during the previous 12-month period.

<sup>2</sup>For determining if a member has a WTC-related health condition and for certifying that health condition.

As of the end of FY 2023, the WTC Health Program has certified almost 46,000 cases of cancer—an increase of more than 7,500 cancer certifications since the end of FY 2022. Of those members certified for at least one type of cancer, more than 17,000 members have received cancer care in FY 2023, compared to 14,206 in FY 2022.

The WTC Health Program uses mandatory funding for the following critical activities:

- Monitoring and treatment services, including services for certain types of cancer, for responders and survivors in the WTC Health Program;
- Infrastructure for the Clinical Centers of Excellence (CCEs) and the Nationwide Provider Network (NPN) to support clinical activities;
- Infrastructure for data centers;
- Extramural research projects;
- Outreach and education projects;
- WTC Health Registry activities;
- WTC Health Program Scientific/Technical Advisory Committee support; and
- Youth Research Cohort activities.

The WTC Health Program provides monitoring and treatment services via a fee-for-service model of delivery. These services are provided at no cost to the WTC Health Program members. Where applicable, the WTC Health Program recoups money from Workers' Compensation for work-related health conditions. Similarly, the WTC Health Program seeks to coordinate benefits with public and private health insurance plans for treatment provided for WTC-related health conditions that are not work-related. In FY 2025, CDC will continue contracts with CCEs and the NPN to provide administrative and member services that support the provision of healthcare benefits, and contracts with data centers to provide data collection and analysis. CDC will also renew the interagency agreement with the Centers for Medicare and Medicaid Services to reimburse the CCEs and the NPN for clinical services provided to the WTC Health Program members.

The WTC Health Program provides healthcare benefits through CCEs, which work as a clinical consortium, and through the NPN according to standardized medical monitoring protocols, programmatic policies, and procedures across the clinical sites. This standardization and the fee-for-service model enable the WTC Health Program to track claims-level data for monitoring and treatment, analyze the data for program compliance, and report on spending at a more detailed level across the WTC Health Program. The WTC Health Program also engages with labor representatives and members of the New York City community to ensure awareness of emerging issues.

CDC will use FY 2025 funds to continue research projects and epidemiologic studies to help answer critical questions about physical and mental health conditions related to the September 11, 2001, terrorist attacks. Additionally, a portion of the FY 2025 funds will continue the cooperative agreement with the New York City Department of Health and Mental Hygiene for the WTC Health Registry to conduct regular surveys on more than 71,000 registrants. The WTC Health Registry's analysis of these surveys will continue to help assess health effects among persons impacted by exposures to the WTC disaster.

Funds will also support the WTC Health Program Scientific/Technical Advisory Committee. Upon request from the Administrator of the WTC Health Program, the Advisory Committee makes recommendations regarding additional eligibility criteria, the addition of new health conditions to the list of covered conditions, and research priorities.

In December 2022, the Consolidated Appropriations Act, 2023, was enacted, amending the Zadroga Act to include the Research Cohort for Emerging Health Impacts on Youth (individuals who were 21 years of age or younger on September 11, 2001). This act instructs the WTC Health Program to establish this research cohort, which may include individuals who are described by the following characteristics:

- Individuals who were 21 years of age or younger on September 11, 2001; and
- Individuals who were in the area of Manhattan not further north than 14th Street; outside the New York City Disaster Area, or the borough of Brooklyn; and
- Age-appropriate control populations as needed for research purposes.

The Youth Research Cohort must also achieve three key markers of representativeness:

- Be of sufficient size to conduct future research studies on the health and educational impacts of 9/11 exposures;
- Include sufficient representation of individuals who were 21 years of age or younger at the time of exposure; and
- Include individuals who are screening-eligible WTC survivors or certified-eligible WTC survivors.

The WTC Health Program continues to engage with the public as it builds out the cohort. In FY 2023, the WTC Health Program held a meeting of its Scientific/Technical Advisory Committee (STAC or Committee) to gain input from both the survivor and youth communities affected by 9/11 exposures, as well as the public. The STAC provided recommendations to the Program on methods for recruiting and building a youth research cohort. In addition, the Program published a request for information for potential contractors and a Federal Register Notice (FRN) seeking comment from the public. The Program created and continues to share updates on its progress via its [youth research cohort webpage](https://www.cdc.gov/wtc/youthcohort.html)<sup>215</sup> and listserv.

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<sup>215</sup> <https://www.cdc.gov/wtc/youthcohort.html>



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## GLOBAL HEALTH

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$692.843	\$692.843	\$692.843	\$0
<b>Total Request</b>	<b>\$692.843</b>	<b>\$692.843</b>	<b>\$692.843</b>	<b>\$0</b>
FTEs	1,380	1,444	1,444	64
-- Global HIV/AIDS Program	\$128.921	\$128.921	\$128.921	\$0
-- Global Tuberculosis	\$11.722	\$11.722	\$11.722	\$0
-- Global Immunization Program	<u>\$230.000</u>	<u>\$230.000</u>	<u>\$230.000</u>	<u>\$0</u>
-- Polio Eradication	\$180.000	\$180.000	\$180.000	\$0
-- Measles and Other Vaccine Preventable Diseases	\$50.000	\$50.000	\$50.000	\$0
-- Parasitic Diseases and Malaria	\$29.000	\$29.000	\$29.000	\$0
-- Global Public Health Protection	\$293.200	\$293.200	\$293.200	\$0

**Enabling Legislation Citation:**

PHSA § 214, PHSA § 301, PHSA § 304, PHSA § 307, PHSA § 310, PHSA § 317T,\* PHSA § 319, PHSA § 322, PHSA § 327, PHSA § 340C, PHSA § 361-369, PHSA § 2315, PHSA § 2341, Foreign Assistance Act of 1961 §§ 104A, 104C, 627, and 629, Federal Employees International Organization Service Act § 3, Foreign Employees Compensation Program, Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria (P.L. 110-293, as amended by P.L. 115-305), PEPFAR Stewardship & Oversight Act of 2013 (Pub. L. 113-56)

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with \*

**Allocation Methods:** Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Direct Contracts, Interagency Agreements

CDC leads many critical aspects of U.S. government-wide (USG) efforts to address global health challenges worldwide including immunization, malaria, Human Immunodeficiency Virus (HIV), tuberculosis (TB), and antimicrobial resistance (AMR). CDC, as the nation’s lead public health agency and USG lead for infectious disease response, enhances global health security and works with countries to prevent, detect, and respond to public health threats, whether from humans, animals, vectors, or the environment, before they spread into regional epidemics or global pandemics.

The most effective and least expensive way to protect Americans from infectious diseases and other health threats that begin overseas is to prevent, detect, and respond to outbreaks before they spread to the United States. Public health laboratories and disease surveillance systems are essential public health and global health security functions that are critical for effective response to public health threats. CDC staff are vital resources who serve as the eyes and ears of the United States government as the only public health agency with the expertise, capacity, and credibility to embed staff both within Ministries of Health and with domestic partners at state, tribal, local, and territorial public health agencies. Due to CDC’s global presence and decades of building these trusted peer-to-peer partnerships, collaboration, and public health networks, CDC staff are often the “first call” and learn about outbreaks earliest. The earlier a disease threat is identified, the sooner the response can begin to prevent further spread, including to the United States. In this way, CDC’s global staff further CDC’s mission by serving as the United States’ first line of defense against infectious disease threats and their potential importation.

In addition to the more than 60 country offices around the world, CDC has established five regional offices and is planning to open another in early 2024. These regional offices support emerging crises and help to support response and recovery efforts when physical presence within a country is not possible. For example, the CDC Eastern Europe/Central Asia Regional office, based in Tbilisi, Georgia, has leveraged its assets across the region to support public health systems in Ukraine. This office advised and supported surveillance partners to inform response, stabilization, and recovery efforts by the Government of Ukraine and its partners, provided essential trainings for responders, and supported public health systems recovery for health departments, laboratories, and hospitals. The regional office also focused on infection prevention and control surveillance for hospital-acquired infections and antimicrobial resistance during the surging incidence of traumatic wounds.

CDC has established the following regional offices:

- Eastern Europe/Central Asia – Tbilisi, Georgia
- Middle East/North Africa – Muscat, Oman
- South America – Brasilia, Brazil
- Southeast Asia – Hanoi, Vietnam
- East Asia/Pacific – Tokyo, Japan

And plans to open another in early 2024:

- Central American and Caribbean – Panama City, Panama

### Budget Request

CDC's FY 2025 budget request of **\$692,843,000** for Global Health is level with the FY 2023 final level. CDC will continue to prevent, detect, and respond to public health threats to protect Americans and populations around the globe, improve health outcomes by reducing morbidity and mortality, and build resilient public health systems. In FY 2025, CDC will continue its work to strengthen global health protection, improve global immunization, and advance the control of HIV, TB, malaria, and other parasitic diseases. CDC experts work alongside local, regional, and global partners in more than 60 countries and regional offices to provide unparalleled expertise to support country- and regional-driven efforts.

## GLOBAL HEALTH

### BY THE NUMBERS

- **>22,500**—Graduates of CDC's Field Epidemiology Training Program (FETP), creating a global workforce of field epidemiologists in nearly 90 countries. These partnerships build national, regional, and local capabilities to prevent, detect, and respond to outbreaks.
- **12,500,000**—Men, women, and children living with HIV received life-saving antiretroviral treatment (ART) from CDC in FY 2022, improving quality of life, preventing new infections, and saving lives.<sup>1</sup>
- **10,200,000**—TB screenings supported by CDC, which are critical for early detection and treatment to improve disease outcomes, prevent catastrophic costs, and reduce TB deaths worldwide. TB was the second leading infectious disease killer worldwide in 2022, after COVID-19. It was also the leading killer of people living with HIV and a major cause of deaths related to antimicrobial resistance.<sup>2</sup>
- **11**—Polio cases from January 1, 2023 - November 22, 2023. Polio incidence has dropped more than 99% since the launch of global polio eradication efforts in 1988. Only Afghanistan and Pakistan remain endemic for polio, and CDC works closely with them to implement program improvements to achieve final eradication.<sup>3</sup>
- **4** — CDC supported four states (Maryland, Arkansas, Texas, and Florida) with investigations of locally acquired malaria that likely stemmed from imported cases. 2023 marked the first time in 20 years that a locally acquired malaria case was detected in the United States. Approximately 2,000 travelers become infected with malaria abroad and then travel to the United States each year.<sup>4</sup>

<sup>1</sup> HIV & Tuberculosis. (2023, December 1)., from [Global HIV and TB \(cdc.gov\)](https://www.cdc.gov/global-health/communicable-diseases/hiv-tb/)

<sup>2</sup> [JESS3 x WHO Global TP Report Factsheet 03](https://www.who.int/news-room/factsheets/detail/jess3-x-who-global-tp-report-factsheet-03)

<sup>3</sup> This Week. (n.d.). Retrieved 2023, November 27., from <http://polioeradication.org/polio-today/polio-now/this-week/>

<sup>4</sup> Mace KE, Lucchi NW, Tan KR. Malaria Surveillance — United States, 2018. MMWR Surveill Summ 2022;71(No. SS-8):1–29.

DOI: <http://dx.doi.org/10.15585/mmwr.ss7108a1>\*Unless otherwise noted, all information and calculations are from CDC program data.

Global Health Funding History	
Fiscal Year	Dollars (in millions)
FY 2021	\$591.024
FY 2022	\$646.843
FY 2023 Final	\$692.843
FY 2024 CR	\$692.843
FY 2025 President’s Budget	\$692.843

### Program Accomplishments

CDC invests in preparing forward-thinking public health systems through global infectious disease surveillance, monitoring, and fortifying the readiness capacity of the public health workforce to intercept emerging health threats early and prevent local outbreaks from becoming the next pandemic. In early 2023, CDC coordinated the rapid public health response for multiple outbreaks of high-consequence viral pathogens, including Sudan ebolavirus in Uganda, Marburg virus in Equatorial Guinea and Tanzania, and Nipah virus in Bangladesh. In

collaboration with in-country partners, CDC quickly deployed epidemiology and laboratory teams to provide on-the-ground technical guidance; CDC subject matter experts provided training and analytical support. CDC worked with partners to investigate, identify the source of these outbreaks, and scale up testing and diagnostics to contain the spread and ultimately end the outbreaks. CDC's unique technical expertise, leadership, and trusted in-country relationships were essential for reducing transmission and helping stop these outbreaks before they spread globally and to the United States.

CDC works in partnership with Ministries of Health around the world and is viewed as a trusted advisor by country government counterparts. These peer-to-peer relationships have strengthened outbreak containment capacity, especially in hotspot regions with an increased frequency of high-consequence outbreaks. More than a third of the world's population live in areas at risk for viral hemorrhagic fevers. For example, the Democratic Republic of Congo (DRC) has experienced multiple Ebola outbreaks over the past several years. CDC worked with the DRC to build stronger emergency response, surveillance, laboratory, and health workforce cadre training programs, which tangibly contributed to the earlier detection of Ebola in subsequent outbreaks. To illustrate the high impact and cost-effectiveness of these kinds of investments, in 2018, Ebola circulated for four months in the DRC before it was detected and resulted in over 2,200 deaths. In 2020, Ebola was detected after circulating for only two weeks and resulted in 55 deaths. By 2022, Ebola circulated for just 48 hours before it was detected and resulted in five deaths total. Faster disease detection facilitates faster outbreak containment, which ultimately mitigates loss of human life, economic costs, and the opportunity for a deadly virus to spread further and threaten the lives of Americans.

CDC vaccinated 20.4 million children with polio vaccine in Asia, Africa, and Europe in 2022. CDC's polio eradication activities resulted in decreasing the geographic expanse of all types of polioviruses from 583 districts to 353 districts in the last two years. Additionally, CDC's investments in the development and deployment of the novel type 2 oral polio vaccine led to over 500 million doses of vaccine delivered, resulting in a decrease of new emergences over the last two years.

CDC's experts in more than 45 countries and regions around the world work to support and continuously improve tailored, evidence-based HIV treatment and prevention interventions with measurable impact. In 2022, CDC met and exceeded its treatment target while maintaining high-quality services, with 95 percent of people living with HIV (PLHIV) supported on antiretroviral treatment having achieved viral suppression. In FY 2023, CDC supported laboratory-based surveillance for the emergence of dolutegravir drug resistance in over a dozen partner countries, through the Cyclical Acquired Drug Resistance (CADRE) program. Dolutegravir is a first-line treatment daily tablet used with other medications to treat HIV.<sup>216</sup> CDC's critical role in implementing CADRE included specialized epidemiological and laboratory training, technical assistance focused on quality-assured pathogen genome sequencing and other areas, and use of CADRE data for evidence-based decision making. CDC collaborates on a peer-to-peer basis with government partners, including National Public Health Institutes (NPHIs) and national public health laboratories, to implement the majority of CADRE surveillance and laboratory activities.

*An. stephensi* is a mosquito species from South Asia that is spreading across Africa with the potential to increase transmission of malaria. CDC is building regional capacity in Africa to detect increases in *An. stephensi*-transmitted malaria and helping countries across Africa prepare for spread of invasive *An. stephensi* mosquitoes. CDC has also developed next-generation sequencing techniques which help detect emerging resistance to insecticides and provide clues to countering it. CDC leverages funding to conduct evaluations of new mosquito control interventions such as spatial repellents and attractive targeted sugar baits; vaccines such as RTS,S and

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<sup>216</sup> [Dolutegravir: MedlinePlus Drug Information](#)





R21 which have a 73 percent and 75 percent respective reduction in symptomatic malaria in fully vaccinated children; and a new monoclonal antibody that could prevent malaria in children for a full year.

CDC experts also develop new diagnostics needed to control and eliminate neglected tropical diseases (NTDs) globally, including testing new diagnostics in the lab, conducting field evaluations, and training countries to use them. For example, CDC recently helped create new manuals for managing patients with lymphatic filariasis (LF), commonly known as elephantiasis. CDC also serves in leadership roles for target product profiles for new LF diagnostics and provides leadership on several WHO technical committees for onchocerciasis and LF. In 2023, CDC added to the body of evidence that a species of cutaneous leishmaniasis, a parasitic infection that causes serious skin lesions, is present in certain southern U.S. states and may be transmitted to people who have no reported history of international travel, changing the understanding that persons presenting with leishmaniasis must have been infected in another country.

## Global HIV/AIDS Budget Request

In 2022, 39 million people were living with HIV globally.<sup>217</sup> Additionally, tuberculosis (TB) was the leading killer of people living with HIV.<sup>218</sup> While the number of new HIV infections and AIDS-related deaths have declined dramatically, some populations, including children, adolescent girls, young women, and key populations (KPs) remain disproportionately at risk for HIV and struggle to access life-saving HIV services. CDC’s unique expertise and leadership role in the President’s Emergency Plan for AIDS Relief (PEPFAR) advances global health equity by ensuring greater access to HIV treatment and large-scale implementation of combination HIV prevention programs. Together, CDC efforts save millions of lives, prevent new HIV and TB infections, improve health, and protect families and communities. CDC’s global HIV and TB efforts also enhance the core public health capabilities that partner countries need to protect their populations from other disease threats.

**CDC’S ROLE IN THE FIGHT AGAINST HIV GLOBALLY**

 <p><b>LONG-STANDING RELATIONSHIP WITH MINISTRIES OF HEALTH</b></p> <p>CDC’s peer-to-peer relationships with Ministries of Health allows us to be a significant driver of U.S. progress to fight HIV worldwide.</p>	 <p><b>GLOBAL REACH AND LOCAL IMPACT</b></p> <p>CDC’s reach allows us to use global insights to strengthen domestic programs and apply lessons learned in the U.S. to help accelerate global progress.</p>	 <p><b>SCIENTIFIC EXPERTISE AND TECHNICAL KNOW-HOW</b></p> <p>CDC’s Division of Global HIV &amp; TB is home to one of the largest cadres of public health experts – including epidemiologists, health economists, and medical officers – devoted to the prevention and treatment of HIV.</p>	 <p><b>A GLOBAL LEADER IN LAB STRENGTHENING</b></p> <p>Strengthening laboratory systems around the globe is a hallmark of CDC’s work.</p>
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CDC’s global HIV and TB efforts account for over half of PEPFAR’s key outcomes based on data through September 2022, including: 61 percent of people who received a positive HIV test result; 62 percent of all people on treatment through PEPFAR; 61 percent of people living with HIV (PLHIV) in care screened for tuberculosis; and 66 percent of antiretroviral therapy (ART) to prevent mother-to-child transmission.<sup>219</sup>

### Budget Request

CDC’s FY 2025 budget request of **\$128,921,000** for the Global HIV/AIDS Program is level with the FY 2023 final level. In FY 2025, CDC will continue to lead global HIV/AIDS program innovation and implementation, utilizing CDC’s scientific and technical experts worldwide. CDC will continue to use evidence-based approaches to concentrate efforts on the countries, populations, and programs where resources are known to have the

<sup>217</sup> UNAIDS. Accessed on August 14, 2023, [UNAIDS](#)

<sup>218</sup> [JESS3 x WHO Global TP Report Factsheet 03](#)

<sup>219</sup> [Global HIV and TB \(cdc.gov\)](#)

greatest public health impact. CDC will also optimize staffing and technical resources to address the highest-priority global HIV needs, while ensuring that ongoing activities and optimization efforts are consistent with PEPFAR's overall priorities.

### **Data-Driven Implementation for Rapid Program Improvement**

CDC supports and uses multiple types of data to implement evidence-based interventions and adapt them to specific country and regional HIV epidemic contexts in real-time. Since 2015, CDC has collaborated with partner countries and U.S. university implementing partners to lead population-based HIV impact assessments (PHIAs) in PEPFAR countries worldwide. Working with Ministries of Health, other USG agencies and technical partners, CDC lends expertise in epidemiology, laboratory science, and data analysis to help partners design and implement PHIAs and rapidly harness the results for program improvement in 17 PEPFAR-supported countries.

### **Innovative Technology and Essential Public Health Platforms Expertise**

Public health laboratories and disease surveillance systems serve essential public health functions critical for an effective response to HIV and other public health threats. CDC partners with countries worldwide through PEPFAR to build these essential public health systems to respond to HIV, TB, and other emerging pandemics.

CDC scientists and partners are developing innovative and cost-effective laboratory tools, including new HIV testing technologies that can be used domestically and globally. For example, CDC developed and implemented Dried Tube Specimen testing technologies, which are cold-chain, independent, and stable for at least a month at temperatures encountered in many countries.<sup>220</sup> This technology is now used globally to develop safe, cost-efficient testing materials ensuring the accuracy of rapid and molecular HIV tests, as well as molecular TB tests. CDC also developed a low-cost, laboratory-based assay to distinguish between recent and long-term HIV infections and a low-cost rapid test for recent HIV infection surveillance – informing better public health responses to HIV. In addition, CDC worked with country partners to transfer expertise and increase proficiency of testing staff, ensuring these innovative tools are widely used and leading to a better understanding of geographic locations and specific populations in which HIV transmission is occurring.

CDC's unique disease surveillance expertise and experience drive decision-making for PEPFAR program implementation. Quality data provide critical information about behavior, incidence, prevalence, and mortality in a population's pre- and post- HIV diagnosis. In addition, CDC's global HIV platforms will continue to serve as the platform for many countries' response to emerging pandemics, including expertise in epidemiology, surveillance, contact tracing, and laboratory.

In FY 2025, CDC will continue to provide a data-driven public health response through:

- Supporting the collection, analysis, and use of PHIA data to inform rapid evidence-based changes in programs, including intensive case findings, immediate initiation of treatment for men and young women, and improved treatment initiation and retention of children and youth living with HIV.
- Increasing the use of testing in support of HIV surveillance to inform programs about trends in new HIV infections in the population.
- Improving health information systems that consolidate data from multiple sources and enables more robust analysis to inform decision making.
- Monitoring sentinel events and detecting transmission cycles through case-based surveillance.
- Improving access to optimized ART regimens, particularly for children, whose treatment options lag behind those available for adults.

<sup>220</sup> [Dried tube specimens: a simple and cost-effective method for preparation of HIV proficiency testing panels and quality control materials for use in resource-limited settings - PubMed \(nih.gov\)](#)

- Leading the development and implementation of innovative approaches that help to ensure a better informed, efficient, and evidence-based public health response to HIV, while also helping to strengthen partner countries essential public health platforms.
- Generating and disseminating key implementation science results to maximize the impact of PEPFAR care and treatment programs.

CDC experts will continue to work with our partners to identify, link, and retain PLHIV on life-saving treatment.

CDC will do this through:

- Continuing collaboration with Ministries of Health and implementing partners to plan and implement same-day or same-week treatment initiation and support continuity of treatment to sustain the gains by focusing on closing the gaps within specific sub-populations, including children.
- Implementing evidence-based strategies and person-centered services to improve continuity of treatment and adherence to ART to meet HIV treatment coverage and viral suppression goals.
- Expanding opportunities for antiretroviral treatment optimization, providing easier treatment options for PLHIV, while also helping to minimize the risk of developing drug resistance.
- Supporting laboratory-based surveillance (e.g., Cyclical Acquired Drug Resistance- CADRE) for the emergence of dolutegravir drug resistance, building upon the HIV viral load testing and drug resistance sequencing infrastructure, and public health laboratory quality management systems.
- Ensuring access to HIV testing using up-to-date and innovative approaches at sites, in the community, and in the homes of families living with HIV.

CDC will continue to focus on achieving and sustaining HIV epidemic control, including through:

- Providing technical support to increase access to proven methods that decrease HIV incidence, including HIV treatment, prevention of mother-to-child transmission, pre-exposure prophylaxis (PrEP), and voluntary medical male circumcision.
- Expanding access to quality and timely viral load testing services and use of these data for program and PLHIV monitoring and management.
- Supporting countries' efforts to deliver essential health services more effectively and efficiently.
- Treating persons upon a positive HIV diagnosis, which both saves lives and prevents new infections.
- Supporting sustainable, country-driven disease surveillance alongside the quality diagnostic services and enhanced public health laboratories.

CDC will also continue to enhance countries' abilities to effectively manage HIV co-morbidities, especially TB, which remains the number one cause of death for PLHIV. CDC will ensure PLHIV have access to preventive TB treatment that significantly reduces the chance they will become ill with TB, including through:

- Strengthening TB surveillance and laboratory systems in PEPFAR countries.
- Supporting the screening of PLHIV for TB.
- Leading PEPFAR-supported efforts to provide access to TB preventive treatment for those who screen negative for TB.
- Initiating immediate TB treatment and care for those diagnosed with TB disease.
- Expanding opportunities and providing technical support for identifying and managing coinfections and non-infectious comorbidities affecting PLHIV to decrease morbidity and mortality and improve their well-being.



## Global Tuberculosis Budget Request

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Tuberculosis (TB) remains one of the world's deadliest infectious diseases, despite being preventable and curable. TB was the second leading infectious disease killer worldwide in 2022, after COVID-19, and a major cause of deaths related to antimicrobial resistance.<sup>221</sup> Globally, nearly 2 billion people, a quarter of the world's population, have latent TB infection (LTBI). Without treatment, people with LTBI can develop TB disease. Approximately 10.6 million people, including 1.3 million children, become sick with TB disease each year. Drug-resistant TB is a further threat to public health worldwide, with 410,000 people developing multidrug-resistant or rifampicin-resistant TB (MDR/RR-TB). CDC approaches TB prevention and control with a coordinated and focused global response, as global reduction in TB is key to controlling and reducing TB rates in the United States.

CDC is working on the frontlines with partner governments in more than 25 countries to prevent, diagnose, and treat TB. CDC focuses on strengthening national TB control programs and strategies in priority countries with high rates of TB, drug-resistant TB, and TB/HIV co-infection. CDC's global TB efforts strengthen critical disease surveillance and laboratory systems that are essential for program success. CDC's global TB approach closely aligns with the Sustainable Development Goal for TB, the WHO End TB Strategy, and PEPFAR's continued efforts to accelerate HIV/AIDS epidemic control.

### Budget Request

CDC's FY 2025 budget request of **\$11,722,000** for Global Tuberculosis is level with the FY 2023 final level. In FY 2025, CDC will continue to use its unique expertise, decades of experience, and global network of key public health leaders to help break TB incidence and mortality curves. CDC efforts will continue to equip partner countries with the TB-focused tools, innovative approaches, and specific expertise urgently needed to address the underlying drivers of the epidemic, including missed TB cases, TB/HIV co-infection, and drug-resistant TB.

In FY 2025, CDC's Global TB activities will prioritize the following actions:

- **Prevent:** Implement effective TB infection, prevention, and control (IPC) practices in health facilities and congregate settings and expand these practices into other clinical settings and scale-up TB preventive treatment (TPT) for PLHIV, young children, and those with compromised immune systems.
- **Diagnose:** Improve case-finding approaches, expand access to better screening, particularly for high-risk populations, and improve diagnostic algorithms to optimize new and existing diagnostics.
- **Treat:** Optimize TB and MDR-TB treatment regimens; improve linkage and broaden access to care and treatment, especially among PLHIV; improve treatment adherence and cure rates among patients with drug-resistant TB; assess costs to patients and barriers to care.
- **Sustain:** Scale-up laboratory external quality assessment systems and training; strengthen surveillance systems to identify missing cases across general and priority populations; improve TB and MDR-TB burden estimates and track national TB control programs performance; and train Ministry of Health and national TB program staff on critical technical and programmatic areas, such as IPC, diagnostics, laboratory quality assurance, data management and use, and operational research.

In FY 2025, CDC's TB Reference Lab will:

- Continue to provide expert technical assistance to TB Programs and TB Reference Laboratories in the United States and in partner countries worldwide.
- Maintain the efficiency of diagnostic networks and the accuracy of laboratory and point-of-care TB testing.

<sup>221</sup> [JESS3 x WHO Global TP Report Factsheet 03](#)

- Provide in-house quality assurance testing.
- Categorize TB drug resistance patterns.

## Global Immunization Budget Request

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CDC works to detect, respond to, and prevent importations of vaccine preventable diseases (VPDs) into the United States. These efforts protect Americans from VPDs that have been eliminated or no longer circulate in the United States. CDC's leadership and global immunization activities include the control, elimination, and eradication of VPDs, as well as strengthening immunization programs worldwide.

Emerging global health challenges reinforce the value of vaccination in preventing disease and the need for a flexible and sustainable approach to build immunization program capacity to save lives, prevent disability, and protect the livelihoods of Americans and populations around the globe. Global VPD programs face enormous challenges in reaching all individuals and being prepared to respond to large outbreaks. Almost all zero-dose children—those never vaccinated with a first dose of diphtheria, tetanus, and pertussis (DTP)-containing vaccine—live in low- and middle-income countries, especially in the African and South-East Asian regions.<sup>222</sup> All of these factors increase the risk of importations of VPDs to the United States.

As a result of efforts by CDC and its global partners, the number of children who received no vaccinations improved 21 percent from 18.1 million in 2021 to 14.3 million in 2022, which is still higher than the 2019 pre-pandemic level of 12.9 million. The proportion of children receiving their first dose of measles vaccine increased from 81 percent in 2021 to 83 percent in 2022. Still, as of November 2023, there have been 40 cases of measles imported into the United States, an increase from 23 cases in 2022. The United States is experiencing an outbreak stemming from an unvaccinated individual who traveled to a country facing ongoing measles outbreaks. Outbreaks of measles in the United States are costly to Americans – for example, an outbreak of 72 cases in Clark County, Washington in 2018-2019 cost approximately \$3.4 million.<sup>223</sup> While vaccination coverage rates for measles is greater than 90 percent in the United States, there has been a decline in global rates during the COVID-19 pandemic, which increases the risk of larger measles outbreaks. In 2022, nearly 22 million missed their first dose of measles vaccine and an additional 11 million missed their second dose, where two doses are required to be fully vaccinated. Measles is extremely contagious and can spread quickly – so when measles importations land in communities with under-vaccinated populations, large outbreaks could occur in the United States. This risk is why routine childhood vaccination across the globe remains vital for the safety and security of Americans.

### Budget Request

CDC's FY 2025 budget request of **\$230,000,000** for Global Immunization is level with the FY 2023 final level.

**Polio Eradication:** In FY 2025, CDC will continue to support efforts as part of the Global Polio Eradication Initiative, using proven interventions to move towards global eradication and ensure Americans are no longer at risk from this crippling and sometimes deadly disease. CDC will prioritize activities to stop circulation of wild poliovirus in Afghanistan and Pakistan, stop ongoing poliovirus outbreaks across Africa, and improve disease surveillance capabilities through quality assurance, diagnostic confirmation, and genomic sequencing of samples obtained worldwide.

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<sup>222</sup> Immunization Coverage, Geneva: World Health Organization; 2023. Retrieved August 1, 2023, <https://www.who.int/news-room/factsheets/detail/immunization-coverage>

<sup>223</sup> [Societal Costs of a Measles Outbreak | Pediatrics | American Academy of Pediatrics \(aap.org\)](https://www.pediatrics.org)

**Measles and other Vaccine-Preventable Diseases (VPDs):** Emerging global health challenges reinforce the value of vaccination in preventing disease and the need for a flexible and sustainable approach to build immunization program capacity to save lives, prevent disability, and protect the livelihoods of Americans and populations around the globe. In FY 2025, CDC will focus on mitigating the damage done to essential public health systems by the pandemic and closing gaps that have long existed. Countries with the highest level of need will be prioritized. CDC efforts will be targeted to identify best practices and address urgent issues and needs including:

- **Reducing Number of Zero-Dose Children and Increasing Vaccination Across All Ages:** CDC will work with governments and communities to define vulnerable and underserved populations, identify methods to increase access to vaccine services, generate evidence to improve immunization service delivery for vulnerable populations, strengthen immunization policy, and utilize supplementary immunization activities when warranted to quickly increase population immunity to epidemic-prone pathogens.
- **Preventing and Mitigating Large and Disruptive Outbreaks and Exportations of Measles and other VPDs:** CDC will support the strengthening of VPD eradication, elimination, and/or control activities while building capacity for epidemiological and risk assessments to prevent and mitigate outbreaks.
- **Achieving and Maintaining Global and Regional Immunization Goals and Essential Immunization Service Targets:** CDC will work with governments and partners to strengthen the physical and human capacity of their essential immunization programs, develop focused strategies through intensified efforts to better communicate with populations who require services, and to prevent diseases that can be prevented through vaccination.

In FY 2025, CDC will strategically target its core VPD activities, such as measles and rubella elimination, to countries with the highest disease burden. CDC will continue to support scientific, technical, and operational experts at CDC headquarters and in the field to respond to VPD outbreaks.

## Parasitic Diseases and Malaria Budget Request

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Parasitic diseases lead to devastating health effects for hundreds of millions of people around the world and in the United States. They can be transmitted directly from other people, by insects or animals, from blood or tissue donation, congenitally, or through contaminated food or water. CDC works to protect Americans and the global community from parasitic diseases with three main priorities: reduce parasitic disease related death, illness, and disability in the United States, reduce the global burden of malaria, and control and eliminate targeted neglected tropical diseases (NTDs).

CDC maintains the national parasitic disease reference laboratories, including an online, interactive diagnostic resource, and coordinates national surveillance for notifiable parasitic diseases, including malaria. In 2023, CDC supported Maryland, Arkansas, Texas, and Florida’s health departments with their investigations of locally acquired, mosquito-transmitted malaria cases – the first domestic cases detected in 20 years. CDC helped eliminate domestic sources of malaria 70 years ago. However, approximately 2,000 cases of malaria are reported each year in the United States, mostly in returning travelers and immigrants.<sup>224</sup> *Anopheles* mosquitoes, the species that spreads malaria, are widespread in the United States. If an *Anopheles* mosquito becomes infected after biting an infected person, it can then transmit malaria to other people. Thus, the risk of mosquito-transmitted malaria in the United States persists and underscores the importance of maintaining capacity to

<sup>224</sup> Mace KE, Lucchi NW, Tan KR. Malaria Surveillance — United States, 2018. MMWR Surveill Summ 2022;71(No. SS-8):1–29. DOI: <http://dx.doi.org/10.15585/mmwr.ss7108a1>

address malaria globally as well as domestically (see Figure 1). CDC works to prevent illness and death related to malaria in the United States by:

- Administering the National Malaria Surveillance System.
- Collaborating with health departments and other partners to investigate unusual cases of malaria diagnosed in the United States.
- Providing consultation and guidance to clinicians and U.S. residents for malaria prevention and treatment in the United States.
- Providing testing services and technical assistance to laboratories.

In 2024, CDC will introduce a toolkit to support state and local health departments in managing locally acquired, mosquito-transmitted malaria cases.

### Budget Request

CDC's FY 2025 budget request of **\$29,000,000** for Parasitic Diseases and Malaria is level with the FY 2023 final level.

In FY 2025, CDC will continue to respond to emergent needs, and enhance the activities of its parasitic disease laboratories which support the prevention, diagnosis, and treatment of parasitic diseases in the United States and globally. CDC will maintain and modernize its reference diagnostic capacity needed by states and countries, U.S. government agencies, and other public health partners. CDC will continue to invest in new testing platforms and next generation sequencing to improve parasitic disease diagnosis and aid in outbreak response.

To address the emerging threat of an invasive mosquito, CDC will monitor malaria epidemiological trends and provide scientific leadership and expertise to enhance vector detection and rapid response. CDC will continue to leverage partnerships and its long-standing malaria field station in western Kenya to evaluate the impact of novel vector control tools on malaria transmission including spatial repellents, attractive targeted sugar baits, and housing modifications (such as closing eaves and screening windows). Additionally, in FY 2025, CDC will continue to focus on providing technical support to countries and implement malaria vaccines, where applicable, and strengthen partner countries' immunization systems broadly.

CDC staff will continue to address the diagnostic gap for NTDs in FY 2025, serving on WHO's Diagnostic Technical Advisory Group's disease-specific subgroups and developing target product profiles for lymphatic filariasis (LF or elephantiasis), schistosomiasis, and onchocerciasis. To help close the gap on parasitic disease-related health inequities in the United States, including to help reverse the rising trend in imported malaria infections, CDC will strengthen prevention as well as diagnosis and treatment of parasitic diseases in the United States, starting with malaria and Chagas disease. CDC will also continue to support American Samoa's efforts to eliminate LF.

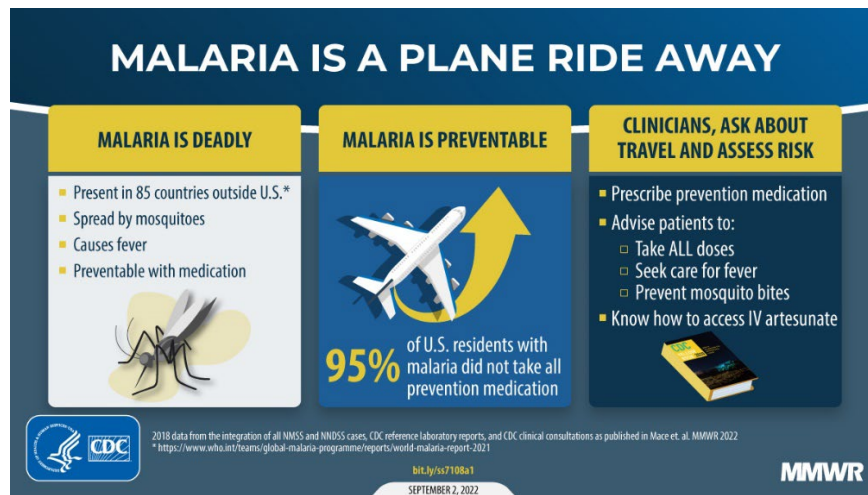


Figure 1 Malaria is a Plane Ride Away – Graphic describing the threat of travel-associated malaria. Malaria is deadly, but preventable. Clinicians should ask about travel and assess risk.

Intestinal worm infections were once prevalent throughout the southeastern United States, disproportionately impacting communities with poor sanitation and limited access to health care. With resources provided by Congress specifically to address soil transmitted helminth (STH) infections, CDC continues to work with academic institutions in Alabama and Mississippi to determine the prevalence of, and risk factors for, STH infections. To date, testing performed by the partners and at CDC has not identified any STH infections. However, a widespread lack of safe and effective sanitation systems has been well-documented, particularly in Alabama. CDC is working with federal, state, and local partners to raise awareness of the threat posed by poor sanitation.

Due to complex parasite biology and scarcity of adequate laboratory tools, cyclosporiasis has been a challenging foodborne illness to detect and investigate. 41 jurisdictions, including 40 states and New York City, reported 2,272 laboratory-confirmed cases of cyclosporiasis in people who likely acquired their infection in the United States between April 1, 2023, and October 24, 2023. That is up from over 1,000 reported cases in 2022. CDC has developed a novel genotyping tool that is supporting epidemiological investigations conducted by CDC, FDA, and state public health departments. CDC uses this tool to clarify relationships among clusters of cyclosporiasis illnesses in states and this information helps inform FDA's traceback investigations. FDA is now able to trace clusters in different states through genetic links, even though suspect foods in each cluster may be different. This tool was used by FDA to expand traceback investigations of clusters in three states, to include two healthcare facilities, because of a genetic link among patients, even though no suspect food could be identified from the clusters. These clusters would not have been linked by traditional epidemiologic methods alone.

As part of ongoing efforts to address health disparities in the United States, CDC works with academic institutions in Texas, Massachusetts, New York, and California to increase healthcare provider awareness of Chagas disease, a parasitic disease that can result in severe heart and gastrointestinal illness. The CDC-funded institutions have become national resources for information. New York's Einstein College of Medicine is working with healthcare providers around New York City to develop Chagas disease centers of excellence to screen and treat patients at risk (one hospital has already screened 2,000 patients). Boston Medical Center developed an online guide to set up screening for Chagas disease<sup>225</sup>, and San Diego State University partners are using their Texas state-accredited Chagas disease curriculum for community health workers in underserved communities and are expanding to community health workers in other states.

<sup>225</sup> [Resources | Chagas Disease \(bu.edu\)](https://resources.bu.edu)

## Global Malaria

CDC is a global leader in preventing and treating malaria, providing scientific expertise to endemic countries and partners to improve surveillance, laboratory systems, and management of malaria cases. CDC jointly implements the U.S. President’s Malaria Initiative (PMI) with USAID. With the addition of three partner countries (Burundi, Togo, and The Gambia) in 2023, PMI provides partner support in 27 African countries and three programs in the Greater Mekong sub-region. CDC plays a unique role within PMI by providing technical leadership and recommendations to the U.S. Global Malaria Coordinator on surveillance, monitoring and evaluation, and operational research, which drives progress toward malaria elimination.

Despite recent successes (11.7 million lives saved and more than 2 billion malaria infections prevented since 2000<sup>226</sup>), malaria remains endemic in many regions and countries. The parasites that cause malaria and the mosquitoes that carry them continue to evolve and are showing signs of resistance to current treatment drugs and insecticides, making it more difficult and costly to prevent and treat the disease. New interventions—and a better understanding of how and where to combine interventions—will accelerate malaria elimination around the world.

CDC contributed to the World Health Organization’s (WHO) 2021 recommendation for the RTS,S malaria vaccine, the first of its kind, for broader use among children in sub-Saharan Africa and in other regions with moderate to high malaria transmission<sup>227</sup>. CDC’s collaboration on the RTS,S pilot in Kenya helped pave the way for wide-scale implementation of this promising new intervention. In 2023, WHO announced the 12 countries in Africa that will be allocated the first 18 million doses of the RTS,S vaccine. CDC also played an integral role through data analytic support, in the October 2023 WHO recommendation of R21/Matrix-M, a new vaccine for malaria.<sup>228</sup>

An invasive malaria mosquito vector in Africa, *Anopheles stephensi* (*An. stephensi*), is an emerging international threat that could reverse progress toward global malaria elimination. It is estimated that as this species continues to spread throughout Africa, it could put an additional 126 million people in urban areas at risk of malaria each year. In the last year, Kenya, Nigeria, and Ghana became the latest countries to confirm the presence of *An. stephensi* mosquitoes. CDC, together with PMI’s *An. stephensi* Task Force, is helping countries across Africa prepare for and mitigate an *An. stephensi* invasion, but there is more to be done to respond to this threat.

In 2022, CDC, NIH, the Kenya Medical Research Institute (KEMRI), and other partners initiated a clinical trial to evaluate the effectiveness of a new monoclonal antibody product which could eventually reduce malaria morbidity and mortality substantially in high-transmission areas. The initial phase, assessing the safety of the product in children, is complete and demonstrated an excellent safety profile, and the second phase, assessing efficacy and safety, began in 2023. This trial will assess whether a single dose of the monoclonal antibody can provide sufficient protection over the course of a year.

<sup>226</sup> [U.S. President’s Malaria Initiative 17th Annual Report to Congress \(d1u4sg1s9ptc4z.cloudfront.net\)](https://www.pmi.gov/annual-report-to-congress)

<sup>227</sup> WHO recommends groundbreaking malaria vaccine for children at risk (October 2021). <https://www.who.int/news/item/06-10-2021-who-recommends-groundbreaking-malaria-vaccine-for-children-at-risk>

<sup>228</sup> WHO recommends R21/Matrix-M vaccine for malaria prevention in updated advice on immunization (October 2023). <https://www.who.int/news/item/02-10-2023-who-recommends-r21-matrix-m-vaccine-for-malaria-prevention-in-updated-advice-on-immunization>

## Neglected Tropical Diseases

Neglected tropical diseases (NTDs) are a group of diseases, including several parasitic diseases, that cause substantial illness for more than one billion people globally. NTDs impair physical and cognitive development, make it difficult for individuals to farm or earn a living, and limit productivity in the workplace.

CDC works to reduce the substantial illnesses and disability caused by NTDs, focusing on those that can be controlled through mass drug administration (MDA) or other low-cost interventions. These include lymphatic filariasis (LF or elephantiasis), onchocerciasis (river blindness), blinding trachoma, schistosomiasis, three soil-transmitted helminths (intestinal worms), and Guinea worm disease.

To accelerate elimination, CDC collaborates with partners to create better tests to detect Guinea worm disease in humans and animals faster as rapid case detection and containment are crucial to preventing spread. As the global reference laboratory for the Guinea Worm Eradication Program, CDC is relied upon to confirm if any suspected cases are positive for the *D. medinensis* parasite that causes Guinea worm. CDC confirmed 13 human cases of Guinea worm disease in 2022—the lowest number in history—down from about 3.5 million cases in 1986.<sup>229</sup> Cases were identified in four countries: Chad, Ethiopia, Central African Republic, and South Sudan. With only 13 human cases of Guinea worm disease reported in 2022, the goal of eradicating this painful parasitic disease has never been closer. To support these efforts, CDC is working on the development of a more easily deployable lab test to detect Guinea worm in dogs, helping to prevent the potential for transmission to humans.

Lymphatic filariasis (LF), or elephantiasis, is a debilitating NTD that has been targeted for elimination as a public health problem globally. CDC is providing financial and technical assistance to American Samoa to eliminate LF. With CDC support, the American Samoa Department of Health (ASDOH) conducted three rounds of MDA and all WHO-recommended MDA monitoring activities, including coverage evaluation surveys and impact assessments. MDA campaigns are a key strategy to stop the spread of LF infection. High treatment coverage has led to decline in infection levels. However, program delivery delays due to the COVID-19 pandemic coupled with the efficiency of the mosquito vector and the frequent movement between American Samoa and LF-endemic Samoa led to the need for an additional round of MDA. CDC supported ASDOH to conduct a fourth round of MDA in August 2023, that reached the most affected LF areas.

CDC also continues to support the elimination of LF in Haiti. In 2023, for the first time ever, Haiti's national NTD program implemented an MDA campaign using the new, WHO recommended triple-drug strategy. The treatment campaign, launched by health ministry partners treated more than 45,000 people, achieving 74 percent population coverage—well above the WHO coverage target of 65 percent.

CDC, alongside its partners, developed new evidence-based tools for strategies to improve the lives of those who suffer from the painful and debilitating effects of LF. This updated guidance gives countries with endemic LF a toolkit for carrying out morbidity management and disability prevention programs that will positively impact the lives of those who suffer from long-term consequences of LF.<sup>230</sup>

CDC has engaged with the African Field Epidemiology Network and country-led onchocerciasis programs to develop new strategies to accelerate programs' abilities to interrupt transmission of this parasite and evaluate/develop new diagnostic tests.

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<sup>229</sup> [Guinea Worm Wrap-Up - Jan. 30, 2023 \(cartercenter.org\)](https://www.cartercenter.org/news/press-releases/2023-01-30-guinea-worm-wrap-up)

<sup>230</sup> [Lymphatic filariasis: managing morbidity and preventing disability: an aide-mémoire for national programme managers, 2nd ed. \(who.int\)](https://www.who.int/publications/m/item/lymphatic-filariasis-managing-morbidity-and-preventing-disability-an-aide-memoire-for-national-programme-managers-2nd-ed)

As NTD programs move closer to control and elimination targets outlined in the WHO NTD Roadmap (2021-2030), diagnostic tools that can support programs' needs are critical for success.<sup>231</sup> Limitations of existing diagnostic tools undermine confidence that program endpoints are being achieved, threatening measurement of progress toward the 2030 goals.

## Global Public Health Protection Budget Request

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In today's closely connected world, a pathogen can spread from a remote area to major cities on all continents in as little as 36 hours. Recent global health emergencies like COVID-19, Ebola, mpox, cholera, and outbreaks of vaccine preventable diseases (VPDs) like yellow fever, Japanese encephalitis, polio, and measles, highlight the existence of critical vulnerabilities that persist in public health systems globally and represent serious threats that Americans and people all around the world face.

CDC is the U.S. government's lead agency for infectious disease outbreak response and implementor of global health security activities aimed at keeping Americans safe at home and abroad. CDC advances the U.S. government's Global Health Security Strategy, National Biodefense Strategy, and the National Strategy for COVID-19 Response and Pandemic Preparedness by leading the response to public health emergencies, including training and deploying outbreak investigators, facilitating international cooperation on and adherence to International Health Regulations (IHR) and global health security architecture standards, and strategically assisting countries around the world to build and improve their disease surveillance capacities and laboratory capabilities.

With its technical expertise and capabilities in emergency response, surveillance, laboratory science, data analytics, and public health workforce, CDC works to fortify public health security systems globally at the regional and country levels by closing gaps in outbreak preparedness and addressing collective global health security challenges. CDC leverages trusted networks across Ministries of Health, Agriculture, Wildlife and Environment, academic partners, the private sector, non-governmental organizations, and faith- and community-based organizations to facilitate this work. CDC subject matter experts monitor disease outbreaks 24/7 and prepare rapid response teams to deploy anytime, anywhere, during an emergency or in response to a public health threat. These innovative and sustained investments ensure CDC is ready to respond quickly and effectively to assist countries in identifying high-consequence pathogens with potential pandemic threat, enhance infection control measures, and conduct outbreak investigations. CDC's scientific expertise and use of data-driven approaches help countries identify vulnerabilities in their public health systems, and CDC collaborates with regional and country partners to develop local and regional capacities to propose priority actions to close identified gaps.

### Budget Request

CDC's FY 2025 budget request of **\$293,200,000** for Global Public Health Protection is level with the FY 2023 final level. In FY 2025, CDC will advance ongoing efforts to strengthen global health security, with a focus on strengthening core public health systems for infectious disease threat detection, surveillance, emergency response, laboratory science capabilities, and training a ready workforce. CDC's on-the-ground experience, expertise, and relationships with partners will support countries in identifying emerging threats and addressing health security gaps more rapidly.

To ensure that CDC's various investments in global health security are used strategically, CDC has partnered with WHO to develop improved versions of the Joint External Evaluation (JEE), which is a comprehensive,

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<sup>231</sup> [Ending the neglect to attain the Sustainable Development Goals: A road map for neglected tropical diseases 2021–2030 \(who.int\)](https://www.who.int/publications/m/item/ending-the-neglect-to-attain-the-sustainable-development-goals-a-road-map-for-neglected-tropical-diseases-2021-2030)



multisectoral assessment by international peers of a country's ability to prevent, detect, and rapidly respond to public health risks, in accordance with the IHR and Global Health Security Agenda (GHSA) targets. The third edition of the JEE was published in July of 2022 and will improve implementation of assessment findings that guide country plans and activities conducted by CDC and other partners for global health security. Since 2016, 126 countries have completed JEEs, and CDC experts have participated in over 60 percent of these JEE assessments to date, which has enabled the U.S. to standardize the international approach on measuring and documenting progress towards global health security targets.

CDC collaborates bilaterally and proactively with key partner countries to address their health security vulnerability in the event of an outbreak. In FY 2025, CDC will continue supporting health security internationally and domestically to mitigate the risk and impact of future emerging outbreaks and health threats. An example of this work's impact is the successful containment of the 2022-2023 Uganda Sudan ebolavirus outbreak, which demonstrated the effectiveness of CDC's strategic global health security investments that trained Ugandan field epidemiologists, strengthened disease surveillance and laboratory diagnostic capabilities, and enhanced local emergency response capacities in the country. In conjunction with the trusted relationship that CDC has developed with the Uganda Ministry of Health, these proactive, multi-faceted investments played a pivotal role in stopping the outbreak in only four months from the official declaration on September 20, 2022. While the outbreak affected nine districts in Uganda, leading to 164 reported cases with 77 deaths, no probable or confirmed cases of Ebola were reported outside of the country due to the effective containment of the outbreak. Domestically, CDC facilitated health monitoring for travelers from Uganda at five U.S. airports, provided clinical consultations to states and local health partners for suspect cases among ill travelers, and prepared to support domestic jurisdictions with rapid deployment teams in the event of a confirmed domestic Ebola case. Stopping the virus' transmission at the source before it spread beyond Uganda's borders prevented the need for further domestic actions and investments to address what would have been a high-consequence health threat in the United States.

Additional examples of how CDC's disease-specific work has been fortifying critical capacities to keep Americans safe include:

- CDC's work in the high incidence meningitis belt in Africa allowing the United States and other countries to track strain emergence, and to develop and maintain effective countermeasures for use domestically and around the world.
- Through PulseNet International, CDC collaborates with country partners to protect the global food supply and prevent the spread of enteric diseases caused by contaminated food, water, or animal contact by building laboratory and surveillance capacity, including training attended by more than 10 countries in FY 2023, and reinforcing data sharing across regional laboratory networks.
- CDC strengthened global health security by working closely with in-country partners to contain outbreaks of deadly diseases of pandemic potential at their source. In early 2023, CDC worked closely with country partners to provide technical expertise that helped to stop the spread of Marburg virus in Equatorial Guinea and Tanzania and Nipah virus in Bangladesh.
- CDC's global healthcare infection prevention and control (IPC) efforts, including the Global Action in Healthcare Network (GAIHN) improves partner country surveillance and laboratory capacity and improves healthcare quality and patient safety.
- CDC's Foodborne, Global Water, Sanitation, & Hygiene (WASH), and fungal disease programs ensure that laboratory systems and surveillance are in place to detect pathogens prior to importation to the United States. These programs build capacity for traditional and novel surveillance (e.g., global wastewater and environmental surveillance), including sequencing and detection of antimicrobial resistance (AMR) in bacteria and fungi and can be applied to other pathogens. In 2023, Global WASH

provided technical assistance to 16 countries for cholera prevention and response, and five countries for wastewater and environmental surveillance.

- CDC’s MicrobeNet, a virtual reference laboratory with language support for 16 languages, provides tools to identify rare and complex pathogens quickly and accurately around the world.
- CDC supports detection and response to identify novel respiratory viruses with pandemic potential. In 2023, CDC supported the investigation of six human cases of avian influenza in Cambodia, including rapidly deploying CDC field staff to work closely with country partners to conduct contact tracing and facilitating coordination between human, animal, and environmental sectors. These efforts resulted in rapid and thorough response that mitigated the risk of additional human cases of avian influenza.
- CDC, working closely with WHO as it transitions out of the COVID-19 public health emergency globally, also supports strategic initiatives (i.e., the WHO Mosaic Respiratory Surveillance Framework and the Preparedness and Resilience for Emerging Threats initiative) at the global and regional level to improve respiratory pathogen surveillance and response initiatives. These activities include support for maintenance and enhancement of existing platforms (i.e., GISRIS+ and CoViNet) to identify emerging SARS-CoV-2 variants as well as other respiratory pathogens including SARS-CoV-2, Respiratory Syncytial Virus (RSV), and Middle Eastern Respiratory Syndrome (MERS).

### *Regional Presence*

In FY 2020, CDC began building a tangible CDC presence in strategic regions across the globe that allows CDC to meet its core global health mission of protecting Americans by responding more rapidly, efficiently, and effectively wherever disease threats occur. Today, CDC has established five regional platforms in Eastern Europe/Central Asia (EECA), Middle East/North Africa Asia (MENA), South America (SAM), East Asia/Pacific (EASP), and Southeast Asia (SEAS).

CDC has Regional Directors in place and will officially open one additional regional office in the first half of 2024 – the Central America and the Caribbean (CAC) regional platform based in Panama City, Panama. These regional offices fill critical gaps in CDC’s geographic reach and provide additional, flexible technical resources and regional health organization representation. Building a strategic regional presence across the globe allows CDC to meet its core global health mission of protecting Americans by responding more rapidly, efficiently, and effectively wherever disease threats occur.

With continued support in FY 2025, CDC will leverage resources through regional offices to identify shared health priorities, coordinate activities across the region, and facilitate technical collaboration with CDC programs, priorities, and scientific expertise both in countries and at CDC headquarters.

### *Disease Detection and Surveillance*

CDC is building the U.S. Government’s knowledge base about the spread and impact of respiratory viruses such as SARS-CoV-2 and RSV and augmenting our partners’ abilities to contain outbreaks from viruses like these before they spread, including detection and monitoring of both seasonal and novel emerging influenza viruses with pandemic potential.

In FY 2025, CDC will strengthen global laboratory networks and ensure supply of critical reagents to partner countries for diagnostic testing to support outbreak response and help modernize global laboratory capacity including advancements in bioinformatics, data visualization capacity, and global data sharing efforts.

CDC will provide support to its global partners on sentinel surveillance systems for SARS-CoV-2, RSV, and influenza and assist country and regional partners with developing and refining event-based surveillance for respiratory pathogens.

CDC will build on its long-term, effective genomic surveillance for SARS- CoV-2 and influenza, to ensure the ability of partners to rapidly identify novel viruses and variants.

### *One Health*

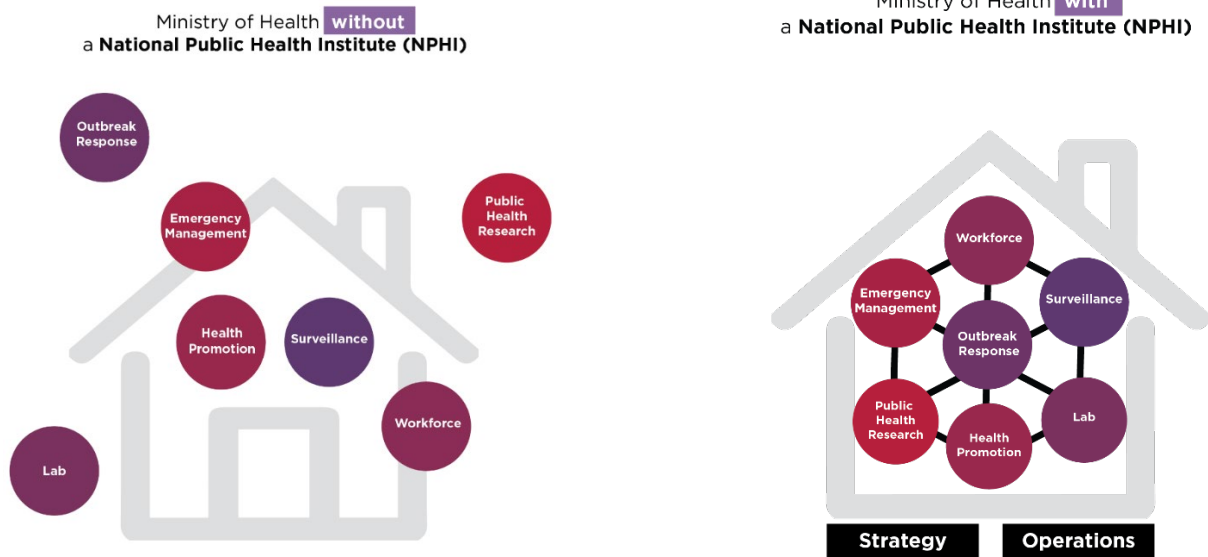
CDC strengthens global health security by promoting and implementing a One Health approach, partnering with public health, animal health (agriculture and wildlife), environment, and other relevant sectors when addressing global public health threats. CDC's One Health Office's work will continue to advance One Health capacity in countries and regions while also building and maintaining strategic partnerships with Ministries of Health, Agriculture, Environment, and others, as well as with international organizations like WHO, Food and Agriculture Organization of the United Nations (FAO), and the World Organisation for Animal Health (WOAH). CDC's One Health Zoonotic Disease Prioritization (OHZDP) trainings and workshops bring together representatives from One Health sectors to prioritize zoonotic diseases of greatest concern and to develop next steps and action plans. To date, CDC has conducted over 45 training workshops on five continents at subnational, national, or regional levels. Conducting these workshops and prioritizing zoonotic diseases has enabled countries to focus limited resources more efficiently on joint activities including strengthening multisectoral coordination, building laboratory capacity, strengthening surveillance within sectors and coordinated cross-sector surveillance, joint outbreak response, implementing multisectoral preparedness, and advancing a One Health workforce.

With continued support in FY 2025, CDC will focus on continuing to support countries and regions in implementation of OHZDP trainings and workshops, strengthening One Health coordinated surveillance for priority zoonotic diseases, and enhancing One Health emergency preparedness and response capacity including through developing One Health Rapid Response Teams to more effectively and rapidly prevent, detect, and respond to One Health related threats.

### *CDC Public Health Outbreaks and Emergency Response Capacity Programs*

Global health emergencies like the COVID-19 pandemic have reinforced the critical necessity of preparedness, coordination, and strong public health emergency response capabilities. CDC's National Public Health Institutes (NPHI) and Field Epidemiology Training Program (FETP) are critical assets that allow CDC to facilitate rapid and effective responses to outbreaks and public health crises.

CDC provides intensive technical assistance to key partner countries in developing their own National Public Health Institute (NPHI), which serves as the focal point for the country's public health activities. CDC has worked with more than 40 countries since 2011 to develop NPHIs that help consolidate public health functions at the national level, bring data and expertise together, and coordinate public health surveillance, laboratory science, workforce development, and emergency response. NPHIs advance the initial impact of CDC's global health security investments by creating permanent in-country institutions facilitated by the country for the implementation of future public health coordination.



In 2021, CDC began supporting NPHI centers of excellence in Colombia, Mozambique, Nigeria, Ukraine, and Zambia. With CDC’s expertise and support, these NPHIs bring in and engage regional expertise to provide neighboring countries with assistance to rapidly intervene and stop high-consequence diseases from spreading, respond to public health emergencies, and support the development of their own country’s respective NPHIs.

The Field Epidemiology Training Program (FETP) offers a country-based training program that is modeled after CDC’s Epidemic Intelligence Service (EIS). FETP trains a global workforce of field epidemiologists, or disease detectives, by combining classroom training with extensive on-the-job experience and mentoring. Epidemiologists graduating from the FETP program become the frontline “boots on the ground” who identify and contain infectious disease threats at their source in their home countries.

CDC also works globally to train skilled laboratorian leaders to develop the skills to not only develop and manage sustainable national laboratory systems, but also to build core competencies in other critical areas that lean on laboratory system contributions, including biosafety and biosecurity, surveillance, and health emergency management. The Global Laboratory Leadership Programme (GLLP), a creation of a GHSA collaboration with CDC and five international partners, develops and trains a cadre of laboratory leaders across the globe to lead national laboratory systems based on a One Health approach to strengthen global health security.

Since 2017, CDC has trained staff from Ministries of Health, Ministries of Agriculture, Bureaus of Statistics, CDC country offices, and non-governmental partners to collect spatial data using GPS units, tablets, and cell phones for disease detection, outbreak response, and program monitoring. CDC has also trained staff to use Geographic Information Systems (GIS) to link, analyze, and interpret critical epidemiology health data.

Global Emergency Alert and Response Service (GEARS) provides a crucial role in national security with CDC experts in Atlanta on duty 24/7 monitoring 30-40 potential public health threats each day. This informs CDC’s response system of experts who are poised for rapid deployment. Since 2007, CDC’s Global Disease Detection Operations Center (GDDOC) has detected and reported on outbreaks of international importance involving diseases in countries and territories around the world.

Since its establishment in 2015, the Global Rapid Response Team (GRRT) has identified and deployed experts for CDC’s response to global outbreaks. With a roster of over 600 CDC responders, GRRT enables CDC experts to deploy within 72 hours to both international and domestic emergencies. GRRT has been a critical asset in CDC’s ability to respond to concurrent and ongoing outbreaks, from Ebola in Guinea to the earthquake response in

Haiti, to here at home in the United States for domestic COVID-19 support. CDC was able to leverage and deploy surge staff from GRRT to support multiple countries, U.S. states, the CDC Emergency Operations Center, and other locations (including the Commonwealth of the Northern Mariana Islands and the U.S. Virgin Islands), and quickly pivot from a global focus to domestic COVID-19 response as needs evolved. As CDC continues to build CDCReady Responder, the umbrella program for all responder readiness functions, GRRT will integrate into that initiative. Eligible GRRT responders who have met readiness requirements for field deployment will be enrolled into CDCReady Responder cadres, and they will be designated as ready for field deployments.

CDC's Global Emergency Management and Capacity Development (GEMCD) program helps countries establish and maintain their own public health emergency management programs by training leaders and staff in Ministries of Health and NPHIs to identify, prepare for, mitigate, respond to, and recover from public health threats. This training and technical assistance ensures that countries have trained staff, established plans and operating procedures, and physical facilities (e.g., Public Health Emergency Operations Centers) to coordinate and manage their own emergency response activities.

Since 2013, CDC has hosted its Public Health Emergency Management (PHEM) Fellowship program in Atlanta to train more than 220 international public health leaders from 58 countries on public health emergency management principles. Building on FY 2024 accomplishments in Southeast Asia and in the Democratic Republic of the Congo, in FY 2025, CDC, through its HQ, regional, and country offices, will scale and adapt the PHEM Fellowship model into immersive trainings on public health emergency management principles that are tailored to specific audiences and needs identified by the countries. As the demand for emergency management technical assistance continues to grow, CDC is evaluating the suitability of establishing Regional Emergency Management Technical Advisors within CDC's regional offices to provide technical assistance and establish related partnerships within each region.

With continued support for these programs in FY 2025, CDC will amplify global health security efforts by working with country partners to help develop strategic capacities necessary for identifying and containing local outbreaks before they become epidemics or pandemics that spread widely and threaten more lives. Led by the world's leading experts in disease detection, outbreak investigation, emergency response, and public health capacity programs, CDC's global health protection programs are essential to keeping Americans healthy, safe, and secure.

### **CDC Implementation of Foreign Assistance Transparency and Accountability Act (FATAA)**

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CDC's activities funded by PEPFAR comply with the Foreign Assistance Transparency and Accountability Act (FATAA) of 2016.

To ensure consistency across U.S. government programs that implement PEPFAR and to ensure compliance with monitoring and evaluation directives, including FATAA, the PEPFAR Country Operational Plan Guidance, and PEPFAR Monitoring, Evaluation and Reporting Guidance, and the PEPFAR Evaluation Standards of Practice provide a robust monitoring and evaluation framework. CDC's routine program data and evaluation are key in generating the evidence needed to know what works and how to implement efficient and cost-effective interventions. CDC's PEPFAR program works with the Office of the Global AIDS Coordinator to implement these frameworks and provide guidance for activities implemented by CDC. FATAA's requirements for monitoring and evaluation are operationalized at CDC as part of the annual program planning and reporting processes and business cycles, which solicit and monitor CDC-funded programs through cooperative agreements with extramural implementing partners. Evaluation and Performance Monitoring Plans are required on every cooperative agreement to ensure alignment and compliance with PEPFAR requirements and FATAA.

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## PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$905.100	\$905.100	\$943.300	+\$38.200
FTEs	493	484	498	5
<b>Total Request<sup>1</sup></b>	<b>\$905.100</b>	<b>\$905.100</b>	<b>\$943.300</b>	<b>+\$38.200</b>
-- Domestic Preparedness <sup>2</sup>	\$905.100	\$905.100	\$943.300	+\$38.200

<sup>1</sup> FY 2023 Final Level and FY 2024 CR level is comparably adjusted to reflect \$21.9 million within CDC's total for HHS Protect. The FY 2023 Joint Explanatory Statement provided \$21.9 million from the Public Health and Social Services Emergency Fund (PHSSEF) for HHS Protect, to support activities implemented by CDC. The FY 2025 Budget proposes directly appropriating funding to CDC for HHS Protect/Response Ready Enterprise Data Integration platform (RREDI).

<sup>2</sup> FY 2025 Budget realigns Public Health Emergency Preparedness Cooperative Agreement; Academic Centers for PH Preparedness; and All Other CDC Preparedness into Domestic Preparedness.

**Enabling Legislation Citation:** PHS A § 301, PHS A § 307, PHS A § 310, PHS A § 311, PHS A § 319, PHS A § 319C-1, PHS A § 319D, PHS A § 319F, PHS A § 319F-2\*, PHS A § 319G\*, PHS A § 351A\*, PHS A § 361, PHS A § 2801, PHS A § 2812

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with\*

**Allocation Methods:** Direct, Federal Intramural, Cooperative Agreements, including Formula Grants/Cooperative Agreements; and Contracts

### Program Description

The United States must be prepared to face emerging health threats in today's highly connected world; the COVID-19 pandemic underscored this fact and highlighted the essential need for sustained investment in our domestic public health preparedness and response infrastructure. Local disease outbreaks can quickly escalate into regional, national, and global emergencies. Over the last two decades, we have seen H1N1, Ebola, Zika, SARS-CoV-1 (SARS), SARS-CoV-2 (COVID-19), and mpox. These emerging infectious diseases and localized disease outbreaks spread rapidly and affect populations around the world. CDC empowers communities to respond to any emergency that may strike, including natural disasters and terrorist attacks. Over the years, investments have been critical to supporting effective responses to extreme weather events, such as hurricanes, earthquakes, wildfires, and floods. CDC's preparedness efforts rely on its expertise in laboratory science, public health surveillance, epidemiology, and public health emergency management, in addition to its longstanding relationships with federal, state, tribal, local, territorial, and global partners.

### Budget Request

CDC's FY 2025 budget request of **\$943,300,000** for Domestic Preparedness is **\$38,200,000** above the FY 2023 final level, when adjusted for \$21.9 million from the Public Health and Social Services Emergency Fund (PHSSEF), for HHS Protect, that was implemented by CDC in FY 2023. This budget request sustains FY 2023 enacted funding levels for the Public Health Emergency Preparedness (PHEP) cooperative agreement program, Academic Centers for Public Health Preparedness, and CDC Preparedness and Response Capability. CDC will continue to support state, tribal, local, and territorial health departments to ensure their capability, flexibility, and adaptability in the face of naturally occurring or intentional events that cause public health emergencies. CDC will continue to fund all 50 states, four large metropolitan areas, and eight U.S. territories and freely-associated states through the PHEP cooperative agreement.

This request includes an increase of **\$38,200,000**, for a total of **\$60,100,000**, to maintain the Response Ready Enterprise Data Integration platform (RREDI), the next generation of HHS Protect, following the transition of platform management from HHS to CDC. RREDI provides nationwide situational awareness and informs key decision-makers. However, it is only able to operate at its current level because of support received from COVID-19 supplemental funding. RREDI is a common operating picture and central hub to collect, integrate, and share public health data in near-real time across federal, state, and local, governments and the healthcare industry. The platform will serve as an important tool to support decision-making and coordination at all levels. Additional base funding, as reflected in the FY 2025 request, is needed to support this core public health data management platform that can be used between emergency responses and can scale up to handle multiple simultaneous responses.

The request carries forward the budget realignment proposal to establish a single Domestic Preparedness Program, to create greater flexibility in CDC's ability to respond to public health emergencies.

#### Addressing Vulnerable Populations in Preparedness and Response

- The COVID-19 pandemic presented unprecedented challenges and exacerbated longstanding systemic health inequities that put disadvantaged groups at increased risk for illness and death. CDC works to ensure that the principles of health equity and best practices are at the core of all emergency responses. CDC partners with state, tribal, local, and territorial (STLT) governments and academia to implement science, intervention, partnership, and workforce-related goals. CDC is incorporating health equity considerations into internal and external funding opportunity guidance, prioritizing frameworks, and performance monitoring to improve health equity in future public health emergencies and disasters.
- CDC is also supporting the maintenance of a health equity lens in agency-led emergency response by building health equity roles into the CDC All-Hazards plan, expanding the health equity focus in response-related workforce training, and coordinating deployment missions to serve specific populations of focus. CDC is advancing public health preparedness health equity goals in the 2024-2028 PHEP notice of funding opportunity, building upon earlier recommendations related to STLT community resilience capabilities. Finally, CDC is developing and delivering an advanced epidemiology training initiative to select members of the current public health workforce in all participating United States-affiliated Pacific Island (USAPI) jurisdictions to strengthen the regional emergency preparedness and response capacity, jurisdictional surveillance capabilities, and data-driven health interventions and services for populations across the USAPI.



## PUBLIC HEALTH PREPAREDNESS AND RESPONSE

### BY THE NUMBERS<sup>1</sup>

- 3,131—Staff partly or wholly supported by PHEP funding in the 62 PHEP jurisdictions; PHEP recipients funded an additional 3,484 personnel in local health departments, filling critical gaps in local public health emergency response.
- 2000+—CDC Responder days worked by over 2,157 personnel to support responses in FY 23.
- 1,800+ staff fully enrolled for 95 response roles in 15 different cadres within CDC Ready Responder.
- 170—Federal Select Agent Program laboratory inspections conducted through CDC’s regulatory authority (42 CFR Part 73) as of November 17, 2023.
- 28,973—Reports disseminated through the Epi-X system in FY 2023, connecting public health reporting through a secure, web-based network that provides rapid reporting and coordination during public health investigations.

\*References

<sup>1</sup>All information and calculations are from CDC program data.

<b>Public Health Preparedness and Response Funding History</b>	
Fiscal Year	Dollars (in millions)
FY 2021	\$839.614
FY 2022	\$862.200
FY 2023 Final	\$905.100
FY 2024 CR	\$905.100
FY 2025 President’s Budget	\$943.300

## Domestic Preparedness Programs

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### Public Health Emergency Preparedness Cooperative Agreement (PHEP)

#### Program Description

In 2022, CDC commemorated the 20<sup>th</sup> anniversary of the Public Health Emergency Preparedness (PHEP) program, which was established after the terrorist and subsequent anthrax attacks of September 2001. CDC established the PHEP cooperative agreement program to develop nationwide expertise in public health emergency preparedness and response, including capabilities to distribute and dispense medical countermeasures, establishing laboratory and epidemiologic systems that enable early threat detection and identification, and training and supporting public health professionals for day-to-day health department operations and surge capacity.

Two decades later, the PHEP program continues to support jurisdictions, particularly in the areas of developing a ready public health workforce, supporting state-of-the-art laboratories, and sustaining domestic preparedness.

CDC's [\*Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health\*](#)<sup>232</sup> provides a national public health framework consisting of 15 capabilities for prioritizing, organizing, and assessing preparedness. This framework supports cross-cutting preparedness and response priorities, including those related to protecting disproportionately affected populations during public health emergencies. PHEP recipients use the capability standards to advance their public health preparedness and response capacity and their ability to support community partners focused on addressing populations with access and functional needs. PHEP funding, planning, training, and exercising have encouraged partner engagement and fostered strong stakeholder relationships that have led to better outreach, education, and message translations for specific communities.

#### Program Accomplishments

During FY 2023, CDC provided additional support for state, local, and territorial (SLT) preparedness in several areas. The increase supported key local health department activities through additional funding for more than 400 local planning jurisdictions that are part of the PHEP program's Cities Readiness Initiative (CRI). Additional funds also advanced SLT workforce development initiatives, including continued implementation of the nationwide Career Epidemiology Field Officer (CEFO) program and expansion of the Preparedness Field Assignee (PFA) program. Funds also supported a dedicated PHEP health equity officer to improve STLT preparedness planning for populations disproportionately impacted by public health emergencies or incidents. The additional funding also enabled CDC to help modernize critical preparedness infrastructure with the replacement of obsolete chemical laboratory testing equipment for 10 testing laboratories in the Laboratory Response Network for Chemical Threats (LRN-C).

#### **Local Support to Enhance Operational Readiness**

CDC provides funding to PHEP recipients to strengthen their medical countermeasure planning and response capabilities. These include providing monthly virtual and in-person training; fulfilling requests for specialized support and assistance; and demonstrating how community planners can use tools such as the COVID-19 surge tool, pandemic influenza electronic exercise tool, and the vaccine targeting checklist in their planning and exercising.

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<sup>232</sup> [https://www.cdc.gov/orr/readiness/00\\_docs/CDC\\_PreparednesResponseCapabilities\\_October2018\\_Final\\_508.pdf](https://www.cdc.gov/orr/readiness/00_docs/CDC_PreparednesResponseCapabilities_October2018_Final_508.pdf)

Since 2004, the PHEP program's Cities Readiness Initiative (CRI) has enabled state and local jurisdictions to respond to public health emergencies that require life-saving medicines and medical supplies. Specifically, CRI funds 72 cities and metropolitan areas (at least one in every state) to develop, test, and maintain plans to quickly receive medical countermeasures (MCM) from the Strategic National Stockpile and distribute and dispense them to local communities. In FY 2023, PHEP recipients received approximately \$79 million in CRI funding, a \$7 million (11%) increase over FY 2022 funding. The funding supports all-hazards planning for MCM distribution and dispensing, as well as preparedness activities across all 15 capabilities outlined in the [Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health](#) within these large metropolitan areas.

CDC's Operational Readiness Review (ORR) is a rigorous, evidence-based assessment that evaluates a jurisdiction's planning capabilities and operational capacity across the 15 preparedness and response capabilities. CDC subject matter experts help PHEP recipients improve their planning and operations in support of national health security efforts by:

- Providing targeted technical assistance to address gaps.
- Offering state, local, and territorial planners ongoing training.
- Supporting innovative partnerships and other strategies to identify staffing solutions for operations.
- Developing guidance and training to clarify annual and five-year exercise requirements and to test all-hazards preparedness and response plans more effectively.

CDC analyzed recipient response data from the 2021-2022 budget period pertaining to the COVID-19 response. CDC assessed data across 15 capability standards, as well as performance of vaccine roll-out activities and partner collaboration. PHEP recipients demonstrated several strengths in their COVID-19 response, allowing them to successfully establish and implement strategies for medical countermeasure distribution and dispensing and vaccine management and distribution. Successful strategies included:

- Engagement of community partners in developing and sharing information.
- Bolstering medical countermeasure dispensing and vaccination administrators by using the National Guard to lead mass vaccination events and coordinating delivery, shipment, and administration of vaccines with traditional and nontraditional partners.
- Adapting preparedness plans to include cold chain management training for local health departments and health care coalitions and leveraging subject matter experts to provide input on vaccine storage, handling, and administration.

While PHEP recipients performed response activities with only some challenges, the uncertainty and duration of the pandemic had a significant impact on the public health workforce. Following are two concrete actions that CDC plans to address with recipients to improve jurisdictional readiness to effectively manage the next public health emergency.

- Build workforce capacity to meet jurisdictional surge management needs and support staff recruitment, retention, resilience, and mental health.
- Improve administrative and budget preparedness systems to ensure timely access to resources for supporting jurisdictional responses.

## Laboratory Preparedness and Response

Established more than 20 years ago, the Laboratory Response Network (LRN) is a national security asset for preparedness and rapid response to biological, chemical, and other high-priority public health emergencies. CDC manages this coordinated national network of public health and other laboratories that provide timely, reliable laboratory tests for biological (LRN-B) and chemical (LRN-C) threats. CDC supports the LRN with expertise in biological and chemical threats, laboratory science, public health response, and clinical recommendations as well as deployment of specific cleared assays. CDC's longstanding partnerships with state and local health agencies and other federal partners connect experts for supporting the LRN. Public health officials use LRN test results to make critical decisions that protect the public from harm. LRN-C test results serve a critical role in identifying harmful exposures and ensuring appropriate medical countermeasures during local responses throughout the United States. For example, in recent years, outbreaks of exposure to poisoned synthetic cannabinoids and nonfatal drug overdoses were all tested in LRN-C laboratories. In 2022, the LRN-C Level 1 laboratory in Virginia provided laboratory emergency response to help local partners including hospitals, county health departments, local law enforcement, and the Office of the Chief Medical Examiner address emergency exposures. Virginia's LRN-C lab reported test results for an attempted suicide using castor beans (i.e., a natural source of ricin) as well as several suspected poisonings involving cyanide, volatile organic compounds, and mercury.

PHEP funding supports both LRN-B and LRN-C state and local laboratories. State public health departments determine how many and what type of laboratories are needed in their jurisdictions and allocate PHEP funds accordingly. In FY 2022 and FY 2023, nearly \$13 million in PHEP funding supported new equipment for LRN-C testing laboratories and other improvements to network capabilities. Funding for LRN-B supports routine and reliable testing for biological threats, emerging infectious diseases, and high-consequence pathogens—such as Ebola and smallpox. Investments in the LRN-B smallpox preparedness capabilities meant that on May 17, 2022, the U.S. was able to identify the first case of mpox through the Massachusetts LRN-B laboratory and then quickly alert other LRN-B laboratories to expand testing to detect additional cases. The cleared assay had already been deployed from CDC to the LRN-B, and nearly 70 public health laboratories across the nation were able to perform the non-variola orthopoxvirus test on day one of this outbreak. From May 17 through June 30, 2022, the LRN-B served as the sole testing resource in the U.S., testing more than 2,000 specimens while it expanded testing capacity within public health laboratories to 8,000 tests per month in 78 public health laboratories. To enhance access to testing, the LRN-B provided materials, technical assistance, and training that allowed five commercial laboratories to begin testing for mpox in July 2022, resulting in a combined testing capacity of up to 80,000 specimens per week. By the end of the public health emergency, the LRN-B tested more than 33,000 specimens for mpox.

CDC's LRN-B provides an adaptive and scalable framework to respond to individual public health threats at the state and/or local level, as well as large outbreaks or large-scale threat events. In FY 2025, these LRN-B laboratories will continue to use PHEP funding to support testing readiness and strengthen national security for biothreats and emerging infectious diseases. However, without additional investments, the LRN-B may struggle to maintain the existing capabilities or expand to prepare for new or emerging infectious disease threats.

Additionally, PHEP provides funding allocations for highly sophisticated and specialized equipment, quality materials and reagents, threat method development, and analysts required for LRN-C Level 1 laboratories to maintain the highest level of national laboratory surge capacity. In FY 2025, LRN-C Level 1 labs will continue to receive dedicated PHEP funding to purchase and maintain critical instrumentation and other lab equipment; train staff and conduct proficiency testing; and support participation in local, state, and national exercises. Importantly, local and state health departments have recently leveraged this established CDC testing capacity to support local responses to the U.S. opioid crisis. Since 1999, more than 1 million Americans have died due to a

drug overdose. In 2021, over 75% of drug overdose deaths involved opioids, including fentanyl and its analogs.<sup>233</sup>

Over the last two years, CDC:

- Obtained 510(k) clearance from the U.S. Food and Drug Administration to enhance its *B. anthracis* real-time PCR Assay and three clearances for the non-variola orthopoxvirus assay to expand capacity and support the mpox response.
- Increased US testing capabilities for Sudan ebolavirus by providing instruments, tests, and verification materials to LRN laboratories and 10 Regional Emerging Special Pathogen Treatment Centers (RESPTCs), located in each Health and Human Services (HHS) region.
- Distributed instruments to select LRN-B laboratories for the new resazurin dye-based antimicrobial susceptibility test and trained 29 laboratory scientists to conduct the Etest for *B. anthracis* antimicrobial susceptibility.
- Partnered with LRN-C member laboratories to introduce high-resolution mass spectrometry (HRMS) capabilities for detecting unknown and emerging chemical threats.
- Implemented HL7 messaging capabilities into several LRN-C laboratories, ensuring real-time access to laboratory response data.
- Updated the instrumentation for testing exposures to nerve agents in 35 LRN-C laboratories and volatile organic compounds in 45 LRN-C laboratories.
- Initiated a pilot to establish an LRN-R to increase the national capacity to test for internal radiation contamination.

In 2023, because of the local and state chemical threat laboratory capacity maintained by CDC, the LRN-C laboratory in Virginia was able to rapidly provide results for volatile organic compounds and toxic metals in samples from an individual who potentially ingested household cleaner. In another case, Virginia's Level 1 lab was able to provide key data to confirm trace levels of fipronil, a broad-spectrum insecticide, in post-mortem blood and urine samples upon a request from the chief medical examiner. In Maryland, the state's Level 2 lab identified four natural poisons in samples from an individual admitted to a local hospital with cardiac abnormalities after ingesting a dietary supplement. Responses from these state labs demonstrate the agile testing capabilities that LRN-C labs maintain for unknown samples.

With CDC's support and expertise, state and local LRN member laboratories are more prepared than ever to quickly identify threats. In 2022, more than 120 LRN-B member laboratories tested more than 34,000 specimens for mpox and nearly 1,700 specimens for all other pathogens. As the world's preeminent public health institution, CDC is uniquely positioned to provide leadership to the LRN's network of integrated laboratories, assuring consistent and confident detection of biological and chemical threat agents and emerging infectious diseases. In 2025, the LRN will continue providing leadership and coordination to LRN's network of laboratories across the U.S. as well as developing, improving, and deploying diagnostic assays to enhance public health laboratory preparedness response.

### **CDC Support to State and Local Public Health Departments**

The majority of PHEP funding supports staffing in PHEP recipients' jurisdictions and funding to local health departments and tribal entities in their jurisdictions. The PHEP program supports more than 3,100 staff in SLT health departments who work daily to strengthen public health preparedness and response capabilities. These staff provide critical public health expertise where emergencies begin, at the local level, enabling faster and

<sup>233</sup> <https://www.cdc.gov/drugoverdose/deaths/index.html>

more effective responses. Areas of expertise include epidemiology, surveillance, outbreak response, information technology, MCM distribution, and MCM dispensing.

As of October 2023, through PHEP funding, 78 CDC preparedness field staff are embedded in SLT jurisdictions. Having trained and dedicated staff providing direct technical assistance and other CDC support is critical to ensuring health departments are prepared to protect the health of their communities. PHEP-funded preparedness professionals use their public health emergency management skills to help states, localities, and territories prepare for and respond to both small and large public health emergencies. These field staff provide a direct two-way connection between CDC and SLT public health partners, leveraged during active responses, including the current COVID-19 response. These specialized preparedness field staff include:

- **49 Career Epidemiology Field Officers** (CEFOs) who strengthen health departments’ epidemiological and response capacity and capabilities for public health emergencies. CEFOs provide mentorship and train state, local, and territorial staff and students in public health emergency management principles, supporting the next generation of public health professionals.
- **29 Preparedness Field Assignees** (PFAs) who support preparedness programs after graduating from the Public Health Associate Program. PFAs are a vital link in the public health preparedness workforce pipeline and help to fill state-level staffing and preparedness capacity gaps.

In addition to preparedness field staff, CDC regional staff support STLT jurisdictional readiness, response, and recovery activities. As of October 2023, 10 regional liaison officers (LNOs) advance STLT readiness, response, and recovery capacity and promote health equity by:

- Ensuring bidirectional communication between public health leaders and CDC.
- Offering and facilitating technical assistance, including consultation, guidance, and rapid access to CDC subject matter experts.
- Fostering collaboration and partnership with STLT partners and other federal agencies.



CDC has significantly enhanced its preparedness field staff program by creating a national CEFO network to support the emergency preparedness and response activities of every state, territory, and locality directly funded by the PHEP cooperative agreement. When fully implemented, the national network will include 57 CEFOs directly funded by CDC to support all 50 states, Chicago, Los Angeles County, New York City, and

Washington, D.C. The CEFO network also includes three regional CEFOs assigned to the U.S.-affiliated Pacific Islands and the Caribbean territories to build their preparedness and response capabilities. Since its inception, the national CEFO network has added 16 new centrally funded CEFOs, with several additional placements underway. The new CEFO assignments are in Alaska, Colorado, Connecticut, Delaware, Kansas, Los Angeles County, Louisiana, Maine, Nevada, New Mexico, New York, Ohio, Rhode Island, Texas, Utah, and Wisconsin. As of October 2023, 41 centrally funded CEFOs support 46 jurisdictions. In addition to the centrally funded CEFO network, eight public health departments have elected to use their PHEP funding to host additional CEFOs to further advance their jurisdictional preparedness and response efforts.

Skilled in public health disaster response, CEFOs provide invaluable support during public health emergencies. CEFOs continue to serve in many jurisdictions as CDC's embedded official points of contact (POCs) for the State, Territorial, Local, and Tribal Task Force. In addition, many CEFOs quickly pivoted to support critical mpox response roles despite ongoing COVID-19 response activities, including leading initial response efforts in California and Washington.

Health departments are also benefiting from recent changes to CDC's Preparedness Field Assignees (PFA) program. CDC is expanding the PFA program to meet the growing preparedness and response needs of PHEP jurisdictions. CDC is initiating a phased approach to strategically grow the PFA program and as of October 2023, 29 PFAs provide boots-on-the-ground support to 28 state and local preparedness programs and provide early-career professionals with additional field experience in state and local emergency preparedness and response.

In FY 2025, CDC will continue to work closely with funded state, local, and territorial health departments to apply the lessons learned from recent large-scale responses, including COVID-19, to identify and develop potential reforms to the PHEP program. Based on recent internal and external feedback on advancing the PHEP program, CDC has developed a Public Health Response Readiness Framework with 10 strategic program priorities to organize these improvements:

1. **Develop a threat-specific planning approach** to augment all-hazards planning, address evolving threats, and support medical countermeasure logistics.
2. **Enhance partnerships (federal and nongovernmental organizations)** to effectively support community preparedness efforts.
3. **Expand local support** to improve jurisdictional readiness to effectively manage public health emergencies.
4. **Improve administrative and budget preparedness systems** to ensure timely access to resources for supporting jurisdictional responses.
5. **Build workforce capacity** to meet jurisdictional surge management needs and support staff recruitment, retention, resilience, and mental health.
6. **Modernize data** collection and systems to improve situational awareness and information sharing with healthcare systems and other partners.
7. **Strengthen risk communications activities** to improve proficiency in disseminating critical public health information and warnings and address mis/disinformation.
8. **Incorporate health equity** practices to enhance preparedness and response support for communities experiencing differences in health status due to structural barriers.
9. **Advance capacity and capability of public health laboratories** to characterize emerging public health threats through testing and surveillance.
10. **Prioritize community recovery efforts** to support health department reconstitution and incorporate lessons learned from public health emergency responses.

**PHEP Funding for Local Jurisdictions**

The PHEP program funds local health departments primarily through three types of funding allocations:

1. **State Health Department Allocations to Local Health Departments:** There are 39 state PHEP recipients with decentralized governance structures that allocate PHEP funding to their local health departments via contracts or subawards; the remaining 11 states have centralized structures whereby they manage funds wholly at the state level and cannot allocate funds to local health departments.
2. **Direct PHEP Funding to Four Large Metropolitan Areas:** Chicago, Los Angeles County, New York City, and Washington, D.C. receive PHEP funds directly from CDC.
3. **Cities Readiness Initiative (CRI):** States allocate PHEP funding to large, heavily populated planning jurisdictions. Approximately 60 percent of the U.S. population resides in one of these jurisdictions. There is at least one CRI jurisdiction in every state.

All 50 states used their FY 2022 PHEP investments to support nearly 3,600 full- or part-time personnel at the local level.

<b>PHEP Awards*</b>			
<b>(whole dollars)</b>	<b>FY 2023</b>	<b>FY 2024</b>	<b>FY 2025</b>
	<b>Final</b>	<b>CR</b>	<b>President’s Budget</b>
Number of Awards	62	62	62
New Awards	0	0	0
- Continuing Awards	62	62	62
Average Award	\$10,666,000	\$10,666,000	\$10,666,000
Range of Awards	\$370,000 - \$44,882,000	\$370,000 - \$44,882,000	\$370,000 - \$44,882,000
Total Awards	\$661,338,000	\$661,338,000	\$661,338,000

\*CDC awards PHEP funding using the formula established under section 319C-1 of the Public Health Service Act. The formula includes a base funding amount, plus funding for population- based on risk and “carve-outs” for Cities Readiness Initiative and Level 1 Chemical Labs.



## **Regional Centers for Public Health Preparedness and Response**

Recent emerging infectious threats (e.g., COVID-19 pandemic and mpox outbreak) coupled with the increasing severity of natural disasters demonstrate the dynamic nature of public health threats and their impact on our nation and world. Regional Centers enable public health practitioners and academic and cross-sector partners to collectively ensure that evidence-based practices are available and implemented by state and local health departments and that new knowledge is available to inform decision-making and the rapid implementation of interventions that protect the public's health during times of crisis. CDC will continue to support implementation, evaluation, new research, translation, dissemination, and training to improve the nation's ability to prepare for, respond to, and recover from local and national emergencies.

In December 2022, through Section 2231 of the federal authorization for FY 2023, CDC was directed to support not fewer than ten Centers for Public Health Emergency Preparedness and Response that are equally distributed among the geographical regions of the United States (referred to as the "network of centers"). To prepare for the establishment of this network of centers, in FY 2023 CDC released two calls for contract proposals to:

- Develop five-year workplans for each region, informed by community needs, in order to improve public health preparedness and response.
  - Establish regional coordinating bodies for each HHS region to inform development of the five-year workplans, thereby coordinating relevant activities with applicable state, local, territorial, and tribal (STLT) health departments and officials, health care facilities, and health care coalitions.
- Provide centralized coordination, technical assistance, and training supporting regional workplan development for public health emergency preparedness and response.

CDC awarded eight contracts to support the creation of seven regional public health emergency preparedness and response (PHEPR) workplans and to provide national coordination, technical assistance, and training in support of the regional workplan efforts. Regional workplan contracts were awarded to institutions in seven of the ten HHS regions (no proposals were received for the remaining three regions).

In addition to supporting the development of regional workplans, CDC competitively funded four of the regions to perform additional, optional contract tasks:

- Establish separate public health emergency preparedness and response (PHEPR) workplans within regions for tribal, rural, or frontier areas with unique needs:
  - Region 8: Tribal
  - Region 9: Pacific Islands
  - Region 10: Tribal
- Establish plans to support development of interoperable regional data ecosystem models, scalable to different emergency events and diverse data sources:
  - Region 4
  - Region 8
  - Region 10

Final workplans developed through these contracts will guide the work of the network of regional centers that will be established via a competitive cooperative agreement NOFO to be published in FY 2024. The centers will build on the work of the regional coordinating bodies to implement the workplans to advance regional PHEPR capabilities, with a focus on increasing uptake of evidence-informed preparedness and response programs.

In FY 2025, CDC will:

- Maintain up to 10 Regional Centers for Public Health Preparedness and Response established in FY 2024.
- Work with broad partnerships to enhance the evidence base to strengthen preparedness and response practice and the 15 Public Health Emergency Preparedness and Response Capabilities, which serve as national standards for federal, state, tribal, local, and territorial public health.
- Disseminate and socialize a public health emergency preparedness and response (PHEPR) research agenda that incorporates health equity goals for STLT health departments emphasizing the 15 public health preparedness capability standards.
- Advance preparedness and response workforce capabilities through the development and delivery of training programs focused on building hazards and disaster research skills among STLT practitioners and tribal and rural communities.

## **CDC Preparedness and Response**

### Program Description

CDC supports critical infrastructure and research to facilitate the prevention of, and rapid response to, public health emergencies by:

- Developing and coordinating an emergency preparedness and response research agenda.
- Building and evaluating the underlying scientific framework supporting the nation’s capacity to prepare for and respond to public health emergencies. Examples of research topics include anthrax response coordination; chemical, radiological, and biological response support; and the special needs of children during responses.
- Ensuring, through the Select Agent Program, that laboratories working with the most dangerous biological agents and toxins do so as safely and securely as possible.
- Staffing, operating, and maintaining a 24/7 Emergency Operations Center (EOC) from which CDC deploys scientific experts; coordinates delivery of supplies and equipment to incident sites; monitors response activities; and provides resources in supporting the public health needs of all populations according to specific cultural, linguistic, and environmental factors.
- Using the Graduated Response Framework to guide the management of CDC’s public health emergency responses, ensuring effective and efficient operations regardless of the event’s size and scope. Under the Graduated Response Framework, CDC responded to a total of seven responses in FY 2023: three agency-wide responses (2011 Polio Eradication, COVID-19, and mpox) and four center-led responses (Hurricane Ian, Haiti Cholera, New York State Polio, and Marburg).
- Designing and conducting emergency management training and exercises that prepare public health leaders and staff to respond to all types of emergencies.
- Enhancing the Laboratory Response Network (LRN) through CDC’s development of guidance, training, and proficiency testing for member labs, enabling rapid detection of biological, chemical, and radiological threats.

CDC will continue to focus on these mission-critical activities.

### **Response Ready Enterprise Data Integration platform (RREDI, formerly HHS Protect)**

The 2019 COVID-19 pandemic has made clear the utility of having a Common Operational Picture that enables and establishes a core public health data management and integration platform for use during and in the steady-state time periods between agency-level emergency responses that can be relied on during an

emergency. Management of the HHS Protect platform was transferred to CDC from HHS in FY 2022. RREDI, the next generation of HHS Protect, is a common operational picture that enables secure data sharing in near-real time across federal, state, and local governments and the healthcare industry. It serves as an important tool to support policymakers, provide critical data to the new Center for Forecasting and Outbreak Analytics, and communicates the latest timely information for COVID-19 and mpox as well as future threats and public health responses. It has enabled data-driven discussions and collaboration between federal, state, and local counterparts around topics such as hospital capacity, data quality issues, compliance issues, and state needs. The budget request supports several remaining critical needs for this platform to continue its success. These include:

- Software licensing to support CDC activities and ecosystem.
- Services and staff to support platform management and response support for future outbreaks.
- Help Desk support to fully support users of the platform.
- System and workforce development training for a data-savvy workforce to operate the platform.
- Support to provide security monitoring (software and services).
- Management of agreements to allow data sharing between CDC and external partners.
- Integration of other CDC data, tools, and platforms with this platform.
- Support of an interagency governance structure to provide strategic objectives and align to CDC strategic planning.

### **Safe and Secure Use of Dangerous Biological Agents and Toxins**

Scientific research in laboratories is critical to our nation's defense against both naturally occurring diseases and bioterrorism. Laboratory research with biological select agents and toxins can lead to important breakthroughs in vaccine development, drug therapies, diagnostic testing, and other discoveries that save lives. Common examples of select agents and toxins include anthrax, Ebola virus, bubonic plague, and ricin. If handled incorrectly—or in the hands of the wrong people—select agents and toxins can pose a severe threat to the health and safety of people, plants, or animals.

CDC develops, implements, and enforces regulations to ensure this work is done as safely and securely as possible. This includes managing two critical programs: the Federal Select Agent Program (FSAP) and the Import Permit Program (IPP).

#### ***Federal Select Agent Program***

CDC partners with the U.S. Department of Agriculture (USDA) to manage the FSAP. Together, the agencies develop and enforce regulations on the possession, use, and transfer of 68 biological pathogens and toxins that can pose a severe threat to human, animal, and/or plant health, and animal and plant products. Laboratories researching with select agents and toxins must register with the FSAP. CDC oversees approximately 86 percent of the registered entities (with the rest overseen by USDA). FSAP and the regulated community use the CDC-developed electronic Federal Select Agent Program (eFSAP) information system—a two-way, high-security, web-based communication portal—to improve regulatory oversight through process improvements. Due to this investment in eFSAP, during the COVID-19 pandemic, CDC has been able to continue FSAP programs operations remotely.

CDC routinely inspects the nearly 250 registered laboratory facilities to ensure compliance with the select agent regulations. These inspections allow CDC to confirm that appropriate biosafety and security measures are in

place and that laboratorians are adequately trained to implement plans and procedures for the containment of select agents at each facility.

### **Import Permit Program**

CDC's Import Permit Program (IPP) regulates the importation of infectious biological materials that could cause disease in humans to prevent the introduction and spread of these materials into the United States. Prior to issuing import permits, IPP reviews all applications to ensure facilities have appropriate biosafety measures in place for working with these imported materials. As needed, the IPP also inspects the applicant's facility to confirm implementation of measures to minimize the risk of accidental release of infectious biological agents or vectors of human disease (e.g., mosquitoes, rodents). CDC issues more than 3,000 import permits each year.

In FY 2025, CDC will continue to:

- Ensure the safe and secure handling of biological agents and toxins.
- Monitor imports of infectious biological materials, which is critical to national security and public health.
- Inspect laboratories working with select agents and toxins and imported materials.
- Enhance eFSAP and eIPP information systems to continue to evolve CDC operations.

### **Emergency Management Program**

CDC's Emergency Management Program (EMP) prepares the agency to facilitate well-coordinated responses to emergencies and disasters, including disease outbreaks, natural disasters, and other public health threats. The EMP integrates public health practice with emergency management principles using the National Incident Management System. An Incident Management System (IMS) is an internationally recognized model for effectively managing emergency responses. Having an IMS in place organizes the command and control for a response so that CDC can rapidly understand the public health problem and develop interventions that reduce harm and save lives during public health emergencies.

CDC's largest-scale emergency response activities are centralized in the agency's Emergency Operations Center (EOC). No matter the type of threat—from infectious diseases to natural disasters and terrorism—highly trained experts and scientists gather in the EOC to monitor information, prepare for known and unknown events, and provide real-time, coordinated response capability. CDC responders include thousands of the nation's top experts in respiratory diseases, epidemiology, laboratory science, and public health data and analytics. In FY 2023, over 720 personnel worked over 90,000 CDC responder days for the COVID-19 response, and more than 1,050 personnel worked over 88,000 CDC responder days for the mpox response. With decreasing severe illness due to COVID-19 and dramatic decreases in cases of mpox, both responses have transitioned from agency-wide to center-led responses.

### **Identifying and Preparing CDC's Public Health Response Workforce (CDC Ready Responder)**

CDC has historically relied on active and passive identification of volunteers to meet its urgent and long-term staffing needs. Response leaders often struggle to find ready, willing, and able volunteers with the right skillsets for the job, and responders frequently need to recruit their own replacements. These challenges re-emerged during COVID-19, mpox, Ebola, and other recent responses. To address them, CDC established the CDCReady Responder program to change the way the agency identifies and prepares responders ahead of public health emergencies. The program centralizes coordination and preparation of staff across the agency for both on-site

and virtual headquarters-based response. This initiative ensures that CDC can rapidly establish and maintain response activities when emergencies occur and bring clarity to how staff support emergency responses.

The CDC Ready Responder program incorporates active and continuous qualification and management of responders rostered into cadres based on experience, training, participation in preparedness activities (such as exercises), and supervisory-approved availability. The CDCReady Responder Program continues to assess and identify training needs for staff who are new to working in the response environment. Currently, the program has identified approximately 60 trainings and is actively working to develop those over the next 9-12 months. These trainings will be made available to all staff and will specifically assist new staff, or staff with little response experience, in becoming acclimated to working in a response environment.

### **Incident Manager Training and Development Program**

The Incident Manager Training and Development Program (IMTDP) continues to be a key success in how CDC strengthens response leader capacity. Since its inception in 2015, IMTDP has graduated a total of 107 CDC response leaders, increasing the cadre of qualified candidates to fill CDC IMS Leadership Team roles by six-fold.

In 2023, IMTDP implemented a new competitive selection process as part of CDC Moving Forward efforts, which resulted in a cohort of 23 leaders from across CDC that represent 30 professional disciplines. In concert with CDC's Graduated Response Framework, CDC now has a trained cadre to lead and manage responses at the program/center/agency-wide levels. IMTDP Class of 2023 participants, alumni, and faculty were heavily involved in leading recent CDC emergency responses, including, the 2019 Novel Coronavirus Response, 2022 Haiti Cholera Response, 2022 Hurricane Response, 2022 Multinational Mpox Response, and the 2022 Uganda Ebola Response. For example, the current IMTDP Class of 2023 (n=23) served in 146 response assignments across these 5 CDC responses. Among agency-wide responses, 96 percent of IMTDP Class of 2023 participants served in the COVID-19 Response (n=22) and 70 percent served in the Mpox Response (n=16). Moreover, IMTDP Class of 2023 participants served in top IMS leadership roles, such as Task Force Lead/Deputy (n=17), Incident Manager (n=2), Principal Deputy Incident Manager (n=4), and Deputy Incident Manager (n=2). CDC's investments in preparing CDC response leaders also include continuing education of IMTDP alumni and faculty. Trainings are offered on an annual basis to emphasize leadership concepts through the lens of emerging response leader topics which they can apply in real-time in their day-to-day work and emergency response. Sixty-seven IMTDP alumni and 41 IMTDP faculty served in 473 response assignments across the 5 CDC responses listed above. In FY 2025, IMTDP will continue to provide leadership training and continuing education for CDC's emergency response leaders and complement the broader response training curriculum offered through the CDCReady Responder program.

## State Table: Public Health Emergency Preparedness Cooperative Agreement<sup>1</sup>

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Arizona	\$13,007,079	\$13,007,079	\$13,007,079	\$0
Arkansas	\$6,989,403	\$6,989,403	\$6,989,403	\$0
California	\$44,882,292	\$44,882,292	\$44,882,292	\$0
Colorado	\$10,612,843	\$10,612,843	\$10,612,843	\$0
Connecticut	\$8,123,961	\$8,123,961	\$8,123,961	\$0
Delaware	\$5,426,073	\$5,426,073	\$5,426,073	\$0
Florida	\$33,336,079	\$33,336,079	\$33,336,079	\$0
Georgia	\$17,681,023	\$17,681,023	\$17,681,023	\$0
Hawaii	\$5,386,337	\$5,386,337	\$5,386,337	\$0
Idaho	\$5,742,299	\$5,742,299	\$5,742,299	\$0
Illinois	\$17,059,039	\$17,059,039	\$17,059,039	\$0
Indiana	\$12,101,913	\$12,101,913	\$12,101,913	\$0
Iowa	\$6,873,572	\$6,873,572	\$6,873,572	\$0
Kansas	\$7,154,030	\$7,154,030	\$7,154,030	\$0
Kentucky	\$8,576,091	\$8,576,091	\$8,576,091	\$0
Louisiana	\$8,919,448	\$8,919,448	\$8,919,448	\$0
Maine	\$5,210,000	\$5,210,000	\$5,210,000	\$0
Maryland	\$12,242,223	\$12,242,223	\$12,242,223	\$0
Massachusetts	\$13,927,467	\$13,927,467	\$13,927,467	\$0
Michigan	\$17,051,164	\$17,051,164	\$17,051,164	\$0
Minnesota	\$12,231,559	\$12,231,559	\$12,231,559	\$0
Mississippi	\$6,893,485	\$6,893,485	\$6,893,485	\$0
Missouri	\$11,168,375	\$11,168,375	\$11,168,375	\$0
Montana	\$5,510,000	\$5,510,000	\$5,510,000	\$0
Nebraska	\$5,807,091	\$5,807,091	\$5,807,091	\$0
Nevada	\$7,683,461	\$7,683,461	\$7,683,461	\$0
New Hampshire	\$5,378,731	\$5,378,731	\$5,378,731	\$0
New Jersey	\$16,937,507	\$16,937,507	\$16,937,507	\$0
New Mexico	\$6,958,927	\$6,958,927	\$6,958,927	\$0
New York	\$19,892,548	\$19,892,548	\$19,892,548	\$0
North Carolina	\$15,763,551	\$15,763,551	\$15,763,551	\$0
North Dakota	\$5,210,000	\$5,210,000	\$5,210,000	\$0
Ohio	\$18,334,549	\$18,334,549	\$18,334,549	\$0
Oklahoma	\$8,008,571	\$8,008,571	\$8,008,571	\$0
Oregon	\$8,471,350	\$8,471,350	\$8,471,350	\$0
Pennsylvania	\$20,247,797	\$20,247,797	\$20,247,797	\$0
Rhode Island	\$5,715,557	\$5,715,557	\$5,715,557	\$0
South Carolina	\$10,505,907	\$10,505,907	\$10,505,907	\$0
South Dakota	\$5,510,000	\$5,510,000	\$5,510,000	\$0
Tennessee	\$11,981,492	\$11,981,492	\$11,981,492	\$0
Texas	\$43,765,264	\$43,765,264	\$43,765,264	\$0
Utah	\$7,233,853	\$7,233,853	\$7,233,853	\$0
Vermont	\$5,510,000	\$5,510,000	\$5,510,000	\$0
Virginia	\$16,335,770	\$16,335,770	\$16,335,770	\$0
Washington	\$13,364,241	\$13,364,241	\$13,364,241	\$0
West Virginia	\$5,531,898	\$5,531,898	\$5,531,898	\$0
Wisconsin	\$11,929,433	\$11,929,433	\$11,929,433	\$0
Wyoming	\$5,210,000	\$5,210,000	\$5,210,000	\$0

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
<b>Localities</b>				\$0
Chicago	\$10,471,504	\$10,471,504	\$10,471,504	\$0
Washington, D.C.	\$21,767,817	\$21,767,817	\$21,767,817	\$0
Los Angeles County	\$20,523,321	\$20,523,321	\$20,523,321	\$0
New York City	\$6,850,546	\$6,850,546	\$6,850,546	\$0
<b>Territories</b>				\$0
American Samoa	\$413,850	\$413,850	\$413,850	\$0
Guam	\$544,542	\$544,542	\$544,542	\$0
Marshall Islands	\$419,776	\$419,776	\$419,776	\$0
Micronesia	\$478,510	\$478,510	\$478,510	\$0
Northern Mariana Islands	\$408,982	\$408,982	\$408,982	\$0
Puerto Rico	\$370,357	\$370,357	\$370,357	\$0
Republic of Palau	\$6,653,125	\$6,653,125	\$6,653,125	\$0
Virgin Islands	\$466,932	\$466,932	\$466,932	\$0
<b>Subtotal States</b>	<b>\$591,969,347</b>	<b>\$591,969,347</b>	<b>\$591,969,347</b>	<b>\$0</b>
<b>Subtotal Localities</b>	<b>\$59,613,188</b>	<b>\$59,613,188</b>	<b>\$59,613,188</b>	<b>\$0</b>
<b>Subtotal Territories</b>	<b>\$9,756,074</b>	<b>\$9,756,074</b>	<b>\$9,756,074</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$661,338,609</b>	<b>\$661,338,609</b>	<b>\$661,338,609</b>	<b>\$0</b>

<sup>1</sup> [Final PHEP Budget Period 3 \(Fiscal Year 2021\) Funding September 2021 \(cdc.gov\)](https://www.cdc.gov/phepbudget/)

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## CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$563.570	\$563.570	\$513.570	-\$50.000
Prevention and Public Health Fund	\$160.000	\$160.000	\$210.000	+\$50.000
<b>Total Request</b>	<b>\$723.570</b>	<b>\$723.570</b>	<b>\$723.570</b>	<b>\$0</b>
FTEs	2,302	2,352	2,352	50
-- <i>Preventive Health and Health Services Block Grant (PPHF)</i>	\$160.000	\$160.000	\$160.000	\$0
-- Public Health Leadership and Support	\$128.570	\$128.570	\$128.570	\$0
-- Infectious Disease Rapid Response Reserve Fund	\$35.000	\$35.000	\$35.000	\$0
-- Public Health Infrastructure and Capacity	\$350.000	\$350.000	\$350.000	\$0
-- Center for Forecasting and Outbreak Analytics	<u>\$50.000</u>	<u>\$50.000</u>	<u>\$50.000</u>	<u>\$0</u>
-- Center for Forecasting and Outbreak Analytics	\$50.000	\$50.000	\$0	-\$50.000
-- <i>Center for Forecasting and Outbreak Analytics (PPHF)</i>	\$0	\$0	\$50.000	+\$50.000

**Enabling Legislation Citation:** PHSA § 301, PHSA § 304, PHSA § 306\*, PHSA § 307, PHSA § 308, PHSA § 310, PHSA § 310A\*, PHSA § 311, PHSA § 317, PHSA § 317F, PHSA § 319, PHSA § 319A, PHSA § 319D, PHSA § 322, PHSA § 325, PHSA § 327, PHSA § 361-369, PHSA § 391\*, PHSA § 399G, PHSA § 399U, PHSA Title XIX Part A, PHSA § 2821, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019 (P.L. 115-245, Division B), and The American Rescue Plan Act of 2021 (P.L. 117-2 Sec 2404).

**Enabling Legislation Status:** Permanent Indefinite

**Authorization of Appropriations for FY 2023:** Indefinite; Expired/Expiring noted with\*

**Allocation Methods:** Direct Federal/Intramural, Contracts, Competitive Grants/Cooperative Agreements

### Program Description

The CDC-Wide Activities and Program Support account supports cross-cutting agency functions that drive coordination, enhance foundational capacities, and support CDC’s ability to deliver rapid, decisive responses to emerging public health threats. The proposed investments are also critical to identifying and repairing systemic weaknesses that create vulnerabilities in America’s health security and contribute to health disparities among Americans.

### Budget Request

CDC’s FY 2025 budget request of **\$723,570,000** for CDC-Wide Activities and Program Support is level with the FY 2023 final level. This request includes **\$210,000,000** from the Prevention and Public Health Fund, which is **\$50,000,000** above the FY 2023 final level. In addition, the FY 2025 request includes **\$50,000,000** for the Center for Forecasting and Outbreak Analytics and **\$128,570,000** for Public Health Leadership and Support.

CDC-Wide Funding History	
Fiscal Year	Dollars (in millions)
FY 2021 (BA)	\$123.570
FY 2021 (PPHF)	\$160.000
FY 2022 (BA)	\$333.570
FY 2022 (PPHF)	\$160.000
FY 2023 Final (BA)	\$563.570
FY 2023 Final (PPHF)	\$160.000
FY 2024 CR (BA)	\$563.570
FY 2024 CR (PPHF)	\$160.000
FY 2025 President’s Budget (BA)	\$513.570
FY 2025 President’s Budget (PPHF)	\$210.000

**Program Accomplishments**

In FY 2023, CDC’s Center for Forecasting and Outbreak Analytics (CFA) developed and improved new modeling tools for pandemic-prone diseases including COVID-19 and seasonal influenza. CFA:

- Co-led the development of CDC’s first-ever monthly fall and winter respiratory season outlook. The outlooks provide key information about what public health decision makers can expect in this year’s respiratory virus season so that jurisdictions can plan for resource allocation and mitigation tactics.
- Launched Insight Net, the nation’s first national network focused on developing a coordinated, national health security approach for preparing for disease outbreaks. The network will focus on creating and refining outbreak analytic tools that the nation needs to be better prepared and will ensure that these tools can be operationalized at the local level. Through the launch of the network, CFA is taking a significant step towards bringing these innovations to state and local public health decision makers in the U.S., where many key decisions are made. Direct funding is going to 13 primary awardees who are connected to more than 100 private sector, academic, and state and local partners, reaching 24 states.<sup>234</sup>

In FY 2023, CDC’s Public Health Infrastructure Center:

- Continued its efforts to build public health infrastructure and workforce in the United States, directly supporting all 50 states, 22 cities, 27 counties, and eight territories and freely associated states to build foundational capabilities and support the people and systems needed to effectively protect health in their jurisdiction. Everyone in the United States lives in a jurisdiction that received funding for recruiting, retaining, and training public health workers who can support communities in ensuring food and water is safe, detect and track diseases, stop outbreaks, provide preventive care for mothers and children, and respond to future threats.
- As directed by Congress, CDC continued to build its new Office of Rural Health. This office will continue to coordinate across CDC programs and work with partners to advance strategies to meet the unique public health challenges of rural populations.

<sup>234</sup> <https://www.cdc.gov/forecast-outbreak-analytics/partners/insightnet/index.html>

## CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

### BY THE NUMBERS

- **4,000**—Correspondences answered on over 1,000 topic areas from stakeholders, including Congress, academia, the business sector, employers, and other federal, state, and local partners.
- **1,098**—Registrants of the annual Public Health Improvement Training (PHIT), which drew 951 registrants (87% of all attendees) from state, tribal, local and territorial health departments to two related events, an in-person training and a virtual training event. Nearly all respondents (98%) said PHIT 2023 was a valuable use of their time and 88% report they plan to use or adapt specific tools or examples from PHIT for their work.
- **90%**—U.S. population served by an accredited health department as of July 2023. The Public Health Accreditation Board (PHAB), supported by CDC, has accredited 436 health departments—41 state, 6 tribal, and 389 local health departments.
- **\$10 million**—Savings to the U.S. government, with \$12,000 in savings to each state or local health department, since CDC began creating medical illustrations previously acquired through commercial licensing.
- **\$26 million**—Awarded to 26 American Indian and Alaska Native Tribal nations and regional tribally designated organizations to strengthen the people, services, and systems needed to prevent disease, promote health, and protect communities from emerging health threats and longstanding health challenges.
- **Over 100**—private sector, academic, and state and local partners included in Insight Net, the nation’s first national network for developing and scaling disease modeling tools.

\*References:

<sup>1</sup> Public Health Accreditation Board. Accredited Health Departments. Available at: <https://phaboard.org/accreditation-recognition/accreditation-activity/>

<sup>2</sup> Public Health Accreditation Board. PHAB Survey of Health Departments and Site Visitors During Response to COVID-19 Pandemic, July 2020. Available at: <https://phaboard.org/wp-content/uploads/Strategic-Planning-Survey-Findings-Final-July-2020.pdf>

\*Unless otherwise noted, all information and calculations are from CDC program data.

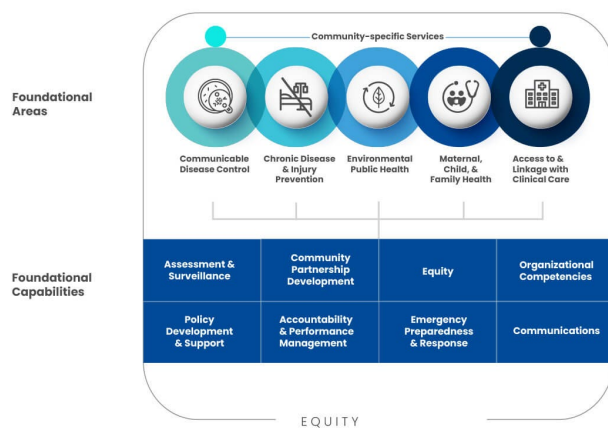
## Public Health Infrastructure and Capacity Budget Request

States and local communities continue to face life-threatening infectious disease outbreaks. Meeting these challenges requires people, services, and systems to protect health in every community. After decades of underinvestment, the need for sustained public health infrastructure investment is deep and largely unmet, with an estimated \$4.5 billion annual gap in foundational public health capabilities in the United States.<sup>235</sup> With a stronger infrastructure, public health departments will be able to help maintain every American’s health by making sure food and water is safe, tracking diseases, stopping outbreaks, providing child and maternal healthcare, and monitoring data.

In a series of listening sessions conducted by CDC, more than 100 partners, including state and local public health officials, consistently articulated a need for flexibility to address specific jurisdiction needs and build capacity to respond to emergencies and provide essential services like tracking the spread of an emerging disease. Jurisdictions also emphasized a need for sustainability to support and maintain a more robust public health system. Informed by these conversations and to support public health infrastructure, CDC announced the funding opportunity, “[Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems](#).”<sup>236</sup> Recipient jurisdictions will continue to receive disease-agnostic funding to build foundational capabilities aligned with the Public Health National Center for Innovations’ Foundational Public Health Services,<sup>237</sup> a framework for a minimum set of capabilities that should be available in every community including assessment and surveillance, community partnership development, equity, organizational competencies, policy development and support, accountability and performance management, emergency and preparedness and response, and communications.

In 2023, CDC awarded \$245,000,000 in Public Health Infrastructure and Capacity base funds to 106 jurisdictions including all 50 states, 22 cities, 26 counties, and eight territories and freely associated states for foundational capabilities. Over the five-year grant period, these funds will be used to create a stronger, more resilient public health system that is ready to face future health threats. These funds will help ensure that every U.S. community has the people, services, and systems needed to promote and protect health<sup>238</sup>.

### Foundational Public Health Services



February 2022

Image from the Public Health Accreditation Board: [FPHS | PHAB](#)

<sup>235</sup> DeSalvo K, Parekh A, Hoagland GW, Dilley A, Kaiman S, Hines M, Levi J. Developing a Financing System to Support Public Health Infrastructure. *Am J Public Health*. 2019 Oct;109(10):1358-1361. doi: 10.2105/AJPH.2019.305214. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6727291/>

<sup>236</sup> <https://www.cdc.gov/infrastructure/>

<sup>237</sup> <https://phnci.org/transformation/fphs>

<sup>238</sup> [Health Department Profiles | CDC](#)

**Budget Request**

CDC’s FY 2025 budget request of **\$350,000,000** for Public Health Infrastructure and Capacity is level with the FY 2023 final level.

CDC will continue to directly fund state, local, and territorial health departments to meet national quality standards, conduct performance improvement activities, increase communication and collaboration across the public health system, and build other foundational capabilities that undergird the success of all public health endeavors. With this investment, health departments will strengthen their abilities to effectively respond to a range of public health threats, while maintaining programs and services in other areas of longstanding public health need.

Jurisdictions will also receive technical assistance for workforce development and foundational capabilities through three national health partners: the Association of State and Territorial Health Officials (ASTHO), National Network of Public Health Institutes (NNPHI), and the Public Health Accreditation Board (PHAB). In addition to technical assistance, these organizations, working in conjunction with other partners, will evaluate the program and facilitate coordination and communication across grantees.

Investing in public health infrastructure will enable health departments to hire and ensure competencies are maintained in their workforce and to benefit from advances in scientific technology for addressing health threats. Sustained investment in public health infrastructure would enable key activities in public health departments:

- Hire and retain a skilled, diverse workforce capable of surging to meet local, regional, or national needs.
- Innovate and establish better practices to collect data, address health equity, and support cross-sector, cross-jurisdictional, and regionally appropriate collaborations with rural pharmacies, academic centers, and industry.
- Support technological improvements to state and regional public health labs and build scalable, cutting-edge scientific capabilities that keep pace with technology.
- Conduct performance improvement to build and sustain high-quality services and meet the needs of local populations.

In FY 2025, CDC will also enhance Indian Country’s capacity to prevent disease, promote health, and prepare for and respond to emerging threats through the “[Strengthening Public Health Systems and Services in Indian Country](#),” cooperative agreement. Building tribal public health infrastructure enhances Indian Country’s capacity to prevent disease, promote health, and prepare for and respond to emerging threats and chronic disease challenges.

**Public Health Infrastructure and Capacity** <sup>1,2,3,4</sup>

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President’s Budget
Number of Awards <sup>3</sup>	106	106	106
- New Awards	0	0	0
- Continuing Awards	106	106	106
Average Award	\$2.311	\$2.311	\$2.311
Range of Awards	\$0.493-\$10.514	\$0.493-\$10.514	\$0.493-\$10.514
<b>Total Awards</b>	<b>\$245.000</b>	<b>\$245.000</b>	<b>\$245.000</b>

<sup>1</sup> Table only reflects funds from CDC’s annual appropriation.

<sup>2</sup> These funds are awarded by formula.

<sup>3</sup> Awards noted for Component A Strategy 2: Strengthening Public Health Infrastructure--Foundational Capabilities.

<sup>4</sup> Awards from FY 2023 appropriation were disbursed in December 2023.

## Center for Forecasting and Outbreak Analytics Budget Request

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As the Nation’s health response agency, CDC is developing the scientific foundation necessary for the U.S. Government and state and local jurisdictions to improve response to future disease outbreaks.

Since its establishment in 2021, CFA has published analytics to inform responses to outbreaks of Marburg, Ebola, mpox, and acute pediatric hepatitis. In FY 2023, CFA continued progress towards its four goals<sup>239</sup>:

- 1) PREDICT – Deliver actionable analysis and response-ready modeling tools.
- 2) INFORM – Generate practical decision support products.
- 3) INNOVATE – Drive technological and analytic innovation.
- 4) ADVANCE – Build a world-class forecasting and outbreak analytics organization.

The U.S. lacks capacity—and no market yet exists—for forecasting and modeling future disease transmission and communicating with state and local jurisdictions about specific public health threats. Therefore, as the nation’s lead for health security, CDC is coordinating the work needed to advance U.S. capacity. CFA is building, testing, and improving open-source models and tools for pandemic-prone diseases. These investments are already advancing the field of infectious disease forecasting and analytics for influenza and COVID-19 hospitalizations.

- Using technology-based approaches to automate the generation of forecasts, CFA has shortened the amount of time needed for processing forecasting data from hours down to minutes.
- Using data from Massachusetts, CFA data scientists evaluated the performance of how a COVID-19 hospitalization forecast performs when compared to a hospitalization forecast that integrates wastewater data. CFA found that incorporating wastewater data into a forecasting model can produce more accurate outcomes. CFA is exploring the potential to expand the wastewater data-enhanced forecasting approach for the nation. Doing so will require addressing multiple challenges, including accounting for variability in wastewater collection practices across the U.S. CFA is working on approaches to these challenges aims to produce state-level COVID-19 forecasts that combine hospitalization and wastewater data in 2024.

CFA recognizes the importance of effectively translating forecasts and outbreak projections to decision-makers. The Center is building a team of expert communicators and is leading projects to create meaningful tools for decision makers and the public. In 2023, CFA collaborated across CDC to develop the first Respiratory Disease Season Outlook<sup>240</sup>, sharing expectations for the severity of COVID-19, respiratory syncytial virus (RSV), and influenza hospitalizations for the winter season. To be sure this work is useful at the state and local level, CFA data scientists work closely with jurisdictions’ staff to discuss likely scenarios and make informed decisions for their communities.

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<sup>239</sup> <https://www.cdc.gov/forecast-outbreak-analytics/about/what-we-do.html>

<sup>240</sup> <https://www.cdc.gov/forecast-outbreak-analytics/about/season-outlook.html>

**Figure 1: Predicted COVID-19 hospital admissions estimated from hospital-only admission data and hospital plus wastewater data, Massachusetts, October-December 2022**

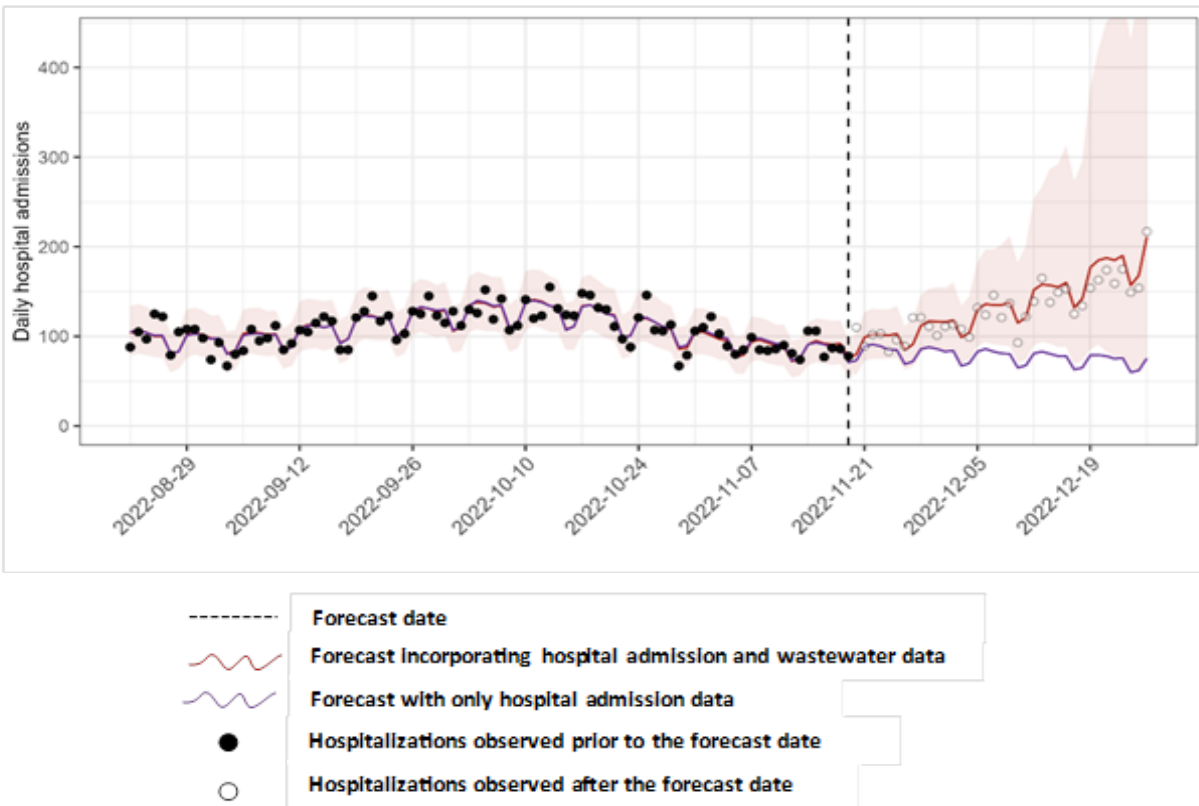
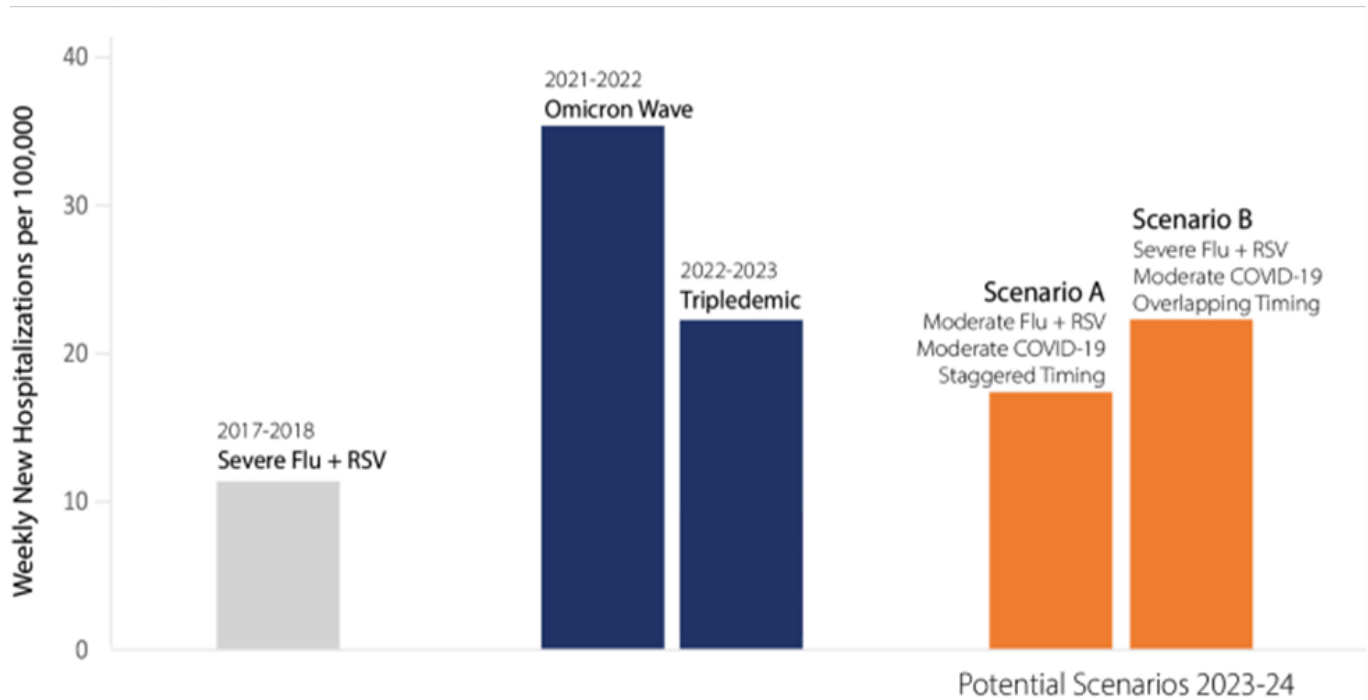


Figure 1 shows how hospital admission data alone (purple line) predicted a stable trend in COVID-19 hospitalizations. However, the actual number of hospitalizations observed after the forecast date increased. When wastewater data was incorporated in the forecast model, the forecast more accurately predicted the true hospitalization trend. Note the alignment of the actual observed hospitalizations, represented by an open circle (o) within the forecasted range that incorporates wastewater data shown with the red line. The addition of wastewater data in disease forecasting is a promising finding, and CFA will continue to evaluate the potential to incorporate this new data source into other models.

**Figure 2: Potential Scenarios for Combined Peak Hospitalization from COVID-19, Influenza, and RSV**



In Figure 2 the orange bars show potential scenarios for the hospitalization burden of COVID-19, influenza, and RSV during the 2023-2024 winter season. These scenarios illustrate how the additional burden from COVID-19 during a moderate season for the three respiratory diseases may generate more hospital demand – potentially resulting in hospital strain – than a severe influenza and RSV season prior to the emergence of COVID-19.

CDC is committed to communicating forecasts and outbreak projections to decision-makers clearly. Innovation is a key component of CFA’s strategy and requires meaningful partnerships with academic institutions, the private sector, and state and local health departments. To advance innovation in disease modeling at the local level, CFA launched Insight Net<sup>241</sup> in November 2023, establishing the first outbreak analytics and disease modeling network in the United States. Insight Net includes 13 funded partners and a large, diverse network of over 100 organizations across the country. The network will design, prototype, test, and scale up data modeling tools that can be used to support decision makers at the local level. Insight Net is a transformative investment that will improve CDC’s forecasting data and analytics and empower state and local decision-makers to use forecasting during the next outbreak. (See Figure 3)

<sup>241</sup> <https://www.cdc.gov/forecast-outbreak-analytics/partners/insightnet/index.html>



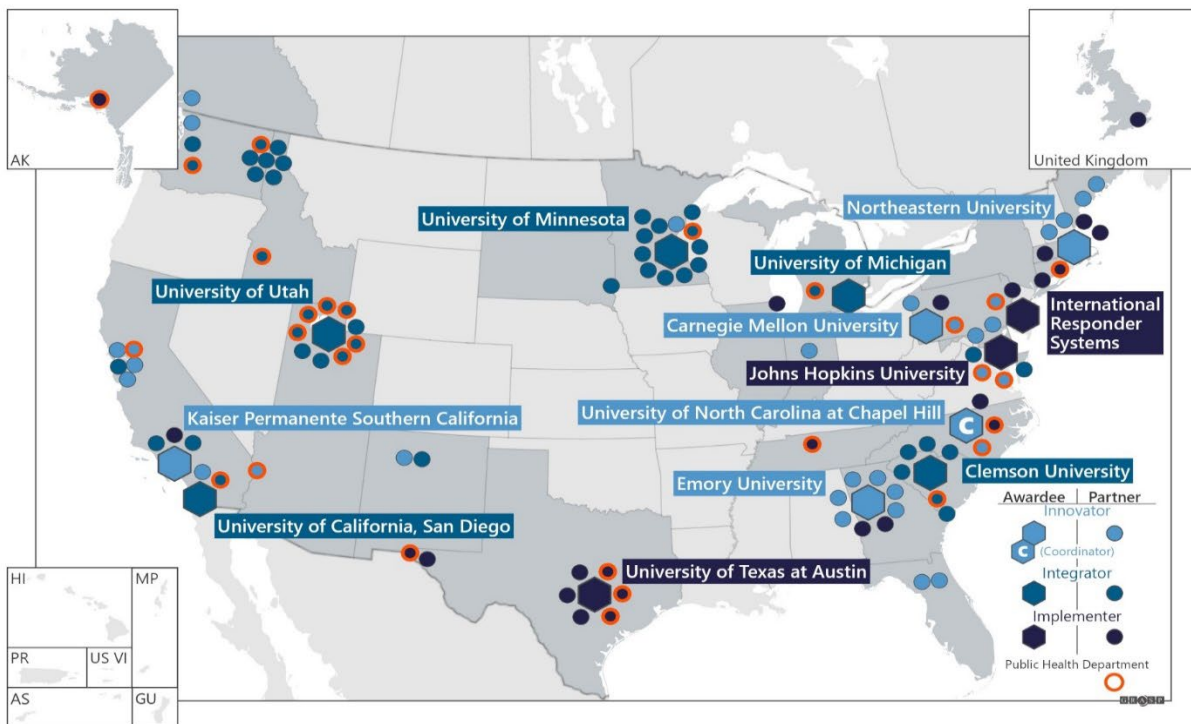


Figure 3 shows the initial 13 Insight Net awardees and their roles in the network, representing the largest US government investment in scale up disease outbreak modeling and forecasting made to date. These innovators, integrators and implementors are focused on developing powerful tools for public health decision makers so that they can better understand the trajectory of the next outbreak.

**Budget Request**

CDC’s FY 2025 budget request of **\$50,000,000** for CFA is level with the FY 2023 final level. This request reflects funding solely from the Prevention and Public Health Fund resources.

Recent outbreaks in the U.S. have highlighted a critical gap in the nation’s public health infrastructure—specifically the capability to quickly model the severity of infectious disease outbreaks and forecast their trajectories. CFA is focused on addressing these needs by creating, testing, and improving open-source models and other tools for outbreak analytics. CFA received its first base appropriation of \$50 million in FY 2023, which is an important step towards establishing the Center as designed. Scaling up outbreak modeling, forecasting and advanced analytics capabilities will require time and sustained investment.

At an operating level of \$50,000,000 in FY 2025, CFA will prioritize funding for Insight Net, but will scale back, delay, or eliminate other activities supported with previously appropriated COVID-19 supplemental resources.

These include:

- Working with state and local public health officials, which includes amplifying the achievements of Insight Net. By connecting with organizations at the state and local level, the impact of Insight Net could extend beyond the network to advance disease forecasting capabilities in additional states and jurisdictions.
- Hiring and training scientists to operationalize data analytics. CFA supports 14 Public Health Analytics and Modeling (PHAM) Fellows participating in CDC's Prevention Effectiveness Fellowship in the 2023-2024 class. These fellows work across the agency to expand CDC's capacity to implement modeling and analytic techniques that advance understanding of public health threats and ensure that data science is informing response activities.
- Engaging extensively with the private sector. CDC benefits from the private sector's contributions to emerging areas of work, including advanced analytics. Since its establishment to address the nation's need for forecasting, CFA has had on-going discussions with private sector entities on how to bend existing data science tools towards solving public health challenges. Limiting these partnerships slows U.S. efforts in bringing existing forecasting and other data science tools to scale for forecasting outbreaks.

## Public Health Leadership and Support Budget Request

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The Public Health Leadership and Support line funds CDC's Immediate Office of the Director, as well as other units across the agency, that enhance collaboration and coordination both within and outside CDC. These funds support essential cross-cutting activities including communications, policy, science, and health equity that enable CDC to manage with efficiency, transparency, and accountability.

In FY 2022, CDC launched [CDC Moving Forward](#),<sup>242</sup> an effort to modernize CDC to better prepare the agency for future public health challenges to include the next pandemic. These changes will improve accountability, collaboration, communication, and timeliness within CDC and with our customers, at all levels of the organization. CDC is continuing to build on the progress of CDC Moving Forward by implementing key actions that will accelerate CDC's modernization effort and anticipates that 80% of action items will be complete by March 2024.

### Budget Request

CDC's FY 2025 budget request of **\$128,570,000** for Public Health Leadership and Support is level with the FY 2023 final level. CDC provides public health leadership, responsive and timely communication, and strong partnership support to non-governmental organizations working on public health issues. With level funding, CDC will continue to enhance partnerships that promote CDC's guidance, communication, and strategy at all levels of government and industry. These investments will support communication with the public, Congress, academia, the business sector, employers, and other federal, state, and local partners through written communications, funding opportunities, audits, briefings, and other engagements.

Expectations of CDC's leadership have grown and become more complex. Universally, individuals' increased consumption of electronic media has transformed almost every type of interaction they have with both businesses and government. Urgent challenges in public health are becoming more numerous and frequent, with CDC frequently managing multiple responses at once. The Public Health Leadership and Support (PHLS) line advances agency priorities in communications, policy, and science. As CDC transforms its capacity for response,

<sup>242</sup> [www.cdc.gov/about/organization/cdc-moving-forward.html](http://www.cdc.gov/about/organization/cdc-moving-forward.html)

it streamlined decision making into the Immediate Office of the Director. However, while the need for responsiveness has grown, the PHLS line supporting these efforts has remained flat at less than one percent of CDC's annual budget authority.

CDC will continue to provide public health leadership to the nation and fulfill its responsibilities for responsive and timely communication to the public, key partners, and Congress. Staff offices will continue to work across the agency to maintain its commitment to minority health and health equity, equal employment opportunity (EEO), efficient business services, and responsive communications, legislative, and policy functions. With support from this line, CDC carries out the following activities:

- Ensures CDC's science, programs, and recommendations are accessible, understandable, and actionable and maximize public trust and credibility.
- Identifies high-value prevention and public health policies and interventions; increases the understanding and use of credible evidence of preventions' impacts by policymakers, health care, and public health professionals; and catalyzes collaboration among public health, health care, and other sectors.
- Guides CDC's policy development work and coordinates review of policies and other documents across the agency and with other federal agencies to ensure consistent federal policies.
- Provides leadership to CDC on all matters related to EEO and works to foster an inclusive culture at CDC through equity, opportunity, and respect. Ensures workforce fairness through Diversity, Equity, Inclusion and Accessibility (DEIA) for all CDC staff through the framework and guidance established by the FY 2020 CDC EEO Strategic Plan and the FY 2022 CDC DEIA Strategic Plan. In accordance with Executive Order 14035 and the subsequent government-wide DEIA Strategic Plan, CDC developed a robust DEIA Strategic Plan and is working to ensure the accuracy of workforce demographic data to inform the agency's EEO initiatives and efforts.
- Administers the agency's budget, grants and contracts, facilities, physical security, workforce health and wellness, human resources, and information technology programs. Align activities with the President's Management Agenda and Cross-Agency Priority (CAP) goals and funds the Office of Appropriations.
- Represents the agency in Washington, D.C., to the Department of Health and Human Services, other agencies, and the Washington, D.C. policy community. Receive and respond to requests for information and assistance from Congress. Work closely with CDC's Immediate Office of the Director, program leadership, policy offices, and Office of Appropriations to respond to congressional requests. The office also works with the Government Accountability Office (GAO) and the Office of the Inspector General (OIG) to facilitate audits and engagements.

These funds will also continue to support the Office of Rural Health to expand its portfolio and increase extramural support and fellowship opportunities. Established in FY 2023, the Office of Rural Health coordinates across CDC programs to advance strategies to meet the unique public health challenges of rural populations.

### **Improving Health Equity**

CDC works to scale up and develop new evidence-based, innovative strategies that address health disparities and longstanding inequities, including social determinants of health. CDC's Office of Health Equity provides leadership for CDC-wide policies, strategies, planning, and evaluation to eliminate health disparities. Central to achieving these goals is transforming the public health workforce to ensure diversity and health equity competencies in existing and future staff, accelerating momentum and public health action to advance health equity for all.

CDC develops and implements diverse strategies and policies toward these goals:

- Collaboration with internal and external partners to address systemic racism in public health and healthcare, gender discrimination, and gendered racism in the workplace.
- Leveraging implementation science and analytic methods throughout CDC's programs, policies, data systems, and funding structures to achieve greater coordination, systems changes, and innovations.
- Engagement and mobilization of community-based organizations and trusted leaders.
- Strengthening of critical networks of state and local minority health and health equity offices.

In FY 2022, CDC published a notice of funding opportunity (NOFO) for the CDC John R. Lewis Undergraduate Public Health Scholars Program (formerly the CDC Undergraduate Public Health Scholars (CUPS) program) and the Dr. James A. Ferguson Emerging Infectious Diseases Fellowship. The programs include awards to state, local, community, and other entities to provide student internship and fellowship opportunities to work in various public health settings, including community organizations, health departments, university-based programs, and federal agencies. Over the course of the programs, CDC anticipates training over 1,500 participants. With increased funds in FY 2023, CDC expanded internship and fellowship opportunities to provide greater networking opportunities for participants and mentors. CDC will continue to work with program recipients to identify and promote best practices in creating career pathways and developing and recruiting mentors.

### **Expanding Partnerships and Collaborations**

CDC will sustain and improve its activities with partners across the public health system. CDC will continue strengthening health departments and enhancing public health system coordination and collaboration to advance public health priorities. It will support expert convenings, including the Infectious Diseases Board of Scientific Counselors (BSC), which advises on emerging topics such as Acute Flaccid Myelitis, food, and waterborne illnesses, vaccinating with confidence, and COVID-19. It will also further build the capacity of Indian Country to identify and mitigate public health threats by managing the CDC/ATSDR Tribal Advisory Committee, connecting tribal nations to CDC programs, providing funding for building and improving tribal health infrastructure, and coordinating tribal consultations to improve American Indian and Alaska Native health. CDC will continue to provide leadership and support for public health strategies, programs, and systems improvements in the five U.S. territories and three freely associated states, recognizing their unique cultural, political, geographic, and disease-burden needs.

CDC will also build and scale collaborative work within the agency. Efforts will include supporting a workgroup focused on improving public health among people experiencing homelessness and high-risk populations. CDC will also prioritize coordination and leadership in ongoing performance monitoring, program planning and improvement, policy analysis, evidence generation, and partnership development across the agency's strategic priorities and current and emerging health issues. CDC's development and use of strategic planning and performance management across its Centers, Institutes, and Offices will provide forums for future collaboration.

## **Infectious Diseases Rapid Response Reserve Fund Budget Request**

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The Infectious Diseases Rapid Response Reserve Fund (IDRRRF) was created by Congress in 2019, following the epidemics of Ebola in West Africa and Zika in the Americas – two public health emergencies in which CDC lacked sufficient funding for early response. The fund provides CDC a source of resources to address emerging outbreaks and prevent future infections quickly. The IDRRRF is designed as a flexible and immediate source of funds for CDC to use to respond quickly to an urgent problem on the ground and prevent spread in or to the United States. It is available for CDC to use to respond to public health emergencies caused by infectious diseases, or infectious disease emergencies with the potential to occur and threaten the national security and health of Americans.

To date, IDRRRF funds have supported CDC’s response to several public health emergencies. The IDRRRF has been a source of funds for immediate action to address Ebola Virus Disease (EVD) in Africa in 2019, with subsequent responses in 2021 and 2022; supported CDC’s early and aggressive response to the global outbreak of COVID-19 in 2020; and the mpox outbreak in the United States in 2022. CDC prioritizes the use of funds to address situations that pose the greatest threat to Americans, including against ongoing or future health threats. In FY 2023, IDRRRF continued to support CDC’s mpox response activities and provide capacity to detect and respond to Ebola outbreaks in Africa, including possible reintroduction of Ebola related to prior outbreaks.

### **Budget Request**

CDC’s FY 2025 budget request of **\$35,000,000** for the Infectious Diseases Rapid Response Reserve Fund is level with the FY 2023 final level. This continued investment allows CDC to respond quickly when an imminent public health emergency is detected, as with mpox, EVD, and COVID-19.

In 2023, IDRRRF investments continued to support surveillance and response of EVD, along with CDC’s response to the ongoing multinational mpox outbreak. During 2021 and 2022, response activities were focused on the Democratic Republic of the Congo (DRC) and in the Republic of Guinea (Guinea). CDC worked directly with ministries of health through longstanding partnerships to support country-led efforts to rapidly stop these outbreaks and help ensure long-term sustainable control. In September 2022, outbreak response activities commenced in Uganda. As with previous outbreaks, CDC supported surveillance, laboratory, border health and screening, and infection prevention and control activities. On January 11, 2023, the Uganda Ministry of Health declared that the outbreak was over. CDC supported Uganda throughout the 90-day post outbreak enhanced surveillance period, which ended on April 11, 2023. Since May 2023, no new cases of ebolavirus have occurred in Uganda. As seen in the prior EVD outbreaks, detecting and responding to infectious disease outbreaks at their source has been proven to be the most cost-effective strategy for preventing their spread.

With IDRRRF funds, CDC rapidly scaled up testing and surveillance capacity for mpox early in the response. Current activities continue to focus on testing, surveillance, vaccination, and rapid response coordination in jurisdictions to provide education and encourage vaccination. In 2023, CDC provided direct support to 53 highly affected jurisdictions to expand vaccination efforts and initiate additional mpox response activities, such as community engagement, case and cluster investigation, and enhanced timeliness and completeness of data reporting on cases and vaccination. CDC continues to work with funded jurisdictions to increase vaccine accessibility, demand, and uptake, specifically among the populations recommended to receive vaccine. Since August 2022, the average number of newly reported mpox cases has steadily decreased. To prevent a resurgence of cases and outbreaks, CDC continues to focus on strengthening vaccination efforts, particularly efforts to reach and build trust in disproportionately impacted populations, including racial/ethnic minorities. Because these response efforts were successful in reducing case incidence and increasing vaccine uptake, CDC deactivated the emergency response to the 2022 multinational mpox outbreak on August 31, 2023. Since then,

mpox prevention activities have been led at the programmatic level as part of normal operations under CDC's National Center for Emerging and Zoonotic Infectious Diseases (NCEZID).

## **Preventive Health and Health Services Block Grant Budget Request**

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CDC administers the [Preventive Health and Health Services \(PHHS\) Block Grant](#) program, which funds 61 recipients, including all 50 states, the District of Columbia, two American Indian tribes, five U.S. territories, and three freely associated states. Recipients implement innovative and community-driven methods that meet their priority public health needs while linking their goals and objectives to the national *Healthy People* priorities. The PHHS Block Grant supports various public health activities, including clinical services, public education, preventative screenings, and services, data surveillance, outbreak control, and chronic disease prevention. Additionally, recipients often partner and share resources with local and tribal public health organizations, community organizations, and others to achieve their goals.

Key findings in the [PHHS Block Grant Evaluation—2022 Framework Measures Assessment](#) show that the PHHS Block Grant helped strengthen the public health system by enabling state, tribal, local, and territorial agencies to use grant funds to improve public health infrastructure, address emerging public health needs, and practice evidence-based public health. Recipients are using PHHS Block Grant funds to improve their ability to collect essential data; improve the quality of programs and services; address emerging needs; and implement interventions that are known to work. Data collected in 2022 show that the use of PHHS Block Grant funds enabled:

1. 632 agencies to improve the capacity of their information systems.
2. 707 agencies to improve the efficiency and effectiveness of their operations, programs, and services.
3. Agencies to address 118 emerging public health needs.
4. Agencies to implement 776 evidence-based public health interventions.

A study released in November 2023 showed that the majority of recipients used the grant's flexibility to address social determinants of health and advance health equity. For example, they were able to pivot work in a timely manner to meet changing priorities, populations, and community needs; implement more upstream policy, systems, and environmental work; use practice-based and innovative approaches to health equity, and fill gaps or enhance other funding sources to comprehensively approach the work.

### **Budget Request**

CDC's FY 2025 budget request of **\$160,000,000** from the Prevention and Public Health Fund resources for the Preventive Health and Health Services Block Grant is level with the FY 2023 final level.

**State Table: Preventive Health and Health Services Block Grant (PPHF)<sup>1</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$2,454,933	\$2,454,933	\$2,454,933	\$0
Alaska	\$536,834	\$536,834	\$536,834	\$0
Arizona	\$1,853,924	\$1,853,924	\$1,853,924	\$0
Arkansas	\$1,379,203	\$1,379,203	\$1,379,203	\$0
California	\$10,515,205	\$10,515,205	\$10,515,205	\$0
Colorado	\$1,923,673	\$1,923,673	\$1,923,673	\$0
Connecticut	\$2,241,045	\$2,241,045	\$2,241,045	\$0
Delaware	\$287,667	\$287,667	\$287,667	\$0
Washington, D.C.	\$1,207,931	\$1,207,931	\$1,207,931	\$0
Florida	\$4,634,919	\$4,634,919	\$4,634,919	\$0
Georgia	\$4,793,352	\$4,793,352	\$4,793,352	\$0
Hawaii	\$1,215,834	\$1,215,834	\$1,215,834	\$0
Idaho	\$578,325	\$578,325	\$578,325	\$0
Illinois	\$3,576,703	\$3,576,703	\$3,576,703	\$0
Indiana	\$2,584,512	\$2,584,512	\$2,584,512	\$0
Iowa	\$1,697,468	\$1,697,468	\$1,697,468	\$0
Kansas	\$1,403,868	\$1,403,868	\$1,403,868	\$0
Kentucky	\$2,069,124	\$2,069,124	\$2,069,124	\$0
Louisiana	\$4,511,871	\$4,511,871	\$4,511,871	\$0
Maine	\$1,388,395	\$1,388,395	\$1,388,395	\$0
Maryland	\$2,914,387	\$2,914,387	\$2,914,387	\$0
Massachusetts	\$4,203,152	\$4,203,152	\$4,203,152	\$0
Michigan	\$6,090,728	\$6,090,728	\$6,090,728	\$0
Minnesota	\$3,925,897	\$3,925,897	\$3,925,897	\$0
Mississippi	\$2,252,174	\$2,252,174	\$2,252,174	\$0
Missouri	\$3,856,685	\$3,856,685	\$3,856,685	\$0
Montana	\$1,030,904	\$1,030,904	\$1,030,904	\$0
Nebraska	\$2,548,387	\$2,548,387	\$2,548,387	\$0
Nevada	\$611,898	\$611,898	\$611,898	\$0
New Hampshire	\$2,226,215	\$2,226,215	\$2,226,215	\$0
New Jersey	\$4,459,508	\$4,459,508	\$4,459,508	\$0
New Mexico	\$2,185,019	\$2,185,019	\$2,185,019	\$0
New York	\$10,621,140	\$10,621,140	\$10,621,140	\$0
North Carolina	\$4,257,622	\$4,257,622	\$4,257,622	\$0
North Dakota	\$396,213	\$396,213	\$396,312	\$0
Ohio	\$6,988,866	\$6,988,866	\$6,988,866	\$0
Oklahoma	\$1,445,519	\$1,445,519	\$1,445,519	\$0
Oregon	\$1,111,737	\$1,111,737	\$1,111,737	\$0
Pennsylvania	\$7,364,266	\$7,364,266	\$7,364,266	\$0
Rhode Island	\$734,093	\$734,093	\$734,093	\$0
South Carolina	\$1,906,350	\$1,906,350	\$1,906,350	\$0
South Dakota	\$359,521	\$359,521	\$359,521	\$0
Tennessee	\$2,511,471	\$2,511,471	\$2,511,471	\$0
Texas	\$6,323,297	\$6,323,297	\$6,323,297	\$0
Utah	\$1,503,520	\$1,503,520	\$1,503,520	\$0
Vermont	\$422,130	\$422,130	\$422,130	\$0
Virginia	\$3,149,594	\$3,149,594	\$3,149,594	\$0
Washington	\$1,557,194	\$1,557,194	\$1,557,194	\$0



West Virginia	\$1,386,669	\$1,386,669	\$1,386,669	\$0
Wisconsin	\$3,021,333	\$3,021,333	\$3,021,333	\$0
Wyoming	\$352,464	\$352,464	\$352,464	\$0
<b>Tribes</b>				
Kickapoo Tribe	\$46,512	\$46,512	\$46,512	\$0
Santee Sioux	\$46,512	\$46,512	\$46,512	\$0
<b>Territories</b>				
American Samoa	\$81,896	\$81,896	\$81,896	\$0
Guam	\$343,189	\$343,189	\$343,189	\$0
Marshall Islands	\$40,740	\$40,740	\$40,740	\$0
Micronesia	\$99,018	\$99,018	\$99,018	\$0
Northern Mariana Islands	\$62,127	\$62,127	\$62,127	\$0
Puerto Rico	\$2,403,334	\$2,403,334	\$2,403,334	\$0
Republic of Palau	\$32,972	\$32,972	\$32,972	\$0
Virgin Islands	\$270,862	\$270,862	\$270,862	\$0
<b>Subtotal States</b>	<b>\$142,572,838</b>	<b>\$142,572,838</b>	<b>\$142,572,838</b>	<b>\$0</b>
<b>Subtotal Tribes</b>	<b>\$93,024</b>	<b>\$93,024</b>	<b>\$93,024</b>	<b>\$0</b>
<b>Subtotal Territories</b>	<b>\$3,334,138</b>	<b>\$3,334,138</b>	<b>\$3,334,138</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$146,000,000</b>	<b>\$146,000,000</b>	<b>\$146,000,000</b>	<b>\$0</b>

<sup>1</sup>Reflects amount of funding distributed through CDC-RFA-TO23-2304: The Preventive Health and Health Services Block Grant.

**State Table: Public Health Infrastructure and Capacity<sup>1,2,3</sup>**

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$3,663,591	\$3,663,591	\$3,663,591	\$0
Alaska	\$856,842	\$856,842	\$856,842	\$0
Arizona	\$5,424,624	\$5,424,624	\$5,424,624	\$0
Arkansas	\$2,368,361	\$2,368,361	\$2,368,361	\$0
California	\$27,037,900	\$27,037,900	\$27,037,900	\$0
Colorado	\$4,298,521	\$4,298,521	\$4,298,521	\$0
Connecticut	\$2,452,692	\$2,452,692	\$2,452,692	\$0
Delaware	\$1,013,538	\$1,013,538	\$1,013,538	\$0
District of Columbia	\$849,048	\$849,048	\$849,048	\$0
Florida	\$15,069,593	\$15,069,593	\$15,069,593	\$0
Georgia	\$7,053,621	\$7,053,621	\$7,053,621	\$0
Hawaii	\$1,234,512	\$1,234,512	\$1,234,512	\$0
Idaho	\$1,440,020	\$1,440,020	\$1,440,020	\$0
Illinois	\$8,521,455	\$8,521,455	\$8,521,455	\$0
Indiana	\$4,797,188	\$4,797,188	\$4,797,188	\$0
Iowa	\$2,211,422	\$2,211,422	\$2,211,422	\$0
Kansas	\$2,075,781	\$2,075,781	\$2,075,781	\$0
Kentucky	\$3,668,501	\$3,668,501	\$3,668,501	\$0
Louisiana	\$3,430,130	\$3,430,130	\$3,430,130	\$0
Maine	\$1,211,521	\$1,211,521	\$1,211,521	\$0
Maryland	\$4,346,858	\$4,346,858	\$4,346,858	\$0
Massachusetts	\$4,782,115	\$4,782,115	\$4,782,115	\$0
Michigan	\$6,768,801	\$6,768,801	\$6,768,801	\$0
Minnesota	\$3,905,589	\$3,905,589	\$3,905,589	\$0
Mississippi	\$2,451,029	\$2,451,029	\$2,451,029	\$0
Missouri	\$4,444,195	\$4,444,195	\$4,444,195	\$0
Montana	\$1,054,522	\$1,054,522	\$1,054,522	\$0
Nebraska	\$1,947,901	\$1,947,901	\$1,947,901	\$0
Nevada	\$2,748,659	\$2,748,659	\$2,748,659	\$0
New Hampshire	\$1,145,359	\$1,145,359	\$1,145,359	\$0
New Jersey	\$5,788,843	\$5,788,843	\$5,788,843	\$0
New Mexico	\$1,821,692	\$1,821,692	\$1,821,692	\$0
New York	\$14,466,752	\$14,466,752	\$14,466,752	\$0
North Carolina	\$7,346,974	\$7,346,974	\$7,346,974	\$0
North Dakota	\$867,861	\$867,861	\$867,861	\$0
Ohio	\$7,619,438	\$7,619,438	\$7,619,438	\$0
Oklahoma	\$3,744,969	\$3,744,969	\$3,744,969	\$0
Oregon	\$3,218,338	\$3,218,338	\$3,218,338	\$0
Pennsylvania	\$8,670,267	\$8,670,267	\$8,670,267	\$0
Rhode Island	\$1,054,912	\$1,054,912	\$1,054,912	\$0
South Carolina	\$3,550,984	\$3,550,984	\$3,550,984	\$0
South Dakota	\$952,126	\$952,126	\$952,126	\$0
Tennessee	\$5,567,916	\$5,567,916	\$5,567,916	\$0
Texas	\$21,948,412	\$21,948,412	\$21,948,412	\$0
Utah	\$2,033,161	\$2,033,161	\$2,033,161	\$0
Vermont	\$789,002	\$789,002	\$789,002	\$0
Virginia	\$5,616,891	\$5,616,891	\$5,616,891	\$0
Washington	\$4,893,269	\$4,893,269	\$4,893,269	\$0

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
West Virginia	\$1,550,586	\$1,550,586	\$1,550,586	\$0
Wisconsin	\$4,189,972	\$4,189,972	\$4,189,972	\$0
Wyoming	\$747,753	\$747,753	\$747,753	\$0
<b>Territories</b>				
America Samoa		\$471,974	\$471,974	\$471,974
Guam	\$565,772	\$565,772	\$565,772	\$0
Micronesia	\$514,127	\$514,127	\$514,127	\$0
Puerto Rico	\$2,788,026	\$2,788,026	\$2,788,026	\$0
Virgin Islands	\$517,468	\$517,468	\$517,468	\$0
Northern Mariana Islands	\$476,550	\$476,550	\$476,550	\$0
Republic of Palau	\$453,958	\$453,958	\$453,958	\$0
Marshall Islands	\$498,118	\$498,118	\$498,118	\$0
<b>Subtotal States</b>	<b>\$238,714,007</b>	<b>\$238,714,007</b>	<b>\$238,714,007</b>	<b>\$0</b>
<b>Subtotal Territories</b>	<b>\$6,285,993</b>	<b>\$6,285,993</b>	<b>\$6,285,993</b>	<b>\$0</b>
<b>Total Resources</b>	<b>\$245,000,000</b>	<b>\$245,000,000</b>	<b>\$245,000,000</b>	<b>\$0</b>

<sup>1</sup> Table only reflects funds from CDC's annual appropriation.

<sup>2</sup> These funds are awarded by formula.

<sup>3</sup> Awards noted for Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems Grant Activity 2: -Foundational Capabilities, awarded December 2023

**Public Health Infrastructure and Capacity** <sup>1,2,3</sup>

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
Alabama	\$2,093,506	\$3,802,717	TBD	TBD
Alaska	\$489,627	\$711,797	TBD	TBD
Arizona	\$3,099,814	\$5,278,450	TBD	TBD
Arkansas	\$1,353,364	\$2,376,351	TBD	TBD
California	\$15,450,383	\$27,225,574	TBD	TBD
Colorado	\$2,456,318	\$4,038,333	TBD	TBD
Connecticut	\$1,401,552	\$2,469,216	TBD	TBD
Delaware	\$579,169	\$884,358	TBD	TBD
District of Columbia	\$485,173	\$703,215	TBD	TBD
Florida	\$8,611,294	\$15,668,131	TBD	TBD
Georgia	\$4,030,685	\$7,304,167	TBD	TBD
Hawaii	\$705,441	\$1,127,703	TBD	TBD
Idaho	\$822,876	\$1,354,018	TBD	TBD
Illinois	\$4,869,459	\$8,920,614	TBD	TBD
Indiana	\$2,741,279	\$4,819,285	TBD	TBD
Iowa	\$1,263,682	\$2,203,519	TBD	TBD
Kansas	\$1,186,172	\$2,054,146	TBD	TBD
Kentucky	\$2,096,308	\$3,576,328	TBD	TBD
Louisiana	\$1,960,098	\$3,545,619	TBD	TBD
Maine	\$692,303	\$1,102,385	TBD	TBD
Maryland	\$2,483,944	\$4,323,361	TBD	TBD
Massachusetts	\$2,732,665	\$4,802,684	TBD	TBD
Michigan	\$3,867,928	\$6,990,511	TBD	TBD
Minnesota	\$2,231,785	\$3,837,413	TBD	TBD
Mississippi	\$1,400,605	\$2,467,390	TBD	TBD
Missouri	\$2,539,566	\$4,430,553	TBD	TBD
Montana	\$602,588	\$929,491	TBD	TBD
Nebraska	\$1,113,093	\$1,681,524	TBD	TBD
Nevada	\$1,570,677	\$2,563,357	TBD	TBD
New Hampshire	\$654,495	\$1,029,524	TBD	TBD
New Jersey	\$3,307,949	\$6,143,133	TBD	TBD
New Mexico	\$1,040,978	\$1,774,335	TBD	TBD
New York	\$8,266,828	\$15,467,859	TBD	TBD
North Carolina	\$4,198,314	\$7,395,426	TBD	TBD
North Dakota	\$495,924	\$723,932	TBD	TBD
Ohio	\$4,354,012	\$7,927,269	TBD	TBD
Oklahoma	\$2,138,546	\$3,425,938	TBD	TBD
Oregon	\$1,839,066	\$3,080,584	TBD	TBD
Pennsylvania	\$4,954,497	\$9,084,494	TBD	TBD
Rhode Island	\$602,811	\$929,921	TBD	TBD
South Carolina	\$2,029,157	\$3,678,707	TBD	TBD
South Dakota	\$544,076	\$816,729	TBD	TBD
Tennessee	\$3,181,699	\$5,436,254	TBD	TBD
Texas	\$12,542,093	\$22,316,220	TBD	TBD
Utah	\$1,161,815	\$2,007,207	TBD	TBD
Vermont	\$450,861	\$637,090	TBD	TBD
Virginia	\$3,209,684	\$5,721,975	TBD	TBD
Washington	\$2,796,179	\$4,925,087	TBD	TBD

	<b>FY 2023 Final</b>	<b>FY 2024 CR</b>	<b>FY 2025 President's Budget</b>	<b>FY 2025 +/- FY 2023</b>
West Virginia	\$886,058	\$1,475,780	TBD	TBD
Wisconsin	\$2,394,292	\$4,150,590	TBD	TBD
Wyoming	\$427,289	\$591,664	TBD	TBD
<b>Territories and Freely Associated States</b>				
America Samoa	\$269,700	\$391,259	TBD	TBD
Guam	\$323,299	\$334,386	TBD	TBD
Micronesia	\$293,788	\$2,838,510	TBD	TBD
Puerto Rico	\$1,593,179	\$338,065	TBD	TBD
Virgin Islands	\$295,697	\$293,004	TBD	TBD
Northern Mariana Islands	\$272,315	\$268,125	TBD	TBD
Palau	\$259,405	\$316,756	TBD	TBD
Marshall Islands	\$284,640	\$391,259	TBD	TBD
<b>Subtotal States</b>	<b>\$136,407,977</b>	<b>\$240,219,895</b>	<b>TBD</b>	<b>TBD</b>
<b>Subtotal Territories and FAS</b>	<b>\$3,592,023</b>	<b>\$4,780,105</b>	<b>TBD</b>	<b>TBD</b>
<b>Total Resources</b>	<b>\$140,000,000</b>	<b>\$245,000,000</b>	<b>TBD</b>	<b>TBD</b>

<sup>1</sup> Table only reflects funds from CDC's annual appropriation. These estimates are consistent with report language accompanying the FY 2023 Consolidated Appropriations Act that requires "no less than 70 percent of this funding be awarded to health departments".

<sup>2</sup> These funds are awarded by formula.

<sup>3</sup> Awards noted for A2: Foundational Capabilities. Does not include Component B awards to public health partners; funded by American Rescue Plan Act and Public Health Infrastructure and Capacity

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## BUILDINGS AND FACILITIES

(dollars in millions)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Budget Authority	\$40.000	\$40.000	\$40.000	\$0
<b>Total Request</b>	<b>\$40.000</b>	<b>\$40.000</b>	<b>\$40.000</b>	<b>\$0</b>
-- Buildings and Facilities	\$40.000	\$40.000	\$40.000	\$0

CDC works 24/7 to protect the health and security of our nation. Safe, secure, and fully operational laboratories, buildings, and facilities equip CDC with the infrastructure needed to protect Americans from the threat of disease, respond to evolving public health needs, and rapidly address public health emergencies. The COVID-19 pandemic, mpox, and other emergencies require urgent action, and CDC laboratories and facilities must continue to be ready to respond. This readiness requires continuous maintenance not normally found in a traditional facilities program.

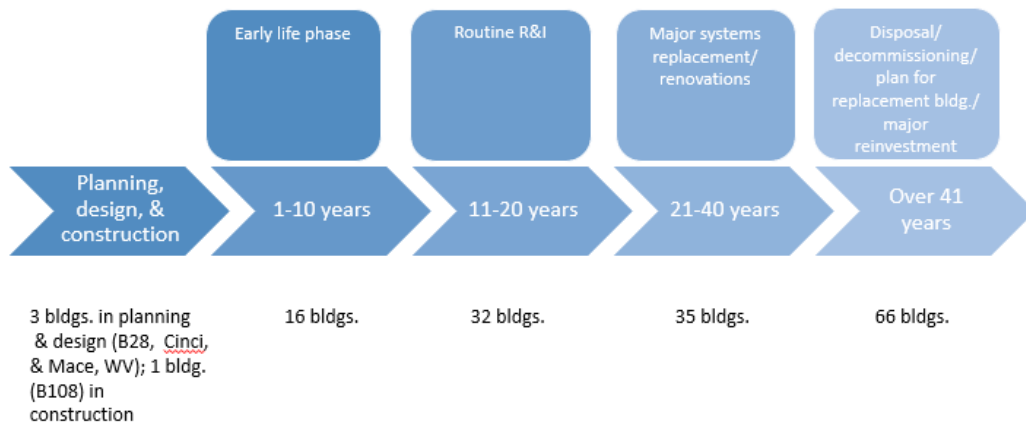
Buildings and Facilities (B&F) funds are used to replace, maintain, and improve existing CDC facilities and construct new facilities necessary to meet CDC’s mission. CDC’s building repair and improvement (R&I) needs are nationwide—covering CDC-owned facilities in seven states and San Juan, Puerto Rico. The gross square footage of CDC’s assets has nearly doubled since 2000. Older facilities, such as those on the National Institute for Occupational Safety and Health (NIOSH) Pittsburgh Campus, increase operating costs due to inefficiency and strain portfolio-wide resources with a burdensome backlog of maintenance and repair (BMAR). Aging facilities and infrastructure also contribute to the failure of equipment and systems in laboratories, causing frequent water leaks and other urgent and costly emergency repairs. Building 15, built in 1987 and home to biosafety levels 2 and 3 (BSL-2 and BSL-3) laboratories, currently houses the oldest laboratories on CDC’s Roybal Campus. Without modernization and refurbishment, this building requires continuous and costly repair. Challenges, such as these, hinder CDC’s ability to perform critical laboratory response diagnostics and research.

### CDC BUILDINGS AND FACILITIES

#### BY THE NUMBERS

- **25,000+**—personnel are supported by CDC’s facilities and protecting Americans from health threats every day.
- **7.7 million**—gross square feet of space supporting CDC’s public health mission.
- **3.1 million**—gross square feet of laboratories.
- **180**—owned assets, including 153 buildings and 27 support structures.
- **66**—buildings over 40 years old.
- **\$4.1 billion**—functional replacement value of CDC buildings and facilities.

## Life cycle of CDC's 153 Buildings\*



\*Federally Owned Buildings. Excludes land, structures, and utilities.

CDC continues to identify opportunities for investments in facilities and leased properties that will ensure facilities across the United States are safe, meet CDC's public health mission, and operate efficiently. In FY 2023, CDC closed out five leased spaces in the Atlanta, GA area, reducing its overall leasing costs by approximately \$15 million. CDC plans to close out another three leased facilities by FY 2026, resulting in an additional \$4 million in lease savings. By consolidating staff from leased space into owned facilities, CDC will not only reduce operating leased facilities costs and but will also gain efficiencies in operational services (e.g., consolidated security services). The new Johnny Isakson Public Health Research Building on the CDC Chamblee Campus was funded through the FY 2020 Appropriations Act and HHS Nonrecurring Expenses Fund (NEF) and named in the Consolidated Appropriation Act of FY 2021. Once operational, the building will consolidate between 1,800 and 2,000 staff and save \$85 million over the next 30 years.

### Budget Request

CDC's FY 2025 budget request of **\$40,000,000** for Buildings and Facilities is level with the FY 2023 Final level. This funding supports nationwide renovations to existing buildings, as well as repair and improvements (e.g., laboratory ventilation upgrades, structural repairs, roof replacements, and electrical and mechanical repairs) needed to restore, maintain, and improve CDC's assets. This investment will allow CDC to reduce its backlog of \$241 million of maintenance and repairs across all CDC and ATSDR campuses. CDC expects the backlog to grow by 11.6% for a total of \$269 million by the end of FY 2024.

CDC laboratories and facilities are critical to the nation's defense against health and national security threats, and many of these facilities are deteriorating. The FY 2025 request of \$40,000,000 will be used to repair and improve CDC-owned buildings and laboratories and protect these assets through a rigorous preventive maintenance program. This investment is critical to keeping CDC facilities fully functional and prepared to identify, respond to, and eliminate the next disease threat to our nation.

While CDC's scientists continue to respond to urgent public health needs, the laboratories and facilities supporting these activities continue to require improvements and maintenance necessary for CDC to conduct its critical mission. Using an Asset Business Plan approach, CDC prioritizes repair and improvement projects by need and available funding within the following categories:



- Execution of fire and life safety required improvements
- Mission-critical support projects
- Replacement of technologically antiquated mechanical and electrical infrastructure
- Improvement of campus energy and water efficiency, and increased resiliency in alignment with federal requirements
- Reduction of the current backlog of maintenance and repair

Several high priority fire and life safety projects as well as emergency projects are planned for FY 2025. Aging infrastructure in laboratory buildings at all federally-owned locations requires major mechanical, electrical, and plumbing system replacements. Components in these systems, such as built-in laboratory equipment, roofs, chillers, and boilers, will be replaced. Many building support systems and elements need to be replaced or repaired, including elevators, superstructure, fire alarm systems, and heating, ventilation, and air conditioning systems.

Critical program support projects and facilities maintenance planned in FY 2025 include the following items:

- Replace Chamblee Campus Domestic and Fire Water distribution system. The Chamblee site pre-dates World War II and has a significant amount of insufficiently documented utility components. Both domestic and fire water systems desperately need replacement by a new system utilizing existing utility tunnels. This will provide safe and appropriately redundant and isolated fire and domestic water distribution piping.
- Replace animal housing lighting control system in Roybal Building 23. Current lighting system for the animal housing spaces is at the end of life. The project will also include linking the lighting system to the building automation system to allow scheduling of light cycles within the animal housing rooms.
- Link animal quarters' watering system to the building automation system in Roybal Building 23. This will provide accurate monitoring of the pumps and filtration system as well as allow the building automation system to generate notifications and alarms when the pumps and filtration system are not operating properly, impacting the quality and quantity of the drinking water provided to research animals.
- Replace outdated animal quarters heating and air conditioning system on NIOSH's Morgantown, West Virginia, campus. Outdated and failing pneumatic controls in the animal quarters will be replaced with direct digital controls, allowing for more precise room temperature/humidity regulation and overall system reliability.
- Improve electrical infrastructure on NIOSH's Spokane, Washington, campus to optimize electrical service for equipment used to conduct specialized testing and research equipment with higher and complex electrical loads. The existing equipment does not support further electrical expansion without upgrade.
- Replace the inventory of 13 laboratory autoclaves (sterilization equipment) on the Ft. Collins, Colorado, campus. Due to the age of the equipment, performing major upgrades is not a viable option as replacement parts are obsolete. Autoclaves are an integral and essential element of daily lab operations.
- All CDC facilities meet requirements in the Americans with Disability Act as well as the Architectural Barriers Act to provide accessible facilities that allow full participation by persons with disabilities. In addition, reasonable accommodation requests from staff pertaining to the built environment are routinely implemented.

<b>Buildings and Facilities Funding History</b>	
<b>Fiscal Year</b>	<b>Dollars (in millions)</b>
FY 2021	\$30.000
FY 2022	\$30.000
FY 2023 Final	\$40.000
FY 2024 CR	\$40.000
FY 2025 President’s Budget	\$40.000

Projects In Progress

**High-Containment Continuity Laboratory**

The 2018 Consolidated Appropriations Act directed CDC to utilize \$240 million from budget authority and directed another \$240 million to be transferred from the NEF for the high-containment laboratory project. The High-Containment Continuity Laboratory (HCCL) will provide approximately 175,000 gross square feet, containing both the laboratory space for research on viruses that threaten the nation’s public health security and mechanical systems space containing the highly specialized building systems to support the laboratory space. Additionally, the HCCL will contain state-of-the art biosafety features, including pathogen containment through high-efficiency HEPA filters, and advanced security to restrict access to laboratories and support spaces.

The design of the HCCL is complete. Procurement for the construction of the HCCL is currently underway. Award of the construction contract is anticipated in summer 2024. CDC anticipates the facility will become operational in fall 2029.

**Cincinnati Consolidated Campus**

CDC, working with the General Services Administration, identified a potential site for a new facility to consolidate NIOSH’s Cincinnati Research Facilities into one central location. This project is supported with \$194 million from the NEF. The Environmental Impact Statement assessment and associated Record of Decision have been completed. Design of the project was completed in summer 2022. The construction contract is anticipated to award in summer 2024, pending the land acquisition in early 2024. The facility is anticipated to be completed in early 2027.

**Underground Mining Safety Research Facility**

CDC acquired a replacement underground mining safety research facility in Mace, West Virginia to support mining safety research capabilities no longer available at the former NIOSH Lake Lynn facility. The Consolidated Appropriations Act of 2023, directs HHS to fund the design and construction of the facility from the NEF, in addition to the funds previously provided in FY 2021 and FY 2022. The new facility will be used to conduct studies and research on mine explosions, mine seals, mine rescue, ventilation, diesel exhaust, evaluation of emerging health and safety technologies, ground control, and fire suppression. The project will provide approximately 180,383 GSF of newly constructed research space. CDC estimates the total project cost to be approximately \$97.4 million. In May 2023, CDC initiated preliminary design activities which will be used to validate and update initial project requirements to ensure the site development supports planned construction efforts. At this time, CDC anticipates design and construction of the facility will take approximately five years.

### **Chamblee Campus Expansion**

In FY 2020, CDC received \$225 million from the NEF to construct the Johnny Isakson Public Health Research Building and supporting infrastructure on CDC's Chamblee Campus. This will allow for the consolidation of 1,800 to 2,000 staff into a new office building. The new building will maximize space utilization rates, minimize long-term operating and maintenance costs, and provide opportunities for increased operational efficiencies. Construction is underway with occupancy anticipated in late 2024.

### **NIOSH Pittsburgh Campus**

Aging buildings on the NIOSH Campus in Pittsburgh, Pennsylvania have frequent infrastructure and utility repair needs, which add to CDC's backlog of maintenance and repairs. In FY 2021, CDC received \$14 million from the NEF to renovate the National Personal Protective Technology Laboratory (NPPTL) at the Pittsburgh Campus. The renovated laboratory space will support NPPTL's Human Performance and Physiology Research Branch Laboratories and the NPPTL respirator certification program as well as needed laboratory support. Design is complete and construction is anticipated to start in second quarter of FY 2024 with occupancy of the new lab space anticipated in late 2025.

### Sustainability

Sustainability at CDC is embedded in design and construction standards. This supports the public health mission, generates a financial return on investment, and promotes a positive environmental impact. CDC is working to make progress towards the ambitious climate and sustainability goals set forth by the President in Executive Order (EO) 14057: *Catalyzing Clean Energy Industries and Jobs Through Federal Sustainability*. CDC's recent and ongoing sustainability efforts include a portfolio-wide sustainability and resilience study, designed with a holistic lens to achieve the following strategic goals:

- Assess current campuses and facilities via the Energy Independence and Security Act (EISA) audit process to determine opportunities for improvements and enhancements to existing facilities.
- Conduct climate vulnerability and climate hazard risk assessments.
- Provide recommendations to enhance building and campus-level resilience.
- Leverage climate specific conditions at portfolio wide scale to optimize projects and future investments.

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## NONRECURRING EXPENSES FUND (NEF)

**Budget Summary**  
(Dollars in Thousands)

	FY 2023 <sup>2</sup>	FY 2024 <sup>3</sup>	FY 2025 <sup>4</sup>
<b>Notification<sup>1</sup></b>	\$35,000	\$154,500	\$209,036

<sup>1</sup> Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

<sup>2</sup> Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on September 23, 2022.

<sup>3</sup> Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 19, 2023.

<sup>4</sup> HHS has not yet notified for FY 2025.

**Authorizing Legislation:**

Authorization..... Section 223 of Division G of the Consolidated Appropriations Act, 2008

Allocation Method..... Direct Federal, Competitive Contract

**Program Descriptions and Accomplishments**

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of these funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

**Budget Allocation FY 2025**

**Building 15 Renovation**

NEF funds are being utilized to provide major renovations to the Building 15 laboratory on Roybal Campus. Building 15 is approximately 95,000 gross square feet (gsf) and houses the following laboratory programs: National Center for Immunization and Respiratory Diseases, National Center for Emerging and Zoonotic Infectious Disease, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, and Center for Global Health. The scope of this project is to provide Building 15 laboratory capacity by extending the life by another 30 years through upgrades to the laboratory space, major building systems, and life safety updates. The facility is mission critical and has not undergone a comprehensive renovation since its 1987 construction.

**Pittsburgh Campus Landfill Remediation Project**

NEF funds are being utilized to invest in CDC’s Pittsburgh Campus Landfill Remediation. CDC receives annual appropriations for Repair and Improvement (R&I) funds which supported its ability to exercise a majority of its necessary R&I projects; however, CDC continues to experience a gap in funding a number of significantly large R&I projects that cannot be funded over several years but require obligation under one contract. NEF funds will ensure that CDC follows state and federal environmental laws and regulations and underwrite the necessary improvements at the Pittsburgh Campus Landfill.

**IT Investments**

NEF funds will be used to invest in scalable secure cloud-computing infrastructure and core machine learning and analytic infrastructure capabilities, as well as data science and analytic capabilities.

CDC will invest in accelerating its migration to cloud computing platforms to implement a robust cloud ecosystem. Enabling enterprise scale access to cloud solutions will provide foundational access to commercial cloud service providers across Infrastructure as a Service, Platform as a Service, and Software as a Service and

support access to evolving sets of data-oriented services native to cloud. Implementing integrated common enterprise-wide data infrastructure, architectures, tools, encryption, interoperability standards, and data solutions will support more efficient and effective management and use of CDC's data and reduce the data reporting and management burden on partners. Building critical data capabilities will enable core enterprise data lifecycle management for cloud infrastructure and secure access to large-scale data sources internally and externally through increased authentication tools. CDC will modernize key public health data systems, rapidly building and moving critical public health data systems to cloud-computing platforms reducing overall number of CDC systems. Enhancing data sourcing and ingestion capabilities will enable the acquisition, ingestion, management and analysis of large-scale datasets from internal and external partners. The use of Machine Learning Operations tools will streamline and improve the development and deployment of machine learning models that will reduce burden of core manual processes. CDC will invest in data science capacity and analytic tools to ensure that the Agency and public health partners can keep pace with the rapidly evolving ecosystem to support modern data analysis. Provisioning new tools will allow CDC to apply advanced data analytics and predictive modeling capabilities. Making use of automated, scalable tools with the assistance of Artificial Intelligence and machine learning will allow CDC to rapidly build analytic methods and tools using computer automation capabilities that can automate core processes.

## **Budget Allocation FY 2024**

### **Underground Mining Research Facility**

CDC acquired a replacement underground mining research facility in Mace, West Virginia to support mining research capabilities no longer available at the former NIOSH Lake Lynn facility. The Consolidated Appropriations Act of 2023, directed HHS to fund the design and construction of the facility from the NEF. The new facility will be used to conduct studies and research on mine explosions, mine seals, mine rescue, ventilation, diesel exhaust, evaluation of emerging health and safety technologies, ground control, and fire suppression. The project will provide approximately 180,383 GSF of newly constructed research space. CDC estimates the total project cost to be approximately \$97.4 million. In May 2023, CDC initiated preliminary design activities which will be used to validate and update initial project requirements to ensure the site development supports planned construction efforts. At this time, CDC anticipates design and construction of the facility will take approximately five years.

### **Building 401 Renovation**

Renovation of Building 401 on CDC's Fort Collins, Colorado campus supports CDC's public health mission and provide the laboratory, insectary, and vivarium space to meet CDC's vector-borne disease research objectives. NEF funding will be used to renovate portions of the first and second floor of Building 401 to recapture and convert existing administrative space to approximately 11,000 GSF of laboratory space (while retaining ~25% of administrative space). The converted space will expand the vivarium and insectary, animal holding rooms, and the molecular testing lab. This renovation will also allow for more space per laboratory to meet HHS laboratory space standards.

### **Roybal Campus Central Utility Plant Chillers Upgrade**

CDC's chilled water system is responsible for maintaining operating temperature for the Roybal Campus and the cold room temperatures required inside laboratory spaces. NEF funding is being used to replace aging chillers and their associated pumps, cooling towers, piping, and controls. When complete, the Central Utility Plant will be restored to a fully operational status with all existing deficiencies corrected, giving CDC another 20+ years of chilled water service to CDC's campus.

### **Laboratory Controls and Building Automation System Upgrades for CDC's Roybal Campus Building 17 and Chamblee Campus Building 103**

CDC's ability to respond to infectious disease threats depends upon the operational readiness of its laboratories. However, laboratory operations are very demanding on building utility systems, causing more rapid deterioration through increased density of utilization than a comparable office building. The cost to maintain laboratory space is approximately 40% higher per square foot than office space.

To ensure the safety of staff and continuity of laboratory operations, NEF funds will be used to replace the entire Building Automation System in its Building 17 Biological Safety Level 2&3 laboratories on the Roybal Campus and the Building 103 laboratory on the Chamblee Campus where these needs have become urgent.

#### **Budget Allocation FY 2023**

##### **National Health and Nutrition Examination Survey (NHANES)**

NEF funds are being used to replace and upgrade essential National Health and Nutrition Examination Survey (NHANES) Mobile Examination Center (MEC) vehicles, equipment, and IT in order to sustain CDC's public health infrastructure. NHANES is the primary source of data for multiple HHS programs and initiatives including the Dietary Guidelines for Americans, the U.S. Surgeon General's Report on Oral Health in America, and the Healthy People 2030 objectives. The new MEC infrastructure will allow the agency to expand its reach to American citizens and conduct public health nutrition examination surveys. CDC will acquire the vehicles and equipment in FY 2023 and FY 2024 for field operations in FY 2025.

#### **Budget Allocation FY 2022 and prior**

##### **National Institute of Occupational Safety and Health (NIOSH) Cincinnati Consolidated Campus**

CDC, working with the General Services Administration (GSA), identified a potential site for a new facility to consolidate NIOSH's Cincinnati Research Facilities into one central location. This project is supported with \$194 million from the NEF. Of this \$129 million was allocated in FY 2015 with an additional \$65 million allocated in FY 2022. The Environmental Impact Statement assessment and associated Record of Decision have been completed. CDC, working with GSA, is in the process of purchasing the site for the facility. Design of the project was completed in summer 2022. The construction contract is anticipated to award in summer 2024 pending the acquisition of the land in early 2024. Project completion is anticipated in early 2027.

##### **National Personal Protective Technology Laboratory (NPPTL) NIOSH Pittsburgh Campus**

Aging buildings on the NIOSH Campus in Pittsburgh, Pennsylvania, have frequent and costly infrastructure and utility repair needs, which add to CDC's backlog of maintenance repairs and disrupt NIOSH's support to American workers. In FY 2021, CDC received \$14 million from the NEF to renovate the National Personal Protective Technology Laboratory (NPPTL) at the Pittsburgh Campus. The renovated laboratory space will support NPPTL's Human Performance and Physiology Research Branch Laboratories; NPPTL's respirator certification program mission focused on workplace health and safety; and the research and development of new personal protective equipment technologies. The research conducted at NPPTL provides ongoing protection for America's workers and has been of critical importance to certifying respirators during the COVID-19 pandemic. Renovation of the facilities will enable more efficient and effective research. Design is complete and construction is anticipated to start in second quarter of FY 2024, with occupancy of the new lab space anticipated in late 2025.

**Chamblee Campus Public Health Research Support Building**

In FY 2020, CDC received \$225 million from the NEF to construct the Johnny Isakson Public Health Research Support Building and additional infrastructure on CDC's Chamblee Campus for consolidation of 1,800 to 2,000 staff into a new office building. The new building will maximize space utilization rates, minimize long-term operating and maintenance costs, and provide opportunities for increased operational efficiencies. Construction is underway, with a goal for occupancy in the fourth quarter of calendar year 2024. This project is critical to the agency's strategy to reduce reliance on expensive leased property.

**High-Containment Continuity Laboratory (HCCL)**

The 2018 Consolidated Appropriations Act directed CDC to utilize \$240 million in budget authority and \$240 million from the NEF to support the High Containment Continuity Laboratory (HCCL) project. The HCCL will enable CDC to continue to protect, defend, and respond to the most infectious disease threats involving high-consequence pathogens. The design of the new 175,000 square foot high containment laboratory is complete. Procurement for the construction is currently underway and award of the construction contract is anticipated in summer 2024. CDC anticipates that the facility will become operational in fall 2029.



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## WORKING CAPITAL FUND

### CDC FY 2025 WORKING CAPITAL FUND TABLE

(dollars in thousands)

	FY 2024 Estimate	FY 2025 Estimate
<b>CDC Programs<sup>1</sup></b>		
Immunization and Respiratory Diseases	\$70,242	TBD
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	\$64,497	TBD
Emerging and Zoonotic Infectious Diseases	\$110,693	TBD
Chronic Disease Prevention and Health Promotion	\$55,981	TBD
Birth Defects, Developmental Disabilities, Disability and Health	\$12,419	TBD
Environmental Health	\$29,327	TBD
Injury Prevention and Control	\$26,925	TBD
Public Health Scientific Services	\$81,045	TBD
Occupational Safety and Health	\$48,205	TBD
Global Health	\$65,647	TBD
Public Health Preparedness and Response	\$42,160	TBD
CDC Wide Activities	\$28,049	TBD
<b>CDC Program Total</b>	<b>\$635,190</b>	<b>TBD</b>
<b>Other CDC Funding Sources</b>		TBD
<i>Agency for Toxic Substances and Disease Registry</i>	\$10,260	TBD
<i>Energy Employees Occupational Illness Compensation Program Act (EEOICPA)</i>	\$3,022	TBD
<i>Vaccines for Children</i>	\$33,285	TBD
<i>World Trade Center</i>	\$8,452	TBD
<i>PEPFAR</i>	\$56,751	TBD
<i>Other Reimbursable Income</i>	\$26,929	TBD
<b>Other CDC Programs Contributions Total</b>	<b>\$138,699</b>	<b>TBD</b>
<b>Total CDC Programs Contributions</b>	<b>\$773,889</b>	<b>TBD</b>

<sup>1</sup>Estimates are based on the WCF Governance Board approved operating budget for FY 2024. The estimate is distributed across budget lines on a pro-rata basis until consumption data is collected and bills are issued. These estimates do not include Specialized Service Agreements, adjustments for increases or decreases to program activities, or supplemental appropriations (e.g., COVID-19 and GHSA), which will result in a change to the consumption/billing across budget lines.

The Working Capital Fund (WCF) supports CDC's core operations to achieve the agency's public health mission.

The WCF is a revolving fund with extended availability and serves as the funding mechanism for centralized business services support across CDC. Business service offices provide services to CDC programs and the WCF bills programs for the services consumed based on pre-established rates. Services include office and other space management, information technology, financial transactions, and security services.

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## REIMBURSEMENTS AND TRUST FUNDS<sup>1</sup>

(dollars in millions)	FY 2022 Actual	FY 2023 Actual	FY 2024 Estimate	FY 2025 Estimate
Reimbursements and Trust Funds	\$769.807	\$715.224	\$718.206	\$718.206

<sup>1</sup>Reimbursement and Trust Fund Levels reflect anticipated collections.

**Authorizing Legislation:** PHSA §§ 214, 301, 306(b)(4), 311, 353; Consolidated Appropriations Act, 2016 (P.L. 114-113)

CDC's reimbursable activities provide scientific and programmatic expertise to other agencies and organizations. CDC has a long history of partnering with other federal agencies in the shared interest of improving public health and prevention programs. Examples of these activities include:

- CDC will continue its longstanding agreements with other agencies of the Public Health Service, HHS, and others associated with CDC's health statistics studies to provide scientific and programmatic expertise in areas such as genetic diseases, laboratory tests, investigations, development of worker safety guidance, and training and model screening programs. In addition to reimbursable agreements and user fees, CDC receives funds from Cooperative Research and Development Agreements (CRADAs) to enhance and facilitate collaboration between the agency's laboratories and various partners.
- CDC will continue to work with the U.S. Agency on International Development (USAID) on various projects including the President's Malaria Initiative (PMI) malaria prevention and control efforts. CDC provides technical and programmatic assistance to Ministries of Health, global and country malaria partners, PMI Resident Advisors and implementing partners in country.
- CDC will continue to work with the Executive Office of the President, Office of National Drug Control Policy (ONDCP) to manage the Drug-Free Communities (DFC) Support Program through implementation of programmatic activities and grants/cooperative agreements to support the efforts of community coalitions working to prevent and reduce substance use among youth.

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# PERFORMANCE BY ACTIVITY

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## IMMUNIZATION AND RESPIRATORY DISEASES

### Immunization Program and Program Implementation and Accountability

**Performance Measure for Long Term Objective: Ensure that children and adolescents are appropriately vaccinated**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
1.2.1c Achieve and sustain immunization coverage in children 19 to 35 months of age for one dose of MMR vaccine (Intermediate Outcome)	FY 2022: 93% Target: 90% (Target Exceeded)	90%	90%	Maintain
1.2.1h Achieve and sustain immunization coverage of at least 90% in children 19-35 months of age for at least 4 doses of pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2022: 84% Target: 90% (Target Not Met)	90%	90%	Maintain
1.2.1i Achieve and sustain immunization coverage of at least 80% in children 19- to 35-months of age for 2-3 doses of rotavirus (Intermediate Outcome)	FY 2022: 77% Target: 80% (Target Not Met)	80%	80%	Maintain
1.2.2a Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of Tdap (tetanus and diphtheria toxoids and acellular pertussis) (Intermediate Outcome)	FY 2022: 90% Target: 90% (Target Met)	90%	90%	Maintain
1.2.2b Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of meningococcal conjugate vaccine (MenACWY) (Intermediate Outcome)	FY 2022: 87.5% Target: 87% (Target Exceeded)	87%	87%	Maintain
1.L.1: Achieve and sustain vaccination coverage of at least 80% for receiving recommended doses of human papillomavirus (HPV) vaccine (among adolescents 13-15 years of age)	FY 2022: 58.6% (Baseline)	65%	65%	Maintain



**Performance Measures for Long Term Objective: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
1.3.1b Increase the percentage of adults aged 65 and older who are vaccinated with at least one dose of pneumococcal vaccine (Intermediate Outcome)	FY 2021: 65.8% Target: 85% (Target Not Met but Improved)	85%	85%	Maintain
1.3.2c Increase the percentage of non-institutionalized adults ages 19 to 64 at increased risk of pneumococcal disease who are vaccinated with at least one dose of pneumococcal vaccine (Intermediate Outcome)	FY 2022: 22.2% Target: 29% (Target Not Met)	29%	29%	Maintain
1.3.3a Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Intermediate Outcome)	FY 2022: 50% Target: 70% (Target Not Met but Improved)	70%	70%	Maintain

**Performance Trends:** Immunization is one of the most effective public health interventions. CDC supports the implementation of state-based immunization programs that make vaccines available to children, adolescents, and adults. CDC estimates that, among children born during 1994–2021, vaccination will prevent an estimated 479 million illnesses, 29.8 million hospitalizations, and 1,052,000 early deaths over the course of their lifetimes, at a net savings of \$476 billion in direct costs and \$2.2 trillion in total societal costs<sup>243</sup>. Starting in March 2020 with the onset of the COVID-19 pandemic, CDC observed notable declines in pediatric outpatient visits and routine childhood vaccination.<sup>244</sup> In August 2020, CDC issued a call to action to increase vaccinations in children and is working with partners to address catch up vaccinations in children. During the 2020-2021 school year, national coverage with state-required vaccines amount kindergarten students declined from 95% to 94%. The 2021-2022 school year saw a further decrease to 93%.<sup>245</sup>

CDC achieved levels above or near national (Healthy People 2030) targets for most of the routinely recommended childhood vaccinations. Since FY 2010, measles, mumps, and rubella (MMR) vaccinations exceeded 90% coverage rates (Measure 1.2.1c). Rotavirus vaccine coverage among children increased by 20 percentage points from 59% in FY 2010 to 79% in FY 2021 an improvement over FY 2020 results (Measure 1.2.1i) and dropped to 77% for FY 2022. Four dose coverage of pneumococcal conjugate vaccine (PCV13) was 84% (Measure 1.2.1h) in FY 2022, slightly lower than FY 2021 (85%), but higher than FY 2020 (83%); however, since 2010 three doses PCV13 coverage has exceeded 90%. Through increasing vaccination rates, CDC has demonstrated an 87% decline in PCV13-type pneumococcal disease among children less than five years old in the U.S. Although CDC did not meet targeted coverage rates for PCV, strategies to improve the fourth dose of PCV coverage are in place and are similar to those used to improve the uptake of other vaccines, and CDC expects more people will become fully vaccinated in the future.

During the past decade, vaccination coverage levels among older adults increased slightly as CDC implemented national strategies and partnered with state and local public health departments to promote adult immunization among healthcare providers and state and local governments. CDC met the target for tetanus, diphtheria, and

<sup>243</sup> Benefits from Immunization during the Vaccines for Children Program Era – United States, 1994–2013. MMWR, 25 April 2014.  
<sup>244</sup> Santoli JM, Lindley MC, DeSilva MB, et al. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020. MMWR Morb Mortal Wkly Rep 2020;69:591–593. DOI: <http://dx.doi.org/10.15585/mmwr.mm6919e2>.  
<sup>245</sup> [Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2021–22 School Year | MMWR \(cdc.gov\)](https://www.cdc.gov/mmwr/preview/mmwrhtml/6909a1.htm)

acellular pertussis (Tdap) and meningococcal conjugate vaccine in FY 2021 but not in FY 2022. Tdap vaccine coverage increased from 74% in FY 2010 to 90% in FY 2021 and 89% in FY 2022 (Measure 1.2.2a). Meningococcal conjugate vaccine (MCV4) coverage increased from 65% in FY 2010 to 88.5% in FY 2021 and 87.5% in FY 2022, which exceeded the target and is slightly lower than the FY 2019 and 2020 results (Measure 1.2.2b). In 2014, ACIP recommended that adults receive two types of pneumococcal vaccine: one dose of PCV13 followed by a dose of PPSV23. Surveys assessing vaccination coverage are currently unable to determine which pneumococcal vaccine was received; therefore, CDC is only able to assess receipt of at least one dose. CDC did not meet the FY 2022 target for pneumococcal vaccination coverage among noninstitutionalized adults at increased risk for pneumococcal disease; coverage remained below 25% for the past five years (range 22.2-24.5%) (Measure 1.3.2c). CDC did not meet the FY 2021 target for pneumococcal vaccination coverage among adults 65 and older; coverage remained below 85% for the past three years (range 65.8-67.5%) (Measure 1.3.1b).

It is important that everyone over 6 months old receives an annual flu shot. Measure 1.3.3a reflects the universal influenza vaccination recommendation and aligns with ACIP's recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults ages 18 years old and over increased slightly from 42% in FY 2015 to 50% in FY 2022. Interpretation of these results should take into account limitations of the survey, including reliance on self-report of vaccination status. Flu vaccination coverage among adults remains at about 5 in 10 adults reporting receipt of a flu vaccination.

In FY 2022, the measure for the full series of human papillomavirus vaccine was revised to measure vaccination coverage data and be more effective as the new measure reflects the short term (e.g., one-year) impact of immunization program processes (Measure 1.L.1). The reported data points should focus on key program public health outcomes, which can be seen with other measures. In FY 2023, CDC revised the HPV measure to align with the Healthy People 2030 HPV measure (Increase the proportion of adolescents who get recommended doses of the HPV vaccine — IID08). In FY 2022 vaccination coverage among adolescents 13-15 years of age receiving the recommended doses of HPV vaccine was 58.6%.

Achieving high vaccination coverage leads to higher levels of population immunity, which reduces occurrence of vaccine-preventable diseases and prevents outbreaks of vaccine-preventable diseases that have been eliminated in the U.S. including measles and polio. CDC's efforts to improve adult vaccination coverage rates include:

- Addressing pandemic-related declines in routine immunizations, through the launch of the CDC Let's RISE initiative, which stands for Routine Immunizations on Schedule for Everyone. Let's RISE is an effort to equip partners and health care providers with actionable strategies, resources, and data to support getting all Americans back on schedule with their routine immunizations. Let's Rise provided technical assistance to 20 jurisdictions resulting in improved Immunization Information Systems (IIS), vaccine confidence, and school vaccination data collection. CDC worked with jurisdictions to:
  - Improve immunization data quality to better help providers, families, and public health officials strengthen provider to patient vaccine discussions and incorporate into public health programs in seven jurisdictions.
  - Increase state and local health department capacity to conduct community assessments, tailor vaccine confidence resources, and build community trust and strengthen uptake of childhood routine immunization in Connecticut.
- Improve data mapping, and multi-pronged interventions to address measles outbreaks and/or low MMR vaccine coverage in eight jurisdictions. Strengthening vaccine confidence and preventing outbreaks of vaccine-preventable diseases in the U.S. by establishing the Vaccinate with Confidence strategic framework. CDC has developed Vaccine Confidence and Demand partnerships with healthcare and community-based organizations to build vaccine confidence and generate demand.
- Collaborating with numerous existing and new partners to develop and implement strategies to improve adult immunization at provider, practice, and systems levels. These partnerships with professional

organizations, pharmacy partners, and other entities help to promote immunization for adults and allow for increased access to vaccination programs through new venues.

## Influenza Planning and Response

### Performance Measures for Long Term Objective: Protect Americans from infectious diseases – Influenza

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
1.M Number of virus specimens received and fully characterized using deep sequencing from global National Influenza Centers for use in determining vaccine strain selection annually (Output)	FY 2023: 5,228 Target: 4,500 (Target Exceeded)	4,500	4,500	Maintain
1.P Percentage of influenza partner countries reporting data routinely into WHO FluNet (Output)	FY 2023: 94% Target: 90% (Target Exceeded)	90%	90%	Maintain
1.Q The number of state/territorial/local health departments with full and partial laboratorians and/or influenza coordinators trained and funded through Epidemiology and Laboratory Capacity (ELC) grant (Output)	FY 2023: 57 Target: 57 (Target Met)	57	57	Maintain
1.R Increase the percentage of influenza partner countries with a respiratory disease surveillance system that demonstrates qualitative improvements by meeting two quality indicators (Output)	FY 2022: 64% Target: 70% (Target Not Met but Improved)	70%	70%	Maintain

**Performance Trends:** As a World Health Organization (WHO) Collaborating Center for Influenza, CDC enhances global capacity to monitor influenza viruses and inform vaccine policy and treatment recommendations.

### Domestic Influenza Surveillance

CDC enhances state and local capacity to gather influenza epidemiology and laboratory data for systematic and accurate surveillance of seasonal and novel influenza viruses by providing training and resources to its grantees. Assisting states, territories, and local health departments to staff laboratorians or influenza coordinators directly aligns with CDC’s goal of enhancing and maintaining sustainable domestic influenza surveillance systems that operate year-round. The support for state and local public health capacity is paramount to the success of domestic surveillance for both seasonal and pandemic influenza preparedness. In FY 2023, there were 57 jurisdictions with full and/or partially funded state, territorial, or local laboratorians or influenza coordinators. CDC training and support of epidemiologists serving as influenza surveillance coordinators in every state and some local jurisdictions has allowed for continuously improving surveillance systems that provide data to inform timely response to annual influenza epidemics. This training and support also provided surveillance systems and a trained workforce that are able to be immediately repurposed to outbreaks of novel influenza, including the ongoing outbreak of highly pathogenic avian influenza A(H5N1) in wild birds, wild mammals and poultry in the U.S. in 2022 and 2023, and can be leveraged for other emergency response needs (Measure 1.Q).

During FY 2023, CDC received and characterized 5,228 virus specimens using next generation sequencing (NGS) from the global National Influenza Centers for use in vaccine strain selection (Measure 1.M). After three years of a lower number of viruses characterized due to a markedly lower level of influenza viruses circulating globally, the target was once again reached and exceeded following an influenza season that returned to more expected levels of activity. CDC has completed its goal of fully converting to NGS for virus genome characterization, including sequencing directly from clinical specimens rather than cultured viruses. CDC has worked extensively with its state and local partners to determine an appropriate representative sample of virus specimens to fully characterize. This process is called “right-sizing” and is a significant program performance enhancement, aimed at sequencing specimens across a range of populations to achieve more targeted results efficiently while streamlining resources. A targeted range of 4,000-7,000 viruses fully characterized using NGS is appropriate for annual influenza epidemics in order to understand patterns of different influenza types and subtypes and to provide the data needed to make recommendations for the composition of seasonal influenza vaccines. This number will naturally rise and fall annually, depending upon the incidence of disease and severity of each influenza season.

### **Global Influenza Surveillance**

CDC strengthens global health security by equipping partner nations’ capacity to improve and sustain influenza detection and response capabilities through timely reporting into their respective influenza surveillance systems and submitting influenza testing data to WHO FluNet. CDC’s efforts to strengthen international influenza epidemiological and virological surveillance and pandemic preparedness have increased as measured by the number of CDC-funded countries routinely reporting to WHO FluNet, which went from 40% in FY 2005 to 94% in FY 2023. Although the emergence of SARS-CoV-2 virus led to a temporary decrease in FY 2020 to 59%, the percent of countries reporting to WHO FluNet has increased with a reporting rate of 70% in FY 2021 and 86% in FY 2022 and a return of 94% in FY 2023 (Measure 1.P). We believe this ongoing increase signals a shift to leverage routine influenza surveillance for SARS-CoV-2 virus, allowing influenza testing and reporting to stabilize. Additionally, all partner countries but one reported greater than 60% of the reporting weeks in FY 2023. To further support our partners, the CDC restructured influenza program operations to support partner countries more directly, efficiently, and effectively, and to promote global health security at home and abroad. CDC-funded countries continued to leverage influenza surveillance staff and infrastructure and are planning for the full integration of SARS-CoV-2 surveillance into their influenza surveillance platforms. Additionally, these same systems are being utilized to support integrated surveillance for other respiratory diseases including Respiratory Syncytial Virus (RSV).

CDC recognizes the importance of collecting weekly data globally on influenza-like illness or severe acute respiratory infection to characterize circulating influenza viruses. In FY 2023, 64% of partner countries met two quality indicators for demonstrating qualitative improvements in surveillance (Measure 1.R). We believe this increase from FY 2022 performance (58%) suggests stabilization of influenza surveillance following the COVID-19 response and the ongoing integration of SARS-CoV-2 and RSV into the existing surveillance systems. Partner countries continue to respond to global emergencies including monkeypox, cholera, Ebola, and continued COVID-19 disease transmission which likely affected influenza surveillance. As respiratory disease surveillance integration work continues throughout FY 2024, we anticipate the overall surveillance quality in partner countries will continue to improve.

CDC continues to work with partner countries to increase their testing and surveillance capacity for influenza. This includes integrating surveillance systems to monitor and test for multiple respiratory pathogens and improving laboratory capacity by conducting trainings on sequencing and the use of new diagnostics that can detect both influenza and other respiratory pathogens. This broader approach to diagnostics will contribute to better global preparedness when responding to infectious diseases. Qualitative improvements in surveillance should occur as partner systems are restructured and strengthened.

## HIV, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS

### Domestic HIV Prevention and Research

Contextual Indicators	Most Recent Result
2.1.1 Reduce the number of new HIV diagnoses by at least 75%	FY 2021: 35,716
2.1.3 Increase the percentage of people with HIV who know their serostatus to 95%	FY 2021: 87.3%
2.1.9 Reduce the number of new HIV infections by 75%	FY 2021: 32,100
2.1.10 Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%	FY 2021: 65.9%
2.2.8 Increase the number of persons prescribed PrEP among those who have indications for PrEP (increase PrEP coverage)	FY 2022: 36.0%

### Performance Measures for Long Term Objective: Reduce new HIV infections

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
2.1.7 Increase the proportion of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active (Outcome)	FY 2021: 89.2% Target: 87.5% (Target Exceeded)	N/A <sup>1</sup>	88.5%	N/A

<sup>1</sup>Targets and results are set and reported biennially.

### Performance Measures for Long Term Objective: Increase access to care and improve health outcomes for people living with HIV

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
2.2.9 Increase the percentage of all persons with newly diagnosed HIV infection in CDC-funded testing sites who are linked to HIV medical care in ≤ 30 days after HIV diagnosis in order to assist national efforts to achieve viral suppression (Outcome)	FY 2022: 78.5% Target: 85% (Target Not Met but Improved)	85%	85%	Maintain

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
2.2.10 Increase the percentage of all persons with newly diagnosed HIV infection in CDC-funded testing sites who were interviewed for partner services (Outcome)	FY 2022: 68% Target: 85% (Target Not Met)	85%	85%	Maintain
2.2.11 Increase the number of jurisdictions complying with the requirement to report all CD4 and viral load values to CDC (Output)	FY 2021: 48 Target: 51 (Target Not Met but Improved)	53	53	Maintain

**Performance Trends:** As the number of persons with HIV increases due to better, life-prolonging treatments, so does the need for CDC prevention activities. The estimated number of people with undiagnosed and diagnosed HIV in the United States is 1.2 million with an estimated 32,100 new HIV infections in 2021. The updated 2022-2025 National HIV/AIDS Strategy (NHAS) identifies a set of priorities and strategic action steps tied to measurable outcomes for moving the nation forward in addressing the domestic HIV epidemic. The strategies and outcomes outlined by the NHAS are in alignment with the federal initiative, Ending the HIV Epidemic in the U.S. (EHE), which aims to reduce new HIV infections in the United States by 90% by 2030. The EHE initiative also identified six corresponding HIV indicators to help quantify progress being made towards EHE goals: incidence, knowledge of status, diagnoses, linkage to HIV medical care, viral suppression, and pre-exposure prophylaxis (PrEP) coverage (Measures 2.1.1, 2.1.3, 2.1.9, 2.1.10, 2.2.8).

Reducing the number of new HIV infections is a shared national and CDC priority. During 2017-2021, new HIV infections decreased from 36,500 infections in 2017 to 32,100 infections in 2021 (Measure 2.1.9) resulting in a 12% reduction in new HIV infections from 2017-2021. The percentage of persons living with diagnosed HIV infection at year-end 2021, compared with 2017, increased from 86.0% to 87.3% in the U.S.<sup>246</sup> (Measure 2.1.3).

In 2021, there were 35,716 new HIV diagnoses in the United States, an improvement from 2019 in reducing the number of new diagnoses (Measure 2.1.1). Data for the year 2020 should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, care-related services, and case surveillance activities in state/local jurisdictions. CDC's analysis of HIV diagnoses data from 2017 to 2021 reveals rates of diagnosis continue to be highest among Black/African American persons compared to other racial/ethnic groups and higher in the South compared to other regions. However, rates of diagnoses for all racial/ethnic groups decreased from 2017 to 2021 except for among American Indian/Alaskan Native persons which increased by 14 and Native Hawaiian/other Pacific Islanders which increased by 49%. Additionally, rates of diagnoses decreased among all age groups except for those aged 25-35, which remained stable. Diagnoses also declined during this period among men and women aged ≥ 13 years (based on sex assigned at birth) but increased among transgender women and transgender men. Of the six populations of particular interest to HIV prevention programs in state and local health departments - (1) Gay, Bisexual, and Other Men Who Have Sex with Men, (2) Persons Who Inject Drugs (PWID), (3) Transgender Persons, (4) Women, (5) Adolescents and Young Adults, and (6) Children Aged <13 Years - HIV diagnoses decreased for all except for among PWID and transgender persons.

<sup>246</sup> Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2017–2021. HIV Surveillance Supplemental Report 2023;28(3). <https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-28-no-3/index.html>. Published May 2023.

These trends suggest that intensified HIV testing and prevention efforts among MSM are having an impact.<sup>247</sup> In addition, from 2017 to 2021, the rate and number of deaths among persons with HIV increased, with excess deaths in 2021 due to COVID-19. Focused public health efforts must continue to maintain the positive trends. Among regions most affected and among groups at substantial risk for HIV, accelerated efforts must continue to ensure access to testing, treatment, and prevention strategies, to ensure that every American has the knowledge and tools needed to protect themselves and their partners from HIV.

Diagnosis of HIV is only the first step in reducing infection. Patients must be linked to, and retained, in medical care to achieve and maintain viral suppression (having very low levels of HIV [viral load] present in the body). Evidence shows that viral suppression helps people with HIV to maintain their health and prevents sexual transmission of HIV to others. In 2021, 65.9% of persons with diagnosed HIV infection were virally suppressed, an improvement over 2020 (64.6%) (Measure 2.1.10). In FY 2022, 78.5% of persons with newly diagnosed HIV infection in CDC-funded testing sites were linked to HIV medical care in  $\leq$  30 days after HIV diagnosis (Measure 2.2.9). Early linkage to HIV care and treatment, especially when viral suppression is attained and sustained, is positively correlated with better health outcomes, thus helping persons living with HIV live longer, healthier lives and lowering their risk of transmission of HIV to others.

Testing provides a bridge to care for people with HIV. The majority of Americans with HIV are aware of their infection due, in part, to expanded HIV testing efforts. CDC estimates that 87.3% of people with HIV were aware of their status in 2021, up from 87.0% in 2020 (Measure 2.1.3). This means one out of seven people with HIV in 2021 did not know their status. Data for calendar year 2021 indicate that CDC-funded HIV testing programs performed approximately 1.7 million HIV tests and identified about 8,149 persons with newly diagnosed HIV infection<sup>248</sup>. For those who receive an HIV diagnosis, the test is the first step toward care and treatment. For those who are not infected, but at risk, testing opens the door to prevention services, like PrEP that can keep them healthy and HIV free.

Partner services programs are essential in preventing and controlling HIV in the U.S. and offer benefits to three principal groups: persons with HIV, their partners, and the community. A function of partner services is notifying partners of persons with diagnosed HIV infection of their possible HIV exposure and risk. Other functions of partner services interventions include prevention counseling, testing for HIV and other sexually transmitted infections (STIs), treatment or linkage to medical care, and linkage or referral to other prevention and social services. Partner services have been associated with positive behavior changes and reduced risk for HIV infection, along with reduced HIV transmission. Among all people newly diagnosed with HIV through CDC-funded HIV testing programs in 2022, 68.0% were interviewed for partner services<sup>249</sup> (Measure 2.2.10). In 2021, HIV partner services programs in 54 CDC-funded state and local health departments interviewed 28,407 persons with newly or previously diagnosed HIV infection and elicited information (e.g., names, location) for 14,548 sex or needle-sharing partners. Among the 10,302 notified partners, 71% were tested for HIV, and 18% of those tested were identified with a newly diagnosed HIV infection.<sup>250</sup> As the cornerstone of national HIV prevention and surveillance, beginning in 2018 through 2023, CDC awards more than \$400 million per year to state and local health departments to implement a comprehensive HIV surveillance and prevention program to prevent new HIV infections and achieve viral suppression among persons living with HIV. Additionally, CDC will continue to provide expert advice and assistance to recipients to further improve performance in these areas.

CDC also supports efforts to get effective HIV biomedical prevention tools, like PrEP, into the community and in the hands of persons who need them most. From 2021 to 2022, CDC EHE-funded programs provided more than 44,000 people prescriptions for PrEP. Among CDC EHE-funded programs, five jurisdictions met the 2025 goal linking or prescribing PrEP for at least 50% of eligible people. CDC investments in STI clinics also identified more

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<sup>247</sup> Centers for Disease Control and Prevention. CDC HIV Prevention Progress Report, 2019. <https://www.cdc.gov/hiv/pdf/policies/progressreports/cdc-hiv-preventionprogressreport.pdf>.

<sup>248</sup> <https://www.cdc.gov/hiv/library/reports/testing/2021/index.html>

<sup>249</sup> <https://www.cdc.gov/hiv/library/reports/testing/2021/index.html>

<sup>250</sup> <https://www.cdc.gov/pdf/library/reports/cdc-hiv-partner-services-annual-report-2021.pdf>

than 15,000 patients as PrEP eligible, and of these, 40% of the patients were newly prescribed PrEP or continued PrEP.

For those at high risk for HIV, PrEP can significantly reduce the risk of HIV infection if taken daily. To address barriers in prescribing PrEP among health care providers, CDC initiated an online Continuing Medical Education program, starting in 2016 with additional courses released in 2017 and 2020, and over 20,000 healthcare providers accessing each course. The latest continuing education program titled “HIV Testing, Prevention, and Treatment: A Stepwise Approach” addresses the entire prevention-care continuum and includes information about prescribing PrEP. The program was accredited until June 1, 2023. At that time, 26,208 healthcare providers had accessed this course, with 13,535 participants taking the final test for continuing education credits. The most recent program, released in April 2022, is titled “Individualizing Sexual Health Care: A Virtual Patient Simulation.” This program contained one case challenge that specifically focused on PrEP. As of October 1, 2023, 13,005 healthcare providers had accessed this course, with 2,652 participants completing the final test for credits.

In August 2018, CDC launched "Prescribe HIV Prevention" (PHP), an additional PrEP/PEP educational resource for clinicians. This communication effort supports healthcare providers to use PrEP and post-exposure prophylaxis (PEP) to prevent new HIV infections and improve health outcomes for patients at high risk for acquiring HIV. "Prescribe HIV Prevention" is part of CDC's "Let's Stop HIV Together" communication campaign designed to help reduce HIV incidence in the United States. The PHP initiative includes print and electronic resources that outline PrEP/PEP clinical trials and efficacy, prescribing information, and lab monitoring procedures, as well as patient education materials. Resources are distributed via CDC-INFO, at conferences, and are made available for download on the PHP website. As of October 2023, 1,489 PrEP resource kits, 22,659 brochures, and 2,336 posters were distributed by CDC-INFO. An additional 11,803 brochures and 467 posters were downloaded from our website. During FY 2023, the PrEP page within the HIV Nexus website had 126,179 views. CDC also supports HIV prevention programs through technical assistance. From April 1, 2019, to September 30, 2023, there were 121 technical assistance requests (completed and in progress) related to PrEP.

Data show an increase in awareness of PrEP and willingness to either use it or prescribe it, although additional awareness and implementation efforts are needed, particularly among most affected populations and their care providers, to scale up this highly effective biomedical intervention. In FY 2021, 30.2% of persons with indications for PrEP were prescribed PrEP (Measure 2.2.8). Reflecting CDC's continued investment in supporting the nation's HIV prevention workforce and improving its overall performance, CDC awarded up to \$120 million over five years to 17 organizations under its 2019 program, Capacity Building Assistance (CBA) for High Impact HIV Prevention Program Integration. The program supports the federal initiative, Ending the HIV Epidemic in the U.S. By strengthening the capacity and improving the performance of the nation's HIV prevention workforce – including thousands of staff within state and local health departments, community-based organizations (CBOs) and healthcare organizations – the program will provide the communities with the highest burden additional expertise, technology and resources required to address the HIV epidemic.

The funding supports a CBA Provider Network that is implementing national training, regional technical assistance, continuous quality improvement and sustainability for CBOs, and marketing and administrative support. By enabling the HIV prevention workforce to optimally plan, integrate, implement, and sustain comprehensive programs and services, the CBA Provider Network will help make it possible to achieve the nation's HIV prevention goals. The CBA program is designed to respond to the evolving needs of the HIV prevention workforce and differs from previous capacity building programs in several important ways. Successes that have resulted from the CBA program include the following:

- Training available in a variety of formats and at different skill levels, to effectively reach a wide range of HIV service providers. From April 1, 2019, through September 30, 2023, CDC conducted 746 training sessions for 7,388 participants; updated 20 training curricula; converted 14 training curricula into live virtual trainings, developed 22 new curricula which were or are in the process of being translated into



Spanish including eLearning trainings), and there are 15 curricula being either converted and updated to a live virtual training or translated into Spanish.

- Tailored technical assistance services focused on responding to specific regional and jurisdictional capacity building needs and preferences; addressing implementation challenges for HIV prevention programs and services; and peer-to-peer learning, support, and mentorship. From April 1, 2019, to September 30, 2023, 762 technical assistance support services were delivered to 736 unduplicated organizations.
- The National Learning Community (NLC) for HIV CBO Leadership is a distance-based learning program for senior and mid-level HIV prevention program managers with CBOs that provides a tailored learning experience that will empower participants to manage the people, programs, and organizations to end the HIV epidemic in the United States. The program is comprised of online self-paced short courses designed by and for CBO HIV program managers, a virtual, cohort-based Creative Problem Solving Intensive, and an online community of peers, coaches, and mentors in the HIV prevention workforce. As of July 24, 2023, 32 learners attended the pilot for this program. Since the live launch on March 15, 2021, 340 submitted the eligibility assessment (276 were eligible to participate and 265 registered in the NLC). Seventy-four learners applied to the Creative Problem-Solving Intensive, 30 were eligible and 13 have completed the program and five are currently participating.

The success in preventing new HIV infections among people who inject drugs (PWID) is threatened by national increases in unsafe, nonsterile injection practices that have been rising due to the opioid crisis. In 2021, eight percent of new HIV infections in the U.S. were among PWID. Research shows that syringe services programs (SSPs), community-based prevention programs that address drug use and infectious disease, offer several benefits as part of a comprehensive HIV prevention strategy. SSPs can play a role in preventing HIV among PWID, can facilitate entry into substance use disorder treatment (including medication-assisted treatment) and medical or social services, and do not increase illegal drug use. CDC supports state and local communities who wish to use Federal funds to implement SSPs, after consulting with CDC and in accordance with state and local law. There are currently health departments in 44 states and District of Columbia, one territory, and one tribal nation that have adequately demonstrated need and received CDC concurrence according to Federal law. The opportunity for CDC and its recipients to use federal funds to support certain components of SSPs provides at-risk communities with an additional HIV prevention tool.

CDC-led studies and broader scientific evidence demonstrate that school health programs can positively impact health-risk behaviors, health, and educational outcomes, and are cost effective. CDC is supporting state and local education agencies and addressing critical health issues including HIV/AIDS, STIs, and teen pregnancy prevention in schools. For example, the percentage of high school students who have ever had sexual intercourse decreased from 54.1% in 1991 to 30% in 2021. The percentage of adolescents in grades 9 to 12 abstaining from sexual intercourse, or using condoms if currently sexually active, increased from 86.3% in FY 2013 to 89.2% in FY 2021, exceeding the target (Measure 2.1.7). However, condom use among currently sexually active students decreased from 63.0% in 2003 to 51.8% in 2021.

CDC, in collaboration with state and local health departments, is working to better monitor the effects of HIV medical care through expanded reporting of CD4 and viral load test results. Test results are vital indicators of which patients are in care and virally suppressed, and those patients who have fallen out of care. In FY 2022, 48 jurisdictions complied with the requirement to report all CD4 and viral load values to CDC, an increase over FY 2019 (Measure 2.2.11). CDC data from 48<sup>251</sup> jurisdictions with complete laboratory reporting demonstrate progress on increasing linkage to care and viral suppression compared to previous national estimates. Data from

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<sup>251</sup> There are 47 states and DC that meet the criteria of complete lab reporting (i.e., have the law, 95% of labs are reporting to the state and 95% of labs received by the state are reported to CDC).

these jurisdictions represent 90% of the total number of HIV diagnoses in the U.S. CDC continues to prioritize expanded reporting of CD4 and viral load reporting in the HIV surveillance and prevention program.

With stronger reporting, CDC’s Data to Care tools increase health department capacity to use routinely collected HIV surveillance data to identify and follow up with people with HIV who are not in care. CDC continues to learn best practices through Data to Care demonstration projects and related activities in the HIV surveillance and prevention program. From 2012-2016, seven health departments used HIV surveillance and other data to re-engage 82% of persons with HIV diagnosis in their jurisdictions who were known to be out of care and offered linkage or reengagement services. CDC expanded Data to Care activities to all U.S. health department jurisdictions in 2018. As of December 2022, 56 jurisdictions had begun reporting Data to Care investigation outcome data and CDC is working with jurisdictions to evaluate program outcomes.

Complete reporting of laboratory results that includes HIV molecular sequence data also supports efforts to rapidly detect and interrupt clusters of active HIV transmission. Cluster detection and responses uses data routinely reported to health departments to identify communities where HIV may be spreading quickly. Once clusters are identified, public health officials can identify gaps in and barriers to prevention and care services and direct resources to ensure that these services (engagement in care, partner services, HIV testing, PrEP, SSPs) reach the populations that need them most, which in turn saves health care dollars associated with HIV and other related health outcomes. Health departments can identify clusters in numerous ways, including by providers or CBOs who report an increase in diagnoses, by contact tracing through partner services that identifies a group of people with potentially related infections, or through routinely reported surveillance data. Surveillance data can identify clusters either through detecting increased diagnoses in a particular geographic area or population subgroup or through analysis of HIV molecular sequence data, which are routinely reported in most jurisdictions. From 2020 to 2023, 266 clusters of HIV infections were reported to CDC and addressed by 46 health departments. Fifty-two jurisdictions use a bioinformatics tool developed and managed by CDC that allows these health departments to identify molecular clusters of HIV infections within their jurisdiction in near-real time. CDC includes highlighted stories from communities on a [new webpage](#), showing how cluster and outbreak response efforts are used to detect HIV cases and prevent greater transmission. CDC is working to ensure that all jurisdictions can incorporate HIV sequence data into existing laboratory reporting processes and address barriers to this reporting. Using these data in near-real time to inform prevention efforts requires close coordination between surveillance and prevention programs and between state and local programs.

## Viral Hepatitis

### Performance Measures for Long Term Objective: Reduce the rates of viral hepatitis in the United States

Measure	Most Recent Result and Target	FY 2024 Target <sup>1</sup>	FY 2025 Target <sup>1</sup>	FY 2025 +/-FY 2024
2.6.4 Increase the number of health departments (states and District of Columbia) reporting acute and chronic viral hepatitis data of sufficient quality to be included in national surveillance reports (Output)	FY 2021: 32 Target: 32 (Target Met)	45	45	Maintain
2.6.7 Reduce estimated new hepatitis A virus infections	FY 2021: 11,500 Target: 4,900 (Target Not Met but Improved)	3,700	3,400	-300

2.6.8 Reduce estimated new hepatitis B virus infections (Outcome)	FY 2021: 13,300 Target: 19,400 (Target Exceeded)	14,840	11,680	-3,160
2.6.9 Reduce estimated new hepatitis C virus infections (Outcome)	FY 2021: 69,800 Target: 38,233 (Target Not Met)	28,880 <sup>1</sup>	22,760	-6,120
2.6.10 Reduce reported rate of hepatitis C-related deaths per 100,000 population (Outcome)	FY 2021: 3.18/100,000 Target: 3.38/100,000 (Target Exceeded)	2.69/100,000	2.38/100,000	-0.31
2.6.11 Reduce reported rate of hepatitis B-related deaths per 100,000 population (Outcome)	FY 2021: 0.44/100,000 Target: 0.41/100,000 (Target Not Met but Improved)	0.33/100,000	0.29/100,000	-0.04

<sup>1</sup>CDC has set its viral hepatitis targets based on the HHS National Viral Hepatitis Strategic Plan (NVHSP) elimination targets. The NVHSP goals are based on calendar year and apply to surveillance data results reported that year (i.e., the 2026 targets in the strategic plan apply to 2024 surveillance data).

**Performance Trends:** In the United States, hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV) are the main causes of viral-induced hepatitis. During January 2017–March 2020, approximately 2.2 million civilian, noninstitutionalized adults had hepatitis C virus infection in the United States<sup>252</sup>, and an estimated 660,000<sup>253</sup> were living with hepatitis. B. Without treatment, chronic viral hepatitis can result in severe liver disease, liver cancer, and death. Together, HBV and HCV infections cause more than half of all liver cancer cases in the United States. Fortunately, hepatitis B can be treated, and hepatitis C can be cured. Testing is the first step in accessing treatment, yet about half of people with hepatitis B and about one-third with hepatitis C in the United States remain unaware of their infection. The introduction of life-saving medications to cure hepatitis C has resulted in declining hepatitis C mortality in the United States, however cure rates are low overall and vary by age and insurance payor. CDC data<sup>254</sup> revealed that from 2013–2022, only 34% of persons *diagnosed* with hepatitis C were cured (i.e., achieved viral clearance) during this time, indicating that far too few people diagnosed with hepatitis C are accessing curative treatment. Cure rates were lowest (16%) among adults aged 20–39 years who pay for medical care without insurance.

The death rate for hepatitis C during 2021 was 3.18 deaths per 100,000 population, representing a 28% decrease from the mortality rate during 2016 of 4.42 deaths per 100,000 population and exceeding the goal of no more than 3.36 deaths per 100,000 (Measure 2.6.10). However, significant racial and ethnic disparities exist and persist, evident by disparities in hepatitis C-related mortality rates. According to 2021 CDC surveillance data, the highest hepatitis C-related mortality rates continue to be among American Indian/Alaska Native persons (9.99 per 100,000 population) and non-Hispanic Black persons (5.01 per 100,000 population), compared to 2.98 per 100,000 among non-Hispanic White persons.

Additionally, new viral hepatitis cases continue to rise, with the highest rates among adults 20–59 years of age, and injection drug use being the most commonly reported risk factor. From 2014 to 2021, the United States experienced an almost 130% increase in the number of estimated cases of acute hepatitis C, from 30,500 in 2014 to 69,800 in 2021 (Measure 2.6.9). In 2020, CDC updated its hepatitis C screening recommendations and

<sup>252</sup> Karon C Lewis, DrPH, MSBMS, MPH and others, Estimated prevalence and awareness of hepatitis C virus infection among U.S. adults— National Health and Nutrition Examination Survey, January 2017–March 2020, *Clinical Infectious Diseases*, 2023;, ciad411, <https://doi.org/10.1093/cid/ciad411> The NHANES national probability sample includes the noninstitutionalized, civilian population of the United States; because it excludes certain populations known to have high hepatitis C prevalence from its sampling frame, NHANES underestimates the true prevalence of hepatitis C in the United States.]

<sup>253</sup> Bixler D, Barker L, Lewis K, Peretz L, Teshale E. Prevalence and awareness of Hepatitis B virus infection in the United States: January 2017 - March 2020. *Hepatology*. 2023 Mar 30;7(4):e0118. doi: 10.1097/HCG.000000000000118. PMID: 36996000; PMCID: PMC10069827

<sup>254</sup> Wester C, Osinubi A, Kaufman HW, et al. Hepatitis C Virus Clearance Cascade — United States, 2013–2022. *MMWR Morb Mortal Wkly Rep* 2023;72:716–720. DOI: <http://dx.doi.org/10.15585/mmwr.mm7226a3>

now recommends hepatitis C testing for every adult at least once, pregnant women during every pregnancy, and everyone with ongoing risk factors regularly. CDC also published recommendations in 2023 to increase identification and treatment of children with HCV infection acquired during pregnancy or delivery (also known as perinatal HCV infection). Rates of new HCV infections in the United States tripled among reproductive-aged persons during 2010–2021, leading to an increasing number of infants acquiring hepatitis C during pregnancy or delivery. Only about 30% of infants and children perinatally exposed to hepatitis C are tested, and many children with chronic HCV infection are lost to follow-up. CDC is calling on clinicians to:

- Test all perinatally exposed infants at age 2–6 months for HCV with a nucleic acid test (NAT) for detection of ribonucleic acid (RNA) to identify children who might go on to develop chronic HCV infections.
- Test all perinatally exposed infants and children aged 7–17 months who have not previously been tested, using a NAT for HCV RNA.
- Test all perinatally exposed children 18 months and older who have not previously been tested, using an HCV antibody test followed automatically by a NAT for HCV RNA whenever the HCV antibody test is reactive.
- Manage infants and children with detectable HCV RNA in consultation with a health care provider with expertise in pediatric hepatitis C management.

Hepatitis A cases increased over 800% from 2016–2019 due to large outbreaks involving dozens of states in association with person-to-person transmission among people who use drugs and people experiencing homelessness. During 2021, there were an estimated 11,500 hepatitis A infections (Measure 2.6.7); though this missed the 4,900 target, it is an improvement from the 19,900 estimated infections in 2020 and reflects continued decreases in hepatitis A infections. In 2023, CDC stood down its incident management system (IMS) for coordinating its hepatitis A outbreak. Only three states with declared outbreaks currently remain. Nearly twice as many hepatitis A–related deaths were reported during 2016–2022 compared with 2009–2015. Sixty-three percent of these deceased persons had at least one of the preexisting indications for vaccination specified in the Advisory Committee on Immunization Practices (ACIP) recommendations, yet only 4 percent had evidence of previous hepatitis A vaccination. Increased hepatitis A vaccination coverage, particularly among adults at increased risk for infection with hepatitis A virus or for severe disease from infection, is critical to preventing future hepatitis A deaths.

In 2021 there were an estimated 13,300 hepatitis B virus infections in the United States, a 5 percent decrease from 2020 (Measure 2.6.8). Hepatitis B cases were driven by injection drug use, with 30% of acute hepatitis B cases that included risk factor data reporting injection drug use. In 2021, the reported rate of hepatitis B-related deaths (or mortality) was 0.44 per 100,000 population -- slightly higher than the target of 0.41 per 100,000 (Measure 2.6.11). CDC published updated recommendations in 2022 to vaccinate all adults 19 through 59 years of age, as well as adults 60 years and older with risk factors against hepatitis B infection. Adults aged ≥60 years without known risk factors for hepatitis B may also receive hepatitis B vaccination. In March 2023, CDC released new hepatitis B screening and testing recommendations calling for universal screening at least once in a lifetime for all adults aged 18 years or older to address historically high rates of acute hepatitis B cases that are missed with a risk-based testing approach. CDC is partnering with immunization organizations to promote the updated screening and vaccination recommendations with health professionals' organizations.

To stop the spread of hepatitis A, hepatitis B, and hepatitis C and increase the number of persons vaccinated, tested, and directed to lifesaving care and treatment, CDC partners with health departments, health centers, and community-based organizations to test, link to care and treatment, prevent, monitor, and respond to viral hepatitis in the United States. CDC's *Integrated Viral Hepatitis Surveillance and Prevention for Health Departments* (IVHSP) program supports core viral hepatitis outbreak response, surveillance, and prevention activities in 59 jurisdictions (49 states, eight cities/counties, District of Columbia., and Puerto Rico). Jurisdiction successes during the first two years of funding included:

- established new, effective partnerships and methods for outbreak detection and response,
- improvements to collection/management/sharing of data (e.g., surveillance data, service delivery data collected in high-impact settings),
- more timely entry of hepatitis lab test results into surveillance systems (among health departments entering results into their system, 71% entered at least 85% of results within 60 days of sample collection),
- progress toward identifying laboratories that conduct hepatitis testing (to date, 41% of recipients have completed identifying these laboratories and 75% of these recipients have also identified the high-volume labs that report 95% or more of test results), and
- increased progress towards or completion of viral hepatitis elimination plans (to date, 58% have created elimination planning committees and 32% have completed their elimination plans)

In addition, 18 jurisdictions were funded to complete special projects to improve access to substance use disorder and viral hepatitis services in settings disproportionately affected by drug use. By the end of FY 2022, there were 204,046 client encounters in these high-impact settings (mostly – 82% – persons who inject drugs) across eight types of settings, including syringe services programs (SSPs), substance use disorder treatment centers, and health centers. These services included a total of 40,583,208 syringes distributed. The IVHSP program is aided by the [Viral Hepatitis Prevention and Surveillance Virtual Learning Collaborative \(VLC\)](#), which is a partnership between CDC and the National Alliance of State and Territorial Aids Directors (NASTAD). The VLC provides viral hepatitis health department staff with technical assistance that builds surveillance and prevention capacity.

CDC also funds the Vaccine Ambassadors Program (VAP) to better reach major populations disproportionately affected by viral hepatitis, among other infectious diseases – persons experiencing homelessness, persons with substance use disorders, and persons engaged in sex work. Through this funding agreement with the National Association of Community Health Centers, in partnership with the National Health Care for the Homeless Council, VAP facilitates low barrier vaccination services to these three disproportionately affected populations by meeting them where they are – such as in encampments, clinics, and shelters. In its second year, VAP sites expanded their vaccination services beyond COVID-19 vaccines to include routine adult vaccinations, such as hepatitis A and hepatitis B. Between January and April 2023, 6,086 vaccinations, including 784 hepatitis A and 591 hepatitis B vaccinations, were administered as result of the VAP. VAP also began offering crucial support services for these populations, including transportation, housing, food, mental health care, and substance use disorder services.

### **Expanding Testing and Linkage to Lifesaving Care for Persons Living with Hepatitis B and Hepatitis C**

Ongoing national increases in hepatitis C incidence are primarily associated with injection drug use. People who inject drugs are also at increased risk for hepatitis B, hepatitis A, and other infectious diseases. Building on successes and lessons learned from previous programs that integrated viral hepatitis testing, vaccination, and treatment in ‘high impact settings,’ CDC’s IVHSP funds 18 state and local health departments to expand and facilitate access to viral hepatitis testing, treatment, and vaccination (contingent on funding) for people who inject drugs. The new program also addresses persistent health inequities by expanding much needed hepatitis B and hepatitis C treatment, prevention, and care to other underserved and disproportionately affected populations.

Preliminary program data show that in the first two years, funded recipients reported providing at least 21,344 HCV antibody tests and 6,115 HBV screening tests, ultimately providing at least 1,846 linkages to treatment for persons with HCV or HBV infection. To further promote linkage to hepatitis C care, CDC developed the Hepatitis C Treatment Locator widget. Since its launch in April 2023, the widget has been used to search for treatment about 300 times per month on average. As of November 2023, 21 partner organizations are helping their communities find nearby treatment by hosting the widget on their websites. In November 2022, CDC also

initiated the [Strengthening Syringe Services Programs](#) funding agreement to further increase access to viral hepatitis and harm reduction services for people who inject drug by: 1) supporting a national network of syringe service programs (SSPs) and overseeing implementation and use of an annual national survey of SSPs, and 2) supporting and strengthening implementation of SSPs in the United States, Territories and affiliated states, and tribal nations. In the past year, CDC has provided 700 awards to SSPs through [Strengthening Syringe Services Programs](#) funding agreement, Ending the HIV Epidemic (EHE) initiative, and [Integrated Human Immunodeficiency Virus \(HIV\) Surveillance and Prevention Programs for Health Departments \(PS18-1802\)](#). Together, these funds supported SSPs in over 100 jurisdictions across the nation. By focusing on reaching the highest-need populations, these newly funded prevention and treatment activities will equip jurisdictions across the nation to meet CDC's viral hepatitis performance targets in the years to come.

To further promote hepatitis C elimination efforts. CDC also funded partners to convene a virtual summit, Unlocking HCV Care in Key Settings, attended by about 400 experts with a broad range of experience – from health care providers, national and local level public health professionals, to research scientists and people with lived experience – over a two-day period. The summit showcased promising models and best practices for integrating hepatitis C testing and treatment into health care and community settings critical to achieving hepatitis C elimination (e.g., SSPs, substance use disorder [SUD] treatment clinics, state correctional facilities, and community health centers). CDC has captured recommendations in a summary report to improve awareness and facilitate adoption of proven practices for identifying and eliminating hepatitis C among disproportionately affected populations receiving services in these settings.

### **Supporting Efforts to Prevent Mother-to-Child Transmission of Hepatitis B Virus and Hepatitis C Virus**

Vaccination is the cornerstone of hepatitis B prevention. Hepatitis B vaccination is recommended for all newborns (birth dose), infants (routine childhood immunization), and adults through age 59 years. Virtually all newborns infected with hepatitis B remain infected for life, resulting in one in four infected individuals developing severe liver disease or liver cancer. Hepatitis B birth dose vaccination is the cornerstone of preventing perinatal hepatitis B infection from mother to child.

The elimination of mother-to-child transmission of hepatitis B was an articulated goal in the National Academies' 2017 report, "A National Strategy for the Elimination of Hepatitis B and C," as well as the [Viral Hepatitis National Strategic Plan 2021-2025](#); it is also the priority for CDC-funded Perinatal Hepatitis B Prevention Programs (PHBPP). Evaluation data confirm that perinatal hepatitis B prevention programs are an effective way to prevent hepatitis B infection among infants. CDC is supporting PHBPP by promoting: 1) timely administration of the first hepatitis B immune globulin (HBIG) vaccine dose (within 12 hours of birth) to infants born to mothers living with HBV, 2) completion of the hepatitis B vaccine series, and 3) post-vaccination blood testing to evaluate the infant's response to the vaccine and their HBV infection status. In addition, the American Association for the Study of Liver Diseases (AASLD) guidelines for maternal antiviral therapy to reduce perinatal HBV transmission was published in 2018. CDC ACIP included this AASLD recommendation in the 2018 hepatitis B vaccination recommendations.

CDC launched a partnership with the American College of Obstetrics and Gynecology (ACOG) in September 2021 to improve uptake of recommendations for prenatal HCV screening during each pregnancy. By adopting CDC's prenatal screening recommendations, providers can quickly identify at-risk infants requiring follow-up testing and monitoring, as well ensure that their pregnant patients receive any necessary hepatitis C care before sustaining serious, costly liver damage. In 2021, ACOG released a practice advisory concurring with CDC's recommendation to screen pregnant patients for hepatitis C during each pregnancy. Through this partnership, ACOG disseminated prenatal HCV screening recommendations to their membership and developed informational material on HCV screening for patients. Additionally, ACOG is developing a podcast episode with patient advocates and obstetricians to highlight the importance of maternal hepatitis C screening. CDC and ACOG also leveraged the partnership to collaborate with the four largest commercial laboratories and develop updated obstetrics laboratory panels that incorporate hepatitis C screening with automated confirmatory

testing. The new panels will broaden routine hepatitis C screening during pregnancy, enabling providers to link pregnant patients more quickly and easily to life-saving hepatitis C care.

### **Helping State and Local Jurisdictions Respond to Hepatitis A Outbreaks**

Since 2016, the United States has experienced hepatitis A outbreaks in 37 states, primarily among adults using drugs and experiencing homelessness. Of the hepatitis A cases reported in 2021 that included risk factor data, 44% reported injection drug use. Unprecedented in the vaccine era, hepatitis A cases increased above baselines during 2016-2021, with reported cases peaking in 2019 and steadily dropping thereafter. Most adults are susceptible to hepatitis A (only about 12% self-reported receipt of two or more doses of the vaccine in 2019) through lack of childhood exposure or vaccination and are vulnerable to infection. A CDC analysis of 315 hepatitis A outbreak-related deaths in 27 states during August 1, 2016–October 31, 2022, found that deaths occurred predominantly among males, non-Hispanic White persons, and persons aged 50 years and older. Most of these deceased persons had at least one documented indication for hepatitis A vaccination, including drug use, homelessness, or coinfection with hepatitis B virus or hepatitis C virus; however, only 12 deceased persons had evidence of previous hepatitis A vaccination, indicating substantial missed opportunities to prevent hepatitis A deaths.

Vaccination is the best way to bring down new hepatitis A cases and prevent more than 95% of infections. In response to these outbreaks, CDC has assisted state and local jurisdictions with epidemiological and lab support, as well as provided funding and technical support for developing outbreak response plans. By year 2, 37% of the 59 funded jurisdictions had completed their hepatitis A outbreak plans. In February 2019, CDC updated the hepatitis A vaccine recommendations to include an indication for vaccination among persons experiencing homelessness. CDC updated the full recommendations for hepatitis A vaccination in 2020, adding two new populations for which vaccination is recommended: 1) all children aged 2-18 years who have not previously received the hepatitis A vaccine (catch-up vaccination); and 2) all persons with HIV aged 1 year and older. In response to the lack of long-term vaccine protection observed among persons with HIV, the 2020 recommendations also provide guidance on vaccination, administering immune globulin and postvaccination serologic testing for persons with HIV. Thirty-four states have declared an end to their outbreaks. Moreover, nationally reported case numbers are nearing pre-outbreak levels, and CDC has stood down its incident management system supporting the response to these outbreaks. By helping jurisdictions identify more persons eligible for vaccination, the recommendation updates likely contributed to the significant reduction in HAV outbreaks.

### **Building and Improving Surveillance Capacity**

Recent increases in cases of hepatitis C and the widespread hepatitis A outbreaks associated with person-to-person transmission that were first identified in 2016 highlight the importance of public health surveillance to identify and respond to outbreaks, and to better identify people at risk for infections. Due to under-identification and underreporting, the number of cases reported to CDC is an underestimate of the true number of cases occurring, and case reports do not always include sufficient demographic or risk information. Most states have laws that require reporting of hepatitis A, hepatitis B, and hepatitis C. However, the current volume of viral hepatitis cases overwhelms the existing surveillance capacity of most state and local health departments, as most do not have the resources to process the laboratory results and perform case investigations, classify cases, and act on the data. If the U.S. is to reverse the current trend of steady increases in reported acute hepatitis cases, improvements in surveillances and monitoring efforts are needed. Accurate and complete case identification is especially needed and requires proactive, direct engagement with providers, laboratories, and patients. These improvements would help to rapidly detect and prevent new viral hepatitis infections. They would also help ensure that hepatitis C-infected persons receive appropriate care and curative treatment to prevent transmission and avoid premature death. Currently, too few persons diagnosed with hepatitis C ([34% initiate treatment and get cured](#)).

During 2017 through 2020, CDC provided resources to 17 states to improve viral hepatitis surveillance case reporting and data quality. To ensure that more states and local jurisdictions have the capacity for high-quality, comprehensive viral hepatitis surveillance, in May 2021, CDC began providing funding to 59 jurisdictions (49 state and 10 county or city health departments, including the District of Columbia) to conduct viral hepatitis surveillance. In May 2023, CDC also published [hepatitis C cure cascade guidance](#), which provides standards for monitoring patients along all the steps from testing to treatment. CDC is working with states to implement these guidelines and ensure providers navigate patients through the entire cascade. These efforts, along with CDC's release of [updated surveillance guidelines](#), will further increase the number of states submitting quality data to CDC. In FY 2023, 32 states reported 2021 acute and chronic viral hepatitis data, an increase from the 30 that reported data in 2020, meeting the 2021 target of 32 (Measure 2.6.4). Please note that this measure reflects surveillance capacity before CDC's updated surveillance guidelines (August 2021) and expanded surveillance funding (May 2021) became available.

To further enhance syringe service programs (SSP) surveillance capacity, CDC included implementation and use of findings from an annual, nationwide survey as a component of its new *Strengthening Syringe Service Programs* funding agreement. The results from a separate baseline survey, completed in 2022, and all future surveys completed under the funding agreement, will be used by funding recipients to monitor and evaluate service delivery best practices, capacities, and challenges. They will also provide an evidence base for sustainable, proactive, and continuous SSP program improvements. Infectious disease activities measured by the survey include provision of viral hepatitis, HIV, and sexually transmitted disease testing services, vaccinations, and treatment.

### **Enhancing Surveillance and Prevention with State-of-the-Art Diagnostic Technologies**

CDC's viral hepatitis laboratory supports viral hepatitis surveillance, uses innovative research techniques to develop novel diagnostic methods, and studies how viruses replicate and cause disease. In support of this mission, the Association of Public Health Laboratories (APHL) convened a CDC-sponsored webinar in October 2021 to examine and identify the highest-priority diagnostic tools needed to advance hepatitis C elimination in the United States over the next five years. One such tool, HCV reflex testing, streamlines the process of hepatitis C diagnosis by enabling a single blood draw to establish the diagnosis of current HCV infection and reduce the number of appointments patients must make. To assess the extent to which major laboratories have adopted HCV reflex testing, CDC surveyed five large commercial laboratories in 2022, and found that all five labs had adopted the streamlined practice by 2022 (most had started several years prior). Considered alongside APHL's assessment of public health labs, the remaining gaps in adopting this streamlined process lie with smaller laboratories and improving provider awareness of reflex testing availability. To address these gaps, CDC released [updated operational guidance for HCV testing](#) in 2023 that includes a recommendation that hepatitis C testing be completed in a single healthcare visit and explicitly calls out hepatitis C antibody testing without HCV RNA testing of antibody-positive samples as incomplete testing. Finally, in support of state and local health department surveillance efforts, the viral hepatitis laboratory completed 15,000 viral hepatitis tests in 2022.

CDC continues to use its novel, web-based system, Global Hepatitis Outbreak and Surveillance Technology (GHOST), which allows investigators to identify genetic variants of hepatitis A and hepatitis C viruses and map patterns of their transmission. Public health laboratories from 27 states have been trained in using GHOST. This technology was used to investigate and track the spread of the recent (2017-2021), multi-state hepatitis A outbreaks. This modern molecular surveillance of viral hepatitis can be applied to other infectious diseases in the future and may help establish a platform for effective collaboration and communication across the public health system.

### **Sexually Transmitted Infections**

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**National Level Performance Measures and CDC Contextual Indicators for Long Term Objective: Reduce pelvic inflammatory disease in the United States**



Contextual Indicators	Most Recent Result
2.7.6e Increase the proportion of sexually active women aged 16-24 enrolled in commercial health plans who are screened for chlamydia infections	FY 2021: 48.8%
2.7.6f Increase the proportion of sexually active females enrolled in Medicaid plans who are screened for chlamydia infections: Females aged 16-24 years	FY 2021: 58.3%
2.7.7 Reduce the rate of symptomatic gonorrhea cases in men	FY 2021: 169.2

**Performance Measures for Long Term Objective: Reduce syphilis rates (all stages and congenital syphilis) in the United States**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
2.9.1 Reduce the rate of primary & secondary syphilis in women aged 15-44 (per 100,000 population) <sup>1</sup> (Outcome)	FY 2021: 16.3/100,000 Target: 10.03/100,000 (Target Not Met)	7.70/100,000	10.8/100,000	+3.1
2.9.2 Reduce the rate of congenital syphilis (per 100,000 live births) (Outcome)	FY 2021: 77.9/100,000 Target: 66.0/100,000 (Target Not Met)	60.3/100,000	57.6/100,000	-2.7
2.9.4 Increase the proportion of potential congenital syphilis cases averted (Outcome)	FY 2021: 63.5% Target: 75% (Target Not Met but Improved)	75%	75%	Maintain
2.9.5 Reduce the rate of primary and secondary syphilis (Outcome)	FY 2021: 16.2/100,000 Target: 13.5/100,000 (Target Not Met)	13.3/100,000	13.3/100,000	Maintain

<sup>1</sup> Baseline and targets updated to align with HHS Healthy People 2030 (STI-03).

**Performance Trends:** Sexually transmitted infections (STIs) impact the health of millions in the United States each year. Surveillance is key to understanding the magnitude of STIs in the United States and in subpopulations that are most affected. The overall number of reported STIs has been on the rise since 2013 and shows no sign of slowing, with infections disproportionately affecting young people under the age of 25, racial and ethnic minority groups, and gay or bisexual men. Reported cases of the three notifiable diseases for which there are federally funded control programs, chlamydia, gonorrhea, and syphilis, all increased between 2020 and 2021 – reaching a total of more than 2.5 million reported cases.

During 2020 to 2021, the chlamydia rate among men increased 6.9 percent (from 334.2 to 357.4 per 100,000) and the rate among women increased 2.4 percent (from 614.1 to 628.8 per 100,000). In 2021, the highest rate of reported chlamydia cases per 100,000 persons was among non-Hispanic Black or African American persons (1,081.9), followed by non-Hispanic American Indian or Alaska Native persons (650.6). During 2020 to 2021, the greatest increase in rate of reported chlamydia cases per 100,000 persons was among non-Hispanic persons of

multiple races (235.9 to 280.7; 19.0% increase). There were no increases in the rate of reported cases of chlamydia in any region during 2017 to 2021.

Although the number of chlamydia cases increased 4.1 percent from 2020 to 2021, the number of chlamydial infections diagnosed and reported in 2021 was still 9 percent lower than the number reported in 2019 (1,644,416 cases in 2021 vs 1,808,703 in 2019). Most people with chlamydia have no signs or symptoms and most cases are identified through screening at routine preventive care visits. Therefore, it is likely chlamydia was disproportionately affected by reduced screening during the pandemic, resulting in undiagnosed infections. Additionally, in response to reduced staffing resources, many health departments prioritized the diagnosis and treatment of syphilis and gonorrhea. This likely further reduced the number of chlamydia cases processed and reported.

Private and public health plans have improved screening rates for chlamydia, increasing slightly from 2020 to 2021 (commercially insured, 48.4% to 48.8% [Measure 2.6.7e]; Medicaid, 57.9% to 58.3% [Measure 2.6.7f]). Although chlamydia test rates are increasing among sexually active women aged 15-25 years, the slower growth in chlamydia testing rates may relate to the change in the 2009 American College of Obstetricians and Gynecologists (ACOG) Pap testing guidelines, and possibly increases in long-acting reversible contraceptives. Innovative approaches to conduct chlamydia testing during wellness and preventive visits apart from Pap testing are still needed. CDC is collaborating with the health care sector to increase adherence to existing recommendations and developing tools for providers to increase awareness and assist with chlamydia screening implementation.

In 2021, a total of 710,151 gonorrhea cases were reported. Rates of reported gonorrhea have increased 118% since the historic low in 2009. During 2020 to 2021, the overall rate of reported gonorrhea increased 4.6 percent. During 2020 to 2021, rates increased in three regions of the U.S. (Northeast, South, and West). During 2020-2021, the gonorrhea rate among men increased 6.3 percent (from 234.8 to 249.7 per 100,000) and the rate among women increased 2.4 percent (from 173.8 to 177.9 per 100,000). Since 2013, rates of reported gonorrhea have been higher among men compared to women, likely reflecting cases identified in both gay, bisexual, and other men who have sex with men (MSM) and men who have sex with women only. Although there are limited data available on sexual behaviors of persons reported with gonorrhea at the national level, enhanced data from jurisdictions participating in a sentinel surveillance system, the STD Surveillance Network (SSuN), suggest that about a third of gonorrhea cases occurred among MSM in 2021.

Rates of reported gonorrhea increased in most racial/Hispanic ethnicity groups, with the greatest increases observed among non-Hispanic Asian persons (30.2 to 37.8; 25.2% increase). There were no decreases in the rate of reported gonorrhea among any race/ethnicity group during 2017 to 2021. The rate of symptomatic gonorrhea cases in men decreased from 180.8 cases per 100,000 in 2020 to 169.2 cases per 100,000 in 2021 (Measure 2.7.7).

Antimicrobial resistance remains an important consideration in the treatment of gonorrhea. Gonorrhea can quickly develop resistance to antibiotics used to treat infection. Based on gonococcal isolates collected through sentinel surveillance in CDC's Gonococcal Isolate Surveillance Project (GISP), about half of all infections were estimated to be resistant or have elevated minimum inhibitory concentrations (MICs) to at least one antibiotic in 2021; however, almost all circulating strains in the U.S. remain susceptible to ceftriaxone, the primary recommended treatment for uncomplicated gonorrhea. Continued monitoring of susceptibility patterns to antibiotics is critical to inform gonorrhea treatment guidelines.

Reported rates of primary and secondary (P&S) syphilis, the most infectious stages of the disease, are the highest that they have been in more than 20 years. During 2020 to 2021, the P&S syphilis rate among women increased 55.3% (from 4.7 to 7.3 per 100,000) and the rate among men increased 22.9% (from 20.5 to 25.2 per 100,000). Rates of P&S syphilis increased in all racial/Hispanic ethnicity groups, with greatest increases among

non-Hispanic American Indian or Alaska Native persons who also had the highest P&S syphilis rate in 2021 (46.7 per 100,000). During 2020 to 2021, P&S syphilis rates increased in all regions of the United States.

CDC identified a new baseline (10.8/100,000) for reducing the rate of P&S syphilis among women aged 15-44 in 2020, which better reflects the current state of syphilis rates and efforts to reduce them. The rate has steadily increased from 8.7 cases per 100,000 in 2019 to 10.7 cases per 100,000 in 2020 and to 16.3 cases per 100,000 in 2021 (Measure 2.9.1). In 2021, the total rate of P&S syphilis across sexes increased to 16.2 cases per 100,000, missing the target (Measure 2.9.5), and the rate of increase rose to 28.6% (12.7 to 16.2) from 6.7 percent (11.9 to 12.7) in 2020.

CDC has made significant investments in all state and nine territorial and local public health STI programs that focus on surveillance, screening recommendations, epidemiologic studies, and disease intervention specialists. To prevent further increases of syphilis among women, disease intervention specialists play a critical role in identifying and responding to syphilis cases among women and their male partners through case interviews and contact tracing.

Congenital syphilis (CS) has become an alarming problem that urgently requires awareness, attention, and action. Data from the 2021 STD Surveillance Report<sup>255</sup> found that the number of CS cases spiked for the ninth year in a row. In 2021, there were a total of 2,855 cases. This increase represents a 32.4% increase relative to 2020 and a 754.8% increase relative to 2012. It has been more than two decades since this many cases were reported. In 2021, the CS rate was 77.9 cases per 100,000 live births (Measure 2.9.2), the highest reported rate since 1998, and short of the 2021 target. As has been observed historically, this increase in the CS rate has paralleled the rate of P&S syphilis among women of reproductive age during 2017-2021 (219.6%). CS is a preventable disease, which could be eliminated through consistent screening before and during pregnancy and timely treatment of infected women. Elimination of CS would contribute to reductions in lost pregnancies, stillbirths, infant deaths, and preterm/low birth weight infants. The proportion of potential congenital syphilis cases averted increased in 2021 to 63.5% from 62.5% in 2020 but missed the target (Measure 2.9.4).

The continued upward trajectory of most STIs into 2021 was expected as many individuals experienced delays in care and treatment due to reduced or suspended STI services, activities, and drug and test shortages during the COVID-19 pandemic. Because STIs often do not show symptoms, and screening is necessary for timely diagnosis and treatment, changes in access to sexual health care can affect the number of infections diagnosed and reported. Increased case counts seen in late-2020 and in 2021 may reflect an increase in service utilization as health care clinics re-opened and people sought care when available. Increases in diagnosed and reported cases could also reflect higher disease transmission. For example, due to reduced access to care, those with an STI may have had their infections longer, providing more opportunities to transmit infection to their sexual partners. STI program resources at the state, local, tribal, and territorial level, including STI case investigations, were also redirected to COVID-19.

Additionally, following the initial shelter-in-place orders, sexual behaviors like the frequency of new sex partners may have changed, causing STIs to spread in sexual networks. The impact of the COVID-19 pandemic likely continued in 2021 and, as a result, STI surveillance data collected during 2020 and 2021 should be interpreted cautiously. Although 2021 data predates the 2022 mpox outbreak, this public health emergency also monopolized STI program resources and threatened the health of those already disproportionately affected by STIs. Already strained health departments, including STI clinics, were seeing and diagnosing mpox cases, given that the virus spreads predominantly through person-to-person, including sexual, contact and the symptoms mimic symptoms of some STIs.

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<sup>255</sup> Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2021. Atlanta: U.S. Department of Health and Human Services; 2023.

Overall, STI cases increased 7 percent over five years, and health departments reported more than 2.5 million cases of chlamydia, gonorrhea, and syphilis to CDC in 2021. Aside from the consequences of the COVID-19 and mpox pandemics, data suggest that multiple factors may be contributing to the alarming increase in STIs: reduced access to STI prevention and care, including late prenatal care; decreases in condom use among vulnerable groups; and substance use.

Despite these disruptions and challenges, CDC supports the provision of quality STI services in both the public and private sectors through technical assistance, issuing and promoting clinical guidelines and recommendations, and providing education and training for health and medical professionals. CDC supports local efforts, such as disease intervention specialists, outbreak response teams, and training for health care providers, as well as community/partnership engagements. CDC's STI work also supports surveillance, case investigation, contact tracing, and connection to care for patients diagnosed with STIs and HIV, outbreak response, assurance of appropriate screening and treatment by providers, and providing reliable and trustworthy STI information to the public.

Screening improvements and investments in non-traditional evidence based and innovative STI prevention strategies will avert infections and improve national health outcomes, and will prove cost-effective due to the high, and increasing, economic burden associated with STIs and their related health consequences. With new STIs totaling nearly \$17.2 billion in lifetime direct medical care costs, including 2,500 new STI-attributable HIV cases annually at a cost of more than \$1.1 billion, evidence-based prevention, diagnostic, and treatment recommendations are critical to halting continued increases.

CDC's long-term STI objectives are to eliminate congenital syphilis, prevent P&S syphilis, prevent antimicrobial resistant gonorrhea, and prevent STI-related pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. PID is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Infections due to *Chlamydia trachomatis* and *Neisseria gonorrhoea* are major causes of PID. As part of CDC's flagship program among states, cities, and territories to prevent and control STIs, recipients prioritize activities to support the long-term objectives mentioned above while working to address STI-related outbreaks and reduce STI-related health disparities. Priority populations for these activities include adolescents and young adults, men who have sex with men, and pregnant people.

In 2021, half (50.5%) of reported cases of STIs were among adolescents and young adults aged 15 to 24 years. Disparities continue to persist in rates of reported STIs among some racial minority or Hispanic ethnicity groups when compared with rates among non-Hispanic White persons. In 2021, 31% of all cases of chlamydia, gonorrhea, and P&S syphilis were among non-Hispanic Black persons, even though they made up only approximately 12% of the US population.<sup>256</sup> Although American Indian or Alaska Native persons contributed only 0.7 percent of all live births in the US, they made up 3.6 percent of all congenital syphilis cases. MSM are disproportionately impacted by STIs, including gonorrhea and P&S syphilis; further, almost 40% of MSM reported with P&S syphilis had been diagnosed with HIV.

It is important to note that these disparities are unlikely explained by differences in sexual behavior and rather reflect differential access to quality sexual health care, as well as differences in sexual network characteristics. For example, in communities with higher prevalence of STIs, with each sexual encounter, people face a greater chance of encountering an infected partner than those in lower prevalence settings do, regardless of similar sexual behavior patterns. Acknowledging inequities in STI rates is a critical first step toward empowering affected groups and the public health community, to collaborate in addressing systemic inequities in the burden of disease — with the ultimate goal of minimizing the health impacts of STIs on individuals and populations.

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<sup>256</sup> US Department of Health and Human Services. Office of Minority Health. Profile: Black/African Americans. Available at: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61>

Using community engagement methods and partnerships to build local STI prevention and control capacity, CDC’s Community Approaches to Reducing Sexually Transmitted Diseases (CARS) initiative supports the planning, implementation, and evaluation of innovative, interdisciplinary interventions to extend the reach of STI prevention services. All strategies and activities address both individual and structural factors to promote community wellness that will facilitate better public health outcomes (e.g., STI screening coverage of chlamydia, gonorrhea, and syphilis and vaccination for hepatitis A and B, and human papillomavirus).

In 2021, CDC invested an additional \$1.5 million to fund four jurisdictions to develop, implement, and evaluate interventions to reduce CS locally. Recipients have worked to influence one or more of the critical opportunities for CS prevention during pregnancy, such as increasing use of prenatal care, more timely and targeted syphilis testing, and/or appropriate syphilis treatment upon syphilis diagnosis. One site partnered with a local jail to provide testing for women of reproductive age. During June 2023, the overall positivity rate was 26%, and the treatment completion rate was 73% with an additional 7 percent in progress to complete treatment. One site partnered with a prenatal clinic targeting pregnant persons experiencing homelessness or substance use disorders. At this clinic, 92% of patients diagnosed with syphilis completed treatment. Syphilis screening for women in emergency departments is also being pursued. In one month, this site conducted 1,144 syphilis tests in the emergency department and diagnosed 101 patients with syphilis. Of those, five were currently pregnant. In 2023, CDC published a Vital Signs focused on the increasing rates of CS and missed opportunities for prevention. Tailored prevention strategies are critical for addressing newborn syphilis disparities and CDC encourages public health leaders and healthcare providers with pregnant or reproductive-age patients to take specific actions to address increases in CS.

CDC funds and works with the National Network of STD Prevention Training Centers to improve knowledge of CS screening recommendations among healthcare providers, including screening at multiple points during pregnancy in high morbidity areas. In partnership with ASTHO, CDC convened a learning community, in the format of a community of practice, to help jurisdictions address CS. The learning community provided opportunities for peer-to-peer learning and information that state health department staff and leadership could use to develop strategies to address CS in their jurisdictions.

In 2023, CDC released a new campaign for STI Awareness Week to raise awareness about STIs and how they impact lives; to reduce STI-related stigma, fear, and discrimination; and to ensure people have the tools and knowledge for prevention, testing, and treatment. The campaign, along with the jointly released 2021 Sexually Transmitted Disease Surveillance Report, had a reach of 98.1 million (estimate of the potential total audience for this campaign on Twitter) on social media. The campaign included a suite of tools and resources that people can use to assess their personal risk of getting an STI, help people come up with a “game plan” before going out or using a dating app, and communication materials for partners.

In 2023, CDC supported the Sexually Transmitted Infections Impact Research Consortium (STIIRC) which aspires to undertake clinical trials and implementation science research aimed at reversing persistent, troubling trends in reported cases of STIs. Depending upon resource availability, CDC aims to support research to increase the population-level impact of STI prevention and control through public health programs and to improve health equity for populations disproportionately affected by STIs. The STIIRC is an exciting step to potentially beginning to fulfill that commitment and many of the challenges presented in the STI National Strategic Plan<sup>257</sup>.

In June 2023, HHS released the STI Federal Implementation Plan<sup>258</sup> for the STI National Strategic Plan, which outlines federal actions to reduce the burden of STIs through 2025. With the release of the STI Federal Implementation Plan, CDC and other federal partners continue to build on goals, objectives, and strategies of

<sup>257</sup> U.S. Department of Health and Human Services. 2020. Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025. Washington, DC.

<sup>258</sup> U.S. Department of Health and Human Services. 2023. Sexually Transmitted Infections Federal Implementation Plan for the United States: 2021–2025. Washington, DC.

the STI National Strategic Plan. CDC will continue to examine challenges from a health equity lens, address STI-related stigma, and take a syndemic approach to accelerate progress toward ending the STI, HIV, viral hepatitis, and opioid epidemics. CDC will also continue to support STI research, technology, and innovation. Actions involve addressing syndemic-related social determinants of health and implementing harm reduction strategies in STI care settings, as well as optimizing STI care services in Ending the HIV Epidemic (EHE) jurisdictions through identification of new HIV infections, individuals at higher risk for HIV, and PrEP-eligible individuals.

**Tuberculosis**

**Performance Measures for Long Term Objective: Decrease the rate of cases of tuberculosis (TB) among U.S. born persons in the United States**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
2.8.1 Decrease the rate of cases of tuberculosis among U.S.-born persons (per 100,000 population) (Outcome)	FY 2022: 0.80/100,000 Target: 1.1/100,000 (Target Exceeded)	0.5/100,000	0.5/100,000	Maintain
2.8.2 Increase the percentage of newly diagnosed TB patients who complete treatment within 12 months (where ≤12 months of treatment is indicated) (Outcome)	FY 2020: 89% Target: 92% (Target Not Met)	93%	93%	Maintain
2.8.3 Increase the percentage of culture-positive TB cases with initial drug susceptibility results reported (Outcome)	FY 2022: 93.2% Target: 98.5% (Target Not Met)	98.5%	98.5%	Maintain
2.8.4 For contacts to sputum acid-fast bacillus smear-positive TB cases who have started treatment for newly diagnosed latent TB infection, increase the proportion of TB patients who complete treatment (Outcome)	FY 2021: 81.2% Target: 75% (Target Exceeded)	80%	82%	+2

**Performance Trends:** In 2023, the United States reported a total of 8,331 tuberculosis (TB) cases (2.5/100,000 population) for 2022. Reported TB incidence rose 5.5 percent during 2022 compared with 2021 (2.4/100,000 population) but was lower than TB incidence in 2019 (2.7/100,000 population). TB incidence declined substantially in 2020 (2.2/100,000 population), coinciding with the COVID-19 pandemic, possibly due to delayed or missed TB diagnoses, changes in migration and travel, and mortality among persons susceptible to reactivation of a latent TB infection. Incidence rebounded in 2021 and appears to be returning to pre-pandemic levels. TB incidence appears to be returning to pre pandemic levels but concerns about missed or delayed diagnosis and ongoing effects of pandemic-related disruptions to public health persist.

Among persons born in the United States, the incidence rate in 2022 was 0.8/100,000 (Measure 2.8.1), which was unchanged from 2021. U.S. TB case rates remain at levels 25 times higher than the national goal of one case per million population, disproportionately affecting racial and ethnic minority populations and those spending time in close contact with one another, for example, in homeless shelters, correctional facilities, and long-term care facilities.

Treating TB disease until cured is credited with keeping multidrug-resistant (MDR) TB disease in the United States steady at approximately one percent of the total number of new TB cases per year. In comparison, the World Health Organization estimated that globally, 3.6 percent of new cases of TB were multi-drug resistant in 2022.<sup>259</sup> CDC and partners remain vigilant about finding and treating persons with active TB disease. In 2022 and 2023, CDC provided resources to currently funded states, cities, and territories to support TB screening, evaluation, and treatment for *Uniting for Ukraine (U4U)* participants. U4U is a process to provide Ukrainian citizens fleeing war a pathway to temporarily come to the U.S. According to WHO data, the TB rate in Ukraine is almost 30 times higher than in the U.S. and there is a high prevalence of drug resistant TB.<sup>260</sup>

CDC and its funded recipients use performance indicators to monitor programmatic activities that are tied to the U.S. goal of one TB case per million people. By monitoring progress against these indicators, CDC can determine where programs require additional technical assistance.

CDC supports public health laboratory testing for drug resistance and use of [Advanced Molecular Detection \(AMD\)](#)<sup>261</sup> tools to genetically map TB specimens to develop a database to better understand and halt the spread of the disease. For example, AMD methods have enabled CDC to identify extensive ongoing TB transmission within the United States, particularly among high-risk populations. In 2022, 93.2% of culture-positive TB cases underwent initial drug susceptibility testing, which is lower than the target of 98.5% (Measure 2.8.3).

In addition to preventing drug resistance, completion of treatment for TB disease immediately reduces the spread of TB. In 2020, 89.0% of patients with TB disease completed a curative course of treatment for TB within 12 months (Measure 2.8.2). Completion of therapy may be more difficult for people with health problems such as HIV infection, diabetes, substance use disorders, and persons experiencing homelessness or who have been incarcerated. In 2022, CDC released new interim guidance for a 4-month treatment regimen to treat drug-susceptible TB disease. The guidance is based on results from the largest drug-susceptible TB treatment trial that CDC has sponsored, with more than 2,500 participants enrolled at 34 clinical sites in 13 countries. Shortening treatment for TB disease benefits patients, families, healthcare providers and health systems. In 2023, CDC released new recommendations for the use of video Directly Observed Therapy (vDOT) that can help TB programs meet the U.S. standard of care for patients undergoing treatment, while using resources effectively.

CDC-funded recipients conduct contact investigations for every case of infectious TB disease, evaluating more than 30,000 people every year. CDC measures each step of the care cascade for people who were exposed to someone with infectious TB disease beginning with the identification of contacts, medical evaluation for TB disease or latent TB infection, and initiation of treatment as needed. CDC reported that in 2021, 81.2% of persons at highest risk for TB disease completed treatment for latent TB infection (Measure 2.8.4).

Untreated TB disease can be fatal. If sick people are not promptly diagnosed and treated, people in close contact with them will get sick as well. During FY 2023, TB programs continued to report lack of access to TB first-line drugs. The unstable supply is largely driven by the small number of manufacturers. When one company has an issue with production lines or decides to discontinue a product, there are few, if any other producers ready to compensate with increased production. Since 2016, through the HHS Program Support Center, CDC has

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<sup>259</sup> 2.3 Drug-resistant TB (who.int)

<sup>260</sup> TB profile (shinyapps.io)

<sup>261</sup> [Advanced Molecular Detection \(AMD\) and Response to Infectious Disease Outbreaks \(cdc.gov\)](#)

maintained a small stockpile of critical drugs used in treating TB disease and latent TB infection during an FDA-defined shortage.



## EMERGING AND ZONOTIC INFECTIOUS DISEASES

### Emerging Infectious Diseases

**Performance measure for Long Term Objective: Build and Strengthen health information systems capacity in state and local health departments**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.G Proportion of test orders and results processed through Electronic Test Orders and Result Reporting (ETOR) at the PHL (Output)	FY 2023: 54% Target: 60% (Target Not Met but Improved)	75%	80%	+5

**Performance measures for Long Term Objective: Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.3.3a Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR) in acute care hospitals (Outcome) <sup>1</sup>	FY 2022: 0.84 Target: 0.40 (Target Not Met but Improved)	0.92	0.841	-0.08
3.3.2b Reduce invasive healthcare-associated Methicillin-resistant Staphylococcus aureus (MRSA) infections <sup>2</sup> (Outcome)	FY 2021: 52,340 Target: 49,240 (Target Not Met)	43,090	41,040	-2,050

<sup>1</sup> Target based on 40% reduction by 2028 from 2023 baseline via the HHS HAI Action Plan.

<sup>2</sup> Rebaselined and targets updated to reflect 2020-2025 National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025 Objective 1.1

**Performance Measures for Long Term Objective: Improve vaccination safety and effectiveness**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.7.1 Increase the number of associations between vaccines and adverse health events evaluated to ensure the safety of vaccines used in the U.S.(Outcome)	FY 2022: 1,345 pairs Target: 1,200 pairs (Target Exceeded)	1,300	1,350	+50
3.I Percentage of Vaccine Events Reporting System (VAERS) reports received electronically (Output)	FY 2022: 96.4% Target: 93% (Target Exceeded)	99%	99%	Maintain

**Performance Trends:** Electronic Test Order Reporting (ETOR) replaces paper-based orders and results, which accelerates workflows at the public health labs; streamlines ordering from and sending results back to clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. While laboratories rapidly established ETOR solutions and reporting during the pandemic, as testing for COVID has slowed the proportion of reporting in FY 2023 at public health laboratories has plateaued (Measure 3.G). CDC anticipates continued future increases, but at a slower rate, as public health labs increase the number of tests available for ordering through web portals.

HAI-AR Prevention: CDC provides national leadership in healthcare-associated infection (HAI) and antimicrobial resistance (AR) prevention and provides the scientific foundation for preserving quality care, improving patient safety, and advancing U.S. healthcare practices. Adherence to CDC guidelines is the standard of care for HAI prevention of infections such as central line-associated bloodstream infection (CLABSI), catheter-associated urinary tract infection (CAUTI), surgical site infection (SSI), *Clostridioides difficile* infections (CDI), and invasive methicillin-resistant *Staphylococcus aureus* (MRSA) infections. In addition, many HAIs, including CLABSI can be caused by antimicrobial-resistant pathogens.

After several years of declining rates of HAIs, data from CDC's National Healthcare Safety Network (NHSN) showed increases in certain HAIs during 2020 and 2021, such as CLABSI, CAUTI, and invasive hospital-onset MRSA, including those caused by other antimicrobial-resistant pathogens like *Candida auris*.<sup>262,263</sup> For some of these infections, the increases seen in 2020 and 2021 present a strong contrast to the consistent declines in incidence observed prior to the COVID-19 pandemic. The COVID-19 pandemic had impacted hospitals, many of which faced extraordinary circumstances of increased patient caseload, staffing challenges, and other operational changes that may have limited the implementation and effectiveness of standard infection prevention and control practices. CDC continued to invest in its state and local HAI/AR programs to implement response and prevention activities throughout the pandemic. As a result, 2022 NHSN data have shown a decrease in these infections since 2021, as well as continued decreases for other HAIs.<sup>264</sup> The 2022 data highlight that strengthening infection prevention and control practices and building resiliency in these programs can be enhanced and expanded to withstand future pandemics or events that strain the healthcare system and return to the steady progress in improving patient safety.

Reducing HAIs across all healthcare settings supports HHS' mission to prevent infections, improve patient safety, combat AR and its complications, as well as reduce excess U.S. healthcare costs. These efforts also align with the White House National Biodefense Strategy,<sup>265</sup> the National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination (National HAI Action Plan),<sup>266</sup> National Action Plan for Combating Antibiotic Resistance Bacteria (CARB),<sup>267,268</sup> and Healthy People 2030 Goals. CDC did not meet its FY 2022 target for reducing the CLABSI SIR with a result of 0.84, representing a 16% decrease compared to the 2015 baseline and 9 percent reduction since 2021 (Measure 3.3.3a). This decrease was largely driven by reductions in infections reported from intensive care units (ICUs). As previously mentioned, the 2021 increase in CLABSI was likely due to the increased burden on healthcare providers and strain on infection prevention and control programs within healthcare facilities wrought by the COVID-19 pandemic.<sup>269,270</sup> CDC did meet other 2020 National HAI Action Plan targets, e.g., CAUTI and CDI. Similar to what CDC did with 2015 data, the agency will conduct a rebaseline of the SIRs based on 2022 data to update both the source of aggregate data and the risk adjustment methodology used to create the previous baselines to account for the differences in risk that may impact the number of infections reported by a hospital.<sup>271</sup> This process refreshes the data to account for policy, practice, and/or protocol changes that may need to be incorporated in the national data used for external benchmark comparisons and help drive the progress of preventing HAIs, as well as accounting for changes in the risk of HAIs since 2015.<sup>272</sup>

<sup>262</sup> <https://doi.org/10.1017/ice.2021.362>

<sup>263</sup> <https://doi.org/10.1017/ice.2022.116>

<sup>264</sup> <https://www.cdc.gov/hai/data/portal/progress-report.html>

<sup>265</sup> <https://www.whitehouse.gov/wp-content/uploads/2022/10/National-Biodefense-Strategy-and-Implementation-Plan-Final.pdf>

<sup>266</sup> <http://www.nejm.org/doi/full/10.1056/NEJMoa1408913>

<sup>267</sup> [https://obamawhitehouse.archives.gov/sites/default/files/docs/national\\_action\\_plan\\_for\\_combating\\_antibiotic-resistant\\_bacteria.pdf](https://obamawhitehouse.archives.gov/sites/default/files/docs/national_action_plan_for_combating_antibiotic-resistant_bacteria.pdf)

<sup>268</sup> <https://www.hhs.gov/sites/default/files/carb-national-action-plan-2020-2025.pdf>

<sup>269</sup> <https://doi.org/10.1017/ice.2021.362>

<sup>270</sup> <https://doi.org/10.1017/ice.2022.116>

<sup>271</sup> <https://www.cdc.gov/nhsn/2022rebaseline/index.html>

<sup>272</sup> <https://www.cdc.gov/nhsn/pdfs/rebaseline/22-Rebaseline-FAQs-Final-Version.pdf>

The FY 2024 and FY 2025 targets have been adjusted based on the new baseline and the proposed 2023-2028 National HAI Action Plan targets.<sup>273</sup>

The number of healthcare-associated MRSA cases in FY 2021 (Measure 3.3.2b), increased from the 2020 baseline to 52,340. Hospital onset MRSA infections increased significantly during 2021 due to the increased burden on healthcare personnel and strain on infection control programs within hospitals related to the COVID-19 pandemic, driving this increase in healthcare-associated MRSA cases. CDC will continue to provide support, technical expertise, and resources to public health and healthcare partners to reduce MRSA and CLABSI infections across healthcare settings, including continuing to monitor the long-term impact of the COVID-19 pandemic on infection prevention. Preliminary 2022 hospital onset MRSA data shows significant declines from 2021, potentially signaling future decreases in healthcare-associated MRSA cases. Targets for Measure 3.3.2b align with the [U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025 AR](#) overall reduction targets through FY 2025 and HAI action plan targets through FY 2027.

Immunization Safety: CDC is the nation's leading public health agency responsible for providing a safe, effective supply of all licensed vaccines approved for use in the United States. CDC conducts post-licensure vaccine safety monitoring on vaccines licensed and recommend for routine use in the public by ACIP. CDC uses the Vaccine Safety Datalink<sup>274</sup> (VSD) Network and the Vaccine Adverse Event Reporting System<sup>275</sup> (VAERS) to monitor vaccine safety, and, in 2021, introduced the v-safe smartphone-based tool as an active surveillance system for COVID-19 vaccines and developed additional tracking for mpox vaccinations. VAERS is a joint effort with the U.S. Food and Drug Administration (FDA). Together, these surveillance systems evaluate vaccine risks, monitoring any known and potential adverse events for new and existing vaccines, and rapidly detecting unusual patterns of vaccine adverse events.

In addition, VSD works with multiple integrated health systems to conduct vaccine safety pair studies to further assess whether any adverse health events are caused by vaccines. For example, to address safety questions for pregnant women and better understand health outcomes for individuals who receive COVID-19 vaccination during pregnancy, multiple VSD studies were done to review different health outcomes for those who received the COVID-19 vaccine during pregnancy versus those that were unvaccinated. One study provided additional evidence that pregnant women are at higher risk for severe illness from COVID-19 infection without the vaccine and found that COVID-19 vaccination during pregnancy was not associated with increased risk for preterm birth or small-for-gestational-age at birth. These VSD findings help address scientific knowledge gaps when there is limited information available and also strengthens existing evidence that COVID-19 vaccines are safe during pregnancy and support current U.S. vaccination recommendations for pregnant persons.

In FY 2022, there were 147 additional vaccine-adverse event pair studies conducted through VSD totaling 1,345 pair studies conducted to-date. This exceeds CDC's 2022 targets (Measure 3.7.1) and more than doubles the total vaccine-adverse event pair studies conducted since FY 2015. Data from VSD and other CDC studies show that the current U.S. vaccine supply is the safest in history.

VAERS serves as the nation's established 'early warning' system for post licensure vaccine safety for both routine immunizations and new vaccines (e.g., COVID-19 vaccines and respiratory syncytial virus (RSV) vaccines). Electronic submission of VAERS vaccine safety reports helps to improve program decision-making by increasing the timeliness, quality, and quantity of these vaccine safety reports and enhances CDC's ability to quickly evaluate and disseminate safety information to healthcare providers and consumers. For example, within three weeks of beginning the use of Johnson & Johnson (J&J)/Janssen COVID-19 vaccine in the United States, VAERS data identified reports of what would later be termed thrombosis with thrombocytopenia syndrome (TTS) after

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<sup>273</sup> <https://www.federalregister.gov/documents/2022/11/15/2022-24822/notice-for-public-comments-on-healthcare-associated-infections-hai-national-action-plan-targets>

<sup>274</sup> <http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/index.html>

<sup>275</sup> <http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html>

this vaccine, leading to a pause in the use of the vaccine as its safety was reevaluated. VAERS contributed key data showing that the risk of myocarditis after mRNA COVID-19 vaccination was outweighed by the consequences of COVID-19 disease. VAERS continues to provide timely and sensitive monitoring of COVID-19 and routine vaccine safety, and CDC and FDA use this data to inform vaccine policies and to raise awareness to clinicians and the public.

At this time, approximately 96.4% of all VAERS reports were submitted electronically in FY 2022, which exceeds 2021-2023 targets (Measure 3.I). Although the proportion of VAERS reports submitted electronically decreased between 2021 to 2022, this trend likely reflects less vaccination and a decrease in reporting of COVID-19 vaccines as these vaccines become integrated into routine vaccinations and are considered safe and effective. This is expected as there tends to be higher reporting volumes when vaccines are new and there is public attention on new vaccination programs. CDC and FDA continue to implement these information technology enhancements to further increase electronic reporting in VAERS. Improvements include updates to the VAERS reporting interface to facilitate electronic reporting and additional revisions to the VAERS form for more direct electronic reporting.

Vaccine safety is a vital part of the nation’s response to public health emergencies and outbreak responses including the COVID-19 pandemic, other respiratory virus responses, (e.g., RSV and influenza), and CDC’s 2022 Multi-National Monkeypox Outbreak Emergency Response. These core activities continue to be a critical part of CDC activities.<sup>276</sup> As new vaccines are developed and become available, the public’s knowledge of their safety, both initially and during extended use, is an important part of a successful national vaccination program. New vaccine safety systems have been developed, e.g., v-safe, and other data sources have been added to enhance CDC’s existing vaccine safety infrastructure. CDC and FDA have also scaled up VAERS for enhanced COVID-19 safety surveillance, and CDC and FDA expect an increase in electronic reporting to VAERS going forward. Taken together, these multi-layered systems have been leveraged for COVID-19 vaccines to form the most robust vaccine safety monitoring effort in U.S. history. VAERS and other vaccine safety systems continue to provide timely and sensitive monitoring of vaccines safety, including COVID-19 vaccines. CDC continues to monitor and evaluate reports received in VAERS and uses this data to inform vaccine policies and to raise awareness to clinicians and the public.

## Vector-Borne Diseases

### Performance measure for Long Term Objective: Protect Americans from Infectious Diseases—Vector-borne

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.H Number of states that report tick surveillance data to CDC’s vector surveillance system (ArboNET) (Output)	FY 2023: 36 Target: 35 (Target Exceeded)	38	40	+2

**Performance Trends:** CDC serves as a national and international leader in the prevention of vector-borne viral, bacterial, and rickettsial diseases. Vector-borne diseases are now some of the most common nationally reported diseases in the United States, with cases rising with the expansion of mosquito and tick vectors and more vector-borne pathogens discovered or introduced in the United States. Approximately three-quarters of reported vector-borne disease cases are tickborne disease cases. This measure reflects state capacity to conduct tick surveillance, which is a vital component to preventing and controlling tickborne disease and one of the core competencies for prevention and control. Vector surveillance allows public health departments to know which

<sup>276</sup> Duffy J, Marquez P, Moro P, et al. Safety Monitoring of JYNNEOS Vaccine During the 2022 Mpox Outbreak — United States, May 22–October 21, 2022. MMWR Morb Mortal Wkly Rep 2022;71:1555–1559. DOI: <http://dx.doi.org/10.15585/mmwr.mm7149a4>

vectors are present in their area, which informs the selection and implementation of vector-borne disease prevention programs.

In FY 2022, CDC exceeded the target of having 35 states report tick surveillance data to CDC's vector surveillance system (Measure 3.H). A total of 36 states, plus the District of Columbia, reported tick surveillance data to CDC in FY 2023, justifying last year's adjustment for a more FY 2023 aggressive target. The more rapid success that the program achieved can be attributed to continued increases in FY 2021-2023 CDC funding that was used to support vector surveillance within states and CDC's increase in the provision of technical assistance to support this activity within these states. We are getting increasingly close to reaching our ultimate long-term objective of having all states with medically relevant ticks contributing tick surveillance data to CDC's national ArboNET system (49 states). As we get closer to reaching this objective, we are working with the states that may have the most difficult barriers to conducting tick surveillance and reporting these data to CDC. It is for this reason that our pace on increasing this metric has begun to slow and is expected to level off at 49 states.

## Antimicrobial Resistance

### Performance measure for Long Term Objective: Reduce the spread of antimicrobial resistance

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.2.3b Maintain the proportion of hospitals with carbapenem-resistant <i>Klebsiella</i> spp. Or <i>Escherichia coli</i> ( <i>E.coli</i> ) healthcare-associated infections (Outcome)	FY 2022: 3.2% Target: 7.0% (Target Exceeded)	7.0%	7.0%	Maintain
3.2.4b Reduction in hospital-onset <i>Clostridioides difficile</i> infections standardized infection ratio (SIR) (Outcome) <sup>1</sup>	FY 2022: 0.48 Target: 0.50 (Target Exceeded)	0.96	0.92	-0.04

<sup>1</sup> Revised baseline in 2022, but may be revised once 2023 baseline is developed

**Performance Trends:** CDC is a leader in the fight to combat antimicrobial resistance (AR). CDC is committed to protecting America's health, safety, and interests through science, surveillance, and services. AR is a growing threat internationally, and some antimicrobial-resistant infections are already untreatable.

Carbapenem-resistant Enterobacterales (CRE), "the nightmare bacteria," are a group of bacteria resistant to almost all drugs. Because of limited treatment options, CRE bloodstream infections can be fatal in nearly half of all cases. CDC is revising its CRE measure to include data on additional carbapenems. This will broaden CDC's view of the data and provide additional context to improve prevention and track national and regional efforts to prevent infections and contain resistance. In FY 2022, the proportion of all *E.coli* or *Klebsiella* spp. that are carbapenem-resistant causing CLABSI or CAUTI in adult patients was 3.2 percent (Measure 3.2.3b). CDC continues to implement Containment Strategy, through CDC's AR Solutions Initiative, and continues to make investments to better detect, track, and respond to CRE infections at the state and local levels and in Puerto Rico.

*Clostridioides difficile* infection (CDI)<sup>277</sup> is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient healthcare settings. Infections occur most often in people who have taken antibiotics for other health conditions. CDC provides data-driven strategies and tools for targeted intervention to the healthcare community to help prevent CDI, as well as resources to help the public safeguard their own health. These strategies to reduce CDI include improving antibiotic use, infection control, and healthcare facility cleaning and disinfection. CDI prevention is a national priority, with a 2020 target to reduce CDI overall by 50%

<sup>277</sup> <http://www.nejm.org/doi/full/10.1056/NEJMoa1408913>.

in the National Action Plan for CARB and reduce hospital-onset CDI by 30% in the current National HAI Action Plan.<sup>278</sup> In FY 2022, the SIR for hospital-onset CDI was 0.48 (Measure 3.2.4b), exceeding not just the 2022 target, but also surpassing the 2020 HAI Action Plan CDI goal. CDI reductions have slowed the last few years, highlighting the need for ongoing improvement efforts. As previously mentioned, CDC will be conducting a rebaseline of the SIRs. As such, the FY 2024 target will be adjusted based on the new 2023 baseline. The FY 2024 and subsequent targets will be based on decreases aligning with the proposed 2023-2027 HAI National Action Plan Targets.<sup>279</sup>

**Food Safety**

**Performance measures for Long Term Objective: Protect Americans from infectious diseases – foodborne illnesses**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.C Increase the epidemiologic capacity of ELC Section F1 recipients for <i>Salmonella</i> , <i>Listeria</i> , and <i>Shiga</i> Toxin-producing <i>E. coli</i> (STEC), surveillance and outbreak investigations (Output)	FY 2022: 61.1% Target: 85% (Target Not Met)	85%	85%	Maintain
3.D Percentage of isolates of priority PulseNet pathogens ( <i>Salmonella</i> , <i>Shiga</i> toxin-producing <i>E. coli</i> , and <i>Listeria monocytogenes</i> ) sequenced and uploaded to the PulseNet National Database (Output)	FY 2022: 84% Target: 80% (Target Exceeded)	85%	90%	+5
3.E Increase the percentage of cases with positive culture-independent diagnostic tests (CIDTs) for <i>Shiga</i> toxin-producing <i>E. coli</i> (STEC) and culture isolation attempted or specimen metagenomics obtained (Output)	FY 2022: 83% Target: 90% (Target Not Met)	90%	90%	Maintain

**Performance Trends:** CDC estimates the burden of foodborne disease in the United States. to be approximately 48 million cases per year (one out of every six Americans), 128,000 hospitalizations, and 3,000 deaths per year. Foodborne disease is mostly preventable but controlling and preventing outbreaks requires that we understand the foods and settings that cause illness. Fast and effective outbreak investigations are needed to identify and remove contaminated food from the market to prevent additional illnesses and improve the safety of the nation’s food supply.

CDC’s PulseNet transitioned to whole genome sequencing (WGS) in 2019 as the gold standard for foodborne outbreak detection and surveillance. Since then, the bioinformatics demands for processing data have expanded. In 2023, CDC began transitioning to PulseNet 2.0, a cloud-based open-source analytic platform to enhance data analysis, management, and visualization capabilities of WGS data for outbreak detection and surveillance. These improvements will streamline how CDC stores, processes, accesses, and shares data to detect outbreaks earlier and faster. Additionally, PulseNet 2.0 will improve efficiency and reduce the time

<sup>278</sup> <https://health.gov/hcq/prevent-hai-action-plan.asp>.

<sup>279</sup> <https://www.federalregister.gov/documents/2022/11/15/2022-24822/notice-for-public-comments-on-healthcare-associated-infections-hai-national-action-plan-targets>

needed to upload and analyze sequence data while preserving the core functions of PulseNet to identify and monitor outbreaks.

Data indicates in FY 2022, 84% of isolates of priority PulseNet pathogens (*Salmonella*, *Shiga* toxin-producing *E. coli* (STEC), and *Listeria monocytogenes*) were sequenced and uploaded to the PulseNet National Database (Measure 3.D). These data exceeded the FY 2022 target, in part, because changes in state public health laboratories’ workflows, has allowed labs to improve efficiencies to sequence most of their PulseNet organisms.

Every year, over 175 multistate clusters of foodborne disease are identified, which, in turn, will need to be investigated to determine if they are outbreaks. CDC invests in improving interview capacity in state and local health departments to improve the availability of data for multistate foodborne outbreak. Tracking state epidemiologic interview capacity is important to help identify and address challenges in the availability of epidemiologic data critical for multistate foodborne outbreak investigations. The FY 2022 result of 61.1% of cases interviewed in multistate outbreaks of *Salmonella*, *Listeria*, and STEC (Measure 3.C) is below the FY 2022 target (85%). This may indicate a lack of staffing capacity to conduct all interviews due to turnover and difficulty hiring as well as insufficient training once positions have been filled. Additionally, there has been an increase in patients that are unreachable or refusing to be interviewed. All jurisdictions continued to report disruption of routine enteric disease activities due to mpox and the ongoing impact of COVID-19. This included staff being reassigned and decreased capacity to conduct enteric disease interviews and investigations. Continuing to monitor this measure will provide insight into capacity changes and challenges following COVID-19 and mpox.

Recent changes in diagnostic practices at clinical laboratories across the United States to more culture-independent methods is challenging CDC's ability to find outbreaks and monitor disease trends. Culture-independent diagnostic tests (CIDTs) are commonly used by physicians to rapidly diagnose their patients’ diseases. These tests do not provide the data needed by CDC to link cases to outbreaks unless laboratories perform additional testing to isolate cultures, a process called reflex culture. Tracking the increased use of CIDTs and the proportion of specimens for which reflex culture is performed is important to better understand surveillance data on enteric bacteria, identify foodborne disease outbreaks, and inform program decisions.

FY 2022 data show that in about 83% with positive CIDTs for STEC culture isolation was attempted or specimen metagenomics were obtained (Measure 3.E). This is below the FY 2022 target and indicates a lack of resources for state and local health departments related to reflex culture procedures.

**National Healthcare Safety Network**

**Performance measure for National Healthcare Safety Network**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.3.4 Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (Output)	FY 2022: 38,350 Target: 36,000 (Target Exceeded)	37,000	38,000	+1,000

**Performance Trends:** CDC’s National Healthcare Safety Network (NHSN) is the nation’s most comprehensive and widely used surveillance and quality improvement system to identify emerging and enduring threats across healthcare, such as COVID-19, healthcare-associated infections (HAIs), and antimicrobial-resistant infections. NHSN data drive HAI prevention and improve quality of care at local, state, and national levels, supporting goals mentioned in the White House National Biodefense Strategy, the National Action Plan for CARB, Healthy People 2030, and the HHS HAI Action Plan to protect American lives. NHSN data are also used by the following partners:

- Healthcare professionals and health systems to improve the quality of patient care
- Health departments to comply with reporting requirements and target HAI prevention efforts
- The Administration for Strategic Preparedness and Response (ASPR) to provide supply and medical countermeasure assistance to jurisdictions and healthcare facilities
- The Centers for Medicare and Medicaid Services (CMS) to implement and tailor interventions through CMS' improvement programs (e.g., Quality Improvement Networks and Hospital Improvement Innovation Networks) to prevent infections in all healthcare settings, and
- The Agency for Healthcare Research and Quality to evaluate HAI implementation strategies in healthcare.

CDC continues to enroll and provide support for healthcare facilities in NHSN to report HAIs, including those caused by antimicrobial-resistant bacteria. To provide essential data for the COVID-19 response, CDC developed additional reporting modules for both hospitals and nursing homes. Following the enactment of CMS COVID-19 reporting requirements for nursing homes, as of July 2023, there are over 38,300 facilities reporting patient safety and/or COVID-19 data in NHSN (Measure 3.3.4). This includes all hospitals, more than 7,800 dialysis facilities, more than 5,700 outpatient clinics, and more than 17,600 nursing homes and other long term care facilities, including around 15,400 CMS-certified long term care facilities. In addition, CDC tracks the whole scope of critical HAIs/AR infections (e.g., MRSA, CLABSI, CAUTI, SSI, and CDI) being captured in NHSN by healthcare facilities as well as the number of reporting modules (e.g., antimicrobial use and antimicrobial resistance data) being used across multiple healthcare settings to prevent infections, enhance healthcare quality, and improve patient care. CDC continues efforts to modernize NHSN, automate reporting, decrease reporting burden, and increase its value to providers and partners. FY 2025 targets were chosen to encourage continued participation of nursing homes in other NHSN patient safety modules, in addition to their newly mandated participation in COVID-19 reporting modules. However, additional changes to state and CMS quality reporting requirements and programs could lead to changes in the number of facilities participating in NHSN.

## Quarantine and Migration

**Performance measures for Long Term Objective: Prevent the importation of infectious diseases to the U.S. in mobile human, animal, and cargo populations**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
3.4.9 Maintain the number of U.S. ports of entry that have demonstrated a validated capability to respond to a communicable disease event involving mobile populations in the previous 3 years (Output)	FY 2023: 51 Target: 49 (Target Exceeded)	51	51	Maintain

**Performance Trends:** CDC enhances the public health security of U.S. communities and addresses infectious disease risks associated with international travel and globally mobile populations by preventing the importation and spread of disease into and within the U.S. CDC Port Health Stations are strategically located at 20 ports of entry and land-border crossings that cover approximately 80% of international travelers arriving in the United States. Port health protection officers are available 24/7 and rapidly respond to health threats to prevent further spread of communicable diseases.

Having a validated capability to respond to communicable disease events involving travelers at U.S. ports of entry is integral to CDC's preparedness for the next outbreak. In FY 2023, CDC continued its multi-year strategic focus of validating communicable disease event capabilities at ports of entry across the nation. Each station's jurisdiction covers the port of entry where it is located and numerous regional sub-ports to ensure full public health coverage for all U.S. ports of entry for arriving international travelers. Port health station officials often



need to direct the public health response remotely, usually via emergency medical service units and local public health authorities, and to work closely with other ports in their respective jurisdictions and state and local public health partners.

Performing this task is made more effective, efficient, and resilient over time if all ports of entry can routinely demonstrate validated public health response capabilities. In FY 2023, the number of U.S. ports of entry (POEs) that demonstrated a validated capability to respond to a communicable disease event involving mobile populations increased to 51 (Measure 3.4.9). CDC exceeded the FY 2023 target despite the challenges and resources required to respond to the COVID-19 pandemic, the 2022-2023 Uganda Ebola outbreak, and the 2023 Marburg outbreak in Equatorial Guinea and Tanzania. CDC has continued its use of a “priority sub port” strategy based on travel volume and the status of preparedness plans to target POEs nearing a validated capability and to identify and recruit advocates at each CDC Port Health Station to serve as the lead for validating capabilities within their respective jurisdictions. CDC is also evaluating the COVID-19 response, mpox response, and Ebola response with respect to the availability of CDC and local resources, to determine if any sub-ports engaged in the response were able to demonstrate a validated capability. However, given its involvement in ongoing outbreaks, CDC will keep the FY 2025 target level with the FY 2024 target.

## CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

### Tobacco Prevention and Control

**Performance Measures for Long Term Objective: Reduce death and disability due to tobacco use**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.6.2a Reduce the annual adult per-capita combustible tobacco consumption in the United States (Intermediate Outcome)	FY 2022: 847 Target: 755 (Target Not Met but Improved)	631	570	-61
4.6.3 Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers (Intermediate Outcome)	FY 2022: 11.5% Target: 10.7% (Target Not Met but Improved)	9.2%	8.4%	-0.8
4.6.4 Increase proportion of the U.S. population that is covered by comprehensive state and/or local laws making workplaces, restaurants, and bars 100% smoke-free (no smoking allowed, no exceptions) (Intermediate Outcome)	FY 2022: 62.5% Target: 67.2% (Target Not Met but Improved)	71.1%	73.1%	+2
4.6.5a Reduce the proportion of adolescent’s grades 6 through 12 who are current users of any tobacco product (Outcome)	FY 2023: 10% Target: 13.6% (Target Exceeded)	13.6%	13.6%	Maintain
4.6.8 Increase the proportion of ever cigarette smokers aged ≥ 18 years who are former cigarette smokers (quit ratio) (Outcome)	FY 2022: 65.9% Target: 66.3% (Target Not Met)	68.6%	69.7%	+1.1

**Performance Trends:** Although cigarette smoking remains the leading cause of preventable disease and death in the United States, the tobacco<sup>280</sup> product landscape continues to diversify and includes multiple tobacco products such as, e-cigarettes (including multiple types of e-cigarettes), cigars, cigarillos and little cigars, pipe

<sup>280</sup> References to tobacco refer to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

tobacco, roll-your-own tobacco, and hookah. The annual adult per capita combustible tobacco product consumption decreased from 942 cigarette equivalents in FY 2021 to 847 cigarette equivalents in FY 2022 (Measure 4.6.2a). Additionally, the percentage of adults who currently smoked cigarettes decreased from 20.6% in 2009 to 11.5% in FY 2022, an improvement from 14% in FY 2019 (Measure 4.6.3).

Nearly all tobacco product use begins during youth and young adulthood. Youth use of tobacco products in any form is unsafe, irrespective of whether it is smoked, smokeless, electronic, or in another form (e.g., oral nicotine products). In 2023, an estimated 2.8 million (10.0%) U.S. middle and high school students currently used any tobacco product (Measure 4.6.5a), with 940,000 (3.4%) reporting current use of 2 or more tobacco products. E-cigarette use among youth remains a public health concern. For the 10<sup>th</sup> year, e-cigarettes have been the most commonly used tobacco product among youth. In 2023, 10% of high school students (1.56 million) and 4.6% of middle school students (550,000) currently used e-cigarettes.<sup>281</sup> While the 2022 and 2023 National Youth Tobacco Survey (NYTS) estimates may be compared for the same population groups, the youth tobacco product use target remains unchanged until CDC can reestablish the target baseline with a minimum of three comparable data points. This is due to changes in survey administration and data collection methods, initially necessitated by the COVID-19 pandemic.

The tobacco industry uses tactics that appeal to youth, such as marketing and price promotions. Most young people who use tobacco products want to quit. CDC efforts to address tobacco use among youth include 1) continuing to monitor tobacco use trends, including through the NYTS; 2) educating the public about the risks of youth use of tobacco, including e-cigarettes; and 3) supporting state and local tobacco prevention and control efforts through the National Tobacco Control Program.

The adverse health effects of tobacco smoking are not limited to the person who smokes. Exposure to secondhand smoke from burning tobacco products causes significant disease and death; there is no risk-free level of secondhand smoke exposure. The percentage of the population covered by comprehensive smoke-free laws that prohibit smoking in all indoor areas of private worksites, restaurants, and bars has increased substantially over the past two decades. As of January 1, 2023, 62.5% of all U.S. residents are covered by comprehensive smoke-free laws at the state or local level (Measure 4.6.4), missing the FY 2022 target, but improving from FY 2021. While progress has been made, nearly 38% of the U.S. population is still not protected by state or local level comprehensive laws; moreover, only 28 states, American Samoa, the District of Columbia, the Marshall Islands, Puerto Rico, and the U.S. Virgin Islands have adopted such laws as of September 30, 2023.

CDC will continue to supply credible evidence showing the dangers of secondhand smoke, as well as proven interventions to reduce exposure, which provide a strong foundation for state and community efforts to promote smoke-free environments. CDC research contributes to the evidence base that informs the activities of CDC's National Tobacco Control Program (NTCP), the only nationwide investment that supports all 50 states, the District of Columbia, eight U.S. territories, and 26 tribal organizations for comprehensive tobacco control efforts including reducing secondhand smoke exposure.

Smoking cessation reduces both the risk of premature death as well as the risk of many adverse health events. CDC connects people who smoke with resources to help them quit, including a free quitline portal, 1-800-QUIT-NOW, which links callers to their state quitline, as well as web-based, text-based, and app-based cessation support resources. Evidence-based web and text-based services are an important complement to 1-800-QUIT-NOW, as texting services may reach people who want additional quit support but may be less likely to call a quitline.

CDC's *Tips*<sup>®</sup> *From Former Smokers*<sup>®</sup> (*Tips*<sup>®</sup>) campaign, the first federally funded national tobacco education campaign, has been on air since 2012. *Tips* profiles real people who are living with serious long-term health

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<sup>281</sup> Birdsey J, Cornelius M, Jamal A, et al. Tobacco Product Use Among U.S. Middle and High School Students — National Youth Tobacco Survey, 2023. *MMWR Morb Mortal Wkly Rep* 2023;72:1173–1182.

effects due to smoking and secondhand smoke exposure. *Tips* is effective at increasing calls to 1-800-QUIT-NOW and at helping people quit. From 2012-2022, the *Tips* campaign was associated with more than 1.95 million additional calls to 1-800-QUIT-NOW. In addition, from 2012-2018, CDC estimates more than 16.4 million people who smoke attempted to quit and approximately 1 million successfully quit because of the *Tips* campaign. The average weekly call volume to 1-800-QUIT-NOW during the 29-week 2023 campaign was over 40% above the baseline measurement of three weeks prior to the launch of the campaign. Call volume was 11% higher during weeks when *Tips* TV ads featured promotion of nicotine replacement therapy (NRT) than during other campaign weeks when NRT promotion was not featured on TV and digital ads, including weeks when media were paused. In addition, during the 2023 campaign, 6,260 people opted into text-based cessation services via the texting portal (English and Spanish). Among those, nearly 1,800 opt-ins can be attributed to the 2023 *Tips* campaign promotion.

Recent findings indicate that the quit ratio, or the proportion of people ≥18 years of age who formerly smoked cigarettes among those who ever smoked, has decreased slightly, although this had consistently increased in previous years. In FY 2022, the quit ratio was 65.9%, a slight decrease from 66.5% in FY 2021 (Measure 4.6.8). In FY 2025, CDC will continue to provide resources to state quitlines, as well as state tobacco control programs, as part of its National Tobacco Control Program and fund year 3 of a community-based program to increase awareness of cessation services and coverage options among populations experiencing health disparities. In addition, CDC will continue the *Tips* campaign on national TV, radio, print, digital, and out-of-home media.

### Nutrition, Physical Activity, and Obesity

**Performance Measures for Long Term Objective: Promote evidence-based interventions to improve nutrition, increase physical activity, and reduce obesity**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.11.7 Increase the proportion of infants that are breastfed at 6 months (Intermediate Outcome)	FY 2020 58.2% Target: 65.5% (Target Not Met but Improved)	65.9%	66.0%	+0.1
4.11.8a Increase the contribution of vegetables to the diets of the population aged 2-18 years (cup equivalents per 1,000 calories) <sup>1</sup> (Intermediate Outcome)	FY 2020: N/A2 Target: 0.51	0.55	N/A	N/A
4.11.8b Increase the contribution of vegetables to the population aged 19 years and older (cup equivalents per 1,000 calories) <sup>1</sup> (Intermediate Outcome)	FY 2018: N/A2 Target: 0.82	0.86	N/A	N/A
4.11.9 Increase the proportion of adults (age 18 and older) that engage in leisure-time physical activity <sup>1</sup>	FY 2022: 73.7% Target: 74.7% (Target Not Met)	75.5%	N/A	N/A

(Intermediate Outcome)				
4.11.10a Reduce the age-adjusted proportion of adults (age 20 years and older) who have obesity <sup>1</sup> (Intermediate Outcome)	FY 2020: N/A <sup>2</sup> Target: 41.9%	40.9%	N/A	N/A
4.11.10b Reduce the proportion of children and adolescents (ages 2 through 19) who have obesity <sup>1</sup> (Intermediate Outcome)	FY 2020: N/A <sup>2</sup> Target: 18.8%	17.8%	N/A	N/A
4.U Increase the average percentage of obesity prevention standards fully met across states for licensed Early Care and Education (ECE) centers (Output)	FY 2022: 31.7% Target: 32.5% (Target Not Met but Improved)	34.5%	35.5%	+1

<sup>1</sup> Targets and results are reported biennially

<sup>2</sup> Due to the COVID-19 pandemic, NHANES did not collect the regular FY 2020 data. Regular data reporting will resume with FY 2024 data.

**Performance Trends:**

**Breastfeeding:** The proportion of infants that are breastfed at six months (Measure 4.11.7) increased from 46.6% in 2009 to 58.2% in 2020, improving but missing the target of 65.5%. To meet its targets, CDC will continue to support birthing hospitals, worksites, and communities to implement policies and practices that help women breastfeed and address racial disparities in breastfeeding. CDC increased efforts to support breastfeeding in communities by focusing on continuity of care, including increasing equitable access to lactation resources and culturally congruent lactation support within the communities. CDC continues to support capacity building of communities and breastfeeding coalitions to implement sustainable policy, systems, and environmental improvements focused on promoting and supporting breastfeeding. CDC funds states, communities, and organizations with national reach to improve access to breastfeeding supports. These investments contributed to improvements in initiation and duration of breastfeeding. CDC funded activities have contributed to about 1 million babies being born per year in over 600 hospitals with supportive breastfeeding practices across 50 states, District of Columbia., and Puerto Rico. This accounts for 27% of babies born annually in the U.S.

**Healthy Eating:** The total vegetable intake remains low for all populations. Due to the COVID-19 pandemic, NHANES did not collect the regular FY 2020 data. Instead, the National Center for Health Statistics released a combined 2017-2018 plus 2019 - pre pandemic (March 2020) data set and estimates in June 2021 which showed children aged 2-18 years consumed 0.48 cup equivalents of vegetables per 1,000 calories and adults consumed 0.82 cup equivalents per 1,000 calories (Measures 4.11.8a-b)<sup>282</sup>. Making progress in improving diet is challenging given the complex and multiple factors that influence the marketing of, access to, affordability of, and

<sup>282</sup> <https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating/increase-vegetable-consumption-people-aged-2-years-and-older-nws-07/data>

consumption of both healthy and less healthy food options. CDC will continue to work with state, local, tribal, and territorial health departments to help worksites, schools, childcare, and community settings to support access to healthy food and beverage choices for people of all ages.

**Active Living:** The proportion of adults who engage in leisure-time physical activity increased from 63.8% in FY 2008 to 74.6% in FY 2018. The National Health Interview Survey changed the survey question and methodology after FY 2018, and as a result, data collected after FY 2018 cannot be compared to previous results. A new baseline (73.9%) was established in FY 2020 using the updated question and methodology (Measure 4.11.9). In FY 2022, there was a slight decrease (73.7%) from the FY 2020 baseline, however additional years of data are needed to confirm if this is a true decline. CDC's Active People, Healthy Nation<sup>SM</sup> is a national initiative to help 27 million Americans become more physically active by 2027. CDC funds states, communities, and organizations with national reach to improve access to safe and convenient places for physical activity. In addition, CDC trains states and communities to implement strategies to improve the walkability of communities. For example, the CDC funded *Active People, Healthy Nation<sup>SM</sup> Walkability Action Institutes* has trained cross-disciplinary teams representing public health, planning, transportation, elected officials, and other disciplines in 79 jurisdictions in 32 states and two territories. As a result of the training, the jurisdictions cumulatively achieved over 850 outcomes related to improving walkability with a focus on community and transportation design for over 41 million Americans (e.g., adopting Complete Streets policies and revising Comprehensive Land Use plans). CDC will continue to promote the critical need for safe and convenient places for physical activity and help implement high impact strategies for walking and walkable communities like Complete Streets and Safe Routes to Schools.

**Adult Obesity:** In adults, NHANES data show 42.4% had obesity in 2017-2018 (Measure 4.11.10a). Due to the COVID-19 pandemic, NHANES did not collect the regular FY 2020 data. Instead, the National Center for Health Statistics released a combined 2017-2018 plus 2019 - pre pandemic (March 2020) data set and estimates in June 2021 which showed 41.9% of adults had obesity<sup>283</sup>. However, these data are not independent of the prior FY 2018 results. CDC will continue to support recipients in implementing evidence-based strategies to help increase healthy eating and active living through partnerships with states, territories, tribes, and communities throughout the U.S.

**Child/Adolescent Obesity:** The percentage of all children and adolescents (ages two to 19 years) that have obesity was 16.8% in FY 2008 and 19.3% in FY 2018 (Measure 4.11.10b). Due to the COVID-19 pandemic, the National Health and Nutrition Examination Survey (NHANES) did not collect the regular FY 2020 data. Instead, the National Center for Health Statistics released a combined 2017-2018 plus 2019 - pre pandemic (March 2020) data set and estimates in June 2021. These data are not independent of the prior FY 2018 results. These data showed that 19.7% of children aged 2 through 19 years had obesity. Research shows behaviors that influence excess weight gain include early infant weight gain, lack of responsive feeding approaches, eating high-calorie, low-nutrient foods and beverages, physical inactivity, sedentary activities such as watching television or other screen devices, medication use, and sleep routines. CDC funds several interventions that target obesity prevention as well as other related chronic diseases. To meet its targets, CDC will continue promoting good nutrition and physical activity in children and adolescents, caregivers, and individuals to help prevent obesity and other chronic diseases.

In addition, CDC's third Childhood Obesity Research Demonstration project (CORD 3.0), increased the availability and number of packaged, effective Family Healthy Weight Programs (FHWPs) with 5 scalable, sustainable, evidence based FHWPs for implementation in a broad range of settings that serve low-income children and families. FHWPs are evidence-based, multicomponent, family centered lifestyle programs that promote health and weight reduction for children living with excess weight, and their caregivers. Over the 2023-2028 cycle, 57 CDC funded recipients will work to implement FHWPs in clinical and community setting throughout the United States such as federally qualified health centers (FQHCs) and community health centers. Early Care and

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<sup>283</sup> <https://stacks.cdc.gov/view/cdc/106273>

Education (ECE): Of the 21.2 million children from birth through age 5, approximately 3 in 5 (about 12.5 million, or 59%) are in a nonparental care arrangement at least once a week. Center-based care being the most frequently reported care type. Measure 4.U captures the progress that the nation is making toward all 47 high-impact obesity prevention standards, including healthy weight best practices in infant feeding, nutrition, physical activity, and screen time. The average percentage of obesity prevention standards fully met across states for licensed ECE centers increased from 20.5% in FY 2016 to 31.7% in FY 2022 an increase over FY 2021 though not meeting the 32.5% target (Measure 4.U). CDC continues to provide funding and direct technical assistance to states to work on specific activities designed to have statewide impact by embedding nutrition and physical activity standards or implementation supports for these standards into their state ECE system. This occurs through state licensing, integrating the use of an evidence-based intervention into state systems and improving the capacity of technical assistance providers on CDC’s topic areas to support ECE providers to improve their nutrition and physical activity policies and practices. For example, in 2022, Tennessee updated new childcare regulations for licensed childcare facilities and homes and align with 26 of the 47 High Impact Obesity Prevention Standards.

CDC also supports professional development opportunities for ECE providers through the development of 15 on-demand online training courses in partnership with Penn State University's Better Kid Care (BKC) program. As of June 2023, ECE providers achieved a cumulative total of 94,588 training hours for fiscal years 2017-2023 from these 15 courses.

### School Health

**Performance Measures for Long-Term Objective: Improve the health and well-being of youth and prepare them to be healthy adults**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.12.6 Increase the percentage of schools that do not sell less healthy foods and beverages (soda pop or fruit drinks, baked goods, salty snacks, candy, sports drinks) <sup>1</sup> (Outcome)	FY 2020: 53.4% Target: 72% (Target Not Met)	72%	N/A	N/A
4.12.7: Percentage of schools that have established, implemented and/or evaluated a Comprehensive School Physical Activity Program (CSPAP) (Outcome)	FY 2020: 48.7% (Baseline)	51%	N/A	N/A
4.12.8: The percentage of secondary schools that provide case management for students with chronic health conditions (e.g., asthma, diabetes) (Outcome)	FY 2020: 74.5% (Baseline)	78%	N/A	N/A

<sup>1</sup> Targets and results are set and reported biennially.

**Performance Trends:** Schools have direct contact with more than 95% of our nation’s young people aged 5 to 17 years, for about 6 hours per day and up to 13 critical years of their social, psychological, physical, and intellectual development. CDC funds state education agencies (SEAs) to oversee curriculum and instruction to build school health infrastructure, provide professional development and training, and offer technical assistance to local education agencies to improve school environments, policies, and practices that promote nutrition, physical activity, and school health services for students with chronic conditions.

Obesity rates among school-aged children and adolescents have more than tripled since 1980. The prevalence of obesity is higher among youth aged 6-11 years (20.7%) and adolescents aged 12-19 years (22.2%) compared with children aged two to five years (12.7%). Most children and adolescents do not meet recommendations for healthy eating (fruits, vegetables, and dairy) and 45% of high school students are not eating even one vegetable each day (CDC YRBS, 2021). Students attending schools that sell high-calorie, low nutrient foods and beverages outside the school food service program have lower intake of fruits and vegetables and higher daily percentage of calories from total fat and saturated fat. Results from the 2020 School Health Profiles report showed that 53.4% of secondary schools did not sell less healthy food and beverages (soda pop or fruit drinks, baked goods, salty snacks, candy, sports drinks) outside of the school food service program (Measure 4.12.6) not meeting the target of 72%. CDC funded SEAs have made some progress, the mean percentage of schools per state that reported not selling less healthy foods and beverages increased from 49% at the start of the Healthy Schools Program to 57% by the end of year 3.

The Task Force on Community Preventive Services recommends enhanced, school-based physical education as an effective strategy for increasing physical activity among students. Physical education classes increase students’ daily moderate to vigorous physical activity and help children and adolescents meet daily physical activity recommendations. However, from 2019 to 2021, only 1 in 6 (16%) students met both aerobic and muscle-strengthening guidelines (CDC YRBS, 2021). In 2020, only 48.7% of states (Measure 4.12.7) established, implemented and/or evaluated a Comprehensive School Physical Activity Program (CSPAP), an action that aligns with CDC’s School Health Guidelines to Promote Healthy Eating and Physical Activity as well as recommendations from the American Heart Association and SHAPE America in order to increase students’ physical activity. Notable progress has been made among CDC funded SEAs, the mean percentage of schools per CDC funded state that reported having established, implemented, and/or evaluated Comprehensive School Physical Activity Programs increased from 10% to 47% by the end of year 3.

In the United States, more than 40% of school-aged children and adolescents have at least one chronic health condition, such as asthma, obesity, food allergies, or other physical conditions. Schools can help students manage their chronic health conditions by providing case management support from school nurses and other health professionals who can help coordinate and track students’ health status and medications. This is a critical school health service that many students living with chronic health conditions need to properly manage their condition during the school day and at home with family members. Students in schools with case management have significantly fewer urgent care visits, emergency room visits, and hospitalizations. However, the 2020 School Health Profiles data showed that only 74.5% of schools provide case management to students with chronic conditions which may leave students’ vulnerable to additional health challenges and decreased quality of life (Measure 4.12.8).

**Heart Disease and Stroke**

Contextual Indicator	Most Recent Result
Coronary Heart Disease: Reduce the annual age-adjusted rate of coronary heart disease deaths (per 100,000 population)	FY 2021: 92.8
Stroke: Reduce the annual age-adjusted rate of stroke deaths (per 100,000 population)	FY 2021: 41.1



**Performance Measures for Long Term Objective: Reduce risk factors associated with heart disease and stroke**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.11.5a: Increase the proportion of persons 18+ in the U.S. population with high blood pressure who have it under control (<140/90) <sup>1</sup> (Outcome)	FY 2020: 49.2% Target: 59.9% (Target Not Met but Improved)	61.7%	N/A	N/A
4.11.14 Increase the proportion of persons aged 21 years and older in the US population, for whom therapy is recommended, that are using medication to manage their blood cholesterol <sup>1</sup> (Outcome)	FY 2020: 53.8% Target: 53.2% (Target Exceeded)	57.2%	N/A	N/A
4.N1 Increase the percentage of at risk WISEWOMAN participants who received at least one evidence-based healthy behavior support service (Output)	FY 2020: 78.0% Target: 62.0% (Target Exceeded)	64%	64%	Maintain
4.N2 Increase the number of evidence-based behavioral support services provided to WISEWOMAN participants (Output)	FY 2020: 29,696 Target: 32,550 (Target Not Met but Improved)	34,000	34,000	Maintain

<sup>1</sup>Targets and results are set and reported biennially.

**Performance Trends:** High blood pressure, also known as Hypertension, affects one in two adults. In 2020, nearly 700,000 American deaths included hypertension as a primary or contributing cause. In addition, uncontrolled hypertension leads to largely preventable heart attacks, strokes, kidney disease, heart failure, dementia, and complications of pregnancy that results in lifetime risks of cardiovascular disease for women and their offspring.

In 2020, the rate of blood pressure control among all U.S. adults 18 and older with hypertension reached 49.2%, missing the target of 59.9% (Measure 4.11.5a). Due to delays in the NHANES cycle, the FY 2022 estimates have been delayed. However, 2020 data suggest that younger men ages 18-39 had significantly lower rates of control compared to men over the age of 40, and control rates are lower in rural areas, and among Blacks, Hispanic-, and Asian-Americans compared to Whites. Potential reasons for this include continued increases in obesity and diabetes, high rates of physical inactivity, lack of access to quality healthcare, and failure of clinicians and health systems to prioritize hypertension control. In addition, high cholesterol is a significant risk factor for cardiovascular disease, which is the #1 killer of Americans. CDC’s measure—to assess whether people for whom

medication is recommended are on medication—is an effective way of showing progress towards cholesterol control. In FY 2020, the prevalence of persons using medication to manage their blood cholesterol reached 53.8% exceeding the target (Measure 4.11.14).

CDC provides all 50 states and the District of Columbia with funding, expertise, and technical assistance to implement programs to improve cardiovascular health and improve blood pressure control through proven, evidence-based strategies. Improving control of risk factors means improving the quality of care using proven, evidence-based approaches that improve outcomes and save money. These approaches include encouraging multidisciplinary team-based approaches to care, increasing the use of electronic health records and health IT to improve diagnosis of high blood pressure and patient follow-up, promoting patient self-management of high blood pressure, and increasing the number of community health workers that are equipped to help people control their risk factors. By increasing uptake of these approaches, CDC has improved the quality of care and lowered the risk of heart attacks and stroke for millions.

These improvements in the quality of care are improving outcomes. For example, in Hawaii, health systems and clinics partnering with the State achieved a 65% blood pressure control rate, up nearly 13 points from 2018. Similarly in Maine, the states worked to promote team-based care throughout the state, including and integrating EMTs and paramedics into the care team in rural areas to compensate for lack of access to doctors and pharmacies. Statewide, partner health systems and clinics achieved a 72% blood pressure control rate in mid-2022, up 16 points from 2018. The program is also achieving national success, having achieved a 5% improvement in blood pressure control rates among participating health systems and centers between 2018-2022. These improvements came despite the nation’s overall cardiovascular health worsening during the pandemic.

In FY 2023, CDC began a new five-year funding cycle for the cooperative agreements that funds all 50 states to support core cardiovascular disease prevention and control activities as well as smaller subset of recipients to implement innovative approaches to prevention and control. In the prior funding cycle, for example, Pennsylvania recruited over 80 sites, mostly in rural areas to help improve high blood pressure and cholesterol management activities. Also, Arizona partnered with the University of Arizona to provide patients in rural areas with high-risk conditions or issues accessing care with the latest telehealth equipment to improve the self-management of high blood pressure and cholesterol. In the new funding cycle, states will have the opportunity to focus on the cardiovascular disease disparities among rural residents if they so choose.

**Million Hearts®:** Within its first five-year cycle (2012-2016), CDC Million Hearts® prevented an estimated 135,000 heart attacks, strokes, and other related acute cardiovascular events. CDC Million Hearts® also saved \$5.6 billion in direct medical costs, and much of those savings were realized by public insurance like Medicare and Medicaid. Since 2014, Million Hearts® has partnered with the National Association of Community Health Centers (NACHC) on quality improvement projects in a diverse set of clinics to improve diagnosis and control of high blood pressure and high blood cholesterol for people who rely on community health centers. Recently, for example, even with the disruptions in health care delivery due to the COVID-19 pandemic, Million Hearts worked with 32 health centers to improve blood pressure control and improve cholesterol management for African Americans at a time when many people stopped making routine visits to their doctor. During the height of the pandemic, the participating health centers reported an average 5.23 mmHg decrease in systolic blood pressure among nearly 18,000 African American adults. Studies have shown that for every 5mmHg reduction in systolic blood pressure, the risk of major cardiac events drops by 10%. This partnership with NACHC has directly improved the quality of care for more than 700,000 at-risk patients in community health centers across the nation for an extremely low cost of about \$14 per person helped. These direct efforts are being scaled up and spread to millions more at-risk patients.

**WISEWOMAN:** In FY 2023, CDC launched a new five-year cooperative agreement with 32 state health departments, two tribal organizations, and one pacific island receiving funding. WISEWOMAN screens women aged 35 to 64 who have low-incomes and are uninsured or underinsured for heart disease and stroke risk

factors. WISEWOMAN refers clients to healthy behavior support services, such as evidence-based lifestyle programs, health coaching, and community-based resources that promote lifestyle changes like tobacco cessation, healthier eating, physical activity, weight management, and blood pressure control. In FY 2020, 78% of at-risk women (program participants) received at least one support service, exceeding the target (Measure 4.N1). However, program recipients only provided 29,696 evidence-based healthy behavior support services to WISEWOMAN participants, missing the FY 2020 target but an improvement from FY 2019 (Measure 4.N2).

Despite facing significant challenges in enrolling new participants during the pandemic because the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), had to stop navigating women to WISEWOMAN, program recipients successfully adapted to the pandemic by providing healthy behavior support services (HBSS) to existing participants via telehealth to improve the provision of services. We are hopeful that funded states will continue to utilize virtual options for service delivery and continue to maximize impact to reach the target population. FY 2025 targets remain flat as the new cooperative agreement is being implemented with new recipients who will need time to stand up their program.

**Diabetes**

Contextual Indicator	Most Recent Result
Diabetes: Reduce the annual age-adjusted rate of diabetes-related deaths (per 100,000 population)	FY 2021: 98.1

**Performance Measures for Long Term Objective: Improve prevention, detection, and management of diabetes**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.11.12 Reduce the age-adjusted incidence of diagnosed diabetes per 1,000 among U.S. adults aged 18 to 84 (Outcome) <sup>1</sup>	FY 2021: 5.5 (Baseline)	5.6	4.8	-0.8
4.11.13a Increase the cumulative number of CDC recognized organizations delivering the National DPP lifestyle intervention that show a reduction in risk of developing type 2 diabetes among 60% or more of their program completers (Outcome)	FY 2022: 791 Target: 815 (Target Not Met)	945	1,010	+65
4.S Increase the annual number of people with at least one encounter at an ADA recognized or ADCES accredited diabetes self-management education and support	FY 2022: 981,266 Target: 1,197,128 (Target Not Met)	1,257,128	1,287,128	+30,000

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
(DSMES) program (Output)				
4.T Increase the cumulative number of participants enrolled in CDC recognized organizations for the prevention of type 2 diabetes (Output)	FY 2022: 661,607 Target: 750,000 (Target Not Met but Improved)	850,000	900,000	+50,000

<sup>1</sup> Measure was rebaselined and targets updated to align with HP 2030.

**Performance Trends:** CDC estimates that more than 97.6 million American adults aged 18 years or older, or one in three adults, have prediabetes, and eight out of 10 people with prediabetes do not know they have it<sup>284</sup>. Without a structured intervention, many of these individuals will develop type 2 diabetes within five years<sup>285</sup>. The Diabetes Prevention Program clinical trial showed that participants who engage in lifestyle changes through a structured program can lose five to seven percent of their body weight and reduce development of type 2 diabetes by as much as 58% (71% for those 60 years of age and older)<sup>286</sup>. Based on this research, CDC established the National Diabetes Prevention Program (National DPP) in 2010 to address the growing epidemic of type 2 diabetes. The National DPP lifestyle change program is led by trained coaches who facilitate participants’ strategies for eating a healthy diet, increasing physical activity, and developing coping skills.

CDC provides training and technical assistance to National DPP lifestyle change program providers, health care providers, payers, and other partners to support the National DPP’s type 2 diabetes risk reduction strategies. CDC aims to continue reducing the age-adjusted incidence trend (5.5 per 1,000 in 2021) of diagnosed type 2 diabetes among U.S. adults aged 18 to 84 through large-scale interventions such as National DPP lifestyle change program (Measure 4.11.12). In FY 2022 there were 661,607 cumulative participants which did not meet the target of 750,000 but is nearly 100,000 more participants than FY 2021 (Measure 4.T). This is heavily attributed to the decrease in participants due to the COVID-19 pandemic and CDC ambitiously increasing the target from 470,811 in FY 2021 to 750,000 in FY 2022. As of November 2023, cumulative enrollment in the National DPP lifestyle change program was nearly 725,000 participants. So far, evaluated participants have lost an average of 5.4 percent of their body weight, lowering their risk of developing type 2 diabetes. To date, there are more than 1,500 CDC-recognized organizations offering the program in-person, online, and through distance learning. In addition, CDC continues to work to increase the number of CDC-recognized organizations that show a reduction in risk of developing type 2 diabetes among 60% or more of their program completers (4.11.13a). In FY 2022, there were 791 CDC-recognized organizations achieving this requirement, a slight decrease from 818 in FY 2021. This reduction is due to difficulties enrolling and retaining participants during the COVID-19 pandemic.

With technical assistance and support from CDC, state health departments and other partners have expanded access to the National DPP lifestyle change program for populations at higher risk of type 2 diabetes by providing insurance coverage. Thirty-one states have secured health insurance coverage for the National DPP lifestyle change program for state or other public employees and their dependents. Since 2012, twenty-seven state Medicaid programs and District of Columbia have also achieved varying levels of Medicaid coverage for the program as a benefit for eligible Medicaid beneficiaries. In addition, 90 private employers across the United States include the National DPP lifestyle change program as a covered health or wellness benefit for their employees at high risk for type 2 diabetes, and 57 commercial health plans provide some coverage for the program. Approximately 27 million American adults with prediabetes aged 65 years or older could directly

<sup>284</sup> <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>

<sup>285</sup> <https://www.cdc.gov/diabetes/prevention/about-prediabetes.html>

<sup>286</sup> <https://www.cdc.gov/diabetes/data/statistics-report/index.html>

benefit from the Medicare Diabetes Prevention Program, which is based on the National DPP and administered by the Centers for Medicare and Medicaid Services.

Raising awareness of prediabetes is also critical for reducing type 2 diabetes incidence. CDC’s national Do I Have Prediabetes? campaign increases awareness of prediabetes and encourages enrollment in the National DPP lifestyle change program. As of October 2023, the campaign resulted in 12.7 million online and video prediabetes risk test completions. In addition, the campaign has documented 6.8 million unique visitors to the campaign website and over 263,000 visits to the National DPP website to find a lifestyle change program. Since the campaign launched, awareness of the term “prediabetes” reached a high of 68% in 2022 (up from a 50% baseline in 2015) among English speakers nationally. Among Spanish speakers, awareness of the term reached a high of 87% in 2022, up from 53%.

CDC supports all 50 states, and District of Columbia, through a five-year cooperative agreement to improve access to, participation in, and coverage for American Diabetes Association (ADA)-recognized or Association of Diabetes Care and Education Specialists (ADCES)-accredited diabetes self-management education and support (DSMES) programs among people with diabetes. CDC also works with states to increase engagement of pharmacists in the provision of medication management and DSMES for people with diabetes.

In 2022, 2,090 DSMES programs offered services across the U.S., and nearly 1 million people with diabetes participated in an ADA-recognized or ADCES-accredited DSMES programs that met national quality standards (Measure 4.S). COVID-19 presented challenges to reaching the target number of people with at least one encounter at a recognized or accredited DSMES program in FY 2022. DSMES programs suspended in-person classes and experienced staffing shortages, lower partner participation, and decreased commitment to the accreditation and recognition processes. There were 129 new DSMES programs established in 2022 and 119 programs closed. CDC aims to increase access to DSMES services by establishing new DSMES programs in underserved areas. Cooperative agreement recipients, with training and technical assistance provided by CDC, have identified potential gaps and opportunities to engage in policy and systems-level work that could reduce barriers to access and utilization in underserved areas; strengthen support for DSMES among health care systems, providers, insurers, and policy makers; improve DSMES coverage; and increase participation in recognized or accredited DSMES programs.

CDC’s diabetes surveillance programs, the United States Diabetes Surveillance System<sup>287</sup>, and the SEARCH for Diabetes in Youth study<sup>288</sup>, have documented 20-year improvements in some diabetes-related complications while identifying new areas of concern. These include recent increases in amputation rates, hyperglycemic episode rates, and hyperglycemic death rates; continued increases in diabetes incidence in youth; and continued disparities in diabetes burden among people from racial and ethnic minority groups. To address this, CDC is conducting three large-scale research projects aimed at prioritizing solutions to diabetes complications and persistent disparities<sup>289</sup>.

## Cancer Prevention and Control

### Performance Measures for Long Term Objective: Improve health outcomes related to cancer

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.9.2 Increase the percent of adults age 50 to 75 receiving	FY 2022: 72.2% Target: 70.5% (Target Exceeded)	73%	N/A	N/A

<sup>287</sup> <https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html>

<sup>288</sup> <https://searchfordiabetes.org/dspHome.cfm>

<sup>289</sup> <https://www.cdc.gov/diabetes/research/index.html>

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
colorectal cancer screenings <sup>1</sup> (Outcome)				
4.9.5a Increase the mean colorectal screening rate among Colorectal Cancer Control Program (CRCCP) health system clinics (Outcome)	FY 2022: 45% Target: 51% (Target Not Met)	55%	55%	Maintain
4.Q Number of breast or cervical cancers and pre-malignant lesions detected among women served (Outcome)	FY 2022: 8,717 Target: 10,900 (Target Not Met)	11,000	11,000	Maintain
4.R Number of women served through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (Outcome)	FY 2022: 310,993 Target:365,000 (Target Not Met but Improved)	320,000	330,000	Maintain
4.V Increase the percentage of CDC-funded state central cancer registries receiving laboratory data through a cloud-based platform (Output)	FY 2023: 100% Target: 100% (Target Met)	100%	100%	Maintain

<sup>1</sup>Targets and results are set and reported biennially.

**Performance Trends:** Cancer is the second leading cause of death in the United States, resulting in over 602,000 deaths annually – over 1,650 deaths each day. Cancer is responsible for more potential years of life lost than all other causes of death combined. Since cancer patients overall are living longer, the number of cancer survivors is expected to increase to more than 20 million by 2026.

The number of new cancers can be reduced, and many cancer deaths can be prevented. Effective screening tests are available to detect breast, cervical, colorectal, and lung cancers. Finding cancers early makes it possible for treatment to be more effective. Screening tests for cervical and colorectal cancers can also help to prevent cancer by finding pre-cancerous lesions and polyps. CDC is actively focused on increasing breast, cervical and colorectal cancer screening by emphasizing the implementation of evidence-based interventions in health system clinics, expanding patient navigation to reduce barriers to screening, and partnering with community-based organizations to connect them to screening services.

Colorectal cancer (CRC) is the second most diagnosed cancer and the second leading cause of cancer deaths among cancers affecting both men and women in the U.S. CRC screening can detect cancer early when treatment is more effective, and a colonoscopy can prevent cancer by finding and removing precancerous polyps before they turn into cancer. In 2022, 72.2% of adults aged 50-75 were up to date on CRC screening for CRC (Measure 4.9.2), about a 2.5 percentage point improvement over FY 2020. In 2020 and 2021, the COVID-19 pandemic had a significant impact on access to preventive health services, including CRC screening, however,

increases in home-based screening through the use of stool testing likely negated much of the difficulty in accessing clinic and hospital-based screening services such as colonoscopy.

In July 2023, the Colorectal Cancer Control Program (CRCCP) entered year 4 of 5-year cooperative agreement funding 35 recipients. Recipients partner with clinics and health systems with low screening rates that serve populations with lower incomes to implement evidence-based strategies known to be effective in increasing CRC screening (e.g., patient and provider reminders, reduction of structural barriers, and provider assessment and feedback), recommended by the [Task Force on Community Preventive Services](#). For example, The New York State Department of Health (NYSDOH) partnered with two clinics from a Federally Qualified Health Center (FQHC), SunRiver Health (SunRiver), on a project to increase colorectal cancer (CRC) screening rates in clinics serving low-income populations who bear a disproportionately high burden of CRC. Both clinics saw increased monthly screening rates and sustained increases in annual screening rates (using the UDS measure), with Clinic 1 increasing from 39% in June 2020 to 58% in June 2022 and Clinic 2 from 43% to 51% over the same period.

The definition of those eligible for colorectal cancer screening changed in May of 2021, when the U.S. Preventive Service Task Force expanded the age range recommended for CRC screening to include those 45-49 years old. While this changed practice and reimbursement coverage, standard measures of CRC screening have not all officially changed to include those 45-49. This change will also likely affect screening rates in the CRCCP with data collected in 2023 as the program will align with updated measures to incorporate this new, largely unscreened population.

Several factors have impacted colorectal cancer screening rates for CRCCP during the current cooperative agreement. At the end of the second program year (June 2022), the program included 512 clinics of which 380 (74%) were new and 132 clinics were continuing from the previous initiative. Given this influx of new clinics with lower baseline screening rates along with the national impact on cancer screening rates from the COVID-19 pandemic we continue to see decreases in clinic screening rates with the overall mean clinic screening rate decreasing from the baseline rate of 48% (in FY 2021) to 45% in FY 2022 (Measure 4.9.5a). However, CRCCP has seen many improvements during the first two years of the new cooperative agreement. Among the 512 clinics in the program, we saw increases in the implementation of all four evidenced-based interventions for improving CRC screening rates and increases in other activities important for increasing screening such as clinics having CRC screening champions and providing free CRC fecal test kits. Clinics are also working on improving their tracking and monitoring of CRC screening completion rates to better identify areas for improvement.

CDC's current five-year cooperative agreement for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds all 50 states, the District of Columbia, five U.S. territories, two freely associates states, and 13 American Indian/Alaska Native tribes or tribal groups to increase breast and cervical cancer screening rates among women with low incomes who do not have adequate insurance coverage. Recipients implement evidence-based strategies, provide patient navigation to assist with overcoming barriers to screening, and expand outreach into communities to reach populations who are disproportionately affected by breast and cervical cancer.

It is important to note that the COVID-19 pandemic had a significant negative impact on access to preventive health services. CDC conducted an analysis of NBCCEDP screening data to examine the impact of COVID-19. Trends show increasing test volume in the second half of 2020; however, neither breast nor cervical cancer screening volume reached pre-COVID-19 pandemic levels. CDC is continuing to monitor the recovery of screening through the NBCCEDP. To reflect the impact and reach of the NBCCEDP, two measures for the NBCCEDP are reported: 1) number of cancers and pre-malignant lesions detected and 2) total number of women served by the program. In FY 2022, the NBCCEDP reported 8,717 cancers and pre-malignant lesions detected (Measure 4.Q), 2,183 fewer than the target of 10,900. The total number of women served by the NBCCEDP (Measure 4.R) in FY 2022 was approximately 310,993, which is 4,007 fewer than the target of 365,000 but an improvement from FY 2021. These measures capture a broad spectrum of the program's activities including direct cancer screening, diagnostic follow-up including for women referred into the NBCCEDP, and navigation of

women along the cancer continuum from early detection to treatment referral. NBCCEDP recipients and clinics are still recovering from the significant impact of the pandemic on screening. While the NBCCEDP has not reached its target, the program has had a steady increase in the number of women screened since the onset of the pandemic in 2020. With the ending of the Public Health Emergency, CDC anticipates that more women will become eligible from the program due to the Medicaid redetermination process. In the new cooperative agreement that began in 2022, recipients are now required to increase their screening levels 5% each year along with implementing population-level activities within health systems and communities.

CDC has prioritized data modernization and is working to increase real-time cancer registry data collection through a cloud-based platform. Increasing the number of CDC-funded state central cancer registries receiving electronic cancer pathology reports via a cloud-based platform will allow for real-time identification of cancer incidence for 90-95% of U.S. cancer diagnoses, which could lead to more timely identification of people eligible for clinical trials and more timely data for decision-makers to develop and improve strategies for cancer prevention, screening, treatment, and survivor support. In 2023, 100% of CDC-funded cancer registries received lab data through a cloud-based platform for real-time reporting, exceeding the target (Measure 4.V).

## Oral Health

### Performance Measures for Long Term Objective: Prevent oral health diseases and promote effective interventions that support optimal oral health

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.7.1 Increase the proportion of the people served by community water systems who receive optimally fluoridated water <sup>1</sup> (Intermediate Outcome)	FY 2020: 72.7% Target: 76.5% (Target Not Met)	76.5%	N/A	N/A

<sup>1</sup>Targets and results are set and reported biennially.

**Performance Trends:** For more than 75 years, community water fluoridation has been a safe and healthy way to effectively prevent tooth decay and was recognized by CDC as one of 10 great public health achievements of the 20th century. CDC works with national partners, states, communities, and water operators to support the U.S. population having access to optimally fluoridated water to prevent tooth decay. Information about populations served by community water systems (CWS), including both systems that adjust and that do not adjust fluoride levels, is reported to the Water Fluoridation Reporting System (WFRS) by state oral health or drinking water programs, and data are released on a biennial basis. The decision to implement or continue community water fluoridation is made at the state or local level. CDC supports the decision-making process by sharing evidence-based research about the safety, effectiveness, and cost-effectiveness of community water fluoridation. In 2020, 72.7% of the CWS had access to optimally fluoridated water (Measure 4.7.1). This slight decrease from FY 2018 (73.0%) is due to state-reported data quality improvements attributable to increased capacity as a result of dedicated funding starting in FY 2018 for reporting these measures. Although the percentage decreased slightly, the number of people served by CWS with access to fluoridated water increased by over 1 million people.

Rural communities often experience the greatest disadvantage in receiving the benefits of water fluoridation, because of the challenges and relative high cost associated with scaling traditional fluoridation technologies for use in small, rural public water systems. Of the about 40,000 public water systems that do not currently provide optimally fluoridated water, an estimated 32,000 are small systems, serving about 19 million people. Recognizing that significant disparities persisted within these communities, CDC invested in a Small Business Innovation Research project to explore the feasibility of a fluoride delivery system designed specifically for this environment. The resulting fluoride tablet system is being pilot tested in several states to meet each state’s



drinking water program permitting requirements for installing new technology. This new technology will provide a lower-cost option for small water systems that serve between 50 and 10,000 people to increase the number of people with access to optimally fluoridated water.

As part of its role in promoting community water fluoridation, CDC provides technical assistance and offers a variety of resources designed to build the capability of state drinking water program officials, state and local health department staff, oral health program staff, and water system operators to improve and maintain the quality and results of community water fluoridation. This includes Fluoridation Learning Online (FLO), a web-based modular training course providing information on the fundamentals of community water fluoridation, including how fluoride works and why we use it, how state programs support and communicate fluoridation’s benefits, and how water treatment systems are designed and operate. CDC has provided technical assistance to 12 states to obtain water operator continuing education credits/training units as an incentive to increase the number of learners who complete the online training. More than 2,000 learners have registered for this training since it launched in 2019.

**Safe Motherhood and Infant Health**

**Performance Measures for Long Term Objective: To improve the health of women and infants through public health surveillance, research, capacity building and science-based practices**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.8.5 Reduce birth rates among adolescent females aged 15 to 19 years (per 1,000 females) (Outcome)	FY 2021: 13.9 Target: 17.4 (Target Exceeded)	16.0	15.9	-0.10
4.8.7 Decrease the infant mortality rate (infant deaths in the first year of life) per 1,000 live births) (Outcome)	FY 2021: 5.43 Target: 5.66 (Target Exceeded)	5.33	5.31	-0.02
4.8.8 Reduce the ratio of in-hospital maternal deaths per 100,000 delivery hospitalizations <sup>1</sup> (Outcome)	FY 2020: 7.09 Target: 6.2 (Target Not Met)	5.4	5.2	-0.20

<sup>1</sup> Targets adjusted to align with FY 2018 baseline.

**Performance Trends:** CDC strengthens the evidence base for effective interventions that improve both maternal and infant health.

In the past decade, the birth rate for teenagers aged 15-19 has decreased over 50%. This rate dropped from 17.4 per 1,000 in 2018 to 13.9 per 1,000 in 2021, reaching yet another record low for the U.S. and exceeding the target (Measure 4.8.5).

Infant mortality rate is the number of deaths per 1,000 live births that occur before the infant’s first birthday. In 2021, the infant mortality rate in the U.S. was 5.43 deaths for every 1,000 births (Measure 4.8.7), exceeding the target, but did not change significantly from the rate in 2020. CDC works to prevent these deaths through a range of activities. CDC funds the Sudden Unexpected Infant Death (SUID) Case Registry. SUID is the death of an infant less than one year of age that occurs suddenly and unexpectedly and whose cause of death is not immediately obvious before investigation. In FY 2023, the SUID Case Registry expanded to 32 sites, covering

about 2 in 5 SUID in the United States. Participating sites work to improve data quality on SUID cases and leads to a better understanding of circumstances that may increase the risk of SUID. New this funding cycle, CDC provided additional support to 10 of the participating sites to implement enhanced community-based SUID prevention activities using Case Registry data and evidence-based AAP recommendations. Innovative collaborations have led to data sharing across agencies that serve women, infants, children, and families, including hospitals, housing authorities, childcare organizations, prisons, and clinical care practitioners. These data have resulted in changing policies and practices within these agencies to promote safe sleep and reach disparate populations. As a result of the Case Registry, awardees have also increased the availability of death scene investigations in their communities including instruction on using dolls for reenactments.

Maternal deaths during delivery hospitalization is an important measure of progress to monitoring and improving maternal mortality. In 2020, the in-hospital maternal death per 100,000 delivery hospitalization ratio was 7.09, not meeting the target and an increase from 5.58 per 100,000 in 2019 (Measure 4.8.8). NCHS also recorded an increase in maternal deaths (during and up to 42 days postpartum) from 2019 to 2021. The maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. At this time, it is difficult to tell what extent direct or indirect effects (e.g., disruption of prenatal care, care during delivery, care for other pregnancy-related conditions) of the pandemic have had on maternal mortality. Jurisdictional-based Maternal Mortality Review Committees (MMRCs) are well-poised to answer these questions and can assess deaths where COVID-19 was the underlying cause of death, as well as identify indirect pandemic-related factors such as social isolation and delays in care that may have contributed to pregnancy-related deaths from all causes. CDC is working, in partnership with the states, to better understand the direct and indirect impacts of COVID-19 on maternal deaths. For example, the MMRC in Tennessee found that pregnancy-related deaths with an underlying cause of death of COVID, the contributing factors included: patients unvaccinated for COVID-19, facilities unable to accept patients for advanced care due to bed shortages, provider delay in initiation of treatment, discrimination due to obesity and race, patient non-adherence to postpartum follow-up visit and patient delay in seeking care after onset of symptoms.

In our work to eliminate preventable maternal mortality, in FY 2023, CDC significantly expanded its investment in the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, with new awards to support additional MMRCs in seven additional jurisdictions. CDC now supports MMRCs in 44 states and two U.S. Territories. This funding directly supports agencies and organizations that coordinate and manage MMRCs to identify, review, and characterize pregnancy-related deaths; and identify prevention opportunities. With increased appropriations in FY 2023, the number of funded PQCs increased by nine, with 36 total PQCs funded. PQCs are networks of teams working to improve health outcomes for mothers and babies. PQC members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible. With CDC support, PQCs have contributed to measurable improvements in postpartum outcomes. For example, the Illinois Perinatal Quality Collaborative (ILPQC) developed provider tools and implemented system changes to improve opioid use disorder care in hospitals, successfully erasing racial disparities that existed on several measures of quality care while improving care for all women.

## Arthritis

### Performance Measures for Long Term Objective: Reduce pain and disability and improve quality of life among people affected by arthritis

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.10.1 Increase the age-adjusted percentage of adults (age 18+) diagnosed with arthritis who were counseled by a doctor	FY 2021: 68.2% Target: 70.3% (Target Not Met)	N/A	71%	N/A

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
or other health professional to be physically active or exercise to help arthritis or joint symptoms, in states funded by the CDC Arthritis Program1 (Outcome)				

<sup>1</sup>Targets and results are set and reported biennially.

**Performance Trends:** Arthritis affects more than 53 million adults, almost 50% of whom are working-aged adults (< 65) and is projected to affect 78.4 million adults by 2040. Projections indicate that arthritis prevalence and arthritis-associated limitations are increasing and confirm that arthritis remains a top cause of morbidity, work limitations, and compromised quality of life. Physical activity can reduce joint pain, improve function, and halt or delay physical disability among adults with arthritis, but physical activity levels are lower for adults with arthritis than adults without arthritis. CDC funds states to create or adapt innovative and systems-based approaches to facilitate healthcare provider-patient counseling about physical activity for arthritis management and promote walking for exercise and referrals to proven arthritis interventions, with a secondary aim of addressing health inequities and having state-wide impact.

Among states funded by the CDC Arthritis Program in 2021, 68.2% of adults diagnosed with arthritis were counseled by a doctor or other health professional to be physically active to help arthritis or joint symptoms (Measure 4.10.1), slightly missing the target. In addition, three of the state grantees, Oregon, New York, and Massachusetts, were successful in having Medicare and Medicaid reimburse for Arthritis-Appropriate, Evidence-Based Interventions, a critical step to the sustainability of arthritis-appropriate interventions for people with arthritis. In FY 2025, CDC will continue to fund 12 states to better understand the barriers and challenges of promoting provider physical activity counseling for arthritis and implementing innovative strategies to overcome these challenges.

**Behavioral Risk Factor Surveillance System (BRFSS)**

**Performance Measures for Long Term Objective: Improve validity, coverage, and dissemination of BRFSS**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
4.P Increase the average percentage of completed cell phone interviews to maintain population coverage in the Behavioral Risk Factor Surveillance System (BRFSS) (Output)	FY 2022: 78% Target: 70% (Target Exceeded)	77%	N/A	N/A

**Performance Trends:** CDC established the Behavioral Risk Factor Surveillance System (BRFSS) as a landline telephone-based health survey system conducted by states and territories to monitor population risk factors for chronic disease and other leading causes of death and disability. CDC moved to a dual, but separate, landline and cellular telephone sampling frame in 2011. As the BRFSS landline sample continues to yield fewer completed

surveys, states are increasingly dependent on the cell phone sample to capture an effective representation of their state population. Since then, CDC has demonstrated measurable improvements in reaching cell phone respondents, with the average percentage of completed cell phone interviews increasing to 78% in FY 2022, exceeding the target (Measure 4.P). CDC will discontinue this measure as data over the years has exceeded the target and indicates a sustained population coverage with BRFSS cell phone sampling.

## BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

### Child Health and Development

Contextual Indicators	Most Recent Result
5.1.5e Increase the proportion of children 8 years of age who have autism spectrum disorder but do not have intellectual disability who were first evaluated by age 36 months <sup>1</sup>	FY 2023: 46.0%
5.1.5f Increase the proportion of children 8 years of age who have intellectual disability and autism spectrum disorder who were first evaluated by age 36 months <sup>1</sup>	FY 2023: 61.9%

<sup>1</sup>Results are reported biennially.

#### Performance Measures for Long-Term Objective: Prevent birth defects and developmental disabilities

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
5.1.10 Increase the proportion of Hispanic women of reproductive age who have an optimal blood folate concentration for neural tube defect prevention <sup>1,2</sup> (Outcome)	FY 2019: 80.3% <sup>2</sup> Target: 82.1% (Target Not Met)	N/A	82.6%	Maintain

<sup>1</sup>Data reported biennially (in odd years).

**Performance Trends:** Birth defects affect three percent of infants and account for more than 20% of infant deaths in the U.S. A primary way CDC prevents birth defects is by identifying and reducing risk factors (such as exposure to alcohol or other substances in pregnancy) and by identifying and increasing protective factors (such as sufficient levels of folate in the blood). Since 2012, CDC has promoted alcohol screening and brief intervention (SBI) activities, including educating multi-disciplinary healthcare providers and evidence-based interventions for women of reproductive age; conducting research to improve patient-provider communication on the risks of alcohol use during pregnancy, including efforts to understand disparities related to screening and brief intervention to better serve underserved populations. CDC has also developed evidence-based messaging and tools for healthcare providers on the risks of alcohol use during pregnancy and the delivery of alcohol SBI; implemented evidence-based interventions, including alcohol SBI, to reduce alcohol use during pregnancy; developed clinical decision support tools for electronic health systems to improve uptake of SBI; and provided monitoring and reporting of SBI provider practices using data from the alcohol SBI Behavioral Risk Factor Surveillance System module.

In FY 2025, CDC will retire its measures focused on alcohol use and exposure during pregnancy recognizing that multiple systemic factors, such as access to substance use and mental health services, contribute to successful implementation of alcohol and other substance screening and brief intervention. CDC is also focusing recent and future efforts on enhancing understanding of screening and interventions for pregnant populations using substances as this population has unique needs requiring tailored screening tools and intervention approaches.

In addition, polysubstance use is very common so addressing a single substance alone may not be sufficient. These additional complexities should be accounted for in future performance measures.

To prevent neural tube defects (NTDs), CDC works to help women of reproductive age attain optimal concentrations of folate, a B vitamin, in their blood. For many reasons, Hispanic mothers have higher prevalence of NTD-affected births compared to non-Hispanic white and black women. CDC monitors red blood cell folate concentrations among women of reproductive age, including Hispanic women, to inform interventions in these populations. Based on data from NHANES, 80.3% of Hispanic women of reproductive age (12-49 years) were found to have an optimal blood folate concentration for neural tube defects prevention in FY 2019 (Measure 5.1.10).

In April 2016, FDA approved voluntary folic acid fortification of corn masa flour, a major food staple for many Hispanic women. Corn masa flour products with folic acid reached the first store shelves at the end of the summer 2016. CDC assessed the effects of this voluntary fortification and the data after corn masa flour fortification (NHANES 2017–2020) showed essentially no change in the proportion of Hispanic women of reproductive age who have an optimal blood folate concentration when compared to data pre-fortification (NHANES 2007–2016). In 2017–2020, more Hispanic women reported consuming enriched cereal grain products and corn masa flour (62.4%) as their only source of folic acid compared to previous years (56.3%). This trend is also reflected in the overall population but is magnified in the Hispanic population. Hispanic women who were less acculturated, primarily speaking Spanish at home, showed more substantial improvements than Hispanic women overall, with 85.3% of this subpopulation reaching optimal blood folate concentrations. To improve the stability and reliability of statistical estimates, additional years of NHANES data are needed to assess the effects of voluntary fortification of corn masa flour with folic acid on optimal blood folate concentrations, in particular as it relates to the acculturation status of Hispanic women. In FY 2023, CDC is examining the availability in the United States of retail corn masa flour and corn masa flour products voluntarily fortified with folic acid. In addition, CDC is conducting formative research with Hispanic women of reproductive age to understand their current knowledge, attitudes, and practices around folic acid intake and neural tube defects prevention.

CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network monitors the prevalence of autism spectrum disorder (ASD) and other developmental disabilities in 16 communities across the United States. In 2018, CDC updated and simplified the ADDM methodology and data system to directly reflect community identification of autism by healthcare provider diagnosis or special education eligibility. These changes provide similar prevalence estimates as the previous method and allowed for faster publication of results (1 year faster), expanded tracking of early autism identification, and enhanced ability to support more sites. In 2023, CDC released the most recent ADDM data that estimated that 1 in 36 children living in ADDM Network communities in 2020 have ASD. In addition to providing a prevalence estimate, ADDM data are used to track the age at which children with ASD receive developmental evaluations and ASD diagnoses. CDC revised its measures to better evaluate the proportion of children with early identification of ASD and to look at children with and without intellectual disability. The proportion of children 8 years of age who have intellectual disability and ASD who were first evaluated by age 36 months increased from 61.0% in FY 2022 to 61.9% in FY 2023. The proportion of children who have ASD but do not have intellectual disability who were first diagnosed by age 36 months increased from 45.5% in FY 2022 to 46% in FY 2023 (Measures 5.1.5e-f).

## **Health and Development for People with Disabilities**

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**Performance Measures for Long-Term Objective: Improve the health and quality of life of Americans with disabilities**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
5.2.8 Decrease the proportion of young children with permanent hearing loss whose enrollment status for early intervention services is unknown (Outcome)	FY 2021: 16.2% Target: 15.0% (Target Not Met but Improved)	12.0%	11.0%	-1.0
5.2.9 Decrease the disparity between adults with and without a disability who report no aerobic activity <sup>1</sup> (Outcome)	FY 2021: 17.6% Target: 15.0% (Target Not Met)	N/A	11.0%	-1.0

<sup>1</sup> Targets and results reported biennially

**Performance Trends:** Hearing loss among young children can have serious consequences and is relatively common compared to other newborn conditions (at least 6,000 infants identified each year in the United States). Without early identification and intervention, hearing loss can have a profound and lasting impact on the speech and language, social, and emotional development of thousands of children born each year. CDC supports state and territory-based Early Hearing Detection and Intervention (EHDI) Information Systems in 38 states and Puerto Rico to ensure young children with hearing loss are identified early and receive the intervention services that can help them reach their full potential. CDC recently developed a new measure to maximize the proven benefits of early identification and intervention and promote improved long-term outcomes. The relevance of this measure is reflected by the fact that in 2021, it was unknown if 16.2% of the young children identified with a permanent hearing loss were receiving recommended intervention services (Measure 5.2.8). While this did not meet the FY 2021 target it is an improvement over FY 2020. This is an issue because the benefits and return on investment from early identification are reduced without the timely receipt of intervention. By decreasing the proportion of children where it is unknown if they are receiving intervention, CDC can help ensure all children with hearing loss are receiving valuable and recommended services while concurrently reducing the need for longer-term investments in services, and directly supporting ongoing academic success.

Up to 27% of U.S. adults has at least one disability, such as difficulty walking or climbing stairs; hearing; seeing; or concentrating, remembering, or making decisions. Living with a disability is often associated with significant health risk factors and increased economic costs compared with not having a disability. CDC is dedicated to promoting inclusive communities, programs, and policies that provide opportunities for people with disabilities and their families to live full, healthy lives. CDC works with partners and offers tools and resources to improve the accessibility and inclusivity of public health programs focused on healthy living. Physical inactivity is one of the leading risk factors for noncommunicable diseases mortality. Adults with disabilities are three times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities. Aerobic physical activity can help reduce the impact of these chronic diseases, yet nearly half of all adults with disabilities get no leisure time aerobic physical activity. Reducing the aerobic inactivity disparity between adults with and without a disability have a major public health impact across the United States. In 2021, the disparity between adults with and without a disability who report no aerobic activity was 17.6% (Measure 5.2.9) and this is a slight increase from the baseline (17.2%) in 2019.

**Public Health Approach to Blood Disorders**

**Performance Measures for Long-Term Objective: Improve the health and quality of life for Americans with blood disorders**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
5.3.2 Decrease the prevalence of hemophilia treatment inhibitors among Community Counts - Health Outcomes Monitoring System for People with Bleeding Disorders at HTC (Outcome)	FY 2022: 11% (Baseline)	10.6%	10.4%	-0.2
5.B Increase the proportion of children less than 4 years old with severe hemophilia A or B who are prescribed early prophylaxis (Output)	FY 2022: 85.4% Target: 82.1% (Target Exceeded)	86.0%	86.5%	+0.5

**Performance Trends:** CDC protects people and prevents complications of blood disorders by reducing the prevalence of inhibitors among hemophilia patients and increasing the proportion of very young hemophilia patients receiving early prophylaxis treatment. Through Community Counts Monitoring System, CDC collects data on health issues and medical complications for people living with bleeding disorders, incorporates screening for inhibitors, and monitors treatment use, including prophylaxis, to facilitate best practices that help prevent or eradicate complicated, costly, and debilitating health conditions.

Approximately 15-20% of people with hemophilia develop an inhibitor, a condition where the body stops accepting the factor treatment product (which helps the blood clot properly) as a normal part of blood. The body treats the “factor” as a foreign substance and mounts an immune system response to destroy it with an inhibitor. When people develop inhibitors, treatments to prevent and stop bleeding episodes are less effective. Special treatment is required until the body stops making inhibitors, which can increase hospitalizations, compromise physical function, and exceed \$1,000,000 a year for a single patient.

Discovering an inhibitor as soon as possible helps improve outcomes and reduce costs. Although hemophilia care providers widely accept that development of an inhibitor is a serious issue, routine screening for inhibitors is not current practice for local laboratories because of the high cost and the inability to perform the proper tests.

Recently, CDC scientists were able to include multiple data sources to detect inhibitors among participants in the Community Counts program, including new cases, history of an inhibitor, and lab specimens. This more accurate representation of the population yields a new baseline where 11% of the sample population had an inhibitor as of FY 2022. A target of 10.8% has been established for FY 2023, and preliminary data indicates continuation of a decrease in cumulative prevalence (Measure 5.3.2). By continuing to monitor the prevalence of inhibitors in people with hemophilia subject matter experts aim to better understand factors that may contribute to the trends and assess the impact of CDC’s programs and partnerships to reduce complications from bleeding disorders.

People with hemophilia are also at risk for joint bleeds, a health problem that occurs when a person bleeds internally into their joints causing damage. Joint bleeds can happen following injury or trauma but can also occur



spontaneously. Frequent joint bleeds can lead to joint disease, an irreversible condition, making mobility painful and difficult. CDC data shows that regular treatment to prevent bleeding (prophylaxis) initiated before age 4 has the greatest impact on preventing bleeds, thereby preventing joint disease. Data from the Community Counts program helps CDC measure and monitor the proportion of children less than 4 years old with severe hemophilia A or B who are prescribed early prophylaxis.

In FY 2022 85.4% of children less than 4 years old were prescribed early prophylaxis, an increase over FY 2021 and exceeding the FY 2022 target (Measure 5.B). One factor that may have contributed to this increase was the use of emicizumab, still a relatively new prescription treatment used for prophylaxis among children and adults with hemophilia A to prevent the frequency of bleeding events. Data from Community Counts show that the use of emicizumab increased from 18.5% in 2019 to 60.8% in 2022. CDC scientists continue to monitor treatment utilization in Community Counts and engage with HTC and community partners on the importance of early prophylaxis and assess the impact of CDC's programs and partnerships to reduce complications from bleeding disorders.

## ENVIRONMENTAL HEALTH

### Childhood Lead Poisoning Prevention

Contextual Indicator	Most Recent Result
6.2.5a Reduce health disparities associated with blood lead levels in children aged 1-5 in the U.S. such that: a. The gap in blood lead levels between black children and children of other races is reduced (Contextual Indicator) <sup>1</sup>	FY 2015-2016: 0.20
6.2.5b Reduce health disparities associated with blood lead levels in children aged 1-5 in the U.S. such that: b. The gap in blood lead levels between children living above the federal poverty level and those living below the poverty level is reduced (Contextual Indicator) <sup>1</sup>	FY 2015-2016: 0.17

<sup>1</sup>Data is reported every four years.

**Performance Trends:** While overall child lead levels in the U.S. have fallen significantly in the last decade, reducing disparities is critical to decreasing the average blood lead levels among all young children. An estimated 29 million homes in the United States have one or more significant lead-containing paint or dust hazards, which places children at high risk of lead poisoning. CDC’s lead program supports 62 jurisdictions that serve more than 20 million children under the age of six.

CDC will retire its measures focused on the reduction in health disparities associated with blood lead levels in children. CDC’s access to the NHANES restricted-use data to compute values for those measures has been delayed and it is no longer feasible to expect this data. CDC will continue its efforts to reduce health disparities in children’s blood lead levels by providing resources and technical assistance to our jurisdictional partners for identification of children most at risk for lead exposure, conducting primary prevention activities where they live, attend school, worship and play, and using principles of health equity to ensure that all children exposed to lead have an equal opportunity to receive appropriate medical treatment and social services.

### Environmental and Health Outcome Tracking Network

#### Performance Measures for Program: Environmental Public Health Tracking

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
6.C Number of public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures (Output)	FY 2023: 73 Target: 60 (Target Exceeded)	60	75	+15

**Performance Trends:** The Environmental and Health Outcome Tracking Network covers over 185 million people, which made up about 57% of the United States population. The Tracking Network serves as a source of information on environmental hazards and exposures, population data, and health outcomes. Since FY 2013, CDC has consistently exceeded expectations for the number of data-driven actions to improve public health using the Tracking Network (Measure 6.C). CDC is refining how public health actions are captured and anticipates that the total number of actions may be reduced or remain flat. This consideration is reflected in the

FY 2025 target which is slightly above the FY 2024 target level. From FY 2005 to FY 2023, state and local public health officials have used the Tracking Network to implement over 900 data-driven public health actions to save lives and prevent adverse health effects that are due to environmental exposures.

For example, in 2023 there were 73 public health actions reported, with air quality, climate change, lead poisoning, cancer, and environmental justice as the most common environmental health topics addressed. Programs or interventions described by Tracking recipients included using their Cooling Center Finder to offer real-time cooling center availability information; adding acute and chronic health outcomes related to environmental exposures to the state public health accountability metrics; and implementing a policy requiring the state to use health disparity mapping tools to plan urban tree planting and reforestation efforts. The Tracking Network continues to serve as a source of information for health professionals, elected officials, researchers, parents, and the public on environmental hazards and exposures, population data, and health outcomes. Because of CDC’s concerted efforts to encourage Tracking grantees to report public health actions, CDC continues to meet this important measure of program success.

### Environmental Health Laboratory

**Performance Measures for Program: Environmental Health Laboratory**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
6.1.1 Number of environmental chemicals and nutritional indicators that are measured in surveys and studies of the U.S. population (Output)	FY 2023:435 Target: 415 (Target Exceeded)	420	425	+5
6.1.3 Number of laboratories participating in DLS Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements (Output)	FY 2023: 1,673 Target: 2,000 (Target Not Met but Improved)	2,050	2,055	+5
6.1.4 Number of chronic disease biomarkers included in standardization programs that improve the quality of laboratory measurements (Output)	FY 2023: 45 Target: 26 (Target Exceeded)	46	47	+1
6.A Number of environmental chemicals for which methods were developed or improved (Output)	FY 2023: 48 Target: 65 (Target Not Met but Improved)	70	72	+2

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
6.B Number of laboratory studies conducted to measure levels of environmental chemicals in exposed populations (Output)	FY 2023: 68 Target: 80 (Target Not Met)	85	90	+5

**Performance Trends:** CDC’s biomonitoring measurements track environmental chemical and nutrition indicator levels within the U.S. population and provide national reference information for scientists, physicians, and health officials. CDC also provides voluntary quality assurance and standardization programs that help ensure the quality and comparability of important laboratory measurements for chronic diseases, newborn screening disorders, nutrition status, and environmental exposures. CDC’s environmental health laboratory output decreased in FY 2021 and FY 2022 because of building occupancy limitations to maintain a safe working environment during the COVID-19 pandemic. CDC expects upward trends on affected measures to continue in 2025.

In FY 2023, CDC measured 435 environmental chemicals and nutrition indicators in surveys and studies (Measure 6.1.1). CDC continued its trend of publishing more data on human exposure to environmental chemicals faster and with greater accuracy, reporting biomonitoring data for more than 400 chemicals in the *National Report on Human Exposure to Environmental Chemicals*. In FY 2023, CDC added data for ten new chemicals, including chlorinated tyrosines, terpenes, and volatile organic compound metabolites, and updated tables for more than 50 other chemicals.

CDC continues to innovate to monitor Americans’ nutrition status and exposure to chemicals of concern. By FY 2025, CDC intends to add new measurements for several new chemicals, including biomarkers of dietary polyphenol intake, thyroid function, blood pressure, and B vitamins, while also cycling out some measurements for chemicals infrequently detected in the U.S. population.

In FY 2023, the number of laboratories using CDC quality assurance and standardization programs increased from 1,461 in FY 2022 to 1,673 in FY 2023. Though the FY 2023 result is below the target, it indicates a marked increase over the FY 2022 result. CDC expects an upward trend to continue in FY 2024 (Measure 6.1.3) and set its target to reflect the expected pace of increased participation.

In FY 2023, CDC added priority biomarkers of bone disease and heart disease to its chronic disease biomarkers standardization program, exceeding the target. CDC anticipates adding one additional biomarker to its programs in FY 2024 and one biomarker in FY 2025 (Measure 6.1.4).

In FY 2023, CDC developed or improved 48 tests to measure environmental chemicals, a substantial increase over the FY 2022 result (Measure 6.A). CDC developed a method for measuring a novel biomarker of benzene exposure that will improve studies of this ubiquitous environmental and industrial chemical. In FY 2025, CDC expects to develop or improve methods for more than 72 environmental chemicals.

In FY 2023, CDC collaborated on 68 studies of environmental chemicals (Measure 6.B), which was fewer than expected but included several major population studies that required the application of time-consuming laboratory methods on a large scale. In addition, CDC supported emergency testing for chemical exposure events in several states, which required shifting of priorities and resources. Collectively, collaborative studies help evaluate health outcomes related to exposures of concern. For example, CDC measurements of per-and polyfluoroalkyl substances (PFAS) helped assess links between PFAS exposure and testicular and kidney cancer risk, generating important data that can be used for determining carcinogenicity of common PFAS. CDC expects an upward trend to resume in FY 2024 and FY 2025 as resources and priorities allow.

## Asthma

Contextual Indicator	Most Recent Result
6.B.2.4 Reduce visits to emergency departments (EDs) for asthma among U.S. children (aged 0-17 years) (Contextual Indicator) <sup>1</sup>	FY 2020: 36.4

<sup>1</sup> ED visit rate per 10,000 population

### Performance Measure for Program: Asthma

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
6.2.4a: Increase the percent of National Asthma Control Program funding recipients that expand or scale up EXHALE interventions (Output)	FY 2022: 28% Target: 22% (Target Exceeded)	27%	29%	+2

**Performance Trends:** In the United States, nearly 25 million people have asthma, including almost 5 million children. While there is no cure for asthma, self-management training can teach people to manage their disease with medical care and to prevent asthma attacks by avoiding triggers. Uncontrolled asthma results in significant costs to families and society when individuals go to the emergency department or are hospitalized for an asthma exacerbation. Children ages 0-17 years have a higher ED visit rate compared with adults ages 18 and over. In 2010, the average annual ED visit rate with asthma as the first-listed diagnosis was 95.2 per 10,000 children compared with 53.3 per 10,000 adults. In FY 2020, the rate of asthma related ED visits among U.S. children was 36.4 per 10,000 children (Measure 6.B.2.4), which was significantly lower than the rate in 2019 (74.8 per 10,000 children). This decline is likely attributable to the decline in emergency visits due to the COVID-19 pandemic in 2020.

CDC’s National Asthma Control Program (NACP) seeks to decrease the number of emergency department visits and hospitalizations through a tiered approach for asthma control by using interventions with the strongest evidence of effectiveness. Comprehensive asthma control strategies (based on the National Institutes of Health’s Guidelines for the Diagnosis and Management of Asthma) are vital to helping people to stay out of the hospital, avoid the emergency department, and manage their asthma.

CDC’s EXHALE is a technical package of evidence-based interventions that work together to reduce asthma exacerbations and prevent asthma-related ED visits and hospitalizations in adults and children. Increasing the expansion or scale-up of these interventions each year will reach more people with asthma and improve their quality of life. In FY 2022, 28% of NACP-funded recipients expanded or scaled up EXHALE interventions, exceeding the target of 22% (Measure 6.2.4a).

## Environmental Health Activities

### Performance Measures for Program: Environmental Health Activities

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
6.1.5 Number of states using National Environmental Assessment Reporting System (NEARS) to prevent foodborne illness outbreaks (Output)	FY 2022: 25 Target: 30 (Target Not Met)	32	32	Maintain

**Performance Trends:** State, tribal, local, and territorial food safety programs use CDC’s National Environmental Assessment Reporting System (NEARS) to identify environmental factors that they can routinely monitor to prevent or mitigate foodborne illness outbreaks associated with food service establishments. These environmental factors include worker health policies and food handling practices.

The number of states using NEARS decreased by one to 25 (Measure 6.1.5); however, use by city and county health departments and other jurisdictions increased from 64 to 73 participants. Of 73 NEARS participants, 46 (63%) are city and county health departments. Although CDC does not fund jurisdictions to use NEARS, CDC is committed to continuing the NEARS Explorer Program with health departments and jurisdictions that want to use NEARS and anticipates interest in other jurisdictions will continue to increase.

A 2023 report showed norovirus was the most-identified cause of outbreaks reported to NEARS. This report summarized data from 800 foodborne illness outbreaks reported by health departments at U.S. restaurants in 25 states during 2017–2019. Four in 10 outbreaks with an identified cause were linked to sick workers. Only 1 in 6 restaurants with outbreaks had a detailed policy to prevent contamination from sick workers. It’s important for restaurants to develop and enforce policies that require workers with certain symptoms to 1) notify their manager, and 2) stay home or not work with food. NEARS data allowed CDC to make these actionable recommendations to state, tribal, local, and territorial health departments.

## INJURY PREVENTION AND CONTROL

### Intentional Injury Prevention

**Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from intentional injuries for people at all life stages**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
7.1.6 Reduction in suicide rates among vulnerable populations selected by Comprehensive Suicide Prevention Program recipients (Outcome)	FY 2023: 5.3% Target: 3.0% (Target Not Met)	6%	10%	+4
7.F Increase the number of prevention and response strategies from CDC’s Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence being implemented by state and local health departments funded through the multistate ACEs cooperative agreement (Output)	FY 2023:15 Target: 15 (Target Met)	16	17	+1
7.G Expand the number of evidence-based resources on best practices and core components of trauma-informed care for clinical practice that are available on the National Center for Injury Prevention and Control website (Output)	FY 2023: 1 Target: 5 (Target Not Met but Improved)	7	7	Maintain
7.1.8 Increase the percentage of Rape Prevention Education (RPE) states that are assessing community-level risk and protective factors related to sexual violence perpetration & victimization (Outcome)	FY 2022: 80% (Baseline)	84%	86%	+2

**Performance Trends:** CDC is leading efforts to prevent suicide and stop violence before it begins. CDC actively engages diverse audiences with innovative prevention strategies, tailoring our approach to meet the unique needs of individuals at risk. CDC is assessing the impact of these strategies and approaches through its performance measure which tracks the percentage of Rape Prevention Education<sup>290</sup> (RPE) funded states that assess the outcomes and impact of sexual violence prevention activities. The FY 2023 percentage of Rape Prevention Education (RPE) states that are assessing community-level risk and protective factors related to sexual violence perpetration & victimization will be determined by April 2024 (Measure 7.1.8).

This metric tracks the extent to which CDC's evidence-based strategies are achieving uptake and traction in applied settings. Through FY 2023, the Preventing Adverse Childhood Experiences: Data to Action programmatic award supported states in building their ACEs data and surveillance infrastructure and implementing strategies based on the best available evidence for adverse childhood experiences (ACEs) prevention. In FY 2023, 15 prevention and response strategies were implemented by recipients (Measure 7.F). The new Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action programmatic initiative was funded for FY 2024. Twelve funded recipients will enhance state-level surveillance infrastructure and implement data-driven prevention strategies to prevent [adverse childhood experiences](#) (ACEs) and promote [positive childhood experiences](#) (PCEs). This work is on track to continue meeting targets associated with this measure.

Relatedly, Measure 7.G ensures that CDC is generating and disseminating resources on trauma-informed care for clinical settings (and across other partners like first responders, educational settings, and businesses), to ensure that system responses to people who have experienced ACEs are not harmful. Progress on this measure has been slower than expected which led us to not meet our goal for 2023; and we have concerns about new requirements regarding our web presence that may impact the feasibility of our future targets. Our work to generate publicly facing resources to support implementation of trauma-informed care in all settings continues, and we will ensure availability to the public. However, the venue for dissemination may include partner outlets rather than including content on the NCIPC web page. CDC is also deeply engaged in the Interagency Task Force on Trauma-Informed Care, which helps ensure that our resources reach a broader audience and are incorporated into the emerging federal strategy for a coordinated approach to TIC. That task force recently submitted a report to Congress detailing the impact of our efforts thus far and proposing next steps for continued interagency collaboration. CDC is committed to providing resources for trauma-informed care for clinical settings, but the way this measure is currently structured is not adequately reflecting that work. We have not been able to meet our initial targets. CDC plans to update the measure in the next budget cycle to better highlight our work and progress in promoting trauma informed care in clinical settings.

CDC's measure on reducing suicide rates among at risk populations was selected for CDC's Comprehensive Suicide Prevention Program funding recipients when first awarded in FY 2020 (Measure 7.1.6). Nationwide suicide rates are increasing, with certain populations disproportionately affected (e.g., veterans, older males). The CSP recipients saw a 5.3% increase overall in FY 2023. Despite this increase, four of the CSP recipients reported decreases in suicide rates among their disproportionately affected populations. For example, Massachusetts reported a decrease of 8.2% in suicide rates overall, including significant decreases among male veterans and Hispanic and Latin males. In addition, CSP recipients who focus on preventing suicide among veteran and service members saw a reduction of 6.5%. This includes a recently funded CSP recipient, Louisiana, which reported a 7.6% decrease in suicide rates among their veterans and service members.

CSP recipients are focused on implementing and evaluating a comprehensive public health approach to suicide prevention, with attention to populations with disproportionately higher risks of suicide. A comprehensive approach to suicide prevention is characterized by strong leadership that convenes multi-sectoral partnerships, prioritization of data to identify vulnerable populations and better characterize risk and protective factors impacting suicide, leveraging existing suicide prevention programs, selection of multiple and complementary

<sup>290</sup> <https://www.cdc.gov/violenceprevention/rpe/index.html>.



strategies with the best available evidence to fill gaps, effective communication, and rigorous evaluation of the overall approach and individual activities with an eye towards quality improvement and sustainability. Program recipients use local data to identify populations disproportionately affected by suicide, including veterans, middle-aged men, youth, people living in rural areas, LGBTQ people, and others. The Comprehensive Suicide Prevention Program continues to grow with additional funding. The total number of recipients expanded to 17 in FY 2022 and 24 in FY 2023.

### Unintentional Injury Prevention

**Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from unintentional injuries for people at all life stages**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
7.2.7b Reduce age-adjusted annual rate of overdose deaths involving synthetic opioids other than methadone (e.g., fentanyl) among states funded through CDC’s multi-state surveillance and prevention cooperative agreement (per 100,00 residents) (Outcome)	FY 2021: 23.4 <sup>2</sup> Target: 7.7 (Target Not Met)	7.7	7.7	Maintain
7.2.7c Reduce the age-adjusted rate of overdose deaths involving natural and semisynthetic opioids (T40.2) or methadone (T40.3) as a contributing cause of death among states funded through CDC’s multi-state surveillance and prevention cooperative agreement (per 100,000 residents) (Outcome)	FY 2021: 5.2 <sup>2</sup> Target: 3.7 (Target Not Met)	3.6	3.6	Maintain

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
7.2.8 Increase the number of data-driven public health actions applied by Core SIPP recipients that promote injury prevention and community readiness. (Outcome)	FY 2023: 170 Target: 99.0 (Target Exceeded)	104	109	+5

<sup>1</sup>The Core SIPP program is cross-cutting and is supported by both the Intentional and Unintentional Injury Prevention budget lines.

<sup>2</sup> Cooperative agreement – 47 states and the District of Columbia.

**Performance Trends:** CDC is tracking the rise of opioid and drug overdose deaths and using the data to inform prevention activities to curb this alarming epidemic. Over 640,000 people in the U.S. have died from overdoses involving opioids—prescription or illicit—from 1999 through 2021. Overdose deaths remain unacceptably high, with 2022 predicted to have seen a record high 110,511 drug overdose deaths, 83,695 of which involved opioids. The increase in overdose deaths over the past several years is largely attributable to illicitly manufactured fentanyl permeating the national illegal drug supply. However, early data show encouraging signs that drug overdoses may be stabilizing. Compared with the 106,699 drug overdose deaths in the U.S. in 2021<sup>291</sup>, provisional data for 2022 predict 110,511 people died from drug overdose in 2022. This 3.6% increase in all-drug mortality represents a smaller year-over-year increase than from 2020 to 2021 (16.2% increase), and from 2019 to 2020 (30.0% increase).

Rapid analysis and dissemination of nonfatal and fatal overdose data are essential for monitoring, preventing, and reducing drug use and misuse-related harms. To maximize the potential impact of nonfatal and fatal overdose data, CDC released two data dashboards in 2022 and two more in 2023. These interactive dashboards provide timely and specific state-level drug overdose data and include visually appealing and easily understandable graphics and messaging aimed at reaching a vast audience. These data provide opportunities for communities to understand the evolving drug overdose epidemic and generate appropriate prevention and response efforts.

CDC’s Drug Overdose Surveillance and Epidemiology (DOSE) System analyzes data from electronic health records to rapidly identify outbreaks and provides situational awareness of changes in suspected drug overdose-related emergency department visits at the local, state, and regional levels ensuring consistent and accurate reporting across all entities which makes it easier to compare data across states. Since 2019, 47 states and the District of Columbia have provided data to CDC which is publicly accessible through interactive dashboards. Forty-two states and DC provide emergency department syndromic surveillance data on a monthly basis, and 25 states provide data from discharge and billing records each quarter. In April 2022, CDC released an interactive dashboard<sup>292</sup> displaying the syndromic data from DOSE. Updated monthly, this dashboard shows near real-time trends in emergency department visits for suspected nonfatal overdoses by drug type, and by state, sex, and age group. This dashboard allows the user to adjust the visuals to show the percentage change in the rate of emergency department visits for drug overdoses for a chosen time period. In May 2023, CDC released a

<sup>291</sup> <https://www.cdc.gov/nchs/products/databriefs/db457.htm>

<sup>292</sup> <https://www.cdc.gov/drugoverdose/nonfatal/dose/surveillance/dashboard/index.html>

companion dashboard<sup>293</sup> updated quarterly with monthly and annual counts and rates of nonfatal overdose ED visits and inpatient hospitalizations from billing and discharge records.

In June 2022, CDC developed an interactive data visualization tool, the State Unintentional Drug Overdose Reporting System (SUDORS) dashboard, which is updated annually and currently displays fatal overdose data for 2020 and 2021. Participating jurisdictions provide data abstracted from multiple data sources including death certificates, medical examiner/coroner reports, and postmortem toxicology. More specifically, the SUDORS dashboard uses interactive graphics to show rates—overall and by state—of drug overdose deaths by drug, used alone or in combination, and potential opportunities for linkage to care or life-saving actions at the time of the fatal overdose. Most visualizations are accompanied by dynamic text that helps the user to interpret and summarize the displayed information. The SUDORS dashboard can inform prevention and response efforts by educating partners about location-specific circumstances and risk factors associated with drug overdose death; alerting healthcare providers, public health professionals, medical examiner and coroner offices, and other partners of newly emerging drug threats; informing drug overdose prevention and response planning using toxicology and circumstance data; and evaluating the impact of overdose prevention and response efforts. The DOSE and SUDORS dashboards offer other federal government agencies, state and local health departments, harm reduction and other community-based organizations, clinicians, and the public the opportunity to view and use these data to inform overdose prevention efforts.

CDC’s response to the opioid epidemic continues to evolve and leverages this substantive data to inform prevention in states and communities. In FY 2025, CDC will continue to support recipients via its Overdose Data to Action cooperative agreements. The first, “CDC-RFA-CE23-2302—Overdose Data to Action in States,” funds 49 states and Washington, DC to improve data and surveillance of fatal and non-fatal drug overdoses and uses that data to inform tailored prevention initiatives. The second cooperative agreement, “CDC-RFA-CE23-2303—Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL),” funds up to 40 local, city, and county health departments to focus on innovative data efforts and the improvement of local, community-based prevention strategies. These cooperative agreements will build off the work and gains made through previous overdose surveillance and prevention investments.

In FY 2021, the age-adjusted annual rate of opioid deaths involving prescription opioids was 5.2 per 100,000 residents among states funded for the OD2A program (Measure 7.2.7c). While this did not meet the FY 2021 target, the rate did not increase from FY 2020 to FY 2021, showing signs of a possible reversal of the worsening trends in previous years. The age-adjusted annual rate of opioid deaths involving synthetic opioids other than methadone (e.g., fentanyl) in FY 2021 was 23.4 per 100,000 residents among states funded for the OD2A program (Measure 7.2.7b). This did not meet the FY 2021 target and was likely exacerbated by growing overdose deaths resulting from illicitly manufactured fentanyl. In 2022, CDC provisional data has shown an increase in deaths related to illicitly manufactured fentanyl; however, acceleration of deaths has slowed. A recent CDC study found that 32 jurisdictions reported 52,969 overdose deaths involving illicitly-manufactured fentanyl from January 2019–June 2020<sup>294</sup>. The growing issue of polysubstance use means that an opioid-involved overdose often occurs in combination with exposure to other opioids and/or other non-opioid substances. Some examples of polysubstance exposures found in combination in overdose deaths include: illicitly-manufactured fentanyl (IMF) and methamphetamine<sup>295</sup>; illicitly-manufactured fentanyl and cocaine<sup>296</sup>; and prescription or illicit opioids and benzodiazepines<sup>297</sup>. The overdose epidemic has grown increasingly complex by co-involvement of prescription and illicit drugs, most recently impacted by the proliferation of xylazine. In the 32 jurisdictions which met reporting requirements for display on the public-facing dashboards, four in five (81.9%) involved at least

<sup>293</sup> <https://www.cdc.gov/drugoverdose/nonfatal/dose/discharge/dashboard/index.html>

<sup>294</sup> [https://www.cdc.gov/mmwr/volumes/72/wr/mm7226a4.htm?s\\_cid=mm7226a4\\_w](https://www.cdc.gov/mmwr/volumes/72/wr/mm7226a4.htm?s_cid=mm7226a4_w)

<sup>295</sup> <https://www.cdc.gov/nchs/data/databriefs/db474.pdf>

<sup>296</sup> [https://journals.lww.com/jphmp/Citation/2023/05000/Suspected\\_Nonfatal\\_Cocaine\\_Involved\\_Overdoses.16.aspx](https://journals.lww.com/jphmp/Citation/2023/05000/Suspected_Nonfatal_Cocaine_Involved_Overdoses.16.aspx)

<sup>297</sup> [Notes from the Field: Illicit Benzodiazepines Detected in Patients Evaluated in Emergency Departments for Suspected Opioid Overdose — Four States, October 6, 2020–March 9, 2021 | MMWR \(cdc.gov\)](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm7010a1.htm)

one opioid, more than half (54.2%) involved at least one stimulant, and two in five (39.9%) decedents' deaths involved both opioid(s) and stimulant(s)<sup>298</sup>.

CDC will continue to strengthen surveillance activities, identify interventions, and implement prevention programs that address the evolving nature of the epidemic. Release of final 2022 mortality data and associated reports have been postponed due to a delay in the receipt of death records from all jurisdictions. A new release date will be announced once NCHS has received and analyzed these data. Provisional data representing everything NCHS has received for 2022 is available in WONDER and updated weekly. The age-adjusted rates for measures 7.2.7b and 7.2.7c should be available by spring 2024.

Unintentional injuries are the leading cause of death for individuals ages 1 to 44 in the United States. Additionally, over half of the total medical and work loss costs of injury deaths are attributable to unintentional injuries (\$129.7 billion)<sup>299</sup>. CDC supports intentional and unintentional injury prevention activities through the Core State Injury Prevention Program (Core SIPP) (Measure 7.2.8) and prior to that the Core State Violence and Injury Prevention Program (Core SVIPP) (Measure 7.2.5). Core SVIPP funding was awarded to 23 states from 2016 to 2021, and 100% of the state awardees achieved 100% compliance in using data to assess state outcomes. CDC retired this measure (Measure 7.2.5) because the target was achieved and Core SVIPP concluded in FY 2021. CDC is now focused on Core SIPP, Measure 7.2.8. In 2022, the 23 Core SIPP recipients applied 94 data-driven public health actions that promoted injury prevention and community readiness, which served as the baseline for this measure. In 2023, Core SIPP recipients applied 170 data-driven public health actions that promoted injury prevention and community readiness, exceeding the target. The goal is to increase the number of data-driven public health actions by five each year.

Core SIPP works primarily with health departments to use data and research to identify and respond to existing and emerging injury threats. Recipients use data and research to implement public health actions that prevent injury. Core SIPP aims to increase protective factors and reduce risk factors, with a focus on adverse childhood experiences, traumatic brain injury, and transportation safety. Recipients can use up to 25% of their award to address local priority injury topics, such as increasing the violence prevention evidence base and demonstrating public health impact. Examples of data-driven public health actions include Kentucky's coordination with public and private partners to implement the teen driver safety program, Checkpoints, which is designed to provide parents and teens a way to manage new teen driver risks. Colorado facilitated multi-sectoral partnerships across the Violence and Injury Prevention network to identify populations disproportionately affected by adverse childhood experiences, motor vehicle safety, and traumatic brain injuries in order to focus on reducing health disparities.

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<sup>298</sup> <https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html>

<sup>299</sup> <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6438a4.htm>

## PUBLIC HEALTH SCIENTIFIC SERVICES

### Health Statistics

**Performance Measures for Long Term Objective: Monitor trends in the nation’s health through high-quality data systems and deliver timely data to the nation’s health decision-makers**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
8.A.E.2 Reduce the number of months after data year for release of the final mortality and natality files (Outcome; Efficiency)	FY 2021: 10 Target: 11 (Target Exceeded)	11	11	Maintain
8.A.1.1b Sustain the percentage of Federal Power Users (key federal officials involved in health and health care policy or programs) that indicate that data quality is good or excellent (Outcome)	FY 2023: 100% Good or Excellent Target: 100% Good or Excellent (Target Met)	100% Good or Excellent	100% Good or Excellent	Maintain
8.A.1.1e Achieve and sustain the percentage of NCHS website users that are satisfied with data relevance and ease of access (Outcome)	FY 2022: 73.6% Target: 65% (Target Exceeded)	65%	68%	+3
8.A.1.3 Increase the number of web visits as a proxy for use of NCHS data (Output)	FY 2023: 27.3 Million Target: 13.5 Million (Target Exceeded)	15 Million	15.5 Million	+0.5
8.G Number of adults interviewed in the National Health Interview Survey (Output)	FY 2022: 27,651 Target: 27,000 (Target Exceeded)	29,000	29,000	Maintain

**Performance Trends:** CDC uses several indicators to measure its ability to provide timely, useful, and high-quality data. CDC released its final 2021 mortality and natality data 10 months after the data year, exceeding the goal of 11 months (Measure 8.A.E.2). More timely data informs relevant, evidence-based policy decisions and planning. Faster access to these data also facilitates timely evaluation and research efforts for natality and all causes of death, providing critical information on public health issues impacting the nation. CDC’s progress on expediting mortality data releases was especially valuable in supporting evidence-based policy decisions during the COVID-19 pandemic, as the agency released provisional COVID-19 and excess mortality statistics on a weekly basis through the National Vital Statistics System. Additionally, starting in February 2022, the time lag for provisional drug overdose data was shortened from six months to four months. Policymakers and researchers now have access to drug overdose data at the national and state levels two months sooner than in previous years, improving analysis and decision making. In August 2023, CDC released provisional suicide data on CDC WONDER, alerting policymakers to a 2.6% increase in suicides from 2021 to 2022.

To drive program improvements, CDC assesses user satisfaction and perceptions of data utility. CDC has revised this measure to assess the percentage of NCHS website users that are satisfied with data relevance and *ease of*

access, as accessibility is a key focus for CDC in its role implementing the Foundations for Evidence-Based Policymaking Act of 2018 and the CDC Moving Forward Initiative (Measure 8.A.1.1e). In 2022, CDC exceeded its target as 73.6% of users were satisfied with data relevance and ease of access. CDC is improving access to NCHS online data sources, including integrating and simplifying existing points of access. Projects underway include developing a scalable data query system and a single data repository with standard and searchable metadata - with the goal of improving user experiences in accessing and using NCHS data. Similarly, CDC interviews Federal Power Users (key federal officials involved in health and health care policy or programs) to assess their satisfaction with CDC's Health Statistics products and services, including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. 100% of federal power users rated NCHS as "good" or "excellent" in data quality in 2023 - reflecting an increase from its 2022 performance (Measure 8.A.1.1b).

CDC tracks the number of web visits to assess the frequency of NCHS data utility. There were 27.3 million web visits in FY 2023, which exceeded the target (Measure 8.A.1.3). This data indicates a continued increase in web traffic compared to the previously flat trend of 12 million visits annually since FY 2013. This substantial change is driven by increased attention on health statistics during the COVID-19 pandemic. The Vital Statistics Rapid Release program provides access to timely vital statistics for public health surveillance through quarterly releases of provisional estimates of births, deaths, and infant deaths. This program helps to increase public interest in the data and enables potential users to easily find recent data on the website. Additionally, to better inform policy and decision makers, counts of provisional drug overdose deaths are published on the NCHS website monthly, and, beginning in 2023, provisional maternal mortality death counts are updated quarterly. Recent improvements in data quality have led to a significant increase in the number of states reporting the specific drugs involved in overdose deaths, improving public health professionals' ability to track recent rises in specific drug classes, such as fentanyl.

The National Health Interview Survey (NHIS) interviewed 27,651 adults in 2022, exceeding its 2022 performance target by over 600 adults (Measure 8.G). Due to the creative efforts of CDC staff and Census Bureau Field Representatives, the NHIS response rate has almost returned to pre-pandemic levels at a time when survey response rates nationwide are declining. CDC continues to implement changes to further improve survey response rates, such as streamlining communication of survey value to potential participants. Sufficient sample size allows NHIS data to be disaggregated to show health trends for smaller demographic and geographic groups while maintaining participant confidentiality.

## Public Health Workforce and Career Development

**Performance Measures for Long Term Objective: Develop and implement training to provide for competent, sustainable, and empowered public health workforce able to meet emerging and future health challenges.**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
8.B.4.2 Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies <sup>1</sup> (Output)	FY 2023: 409 Target: 294 (Target Exceeded)	294	294	Maintain
8.B.4.4 Increase the number of times health professionals earn free Continuing Education (CE) from CDC, demonstrating successful achievement of knowledge <sup>2</sup> (Output)	FY 2023: 634,922 Target: 557,000 (Target Exceeded)	613,000	675,000	+62,000

<sup>1</sup>In FY 2022, this includes ALL (new and continuing) full-time trainees, at least partially funded by CDC PHSS, in the CDC Epidemic Intelligence Service (EIS), Laboratory Leadership Service (LLS), Preventive Medicine Residency and Fellowship (PMR/F), and the Public Health Associate Program (PHAP). It also includes full-time trainees in the CDC/CSTE Applied Epidemiology Fellowship (AEF) and the CDC/CSTE Applied Public Health Informatics Fellowship (APHIF).

<sup>2</sup>Measure language updated to clarify the measure. Methodology remains the same.

**Performance Trends:** Protecting our nation’s health requires a public health workforce prepared to meet emerging and future threats. The COVID-19 pandemic brought into light the significant need to build up the public health workforce by as much as an 80% increase<sup>300</sup>. In the next five to ten years, a substantial number of long-time public health workers plan to leave their jobs or retire, taking with them critical knowledge and experience. The next generation of public health professionals needs to be trained and prepared to fill these vacancies. CDC is making great strides building a competent and sustainable public health workforce through its support of public health departments and partners by providing staff (fellow assignments), technical assistance, and training and education services.

### **Building a Pathway to a Career in Public Health**

CDC fellowship programs promote experiential service and mentored learning at the agency and in the field. CDC fellowship programs offer unique experiences in one of many public health critical disciplines, including applied epidemiology, laboratory sciences, prevention effectiveness, public health leadership and management, and data science. This focus on service while learning allows CDC fellows and trainees to fill critical workforce needs at CDC and in state, tribal, local, and territorial (STLT) public health agencies, while training for careers in public health.

Focusing funding on field placement programs offers jurisdiction direct support from CDC and provides fellows and trainees an invaluable opportunity to work alongside other professionals across a variety of public health settings. Throughout these training programs, CDC provides hands-on experience that will serve as a foundation for these fellows’ public health careers. After completing CDC fellowships, graduates are qualified to apply for jobs with public health agencies and data shows that the majority of CDC fellowship graduates stay in federal, state, or local public health.

CDC placed 409 CDC trainees in STLT public health agencies in FY 2023 (Measure 8.B.4.2). CDC expects trainee placements in STLT public health agencies to reduce to levels prior to short-term emergency supplemental funding and will maintain current targets FY 2024 and FY 2025.

### **Upskilling the Existing Public Health Workforce**

A robust public health workforce depends not only on attracting and retaining new professionals into public health, but also upskilling the existing public health workforce to employ cutting edge technology and best practices. The current workforce must stay up-to-date on the latest science, guidelines, and recommendations from CDC to inform both public health and healthcare practice. An effectively trained public health workforce is our first line of defense against disease outbreaks, like COVID-19, natural disasters, and other health threats domestically and globally. CDC designs, develops, and accredits quality learning opportunities and ensures these opportunities are available to the public health and health care workforce. CDC provides continuing education (CE) for seven different professional disciplines, which are required to keep skills and licensures current, and are delivered at little to no cost to the learner. Access to accredited training opportunities is essential for the public health workforce to maintain and improve knowledge and skills for the greatest impact on health outcomes.

The accredited learning opportunities CDC provides to the public health workforce help ensure workers are able to maintain licensure and certification requirements, improve knowledge and skills, and ultimately enhance their overall competency. In FY 2023, nearly 232,000 unique health professionals earned free CE credit nearly 635,000 times, valued at an estimated \$10 million (Measure 8.B.4.4). This exceeded the target but was less than FY 2021 results which were higher than usual due to the COVID-19 response.

<sup>300</sup> <https://www.tfah.org/story/staffing-up-public-health-workforce-must-grow-to-provide-basic-public-health-for-all-americans/>

## State, Tribal, Local and Territorial Support

**Performance Measures for Long Term Objective: Improve the capacity and performance of state, tribal, local, and territorial public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public’s health**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
8.C.1 (State) Increase the percentage of nationally PHAB accredited state public health agencies (Intermediate Outcome)	FY 2023: 80.4% Target: 82% (Target Not Met but Improved)	84.0%	86%	+2
8.C.2 (Local) Increase the percentage of nationally PHAB accredited local public health agencies (Intermediate Outcome)	FY 2023: 16.8% Target: 16% (Target Exceeded)	18%	20%	+2

**Performance Trends:** Health departments serve Americans where they live, work, and play; every American benefits from their services and never has this been as visible as in the nation's response to the COVID-19 pandemic. CDC support and resources to state, tribal, local, and territorial public health departments help improve the effectiveness, efficiency, and quality of public health programs. Additionally, CDC assists health departments in meeting the nationally recognized, practice-focused, and evidence-based standards of the Public Health Accreditation Board (PHAB)<sup>301</sup>. Meeting these standards provides health departments with tools to advance the quality and performance of public health programs and services and better positions them to rapidly respond to emerging threats and challenges. CDC funds and supports the continuous improvement of the national accreditation program.

Accredited health departments now serve approximately 90% of the U.S. population as of November 2023. PHAB has accredited 436 health departments—41 states, six tribes, and 389 local health departments (including 315 individually accredited local health departments and 67 county health departments through a centralized state application). In 2018, PHAB reaccredited the first health departments and 116 health departments are reaccredited as of November 2023. An additional 105 health departments have formally entered the initial accreditation process and 111 health departments are engaging in, or eligible for reaccreditation. CDC partially met FY 2023 targets with 80.4% of state and 16.8% of local agencies accredited or reaccredited as of the end of 2023 (Measures 8.C.1-2).

A survey in July 2020 of more than 80% of accredited health departments indicated that, overall, accreditation has helped their response to the COVID-19 pandemic in the areas of preparedness plans and policies and relationships with other sectors and stakeholders<sup>302</sup>. Annual evaluation findings also consistently report benefits to participating in accreditation. July 2023 evaluation data indicate that the program has stimulated quality improvement (95% of accredited health departments agree), improved accountability and transparency (88%), and improved their health department’s ability to identify and address gaps in employee training and workforce development (90%). Additionally, comparative studies, published in peer review journals, used longitudinal data to identify substantial differences between accredited and non-accredited health departments. Within a few years after the program had launched and sites began to receive accreditation, the PHAB-accredited sites tended to offer a higher percentage of public health activities, contribute more effort to almost

<sup>301</sup> <http://www.phaboard.org/about-phab/>

<sup>302</sup> Public Health Accreditation Board. PHAB Survey of Health Departments and Site Visitors During Response to COVID-19 Pandemic, July 2020. Available at: <https://phaboard.org/wp-content/uploads/Strategic-Planning-Survey-Findings-Final-July-2020.pdf>.



all those activities, and report higher levels of contribution from most other public health system partners<sup>303</sup>. Another study found substantial increases in quality improvement engagement among accredited health departments compared to ones not engaged in accreditation<sup>304</sup>.

From FY 2011 until present, CDC has made investments to support accreditation and performance improvement activities through small awards and customized technical assistance (originally called the Accreditation Support Initiative [ASI] and since FY 2019 titled the Strong Systems, Stronger Communities program). These initiatives show how even small awards and technical assistance can play critical roles in supporting health department efforts to meet standards and achieve accreditation. Also, investments in accreditation readiness often require significant lead time to be realized. For example, of the local sites that received ASI awards through 2018, approximately half (54.8%) are now accredited, while approximately three-quarters (70.5%) of local ASI sites supported during the first three years (2011-2013) have now been accredited. In FY 2021, state and local health departments received technical assistance on request, and nine tribal sites were competitively selected for small awards to support efforts to use the PHAB standards to strengthen their public health infrastructure.

In addition, CDC invests in cross-cutting capacity building and performance improvement cooperative agreement programs for health departments through which recipients have been able to prepare for and obtain accreditation. This includes the Preventive Health and Health Services (PHHS) Block Grant. For the last four years, block grant recipients have consistently chosen to invest approximately 30% of their funding in public health infrastructure to enhance workforce, data and information systems, laboratory services, epidemiology capacity, and performance improvement and accreditation. In FY 2023, recipients invested approximately \$30M in activities aligning with the performance improvement and accreditation-related objectives in Healthy People 2030.

Another CDC cooperative agreement mechanism initiated in FY 2018 supported 25 American Indian and Alaska Native (AI/AN) Tribal Nations and regional tribally-designated organizations on activities to enhance the quality and performance of the tribal public health system, including infrastructure, workforce, data and information systems, programs and services, resources and communication, and partnerships. In FY 2023, a new cooperative agreement funded 26 AI/AN Tribal Nations and regional tribally designated organizations to strengthen the quality, performance, and infrastructure of Tribal public health systems, including workforce, data and information systems, and programs and services. The funding is well-aligned with supporting efforts toward meeting the national standards for public health accreditation. Similarly, in 2023, CDC provided flexible funding to state, territorial, and local health departments to strengthen workforce, foundational capabilities, and data modernization. Jurisdictions will also receive technical assistance for workforce development and foundational capabilities through three national health partners, the Association of State and Territorial Health Officials (ASTHO), National Network of Public Health Institutes (NNPHI), and Public Health Accreditation Board (PHAB). In addition to technical assistance, these organizations, working in conjunction with other partners, will evaluate the program and facilitate coordination and communication across grantees.

Targets established through FY 2025 are achievable; the field is still benefitting from previous investments in an accreditation preparation and application process with a significant lead time. However, COVID implications continue to cause many delays and elongated timelines. Sites not applying for or achieving reaccreditation can also impact the proportion of accredited sites. Twenty-two sites -- all local health departments -- are no longer accredited, mostly due to not applying for reaccreditation, as a result of financial or staff time considerations and the impact of COVID. CDC plans to continue funding improvements and updates to the PHAB national accreditation program and the advancement of reaccreditation. During 2021, CDC supported PHAB in producing

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<sup>303</sup> Ingram RC, Mayes GP, Kussainov N. Changes in local public health system performance before and after attainment of national accreditation standards. Supplement, Impact of Public Health Accreditation. Journal of Public Health Management and Practice. 2018 (24:suppl 3), S25-S34.

<sup>304</sup> Beitsch LM, Kronstadt J, Robin N, Leep C. Has voluntary public health accreditation impacted health department perceptions and activities in quality improvement and performance management? Supplement, Impact of Public Health Accreditation. Journal of Public Health Management and Practice. 2018 (24:suppl 3), S10-S18.

and vetting updates to the national standards. Revised standards and measures, which incorporate updates in areas such as health equity, data surveillance, and emergency preparedness, were released in spring 2022. CDC supported PHAB in the development and 2022 launch of the Pathways Recognition Program which provides a stepwise process intended to help tribal, territorial, and smaller local health departments advance towards accreditation status. Just as the public expects organizations such as schools and hospitals to be accredited, the national accreditation program for health departments is establishing growing expectations for health departments to meet national standards and become accredited.

**Science and Public Health Information**

**Performance Measures for Long-Term Objective: Improve access to and reach of scientific public health information among key audiences to maximize health impact**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
16.A Increase the electronic media reach of the Morbidity and Mortality Weekly Report (MMWR) through use of mechanisms such as the MMWR website and social media outlets, as measured by page views, social media followers, and email subscribers (Output)	FY 2023: 21,162,636 Target: 30,000,000 (Target Not Met)	21,993,998	21,993,998	Maintain
16.B Increase the electronic media reach of CDC Vital Signs through use of Vital Signs-specific metrics, as measured by Vital Signs page views and email subscribers (Output)	FY 2023: 1,858,884 Target: 3,053,739 (Target Not Met)	3,053,739	3,053,739	Maintain

<sup>1</sup> Since 2018, the followers to CDC’s Main Twitter and Facebook accounts were added to this number. They share MMWR content each week.

**Epidemiology Performance Trends:** During FY 2023, CDC provided critical epidemiological data and recommendations for solving public health problems to approximately 145,000 clinicians and public health professionals through an extensive network of electronic communication channels for the *Morbidity and Mortality Weekly Report (MMWR)*. During FY 2023, *MMWR* published approximately 352 reports, a slight decline from the peak of 400 reports during the peak of COVID-19 and mpox emergency responses. *MMWR* content is shared widely, with traditional and social media coverage averaging in the top three percent of all journal publications. During FY 2023, *MMWR* webpage views decreased, largely due to the end of the Public Health Emergency Declaration. Although *MMWR* did not meet its overall target for FY 2023, *MMWR* continued to reach more than 1.8 million people and continues to evaluate approaches for continuing to expand its reach and audience based on lessons learned from the pandemic (Measure 16.A). Targets for FY 2024 and FY 2025 have been revised to reflect 2020 pre-pandemic levels.

Although webpage views have declined, *MMWR* reports continue to be of high quality and to receive a tremendous amount of attention, as highlighted by their high Altmetric scores. During FY 2023, 26% of reports received Altmetric scores greater than 500. This is notable as any report scoring greater than 222 falls into the top 1% of research outputs tracked by Altmetric. Most of these reports continue to accrue attention weeks after they are released. Five *MMWR* reports were in the “Top 100” highest scores among 24.9 million research outputs tracked.

CDC *Vital Signs* is a science and communication program that targets the public, state and local health departments, healthcare professionals, and policymakers through an *MMWR* report, web page, and print, broadcast, social, and electronic media on a specific, important topic. *Vital Signs* relaunched in November 2021 after a nearly 2-year hiatus during the COVID-19 pandemic response, releasing five issues during FY 2022. The May issue resulted in an outstanding 1,519 news articles and a potential audience reach of over 1.5 billion. Altmetric scores for four of the five *Vital Signs* releases were in the top 1% of more than 24.9 million research outputs tracked. We set a 5% increase year-over-year in the target counts for electronic communication to the *Vital Signs* website alone. These target counts were based on the assumption that *Vital Signs* would publish 11-12 issues per year. In FY 2023, *Vital Signs* published only four issues. It is noteworthy that, in the past fiscal year, despite publishing only four issues, *Vital Signs* still met 61% of the target (Measure 16.B). Thus, *Vital Signs* continued to engage many people in *Vital Signs*' content, offering a testament to the quality and accessibility of this publication. In addition, *Vital Signs* continued to have impressive audience reach and media coverage in FY 2023. The August issue on respectful maternity care garnered 1,747 news stories, with a reach of over 1 billion. Early issues in FY 2024 are on track to break a record for number of news stories generated and audience reach.

**Laboratory Safety and Surveillance**

**Performance Measures for Long Term Objective: Improve the efficiency and accuracy of public health and clinical laboratory testing**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
17.A Increase registrations for CDC laboratory education and training courses and events as measured across all learning dissemination platforms (Output)	FY 2023: 183,000 Target: 61,510 (Target Exceeded)	73,812	88,574	+14,762

**Laboratory Standards and Services Performance Trends:** Maintaining a safe and prepared laboratory workforce is vital to the success of the national and global public health response system. CDC creates, delivers, and maintains trainings on topics critical to the laboratory workforce to build laboratory professionals' competence through laboratory quality, safety, informatics, and emergency preparedness and response capacity-building resources. Laboratory training provides basic continuing education for new laboratory professionals, provides updates or refreshers on current methodology, helps maintain regulatory compliance, and introduces new technology and techniques to improve test procedures.

In FY 2023, CDC delivered more than 300 laboratory systems trainings that included: 76 online (eLearning) courses; three live virtual reality (VR) courses; 50 live webinars; and nine in-person courses. Topics for new trainings are chosen based on relevance to current public health events as well as regular assessment of the target audience's training needs and recommendations from CDC laboratory professionals.

During FY 2023, CDC supported education and training for laboratory professionals to strengthen the public health emergency infrastructure. CDC expanded the OneLab Initiative – which has established an ongoing learning community among US laboratory professionals and tests – through strategic promotion (e.g., earned media articles, conference presentations). This approach, coupled with the urgent need for laboratory training

and preparedness public health emergency responses contributed to CDC exceeding its target (183,000 registrants, target was 61,510) on this measure (Measure 17.A).

CDC’s learning management system, [OneLab REACH](#) (Rapid Education and Capacity-building Hub), launched in the fourth quarter of FY 2022 and has become OneLab’s centralized online hub for free laboratory training. Membership in this learning management system grew to over 11,000+ learners in FY 2023. On May 1, 2023, CDC launched a new community of practice, OneLab TEST (Timely Education and Support of Testers). This first-of-its-kind community of practice supports testers in non-laboratory settings, such as drive through testing sites and nursing homes – a critical component of both disease detection and patient care. By the end of FY 2023, OneLab TEST garnered over 2,000 members. OneLab Network, the complementary community of practice supporting clinical and public health laboratory professionals grew to more than 6,000 members.

**Data and Surveillance**

**Performance Measures for Long Term Objective: Lower barriers to data exchange across jurisdictions as part of an integrated strategy for public health surveillance and response**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
18.A Increase the percentage of notifiable disease messages transmitted in HL7 format to improve the quality and streamline the transmission of established surveillance data (Output)	FY 2022: 76% Target: 40% (Target Exceeded)	40%	40%	Maintain
18.B Increase the percentage of non-federal emergency department facilities that participate in the National Syndromic Surveillance Program to improve the coverage of syndromic surveillance data (Output)	FY 2022: 78% Target: 78% (Target Met)	80%	82%	+2

**Surveillance Performance Trends:** State and local efforts to monitor, control, and prevent the occurrence and spread of infectious and noninfectious diseases are dependent on timely, high-quality data obtained from disease surveillance, a cornerstone of public health practice. The National Notifiable Diseases Surveillance System (NNDSS) is a CDC collaboration with 60 state, local, and territorial public health jurisdictions to receive infectious disease data collected by 3,000 health departments for further analysis and use by CDC programs to better inform disease outbreaks and guide public health interventions. Currently, more than 120 diseases and conditions are under continuous nationwide surveillance.

CDC continues to advance technology, data, and exchange standards. These efforts have further strengthened and modernized the NNDSS infrastructure and helped ensure effective data-sharing and collaboration with relevant partners. Through continuous innovation, CDC is making the NNDSS infrastructure more robust to support interoperable, standardized data and exchange mechanisms. More comprehensive, timely, and higher

quality data enables CDC programs to respond to public health emergencies, implement timelier public health interventions, and develop more informed health policies. Recent technology and infrastructure investments have replaced some of CDC's older legacy infrastructure with more modern data strategies. These investments also positioned CDC to efficiently receive data related to the COVID-19 and mpox outbreaks. As a result of this work, CDC's disease experts and Emergency Operations Center could better understand disease trends and provide targeted support for the jurisdictional response. The impacts of COVID-19 and mpox have amplified the need for improvements in public health practice to achieve health equity. In support of CDC efforts to accelerate progress toward health equity, particularly those to reduce disparate health outcomes by race and ethnicity, programs are advancing efforts to address the broader purpose of data, surveillance, and analytics: data to inform action.

Results for Measure 18.A were impacted by the high volume of COVID-19 cases reported to CDC in 2020-2022. However, as the volume of COVID-19 cases declines, HL7 messaging levels are gradually moving back toward pre-pandemic levels. As of December 2023, NNDSS processed an average of 500,000 HL7 case notifications per month, representing 76% of notifications. In comparison to 2022, this represents more than a 50% decrease in the monthly average of HL7 case notifications. After a temporary pause and landscape analysis in 2023, CDC and health departments continue to actively implement HL7 messaging for additional conditions. Although progress continues to be made, adoption of HL7 for non-COVID-19 conditions remains well below 40%. As a result, CDC has decided to maintain the 40% target for FY 2025.

Although CDC anticipates a lower overall volume of HL7 messages with the end of the declared public health emergency for COVID-19, with the influx of data modernization funding and the best practices adopted to date, CDC anticipates more states transmitting notifications via HL7 messaging for more conditions. Efforts in 2024 continue to modernize the NNDSS infrastructure. Integrating with CDC's planned 'one front door' for reporting and incorporating cloud-native technology will make processing of incoming case notifications faster and more stable. The Case Surveillance Enhancement initiative will increase the standardization of message content, harmonize data with health care, and simplify strategies for data exchange. These efforts will transition NNDSS to an operations mode that seeks continuous innovation and enhancement while laying the foundation for next generation case-based surveillance.

The National Syndromic Surveillance Program (NSSP) provides local, state, and federal health officials with a near real time system for detecting, understanding, and monitoring health events. By tracking symptoms and diagnoses of patients in emergency departments and other automated data sources, including commercial laboratory data, analysts can detect unusual levels or changing patterns of illness. Every day, more than 2,000 users across local, state, and federal health government conduct 4,000 searches of these data for response, decision-making, and action. Analysts at all levels of government, including 73 state and local health departments, collaborate through a Slack site, regular calls, and annual conference.

In 2022-2023, across all levels of government, NSSP data were used to provide critical insights for more than 40 responses addressing infectious diseases (e.g., COVID-19, RSV, domestic polio), disasters (e.g., extreme heat and cold, flooding, chemical exposure), injuries (e.g., overdose, poisonings, child abuse and elder abuse), and for mental health, mass gatherings and other conditions. These data provide a public health situational awareness, with a common awareness of health threats over time and across regional boundaries. Furthermore, multiple new responses between 2022 and 2023 have utilized NSSP data, including the mpox national emergency, domestic malaria, asthma from Canadian wildfire smoke, the train derailment in Ohio, and hepatitis of unknown cause in children. Beyond responses, NSSP data are also used for dashboards on more than 50 local, state, and federal public web sites. In December 2023, real-time emergency department data were the main source for a public CDC situation report monitoring for changes in pediatric pneumonia following reports of increases in China.

While participation in NSSP is extensive, there is room for improvement. CDC uses a measure aimed at increasing the percentage of non-federal emergency department facilities that participate in NSSP to improve

the coverage of syndromic surveillance data (Measure 18.B). As of December 2023, 78% of non-federal emergency department facilities report data to NSSP. The 2023 results show that NSSP has met its FY 2023 target. Improving COVID-19 pandemic conditions, the ending of the public health emergency in 2022, and NSSP's continued robust onboarding support for STLT partners have all contributed to this increase in facility onboardings.

## OCCUPATIONAL SAFETY AND HEALTH

### National Occupational Research Agenda (NORA)

Contextual Indicator	Most Recent Result
9.1.4 Reduce employer reported nonfatal work-related injuries resulting in one or more days from work (per 10,000 FTE)	FY 2021: 73.22

**Performance Measures for Long Term Objective: Conduct research to reduce work-related illnesses and injuries**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
9.1.1b: Increase the effectiveness of occupational safety and health programs by implementing peer review recommendations (Outcome)	FY 2022: 4 out of 5 Target: Score 4 out of 5 or better based on an external review (Target Met)	Score 4 out of 5 or better based on an external review	Score 4 out of 5 or better based on an external review	Maintain

**Performance Trends:** CDC’s role in occupational safety and health is to conduct research and transfer findings into practice through partners and stakeholders, rather than implement workplace safety and health programs. The contextual indicator, focused on non-fatal work-related injuries, is an example of the type of health outcome to which CDC’s research contributes. The national rate of injuries resulting in one or more days away from work per 10,000 FTE (full-time equivalents) has been trending downward for several years, from 104.3 in 2011 to 73.22 in 2021 (Measure 9.1.4). To contribute to further reductions, CDC is focusing its research on high-burden areas such as musculoskeletal disorders (sprains and strains) and motor vehicle crashes and is investigating the potential benefits and risks of emerging technologies such as robots and exoskeletons.

In FY 2022, CDC received a 4 out of 5 for its new measure to track achievement of a plan to implement recommendations received during the program reviews conducted in FYs 2017-2019 (Measure 9.1.1b). Five NIOSH programs were reviewed by an external panel of experts who provided scores for relevance and impact and a set of specific recommendations for NIOSH to consider. During year 3, NIOSH 1) completed the development of the NIOSH Researchers’ Guide for Conceptualizing Projects with Impact in Mind; 2) completed four training modules: Conceptualizing Projects with Impact in Mind (Six sessions); Supporting Researchers in Successfully Conceptualizing and Executing Impactful Projects (Three sessions); Using Logic Models and Results-Based Frameworks During Project Design (Offered FY 2024); Review of Logic Models and Results-Based Frameworks for Projects (Offered FY 2024); 3) completed a proposed outline for a long-term evidence-building strategy, which will include a learning agenda, evaluation capacity-building initiative, and monitoring and evaluation program; and 4) completed implementation science listening sessions. The NIOSH Board of Scientific Counselors, a Federal Advisory Committee, will review the plan and score progress each year from FY 2021-2025. The next NIOSH Board of Scientific Counselors meeting was postponed until the first quarter of 2024.

### Other Occupational Safety and Health Research

Performance Measures for Long Term Objective: Reduce workplace illness, injury, and mortality in targeted sectors

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/-FY 2024
9.2.2e: Achieve and sustain percentage of active underground and surface coal mines in the U.S. that possess NIOSH-approved plans to perform surveillance for respiratory disease (Outcome)	FY 2023: 99% Target: 93% (Target Exceeded)	93%	93%	Maintain
9.2.3c Increase the number of product and manufacturing site audits completed to ensure the quality of NIOSH certified respirators (Outcome)	FY 2023: 377 Target: 250 (Target Exceeded)	260	260	Maintain
9.2.4 Achieve and sustain the percentage of respondents indicating that NIOSH HHEs helped improve workplace conditions <sup>1</sup> (Outcome)	FY 2022: 85% Target: 90% (Target Not Met)	90%	90%	Maintain
9.B Number of certification decisions issued for personal protective equipment (Output)	FY 2023: 484 Target: 400 (Target Exceeded)	425	425	Maintain
9.E Number of research articles published in peer-review publications (Output)	FY 2023: 250 Target: 250 (Target Met)	250	250	Maintain
9.K Annual NIOSH website visits <sup>2</sup> (Output)	FY 2023: 13,579,620 Target: 7,000,000 (Target Exceeded)	7,500,000	7,500,000	Maintain

<sup>1</sup>This measure is reported as a five-year average because the number of HHEs requested varies and therefore year-to-year fluctuations are normal and expected.

<sup>2</sup>Subscribers were purged in 2021 resulting in 15,000 lost subscribers. FY 23 target was adjusted to account for this loss.

**Performance Trends:**

**Reducing Hazardous Exposures**

Exposure to coal mine dust causes various pulmonary diseases, including coal workers’ pneumoconiosis and Chronic Obstructive Pulmonary Disease (COPD)<sup>305</sup>. CDC works with coal mines in the United States to develop plans to perform surveillance for pneumoconiosis and COPD. In FY 2023, 99% of active underground and surface coal mines in the United States had NIOSH-approved plans to perform surveillance for respiratory disease

<sup>305</sup> <https://www.cdc.gov/copd/index.html>



(Measure 9.2.2e). The targets remain at 93% percent as CDC works with mines to incorporate spirometry into their plans, a requirement recently added by the Mine Safety and Health Administration (MSHA).

Tailgate shearer operators traditionally have shown the greatest percentage of samples that exceed allowable limits for dust exposure because they are positioned in close proximity to the longwall cutting machine (shearer), where there are high levels of dust. The percentage of respirable coal mine dust overexposures for tailgate shearer operators dropped from 13.1% in FY 2017 to 2.8% in FY 2023, which can be attributed to use of the continuous personal dust monitor (CPDM) and the lower permissible level of coal dust exposure (2.0 to 1.5 milligrams per cubic meter). The near real-time feedback from the CPDM allows miners to adjust their work practices or operating parameters to lower dust levels if they are approaching the limit. CDC will retire this measure as it has been consistently exceeded over the past seven years and there is no additional progress to be made.

An estimated 20 million workers use Personal Protective Equipment to protect themselves from death, disability, and illnesses. CDC's Personal Protective Technology program provides expertise from many scientific disciplines to advance federal research on respirators and other personal protective technologies for workers. In FY 2023, CDC completed 377 product and manufacturing site audits, a 29% increase from FY 2022 (Measure 9.2.3c). These numbers reflect the program's transition back to routine operations. Since the target of 250 product and manufacturing site audits has been exceeded over the last 5 years, the target for FY 2024 has been increased to 260.

Additionally, in FY 2022 CDC completed 484 certified respirator decisions, a 9% percent decrease from FY 2022 (Measure 9.B). These numbers reflect the programs transition back to routine operations. Since the target of 400 certified respirator decisions has been exceeded over the last 5 years, the target for FY 2024 has been increased to 425.

CDC responds to employer, employee, and union requests for workplace Health Hazard Evaluations<sup>306</sup> (HHEs). CDC assesses the workplace and employees' health by reviewing records and/or conducting on-site testing. Based on the findings, CDC recommends ways to reduce hazards and prevent work-related illness. CDC conducts a follow-up survey of HHE participants to evaluate the program, including whether workplace conditions improved as a result of CDC's recommendations (Measure 9.2.4). The five-year average percentage of respondents who felt NIOSH helped improve workplace conditions was 85% in 2022, four percentage points lower than the previous year. Questionnaires continue to be sent to recipients on multiple occasions and in multiple forms. As travel restrictions loosened in the wake of the COVID-19 pandemic, the HHE program began performing worksite evaluations again as it transitioned from a mainly COVID-19 response back to traditional HHE duties.

### **Expanding Occupational Safety and Health Influence**

CDC communicates current research and recommendations on occupational safety and health (OSH) with its partners and stakeholders through several avenues. These include its website and social media presence, research publications and related promotions, and federal cross-agency and cross sector committee membership.

Website: There were 13,579,620 visits to CDC's NIOSH website in FY 2023, a decrease from FY 2022 but still approximately double the target (Measure 9.K). Much of the traffic increase was related to COVID-19. While the number of web visits is expected to level off in the future as some traffic moves from the web to mobile applications and videos, the target for FY 2024 has been increased from 7,000,000 visits to CDC's NIOSH website to 7,500,000.

<sup>306</sup> [http://www.cdc.gov/niosh/hhe/pdfs/HHE\\_2014\\_Annual\\_Report.pdf](http://www.cdc.gov/niosh/hhe/pdfs/HHE_2014_Annual_Report.pdf).

- Publications: CDC published 250 research articles in peer-reviewed publications in FY 2023, about 1% less than FY 2022 and at target for this measure (Measure 9.E). CDC expects to remain at a similar number of publications as CDC conducts fewer occupational safety and health studies due to the retirement of prolific senior scientists.
- Outreach: CDC also produced 195 information products to expand the reach of many of these publications in FY 2023 with other audiences, such as employers, workers, unions, public health departments, and the public. In FY2022, NIOSH published a Vital Signs article that addressed the overwhelming demands and crisis levels of burden even before the COVID-19 Pandemic. The pandemic exacerbated this situation. Data from the General Social Survey Quality of Worklife Module were analyzed to compare self-reported mental health symptoms among U.S. adult workers from 2018 (1,443 respondents, including 226 health workers) and 2022 (1,952, including 325 health workers)<sup>307</sup>. During this time period, health workers reported an increase of 1.2 days of poor mental health in the last 30 days. The percentage of workers reporting burnout also increased. The study's findings were that even though workers continued to face a mental health crisis, the impact of positive working conditions improved burnout and mental health conditions. CDC's National Institute for Occupational Safety and Health has developed a national campaign, Impact Wellbeing, to provide employers of health workers with resources to improve the mental health of these workers.
- Consensus standards: In FY 2022, CDC participated more than 70 voluntary consensus standards committees that often made use of CDC research findings related to occupational safety and health. Voluntary consensus standards committees are groups of industry and government representatives that work together to decide on rules of standardization to maximize compatibility, interoperability, safety, and quality. For example, in FY 2022, NIOSH was chair of the subcommittee that drafted ANSI/ASSP A10.50, the first ANSI/ASSP Standard related to heat stress in the workplace. Currently, there is no federal OSHA standard or voluntary consensus standard which addresses the issue of heat stress. The final standard will establish minimum requirements for the prevention of heat illnesses and management of heat stress hazards and exposures encountered in outdoor and indoor work environments.

## GLOBAL HEALTH

### Global HIV/AIDS

**Performance measures for Long Term Objective: Partner with ministries of health, international and local partners and other United States Government (USG) agencies to achieve the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) goals of reducing the worldwide rate of new HIV infections and saving lives by focusing on highly effective, evidence-based HIV interventions and quality laboratory service: (1) antiretroviral treatment for prevention and health benefits, (2) voluntary medical male circumcision, and (3) laboratory and point of care testing site quality improvement programs**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
10.A.1.5 Increase the number of adults and children with HIV infection receiving antiretroviral therapy (ART) <sup>1</sup> (Output)	FY 2022: 11,567,241 Target: 9,500,154 (Target Exceeded)	12,098,877	12,200,000	+101,123
10.A.1.7 Increase the number of males age 15 and over circumcised as part of the minimum package of male circumcision for HIV prevention services (Output)	FY 2022: 1,196,016 Target: 700,000 (Target Exceeded)	700,000	800,000	+100,000
10.A.1.8 Increase the total number of laboratories and Point of Care Testing sites enrolled in a continuous quality improvement program (Output)	FY 2022: 12,443 Target: 7,056 (Target Exceeded)	10,050	10,050	Maintain

<sup>1</sup> Targets and results reflect all people on ART, not just those with advanced HIV infection.

**Performance Trends:** Global HIV funding supports CDC’s essential role in implementing the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) in more than 45 countries and regions. Reaching epidemic control in the fight against HIV is a priority for the U.S. Government. Preventing new HIV infections is achievable and critical to the U.S. Government’s commitment to end HIV as a global public health threat, even in the absence of an HIV vaccine.

Through peer-to-peer collaborations with in-country partners, CDC plays a leading role in U.S. Government efforts to reduce AIDS-related deaths, through focusing on accountability, quality, and the use of data to improve decision-making and to enhance program focus.

In partnership with local governments and Ministries of Health in 45 countries, in FY 2022 CDC-supported programs helped sustain 11,567,241 men, women, and children living with HIV (PWH) on lifesaving ART, of the 19.24 million PWH supported by PEPFAR (Measure 10.A.1.5). CDC met and exceeded our FY 2022 treatment target, equating to over 60% of all people receiving PEPFAR treatment support. Despite these successes, access and uptake among sub-populations are lagging, particularly children (< 15 years of age) who face special challenges related to diagnosis, initiation onto antiretroviral therapy (ART), and retention.

In FY 2025, CDC will increase our target for Measure 10.A.1.5 to 12,200,000. CDC will generate and disseminate key implementation science results to maximize the impact of PEPFAR care and treatment programs. CDC will continue to work in close collaboration with partner governments and implementing partners to diagnose children and adults with HIV infection and link them to treatment with a particular focus on closing the gaps within sub-populations. CDC will do this through:

- (1) Continuing collaboration with Ministries of Health and implementing partners on same-day or same-week treatment initiation and supporting continuity of treatment to sustain the gains and close the gaps in specific sub-populations, including children.
- (2) Implementing evidence-based strategies and person-centered services to improve continuity of treatment and adherence to ART to meet HIV treatment coverage and viral suppression goals defined by the Global AIDS Strategy.
- (3) Conducting implementation science to identify PWH at high risk of HIV-associated morbidity and mortality and implement strategies to mitigate these risks.
- (4) Ensuring accessibility and quality of viral load testing and use of these data for program and PWH monitoring and management.
- (5) Expanding opportunities for antiretroviral optimization, providing for easier and less resistant treatment options for adults and children that minimize the risk of developing resistance.
- (6) Expanding opportunities and providing technical support for the identification and management of coinfections and non-infectious co-morbidities affecting children and adults living with HIV, to decrease morbidity and mortality and improve their well-being.
- (7) In addition, CDC will continue working to close the treatment gap in children living with HIV by advancing the efforts of PEPFAR's 'Accelerating Progress for Pediatrics and PMTCT' and the 'Safe Births, Healthy Babies' initiatives, the Global Alliance to end AIDS in Children, and the Elimination of Mother to Child Transmission of HIV, Syphilis and Hepatitis B initiative. CDC will also ensure access to HIV testing using up-to-date and innovative approaches at sites, in the community, and in the homes of families living with HIV, and provide optimized, simplified and effective treatment early.

In FY 2022, CDC-supported partners in 13 high-priority PEPFAR countries performed 1,196,016 voluntary medical male circumcisions (VMMCs) of males aged 15 and older by a qualified clinician, exceeding the FY 2022 target (Measure 10.A.1.7). CDC collaborates with country programs to scale-up VMMC by expanding task shifting, increasing the number of dedicated VMMC teams, and supporting mobile services and other outreach campaigns to make VMMC easily accessible to clients. CDC continues to focus on safety and has developed an adverse events management and reporting guide for use in both VMMC service programs and community health facilities which may see clients in follow up, actively analyzes notifiable adverse events submitted to PEPFAR's notifiable adverse events surveillance system, and routinely conducts quality assurance assessments to PEPFAR-supported sites. In FY 2025, CDC will raise its performance target for Measure 10.A.1.7 to 800,000, with a continued focus on outreach services for hard-to-reach populations in the highest burden regions and evaluating sustainable program delivery models for programs reaching their established goals of circumcising at least 90% of men in their communities.

Laboratory testing is the only way to diagnose and confirm existence of disease, gauge if medications are working, and measure overarching vital indicators. Point of Care Testing (POCT) sites allow traditional laboratory testing to be completed near the point of care or near the patient. CDC supports a Continuous Quality Improvement (CQI) process for laboratories and POCT sites to support accuracy of results. The CQI process works with sites to improve quality by continuously evaluating how they work and identifying ways to improve their processes. This reduces waste, increases efficiency, and increases staff (internal) and patient (external) satisfaction. The more laboratory and POCT sites that participate in CQI processes and receive accreditation or become certified, the more trust is built into the system. Trust in the accuracy of tests allows those who are found to have HIV to be immediately placed on medications which reduces the virus in the blood, lowers opportunity for continued HIV transmission, and moves CDC closer to our goal of controlling the HIV epidemic. By the end of 2022, CDC supported an enrollment of 12,443 facilities with a laboratory or POCT site in CQI

programs globally, exceeding the FY 2022 target (Measure 10.A.1.8). In 2025, CDC will maintain the current level of laboratories and POCT sites enrolled in CQI as we are approaching saturation. In future years, as countries begin to place more local resources into fighting their HIV epidemic, additional laboratories and POCT sites will be transitioned to Ministries of Health, and so the number of CDC supported facilities will decrease. FY 2023 data for measures 10.A.1.5-7 will be available in February 2024.

CDC provides scientific expertise to support all CDC Global HIV countries working directly with Ministries of Health to achieve and sustain HIV epidemic control and address the needs of more than 12 million PLHIV receiving ART with support from CDC. In FY 2025, CDC anticipates increasing technical assistance services and relationships.

## Global Tuberculosis (TB)

**Performance measures for Long Term Objective: Partner with ministries of health, international and local partners, and other United States Government (USG) agencies to speed up progress in the fight against TB worldwide, by focusing on highly effective, evidence-based TB interventions, to include reaching the high-risk HIV population.**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
10.G.1 Increase the number of adults and children with TB and HIV infection receiving antiretroviral therapy (ART) (Output)	FY 2022: 131,551 Target: 65,703 (Target Exceeded)	105,151	128,243	+23,092

**Performance Trends:** Despite being preventable and curable, TB remains the world’s deadliest infectious disease. Globally, nearly 2 billion people—a quarter of the world’s population, are estimated to be infected with TB bacteria. The estimated number of deaths from TB increased between 2019 and 2021, reversing years of decline between 2005 and 2019. In 2021, an estimated 10.6 million people fell ill with TB, an increase of 4.5% from 10.1 million in 2020. Also in 2021, there were 1.6 million TB deaths, including an estimated 187,000 TB deaths among people living with HIV (PLHIV), accounting for 28% of all deaths among PLHIV. The burden of drug-resistant TB is also estimated to have increased between 2020 and 2021, with 450,000 new cases in 2021.

Effectively addressing TB in the United States requires global TB intervention. CDC plays an integral role in U.S. Government efforts to address global TB. CDC Global TB resources advance critical global END TB targets through leveraging PEPFAR, the Global Health Security Agenda (GHSA), the National Strategy for Combating Antibiotic-Resistance Bacteria, and other platforms and resources.

To speed up progress against TB, CDC is supporting cutting-edge research to scale-up innovative TB screening tests, developing best practices in laboratory science to diagnose TB, helping to create the global roadmap to stop TB among children, scaling up TB preventive treatment, and establishing effective strategies to prevent the transmission of TB and other infectious diseases in health facilities. Access to and initiation of ART for those found to be living with HIV and TB is imperative to reduce TB associated mortality among PLHIV. CDC’s global TB program initiated ART for 131,551 people living with both HIV and TB in FY 2022 (Measure 10.G.1), exceeding the FY 2022 target. To increase the number of people on ART, CDC supports service integration, including the provision of universal HIV testing among persons with TB disease, provision of ART among all HIV-positive TB clients, and provision of ART in TB clinics. In 2025, CDC will increase our target for Measure 10.G.1 to 128,243. FY 2023 data will be available in February 2024.

In a continued effort to end TB, CDC continues to focus on TB preventive treatment (TPT) for PLHIV, TB contacts, and young children. Since 2017, CDC has directly supported 7,559,504 cumulative TPT completions. CDC efforts to incorporate TPT and TB treatment into differentiated service delivery models often found in HIV clinics aided in a global acceleration of TPT access, helping to exceed the 2018 UN High Level Meeting TPT targets.

**Global Immunization**

Contextual Indicator	Most Recent Result
10.B.1.3 Reduce the number of countries in the world with endemic wild polio virus (Outcome)	FY 2022: 2

**Performance measure for Long Term Objective: Help domestic and international partners achieve World Health Organization's goal of global polio eradication.**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
10.B.1.2a Increase the number of children vaccinated with Polio Vaccine as a result of non-vaccine operational support funding to implement national or subnational supplemental immunization campaigns in Asia, Africa, and Europe (Output)	FY 2022: 20,399,000 Target: 5,000,000 (Target Exceeded)	6,000,000	10,000,000	+4,000,000

**Performance measure for Long Term Objective: Help domestic and international partners achieve World Health Organization's goal of global polio eradication**

Contextual Indicator	Most Recent Result
10.B.2.1 Reduce the number of global measles-related deaths (Outcome)	FY 2022: 136,200

**Performance measures for Long Term Objective: Work with global partners to reduce the cumulative global measles-related mortality by 95% compared with CY 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- Target
10.B.2.2 Maintain number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission (Outcome)	FY 2022: 1 Target: 0 (Target Not Met)	0	0	Maintain
10.B.2.3 Increase the number of countries that achieve at least 90% immunization coverage in children under 1 year of age for DTP3 (three shot series of vaccines covering diphtheria, tetanus, and pertussis) (Outcome)	FY 2022: 103 Target: 143 (Target Not Met but Improved)	143	143	Maintain

**Performance Trends:** Global immunization funding advances polio eradication and measles mortality reduction and elimination efforts. CDC is the lead technical monitoring agency for the Independent Monitoring Board of

the Global Polio Eradication Initiative<sup>308</sup> (GPEI). The number of countries reporting endemic wild poliovirus (WPV) remained at two in FY 2022 (Measure 10.B.1.3).

Countries at highest risk for polio importation and circulating vaccine-derived poliovirus outbreaks have low routine immunization coverage levels (less than 80%), sub-optimal outbreak response, and weak health systems. CDC's expanded measure of polio vaccination (Measure 10.B.1.2a) improves accuracy by measuring children vaccinated by all types of polio vaccine. It reflects changes to the composition of the global supply of polio vaccine and CDC's enhanced financial support for operational costs of supplemental vaccination rounds, including social mobilization. In FY 2022, CDC vaccinated 20,399,000 children with polio vaccine in Asia, Africa, and Europe, exceeding the targets by 15 million children. The increased number of ongoing outbreaks of vaccine-derived poliovirus across Africa and parts of Southeast Asia resulted in an increased need for special vaccination campaigns to compensate for inadequate coverage by routine immunization systems in high-risk countries. CDC anticipates an increased level of performance in subsequent years and has increased FY 2025 targets by 4 million. CDC's lead role as one of the five core partners in the Global Polio Eradication Initiative (GPEI) will be limited which will eliminate the capacity to verify interruption of poliovirus circulation in 10 high-risk countries. However, CDC will continue to work with partners to reach its vaccination targets, focusing efforts on those areas that have been historically difficult to reach due to security issues and/or political instability.

Reducing cumulative global measles-related mortality by 95% compared with CY 2000 estimates presents unique challenges. Since CY 2008, CDC's collaboration with the Pan American Health Organization has helped ensure cases are detected and contained when measles cases are imported to the Americas (Measure 10.B.2.2). The collapse of public health systems in Venezuela resulted in that country re-establishing endemic transmission of measles in late 2018, which then spread to Brazil. While Venezuela has interrupted measles transmission, Brazil has not and is the only country in the Americas to have re-established measles transmission. The Measles and Rubella Initiative updated the formula for calculating global measles mortality in 2018 with the following parameters: new measles vaccination coverage and annual country measles surveillance data. The updated formula uses and is responsive to annual trends in surveillance data, allowing the model to reflect measles outbreaks better. The actual results from 2017 onward reflect the improved measurement. After the disruptions of the COVID-19 pandemic, measles vaccination rates fell to the lowest rate since 2008, and as the world reopened in 2021, measles mortality rose to 136,200 in 2022<sup>309</sup>, representing an 83% decrease since FY 2000 but an increase over FY 2021 (Measure 10.B.2.1). However, measles immunization activities worldwide were significantly impacted by the COVID-19 pandemic as campaigns around the world were delayed and staff were diverted to support COVID-19 response efforts, resulting in over 61 million doses of measles-containing vaccine postponed or missed. The proportion of children receiving their first dose of measles vaccine increased from 81% in 2021 to 83% in 2022, well below the 2019 pre-pandemic level of 86%, leaving over 20 million children vulnerable to measles.

Measles surveillance continues to be suboptimal, and large and disruptive outbreaks were reported in 37 countries, an increase from 22 countries in 2022. Out of the 37 countries reporting large and disruptive measles outbreaks, 28 occurred in Africa. Measles outbreaks illustrate weaknesses in immunization programs more broadly. As a result, vigorous efforts are urgently needed to expand and strengthen immunization services and surveillance systems to prevent disease and death before large-scale outbreaks and preventable deaths occur, especially as the world reopens from COVID-19-related lockdowns. CDC is working closely with its partners to implement improvements to the quality of the supplemental immunization activities and target efforts to areas with high measles-related mortality.

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<sup>308</sup> <http://www.polioeradication.org/>.

<sup>309</sup> Minta AA, Ferrari M, Antoni S, et al. Progress Toward Measles Elimination — Worldwide, 2000–2022. *MMWR Morb Mortal Wkly Rep* 2023;72:1262–1268. DOI: <http://dx.doi.org/10.15585/mmwr.mm7246a3>.

The number of countries that achieve at least 90% immunization coverage in children under one year of age for DTP3 (third dose diphtheria, tetanus, pertussis vaccine) is the globally accepted performance indicator for national immunization programs. The number of countries meeting this coverage threshold for DTP3 remained stable in FY 2022 at 103 (Measure 10.B.2.3). Thirteen countries report coverage of 87-89%, indicating how close some nations are to reaching the target. Globally, global DTP3 coverage rose to 84% in 2022 from 81% in 2021. To assist both countries who struggle to maintain gains and those that struggle to reach the 90% target, CDC is conducting evaluations to study supply and demand factors that can impact and increase coverage.

CDC’s administrative measure will be discontinued in FY 2024 as part of agency-wide streamlining efforts. CDC will continue efforts to minimize administrative overhead while maximizing direct spending for field-related activities.

**Global Health Protection**

**Performance measures for Long Term Objective: To increase the number of public health staff skilled in epidemiology and surveillance in low and middle-income countries.**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
10.F.1c Number of cumulative Field Epidemiology Training Program (FETP) – Frontline graduates (Output)	FY2022: 15,314 Target: 12,555 (Target Exceeded)	16,786	17,122	+336
10.F.1d Number of cumulative Field Epidemiology Training Program (FETP) – Intermediate and FETP – Advanced graduates (Output)	FY2022: 7,280 Target: 6,915 (Target Exceeded)	7,631	7,784	+153

**Performance Trends:** International Field Epidemiology Training Programs (FETP) are recognized worldwide<sup>310</sup> as an effective means to strengthen countries’ capacity in surveillance, epidemiology, and outbreak response. These graduates strengthen public health capacity so individual countries are able to transition from U.S.-led global health investments to more long-term host country ownership. Frontline is a three-month program that aims to increase the number of capable public health workers in a community setting. Intermediate is a nine-month program for mid-level health officials, and Advanced is a two-year, intensive program that aims to prepare leaders for work at the national level. All three tiers help countries meet International Health Regulation guidelines. As of FY 2022, there have been a cumulative total of 15,314 Frontline program graduates and 7,280 Intermediate/Advanced program graduates. By tracking the number of people who graduate from FETP – Frontline and Intermediate/Advanced programs every year, CDC can better gauge its impact on developing other countries’ abilities to prevent, detect, and respond to disease outbreaks.

**Parasitic Diseases and Malaria**

Contextual Indicators	Most Recent Result
10.C.1 Increase the percentage of children under five years old who slept under an insecticide-treated bed net the previous night in PMI target countries <sup>1</sup> (Outcome)	FY 2022: 55.6% (median)

<sup>1</sup> PMI was implemented in each of the 19 focus countries by 2012. Therefore, starting in FY 2014, data from all 19 countries were included to calculate the median, using the most recent estimate available from each country.

**Budget Output Measure for Long Term Objective: Decrease the rate of deaths from all causes in children under five in the President’s Malaria Initiative (PMI) target countries**

<sup>310</sup> Traicoff D et al. 2015. Strong and flexible: Developing a three-tiered curriculum for the Regional Central America Field Epidemiology Training Program. *Pedagogy in Health Promotion* 1(2): 74–82. <http://php.sagepub.com/content/1/2/74.full.pdf+html>.



Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
10.C.A The number of CDC authored publications that inform the global evidence for malaria control and prevention programs (Output)	FY 2022: 95 Target: 155 (Target Not Met but Improved)	155	155	Maintain

**CDC Performance Measure for Long Term Objective: To deliver timely and accurate reference diagnostic laboratory services for the detection of parasites in specimens submitted by domestic and international public health partners to CDC**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
10.C.4 The percentage of laboratory test results reported within the expected turn-around time upon receipt by CDC labs (Outcome)	FY 2022: 97.5% Target: 90% (Target Exceeded)	90%	92%	+2

**Performance Trends:** Malaria prevention and treatment tools are among the most cost-effective interventions available to improve global maternal and child health and survival. CDC’s research informs the development of new tools to manage and mitigate threats from drug and insecticide resistance, guides future program and policy decisions, and builds the capacity of host country governments through strategic partnerships.

The President’s Malaria Initiative<sup>311</sup> (PMI), which is led by USAID and co-implemented together with CDC, has been scaling up the use of malaria prevention and treatment tools since 2005, and currently works in the Greater Mekong Subregion and in 24 countries in sub-Saharan Africa. In FY 2023, the program expanded to three additional countries Burundi, The Gambia, and Togo. CDC, through PMI, provides technical assistance to all PMI countries.

The median national percentage of children under five years old who slept under an insecticide-treated bed net the previous night (a measure of habitual net use) increased slightly across African PMI partner countries to 55.6% in FY 2022 (Measure 10.C.1). These data come from national surveys that are routinely conducted every two to three years which limits direct comparison from one year to the next. While only one PMI country—Niger—has achieved the 85% goal, estimates from six other countries reported over 65% of children under five years sleeping under an insecticide-treated bed net the night before. PMI anticipates this trend will continue the longer countries are part of PMI and pursue full scale-up of interventions.

CDC continues to develop global policy documents, guidelines, and peer-reviewed scientific publications. In addition to the 17<sup>th</sup> Annual PMI Report to Congress<sup>312</sup> released in April 2023, CDC co-authored reports such as "Higher-Dose Primaquine to Prevent Relapse of *Plasmodium vivax* Malaria,"<sup>313</sup> which describes how a new antimalarial treatment regimen could significantly decrease malaria relapse in the Americas. CDC and PMI are working to learn how and where *An. stephensi* is spreading, how to control it most effectively, and strongly support WHO’s call for intensified surveillance and targeted vector control. CDC co-authored “The potential impact of *Anopheles stephensi* establishment on the transmission of *Plasmodium falciparum* in Ethiopia and

<sup>311</sup> <http://www.pmi.gov/>.

<sup>312</sup> [U.S. President’s Malaria Initiative 17th Annual Report to Congress](#)

<sup>313</sup> [Higher-Dose Primaquine to Prevent Relapse of Plasmodium vivax Malaria | NEJM](#)

prospective control measures<sup>314</sup>” which describes how large increases in vector control interventions could be needed to prevent a major public health emergency. The CDC co-authored article “Efficacy of RTS,S/AS01E malaria vaccine administered according to different full, fractional, and delayed third or early fourth dose regimens in children aged 5–17 months in Ghana and Kenya: an open-label, phase 2b, randomized controlled trial<sup>315</sup>” provides critical information suggesting potential flexibility in the recommended dosing regimen and schedule for the RTS,S malaria vaccine which can be used to modify regimens and facilitate coverage of a larger number of children with the limited available supply of this life-saving vaccine.

Though not included in current data reporting, due to official data reporting availability in April 2024, in FY 2023, the United States experienced its first locally acquired mosquito transmitted malaria case in 20 years. Between May 2023 and October 2023, a total of 10 cases across four states were reported. CDC published two articles in the *Morbidity and Mortality Weekly Report*<sup>316,317</sup>, highlighting many of these cases, ensuring that information was shared as timely as possible. Importantly, these articles noted the swiftness of public health intervention and the importance of vigilance in preventing the continued spread of malaria domestically and globally.

The number of peer-reviewed papers published increased from 76 in FY 2021 to 95 in FY 2022, which did not meet the target but was a 25% increase from FY 2021 (Measure 10.C.A). All publications contribute to growing the evidence base to support policy and program needs. CDC anticipates some variation in the number of publications from year to year based on the publication process and the timelines for study initiation, completion, and data analysis, as well as competing demands such as supporting and leading emergency response.

CDC’s parasitic disease labs serve as global and national resources for ensuring efficient and high-quality analyses, which are essential to timely and accurate diagnosis and treatment. In FY 2022, CDC analyzed and reported results for 97.5% of submitted specimens in a timely manner (within the expected turnaround times posted in the CDC test directory for each test) exceeding the target of 90% (Measure 10.C.4). Results reflect eight months of diagnostic testing (February 2022—September 2022). In September 2021, CDC’s Parasitic Diseases Laboratory temporarily paused all diagnostic testing operations for parasitic diseases to implement laboratory system improvements. CDC has utilized a phased, prioritized approach for bringing tests back online. By the end of FY 2023 all remaining tests set to resume had resumed, which represented more than 90% of historical testing volume at CDC’s parasitic diseases labs. The remaining less than 10% was phased out, leaving the opportunity for increased test modernization.

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<sup>314</sup> [The potential impact of Anopheles stephensi establishment on the transmission of Plasmodium falciparum in Ethiopia and prospective control measures | BMC Medicine | Full Text \(biomedcentral.com\)](#)

<sup>315</sup> [Efficacy of RTS,S/AS01E malaria vaccine administered according to different full, fractional, and delayed third or early fourth dose regimens in children aged 5–17 months in Ghana and Kenya: an open-label, phase 2b, randomised controlled trial - The Lancet Infectious Diseases](#)

<sup>316</sup> Blackburn D, Drennon M, Broussard K, et al. Outbreak of Locally Acquired Mosquito-Transmitted (Autochthonous) Malaria — Florida and Texas, May–July 2023. *MMWR Morb Mortal Wkly Rep* 2023;72:973–978. DOI: <http://dx.doi.org/10.15585/mmwr.mm7236a1>

<sup>317</sup> Duwell M, DeVita T, Torpey D, et al. Notes from the Field: Locally Acquired Mosquito-Transmitted (Autochthonous) Plasmodium falciparum Malaria — National Capital Region, Maryland, August 2023. *MMWR Morb Mortal Wkly Rep* 2023;72:1123–1125. DOI: <http://dx.doi.org/10.15585/mmwr.mm7241a3>

## PUBLIC HEALTH PREPAREDNESS AND RESPONSE

### State and Local Preparedness and Response Capability

**Performance Measures for Long Term Objective: Enhance and sustain preparedness and response capability across state, local, and territorial health departments**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
13.5.3 Increase the percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene, within 60 minutes of notification, a team of trained staff that can make decisions about appropriate response and interaction with partners (Outcome)	FY 2021: N/A <sup>1</sup> Target: N/A <sup>1</sup>	96%	N/A	Maintain

<sup>1</sup> Reporting requirement was waived due to COVID-19. Data will not be reported for FYs 2019, 2020, and 2021.

**Performance Trends:** CDC uses Public Health Emergency Preparedness (PHEP) recipient-reported data to aid jurisdictions in identifying preparedness gaps and developing targeted strategies to improve performance across operations. The ability to assemble key staff for timely decision-making and the establishment of effective incident management structures are essential components of a public health emergency response. In FY 2019 (and up to the current fiscal year), CDC modified program requirements as a result of the COVID-19 pandemic response in the 62 PHEP jurisdictions. To support this critical work and reduce recipient burden, CDC integrated PHEP planning requirements with COVID-19 pandemic response activities, allowing recipients to use their response to the current public health incident to demonstrate their preparedness capabilities. All jurisdictions supported active EOC activations which demonstrated the performance measure.

For measure 13.5.3, trend data was stable with most years meeting or exceeding the target up to FY 2019. CDC will retire this measure as PHEP recipients have documented their abilities to assemble critical staff in 60 minutes over the past 10 years. Efforts will now be targeted in developing new performance measures to demonstrate the impact of the program.

**Performance Measures for Long Term Objective: Integrate and enhance existing surveillance systems at the local, state, national, and international levels to detect, monitor, report, and evaluate public health threats**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
13.1.3 Increase the number of Laboratory Response Network (LRN) member laboratories able to use their current Laboratory Information Management System (LIMS) for LRN-specific electronic data exchange (Output)	FY 2022: 64 Target: 63 (Target Exceeded)	65	65	Maintain

**Performance Trends:** Laboratory results are a critical component of public health practice and help guide decisions during public health response. To support early detection and response activities, public health laboratories that are members of the Laboratory Response Network (LRN) must have the capacity to share standard electronic data in real-time with CDC. This includes both LRN Biological (LRN-B) and LRN Chemical

Threats (LRN-C) laboratories. Local, county, and state public health laboratories have more widely adopted Electronic Laboratory Reporting (ELR), using standardized HL7 codes for data exchange with partners.

In examining the goal of increasing the number of LRN member laboratories that use Laboratory Information Management System (LIMS) for reporting results to CDC (Measure 13.1.3), it has been established that CDC has no mechanism to increase the number of LRN laboratories that use electronic laboratory reporting (ELR). While we will continue to provide technical assistance to public health laboratories and encourage the timely and full adoption of ELR, we cannot control their ability or willingness. Given this finding, Measure 13.1.3 will be retired. This measure no longer reflects the current strategy for LRN electronic data exchange. Additionally, the trend data has been stable, with results meeting or exceeding the target. Increasing the target would not be feasible in that CDC has no mechanism in place to increase the number of LRN laboratories that use electronic laboratory reporting (ELR).

**Performance Measures for Long Term Objective: Enhance and sustain nationwide and international laboratory capacity to gather, ship, and screen and test samples for public health threats and to conduct research and development that lead to interventions for such threats**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
13.3.1 Sustain the percentage of Laboratory Response Network (LRN) laboratories that have demonstrated ability to rapidly detect select biological threat agents (Output)	FY 2023: 94% Target: 92% (Target Exceeded)	92%	92%	Maintain

**Performance Trends:** Laboratory Response Network (LRN) challenge panel program ensures laboratories within the network have the ability to rapidly identify biological threat agents. This includes performing LRN assays using agent-specific testing algorithms and available electronic resources to submit results. In FY 2023, 94% of LRN laboratories passed the challenge panels distributed by the CDC LRN program (Measure 13.3.1). Future targets will remain fixed at 92% which provides CDC with sufficient confidence in the capabilities of the LRN network.

## CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

### Buildings and Facilities

**Performance Measures for Long Term Objective: Improve efficiency and sustainability of CDC Facilities**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
12.E.2 Increase the percent of CDC facilities (10,000 square feet and above) that meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Efficiency)	FY 2023: 29.6% Target: 15% (Target Exceeded)	15% <sup>1</sup>	15% <sup>1</sup>	Maintain <sup>1</sup>
12.E.1a Improve energy (E) consumption per square foot <sup>1</sup> (Efficiency)	FY 2023: 28.9% Target: 30% (Target Not Met)	30% <sup>1</sup>	30% <sup>1</sup>	Maintain <sup>1</sup>
12.E.1b Improve water (W) consumption per square foot (Efficiency)	FY 2023: 34.7% Target: 30% (Target Exceeded)	32% <sup>1</sup>	34% <sup>1</sup>	+21

<sup>1</sup>As advised by HHS: Metrics and targets are expected to be revised by “Executive Order (EO) 14057: Catalyzing America’s Clean Energy Economy Through Federal Sustainability” (issued on 12/8/2021). Data will be provided when guidance is available. EO 14057 Implementing instructions provided by the Council on Environmental Quality (CEQ) in May 2022 and distributed via HHS do not include revised annual targets for Energy, Water, or Sustainable buildings. CDC has been advised that these targets were expected at the end of CY 2023. Therefore, previous targets are applied in the interim.

**Performance Measures for Long Term Objective: Improve CDC's Buildings and Facilities processes and performance<sup>1</sup>**

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
12.2.1c Improve Condition Index (CI), as measured by the ratio of the functional replacement value (FRV) of an asset with its backlog of maintenance and repair (BMAR) needs (Output)	FY 2023: 82.74 Target: 90 (Target Not Met)	90	90	Maintain
12.2.1d Reduce non-mission dependency, as measured by the percentage of real property assets that are not deemed directly necessary to support the Agency's mission (Output)	FY 2023: 1.46% Target: 2% (Target Exceeded)	2%	2%	Maintain

12.2.1e Improve building utilization <sup>3</sup> (Output)	FY 2023: 4.8% Target: 5% (Target Exceeded)	5%	5%	Maintain
12.2.1f Improve buildings and facilities operating costs (Output)	FY 2023: \$12.88/sq. ft. Target: \$10.29/sq. ft. (Target Not Met)	\$10.29/sq. ft	\$10.29 /sq. ft	Maintain

<sup>1</sup> Targets are set by HHS and align to EO 13327; the Federal Real Property Council (FRPC) defines the metrics.

<sup>2</sup> Targets beyond FY 2016 are projected and are not established from FRPC.

<sup>3</sup> Under-utilized (U); FRPC removed the metric Over-utilization (O) for FY 2013 and forward.

**Performance Trends:** CDC's mission is executed in a safe, sustainable, and dynamic workplace environment for approximately 25,000 CDC staff while ensuring efficiency, environmental stewardship, and appropriate management of agency assets due to the Office of Safety, Security, and Asset Management's (Building and Facilities) leadership. In FY 2023, CDC had 29.6% of its owned and active buildings 10,000 gross square feet (GSF) and above meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Measure 12.E.2), far exceeding the target of 15%. Major high-performance buildings are currently in design and construction phases at Chamblee, Roybal, and Cincinnati Campuses. This is expected to increase the GSF of Guiding Principle compliant buildings over the next several years. CDC expects that we may also see smaller gains with the demolition of older and poor performing buildings.

Past targets and baselines set for improving energy consumption (Measure 12.E.1a) were based on the Energy Policy Act of 2005 per Executive Order (EO) 13834. This EO was rescinded and replaced in January 2021 by EO 14057. EO 14057 Implementing instructions provided by the Council on Environmental Quality (CEQ) in May 2022 and distributed via HHS do not include revised annual targets for Energy, Water, or Sustainable buildings. CDC has been advised that these targets are still under development. CDC will provide data when guidance is available. New targets are expected in 2024, therefore, previous targets are applied in the interim.

In FY 2022, the CDC achieved a 30.5% reduction in energy intensity below the 2003 baseline. However, in FY 2023, this progress slightly regressed to 28.9%, leaving the agency 1.6% below its target (Measure 12.E.1.a). This decline can be attributed to a combination of operational adjustments and adverse climatic conditions. While the lower campus population in FY 2022 allowed for reduced energy loads, the phased re-entry of employees contributed to increased energy consumption in FY 2023. The eight-month period from January to August 2023 also marked the second hottest on record for Georgia since record keeping began in 1895. Moreover, the mean temperature for the Atlanta region rose by 2.78 degrees compared to FY 2022, with cooling degree days registering a 5% increase over the two decades since the baseline was set.

**FY 2023 Highlights:**

- Mandated Energy Independence and Security Act (EISA) Audits to be completed as part of current CDC wide resiliency study that may result in new potential recommended ECMs. As well as updated and enhanced CDC High Performance building standards.
- Condensate recovery to be re-evaluated for potential water savings.
- Improvements to the domestic water distribution system at the CDC/NIOSH Pittsburgh campus are underway and is currently projected to reduce water usage by millions of gallons annually.

- CDC continues to implement energy saving projects that will increase the use of renewable energy, efficiencies, and resiliencies while simultaneously decreasing costs. Some examples of energy saving projects include Replacing HVAC equipment with more efficient types; upgrades to lab equipment that use less water and energy; and central utility plan controls and equipment improvements.
- A new facility to consolidate CDC's National Institute for Occupational Safety and Health (NIOSH) Research Facilities in Cincinnati, which is currently in the final stages of design. Design targets include Leadership in Energy and Environmental Design (LEED)-compliant, guiding principle (GP)-compliant, and high-performance components. The CDC established a goal for the facility of LEED Gold under LEED v4 Building Design & Construction. As currently designed, the facility is projected to achieve a Fitwel 2-Star Certification.
- Design targets for the construction of Chamblee Building 108 and supporting infrastructure improvements for the Chamblee Campus, which include Guiding Principle Compliant design for Building 108, campus-wide utility improvements, and LEED certification. This project also includes upgrades to the Chamblee Central Utility Plant to improve energy efficiencies and resiliency. CDC intends to apply for a Department of Energy grant to install a Solar Array to make Building 108 energy net zero.
- 192KW Solar Array at San Juan will be operational in CY 2024. This will improve energy efficiency and enhance resiliency to campus functions via battery backup systems.

Water use intensity in 2022 was measured at 40% below the 2007 baseline of 52.9 gallons per gross square foot. In FY 2023, CDC observed an 11% increase in water consumption compared to FY 2022. This is likely attributed to phased reentry of staff into facilities during 2022. In addition, record heat and warmer days in 2023 elevated demands for cooling and increased water consumption.

In FY 2023, CDC recoded water intensity at 34.7% below the baseline (Measure 12.E.1.b). While exceeding current target of 30%, this represents a regression from previous years. Similar to this year's energy usage, this increase is attributed to higher temperatures and increased staff presence on campus. CDC will evaluate laboratory operations pertaining to water use with the goal of identifying potential water use reductions.

CDC did not meet its target for improving its condition index (CI) in FY 2023 (Measure 12.2.1c), however there was a significant improvement. There was an increase in un-weighted CI from FY 2022 (67.18 CI) to FY 2023 (82.74 CI). CDC's weighted CI remained mostly unchanged from FY 2022 (93.99 CI) to FY 2023 (94.05 CI) but still exceeds targeted goal of 90 CI. CDC moved to new software to manage our Integrated Facility Management Systems (IFMS) data. With the software transition came several unexpected anomalies, including the software re-populating completed deficiencies which inflated Backlog of Maintenance and Repair (BMAR). CDC is in the process of identifying the anomalies and cleaning them up in FY 2024, which will increase the CI. CDC also has large investments in both repair and improvement projects and new capital construction targeted specifically at improving or replacing some of CDC's assets with the poorest CI scores.

CDC exceeded its target for reducing non-mission dependency assets that are not deemed directly necessary to support CDC's mission (Measure 12.2.1d) in FY 2023 with a result of 1.46%. The under-utilization rate increased from 4.76% in FY 2022 to 4.8% in FY 2023 (Measure 12.2.1.e). CDC will continue disposing under-utilized assets to meet or exceed this target.

CDC's operating costs increased slightly from \$12.82/sq. ft. for FY 2022, to \$12.88/sq. ft. for FY 2023 (Measure 12.2.1f). Maintenance costs are largely affected by annual maintenance contract renewals. While energy costs have decreased by improved operating efficiencies, increases to utility rates have offset any additional potential savings. Most assets are not tabulated individually for maintenance costs or metered individually for energy costs. They are pro-rated according to square footage and asset type. It was found that some of this data needed adjustment beyond the yearly increases in utility and maintenance contracts. CDC also reiterates that

the target for reduced operating costs does not consider high operating costs associated with laboratory assets. CDC's laboratories comprise approximately 44% of its square footage, resulting in disproportionately higher operating costs. Benchmarking studies have indicated CDC's asset portfolio is in the medium range of operating costs for similarly equipped institutional and private real asset portfolios with similar laboratory to non-laboratory asset ratios.



## WORKING CAPITAL FUND

### Performance Measures for Working Capital Fund

Measure	Most Recent Result and Target	FY 2024 Target	FY 2025 Target	FY 2025 +/- FY 2024
15.2.2 Maintain the percent of invoices paid on time (Efficiency)	FY 2023: 99.9% Target: 98% (Target Exceeded)	98%	98%	Maintain
15.5.1 Maintain the variance between annual revenues and annual costs (Efficiency)	FY 2023: 8% Target: 3% (Target Not Met)	3%	3%	Maintain
15.5.2 Maintain the variance between estimated and actual cost (Efficiency)	FY 2023: 6% Target: 1% (Target Not Met)	1%	1%	Maintain
15.5.3 Maintain the percent of bills that require correction (Efficiency)	FY 2023: 0% Target: 10% (Target Exceeded)	9%	9%	Maintain

**Performance Trends:** CDC’s Office of the Chief Operating Officer actively supports CDC’s goals and customers through fiscal stewardship and sound financial strategy. Annually, CDC has secured an unqualified audit opinion on the agency’s financial statements since FY 1999.

The Office of Management and Budget's Prompt Payment rule requires federal agencies to pay vendors in a timely manner and assesses late interest penalties against agencies that pay vendors after a payment due date. CDC has maintained a greater than 99% prompt payment level since FY 2013 (Measure 15.2.2). CDC will continue to exceed the 98% requirement of on time payments by ensuring program offices, the acquisition office, and the payment office communicate with each other and the agency's vendors.

CDC’s Working Capital Fund (WCF) aims to achieve greater efficiency and transparency through the provision of Agency-wide business services. Currently, CDC estimates costs for business services 18 months prior to final fiscal year obligations being made. In FY 2023, CDC continued to receive supplemental funding for the COVID-19 response after the start of the fiscal year and as a result did not meet its target (Measure 15.5.1). CDC will maintain its FY 2024 target in FY 2025; however, due to the nature of the ongoing emergency work, CDC expects some continued variation.

In measuring performance from a Center, Institute, Office (CIO) perspective in FY 2023, the original cost estimate varied 6% from the actual costs charged (Measure 15.5.2). Due to continued process improvements, CDC also exceeded its target of 10% for monthly bills requiring correction (Measure 15.5.3). CDC will keep FY 2025 targets for these measures level with the previous year.

## FY 2025 DISCONTINUED MEASURES TABLE

**Measure ID 3.2.3: Maintain the proportion of all E. coli or Klebsiella spp. that are carbapenem resistant causing CLABSI or CAUTI in adult intensive care units (ICUs) at 7% (Outcome)**

FY	Target	Result
2025	Discontinued	N/A
2024	7 %	Dec 31, 2025
2023	7 %	Dec 31, 2024
2022	7 %	Dec 31, 2023
2021	7 %	2.1 % (Target Exceeded)
2020	7 %	2.3 % (Target Exceeded)
2019	7 %	1.9 % (Target Exceeded)

CDC will retire this measure and replace it with a revised measure that includes additional carbapenems.

**Measure ID 3.3.3: Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR)<sup>318</sup> (Outcome)**

FY	Target	Result
2025	Discontinued	N/A
2024	0.92 <sup>319</sup>	Nov 30, 2025
2023	Baseline	Nov 30, 2024
2022	0.4	Nov 30, 2023
2021	0.45	0.92 (Target Not Met)
2020	0.5	0.86 (Target Not Met)
2019	0.6 <sup>320</sup>	0.69 (Target Not Met but Improved)

CDC will retire this measure and replace it with a revised measure to reflect the updated measure in the HHS HAI Action Plan.

**Measure 4.P: Increase the average percentage of completed cell phone interviews to maintain population coverage in the Behavioral Risk Factor Surveillance System (BRFSS).<sup>[1]</sup> (Output)**

FY	Target	Result
2025	Discontinued	N/A
2024	77 %	Apr 30, 2025
2023	73 %	Apr 30, 2024
2022	70 %	78% (Target Exceeded)
2021	68 %	73 % (Target Exceeded)

<sup>318</sup>The Standardized Infection Ratio (SIR) is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN).

<sup>319</sup> Revised baseline in 2022, but may be revised once 2023 baseline is developed

<sup>320</sup>Target was incorrectly reported in the FY 21 PB and has been corrected. Current 2010 CLABSI target is based on the old 2006-2008 baseline. Revision to update the target are pending.

2020	62 %	70 % (Target Exceeded)
2019	56 %	64 % (Target Exceeded)

CDC will retire this measure as the measure’s performance has stabilized and will not change beyond the current level.

**Measure ID 5.1.8a: Increase the percentage of primary care providers who screen women of reproductive age for risky alcohol use (Outcome)**

FY	Target	Result
2025	Discontinued	N/A
2024	50.6 %	Dec 31, 2024
2023	50.6 %	Dec 31, 2023
2022	50.6 %	33.8 % (Target Not Met)
2021	49.3 %	38.1 % (Target Not Met but Improved)
2020	47.9 %	35.5 % (Target Not Met)
2019	46.6 %	36.2 % (Target Not Met but Improved)

CDC will retire this measure because it is not an effective measure as it does not focus on key programmatic outcomes.

**Measure ID 5.1.8b: Increase the percentage of primary care providers who provide appropriate, evidence-based interventions to reduce alcohol-exposed pregnancy for those at risk (Outcome)**

FY	Target	Result
2025	Discontinued	N/A
2024	46.3 %	Dec 31, 2024
2023	46.3 %	Dec 31, 2023
2022	45 %	35.3 % (Target Not Met)
2021	43.8 %	38.9 % (Target Not Met but Improved)
2020	42.5 %	37.5 % (Target Not Met but Improved)
2019	41.3 %	36.6 % (Target Not Met)

CDC will retire this measure because it is not an effective measure as it does not focus on key programmatic outcomes.

**Measure ID 6.2.5a: Reduce health disparities associated with blood lead levels in children aged 1-5 in the U.S. such that:**  
**a. The gap in blood lead levels between black children and children of other races is reduced (Outcome and Contextual)**

FY	Target	Result
2025	Discontinued	N/A
2022	N/A	Dec 31, 2024
2020	N/A	Dec 31, 2022

CDC will retire this measure as it does not have access to the measure’s data.

**Measure ID 6.2.5b: b. The gap in blood lead levels between children living above the federal poverty level and those living below the poverty level is reduced (Outcome and Contextual)**

FY	Target	Result
2025	Discontinued	N/A
2022	N/A	Dec 31, 2024
2020	N/A	Dec 31, 2022

CDC will retire this measure as it does not have access to the measure’s data.

**Measure ID 9.2.3d: Reduce the percentage of respirable coal mine dust overexposures for the tailgate shearer operator (Outcome)**

FY	Target	Result
2025	Discontinued	N/A
2024	3%	Mar 30, 2024
2023	3%	2.8% (Target Exceeded)
2022	3%	2.9% (Target Exceeded)
2021	4.5%	2.4% (Target Exceeded)
2020	5.5%	3.9% (Target Exceeded)
2019	12.4%	6.3% (Target Exceeded)

CDC will retire this measure as the measure’s performance has stabilized and will not change beyond the current level.

**Measure ID 13.1.3: Number of Laboratory Response Network member laboratories able to use their current Laboratory Information Management System (LIMS) for LRN-specific electronic data exchange (Output)**

FY	Target	Result
2025	Discontinued	N/A
2024	65	Dec 31, 2024
2023	65	Dec 31, 2023
2022	63	64 (Target Exceeded)
2021	63	57 (Target Not Met but Improved)
2020	58	56 (Target Not Met but Improved)
2019	53	54 (Target Exceeded)

CDC will retire this measure as CDC has no mechanism in place to increase the measure’s performance.

**Measure ID 13.5.3: Increase the percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners (Outcome)**

FY	Target	Result
2025	Discontinued	N/A
2024	N/A	Feb 28, 2026
2023	N/A	Feb 28, 2025
2022	N/A	Feb 28, 2024
2021	N/A	N/A
2020	N/A	N/A
2019	N/A	N/A

CDC will retire this measure as the measure’s performance has stabilized and will not change beyond the current level.

**Measure ID 14.C: Number of public health assessments and health consultations issued by ATSDR and cooperative agreement partners (Output)**

FY	Target	Result
2025	Discontinued	N/A
2024	119	Dec 31, 2024
2023	119	Dec 31, 2023
2022	119	35 (Target Not Met)
2021	119	46 (Target Not Met)
2020	115	61 (Target Not Met)
2019	110	119 (Target Exceeded)

CDC will retire this measure because of a variety of external factors that make this measure ineffective to measure programmatic progress.

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# SUPPLEMENTAL TABLES

**OBJECT CLASS TABLE – DIRECT**

(dollars in thousands)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Personnel Compensation:</b>				
Full-Time Permanent (11.1)	\$955,545	\$955,545	\$1,026,358	\$70,845
Other than Full-Time Permanent (11.3)	\$110,196	\$110,196	\$113,071	\$2,875
Other Personnel Comp. (11.5)	\$53,249	\$53,249	\$54,638	\$1,389
Military Personnel (11.7)	\$92,438	\$92,438	\$94,849	\$2,411
Special Personal Service Comp. (11.8)	\$2,884	\$2,884	\$2,959	\$75
<b>Total Personnel Compensation</b>	<b>\$1,214,312</b>	<b>\$1,214,312</b>	<b>\$1,291,908</b>	<b>\$77,595</b>
Civilian personnel Benefits (12.1)	\$409,647	\$409,647	\$420,333	\$10,686
Military Personnel Benefits (12.2)	\$22,846	\$22,846	\$24,013	\$1,167
Benefits to Former Personnel (13.0)	\$78	\$78	\$80	\$2
<b>Subtotal Pay Costs</b>	<b>\$1,646,883</b>	<b>\$1,646,883</b>	<b>\$1,736,334</b>	<b>\$89,451</b>
Travel (21.0)	\$49,524	\$49,524	\$50,039	\$515
Transportation of Things (22.0)	\$8,668	\$8,668	\$8,758	\$90
Rental Payments to GSA (23.1)	\$578	\$578	\$590	\$12
Rental Payments to Others (23.2)	\$6,534	\$6,534	\$6,602	\$68
Communications, Utilities, and Misc. Charges (23.3)	\$4,511	\$4,511	\$4,558	\$47
NTWK Use Data TRANSM SVC (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$2,618	\$2,618	\$2,646	\$27
Other Contractual Services (25):	<u>\$2,283,813</u>	<u>\$2,283,813</u>	<u>\$2,307,575</u>	<u>\$23,761</u>
Advisory and Assistance Services (25.1)	\$1,062,277	\$1,062,277	\$1,073,320	\$11,052
Other Services (25.2)	\$91,154	\$91,154	\$92,103	\$948
Purchases from Government Accounts (25.3)	\$1,006,971	\$1,006,971	\$1,017,447	\$10,477
Operation and Maintenance of Facilities (25.4)	\$16,917	\$16,917	\$17,093	\$176
Research and Development Contracts (25.5)	\$42,999	\$42,999	\$43,446	\$447
Medical Services (25.6)	\$4,560	\$4,560	\$4,607	\$47
Operation and Maintenance of Equipment (25.7)	\$58,928	\$58,928	\$59,541	\$613
Subsistence and Support of Persons (25.8)	\$8	\$8	\$8	\$0
Consultants, other and misc. (25.9)	\$0	\$0	\$0	\$0
Supplies and Materials (26.0)	\$67,938	\$67,938	\$69,569	\$1,631
Equipment (31.0)	\$61,308	\$61,308	\$61,946	\$638
Land and Structures (32.0)	\$17,800	\$17,800	\$17,801	\$1
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$4,130,241	\$4,130,241	\$4,130,300	\$59
Insurance Claims and Indemnities (42.0)	\$416	\$416	\$416	\$0
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
<b>Subtotal Non-Pay Costs</b>	<b>\$6,633,949</b>	<b>\$6,633,949</b>	<b>\$6,660,798</b>	<b>\$26,849</b>
<b>Total Budget Authority</b>	<b>\$8,280,832</b>	<b>\$8,280,832</b>	<b>\$8,397,132</b>	<b>\$116,300</b>
<b>Average Cost per FTE</b>				
<b>Civilian FTEs</b>	<b>11,676</b>	<b>12,266</b>	<b>12,464</b>	<b>788</b>
Civilian Average Salary and Benefits	\$131	\$125	\$130	-\$1
Percent change	N/A	-5%	4%	N/A
<b>Military FTEs</b>	<b>728</b>	<b>744</b>	<b>744</b>	<b>16</b>
Military Average Salary and Benefits	\$158	\$155	\$160	\$1
Percent change	N/A	-2%	3%	3%
<b>Total FTE<sup>1</sup></b>	<b>12,404</b>	<b>13,010</b>	<b>13,208</b>	<b>804</b>
<b>Average Salary and Benefits</b>	<b>\$133</b>	<b>\$127</b>	<b>\$131</b>	<b>-\$2</b>
<b>Percent change</b>	<b>N/A</b>	<b>-5%</b>	<b>4%</b>	<b>N/A</b>

<sup>1</sup> Total FTEs represents Direct and Working Capital Fund (WCF) FTE. ATSDR and Reimbursable employees are not included.



## SALARIES AND EXPENSES

(dollars in thousands)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Personnel Compensation:</b>				
Full-Time Permanent(11.1)	\$955,545	\$955,545	\$1,026,358	\$70,845
Other than Full-Time Permanent (11.3)	\$110,196	\$110,196	\$113,071	\$2,875
Other Personnel Comp. (11.5)	\$53,249	\$53,249	\$54,638	\$1,389
Military Personnel (11.7)	\$92,438	\$92,438	\$94,849	\$2,411
Special Personal Service Comp. (11.8)	\$2,884	\$2,884	\$2,959	\$75
<b>Total Personnel Compensation</b>	<b>\$1,214,312</b>	<b>\$1,214,312</b>	<b>\$1,291,908</b>	<b>\$77,595</b>
Civilian personnel Benefits (12.1)	\$409,647	\$409,647	\$420,333	\$10,686
Military Personnel Benefits (12.2)	\$22,846	\$22,846	\$24,013	\$1,167
Benefits to Former Personnel (13.0)	\$78	\$78	\$80	\$2
<b>Subtotal Pay Costs</b>	<b>\$1,646,883</b>	<b>\$1,646,883</b>	<b>\$1,736,334</b>	<b>\$89,451</b>
Travel (21.0)	\$49,524	\$49,524	\$50,039	\$515
Transportation of Things (22.0)	\$8,668	\$8,668	\$8,758	\$90
Rental Payments to Others (23.2)	\$6,534	\$6,534	\$6,602	\$68
Communications, Utilities, and Misc. Charges (23.3)	\$4,511	\$4,511	\$4,558	\$47
Printing and Reproduction (24.0)	\$2,618	\$2,618	\$2,646	\$27
Other Contractual Services (25):	<u>\$2,283,813</u>	<u>\$2,283,813</u>	<u>\$2,307,577</u>	<u>\$23,763</u>
Advisory and Assistance Services (25.1)	\$1,062,277	\$1,062,277	\$1,073,329	\$11,052
Other Services (25.2)	\$91,154	\$91,154	\$92,103	\$948
Purchases from Government Accounts (25.3)	\$1,006,971	\$1,006,971	\$1,017,447	\$10,477
Operation and Maintenance of Facilities (25.4)	\$16,917	\$16,917	\$17,093	\$176
Research and Development Contracts (25.5)	\$42,999	\$42,999	\$43,446	\$447
Medical Services (25.6)	\$4,560	\$4,560	\$4,607	\$47
Operation and Maintenance of Equipment (25.7)	\$58,928	\$58,928	\$59,541	\$613
Subsistence and Support of Persons (25.8)	\$8	\$8	\$10	\$2
Supplies and Materials (26.0)	\$67,938	\$67,938	\$69,569	\$1,631
<b>Subtotal Non-Pay Costs</b>	<b>\$2,423,606</b>	<b>\$2,423,606</b>	<b>\$2,449,749</b>	<b>\$26,143</b>
Rental Payments to GSA (23.1)	\$578	\$578	\$590	\$12
<b>Total, Salaries &amp; Expenses and Rent</b>	<b>\$4,071,068</b>	<b>\$4,071,068</b>	<b>\$4,186,672</b>	<b>\$115,605</b>
<b>Direct FTE<sup>1</sup></b>	<b>12,404</b>	<b>13,010</b>	<b>13,208</b>	<b>804</b>

<sup>1</sup>Total FTEs represents Direct and Working Capital Fund (WCF) FTE. ATSDR and Reimbursable employees are not included.

## OBJECT CLASS TABLE – PREVENTION AND PUBLIC HEALTH FUND

(dollars in thousands)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Personnel Compensation:</b>				
Full-Time Permanent(11.1)	\$16,732	\$16,732	\$21,973	\$5,240
Other than Full-Time Permanent (11.3)	\$1,294	\$1,294	\$1,699	\$405
Other Personnel Comp. (11.5)	\$745	\$745	\$979	\$233
Military Personnel (11.7)	\$1,886	\$1,886	\$2,477	\$591
Special Personal Service Comp. (11.8)	\$75	\$75	\$99	\$24
<b>Total Personnel Compensation</b>	<b>\$20,733</b>	<b>\$20,733</b>	<b>\$27,226</b>	<b>\$6,493</b>
Civilian personnel Benefits (12.1)	\$6,825	\$6,825	\$8,963	\$2,138
Military Personnel Benefits (12.2)	\$790	\$790	\$1,037	\$247
Benefits to Former Personnel (13.0)	\$0	\$0	\$0	\$0
<b>Subtotal Pay Costs</b>	<b>\$28,348</b>	<b>\$28,348</b>	<b>\$37,227</b>	<b>\$8,878</b>
Travel (21.0)	\$988	\$988	\$1,298	\$310
Transportation of Things (22.0)	\$98	\$98	\$129	\$31
Rental Payments to GSA (23.1)	\$0	\$0	\$0	\$0
Rental Payments to Others (23.2)	\$7	\$7	\$9	\$2
Communications, Utilities, and Misc. Charges (23.3)	\$3	\$3	\$4	\$1
NTWK Use Data TRANSM SVC (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$10	\$10	\$13	\$3
Other Contractual Services (25):	<u>\$160,445</u>	<u>\$160,445</u>	<u>\$210,694</u>	<u>\$50,249</u>
Advisory and Assistance Services (25.1)	\$107,558	\$107,558	\$107,558	\$141,243
Other Services (25.2)	\$233	\$233	\$305	\$73
Purchases from Government Accounts (25.3)	\$51,010	\$51,010	\$66,985	\$15,975
Operation and Maintenance of Facilities (25.4)	\$0	\$0	\$0	\$0
Research and Development Contracts (25.5)	\$0	\$0	\$0	\$0
Medical Services (25.6)	\$204	\$204	\$268	\$64
Operation and Maintenance of Equipment (25.7)	\$1,441	\$1,441	\$1,892	\$451
Subsistence and Support of Persons (25.8)	\$0	\$0	\$0	\$0
Consultants, other and misc. (25.9)	\$0	\$0	\$0	\$0
Supplies and Materials (26.0)	\$58,059	\$58,059	\$76,242	\$18,183
Equipment (31.0)	\$993	\$993	\$1,304	\$311
Land and Structures (32.0)	\$0	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$654,348	\$654,348	\$859,279	\$204,932
Insurance Claims and Indemnities (42.0)	\$0	\$0	\$0	\$0
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
<b>Subtotal Non-Pay Costs</b>	<b>\$874,952</b>	<b>\$874,952</b>	<b>\$1,148,973</b>	<b>\$274,022</b>
<b>Total Budget Authority</b>	<b>\$903,300</b>	<b>\$903,300</b>	<b>\$1,186,200</b>	<b>\$282,900</b>
<b>Average Cost per FTE</b>				
<b>Civilian FTEs</b>	<b>155</b>	<b>155</b>	<b>185</b>	<b>30</b>
Civilian Average Salary and Benefits	\$166	\$166	\$182	\$17
Percent change	N/A	0%	10%	10%
<b>Military FTEs</b>	<b>19</b>	<b>19</b>	<b>19</b>	<b>0</b>
Military Average Salary and Benefits	\$141	\$141	\$185	\$44
Percent change	N/A	0%	31%	31%
<b>Total FTEs<sup>1,2</sup></b>	<b>174</b>	<b>174</b>	<b>204</b>	<b>30</b>
<b>Average Salary and Benefits</b>	<b>\$163</b>	<b>\$163</b>	<b>\$182</b>	<b>\$20</b>
<b>Percent change</b>	<b>N/A</b>	<b>0%</b>	<b>12%</b>	<b>12%</b>

<sup>1</sup> PPHF FTEs based on direct hire estimates.

<sup>2</sup> PPHF Civilian Avg. Salary only includes partial compensation.

## OBJECT CLASS TABLE – REIMBURSABLE<sup>1</sup>

(dollars in thousands)	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
<b>Personnel Compensation:</b>				
Full-Time Permanent(11.1)	\$53,835	\$54,059	\$54,059	\$224
Other than Full-Time Permanent (11.3)	\$20,184	\$20,268	\$20,268	\$84
Other Personnel Comp. (11.5)	\$5,385	\$5,408	\$5,408	\$22
Military Personnel (11.7)	\$7,265	\$7,295	\$7,295	\$30
Special Personal Service Comp. (11.8)	\$28	\$29	\$29	\$0
<b>Total Personnel Compensation</b>	<b>\$86,698</b>	<b>\$87,059</b>	<b>\$87,059</b>	<b>\$361</b>
Civilian Personnel Benefits (12.1)	\$29,796	\$29,920	\$29,920	\$124
Military Personnel Benefits (12.2)	\$2,070	\$2,079	\$2,079	\$9
Benefits to Former Personnel (13.0)	\$0	\$0	\$0	\$0
<b>Subtotal Pay Costs</b>	<b>\$118,564</b>	<b>\$119,058</b>	<b>\$119,058</b>	<b>\$494</b>
Travel (21.0)	\$7,739	\$7,771	\$7,771	\$32
Transportation of Things (22.0)	\$3,937	\$3,953	\$3,953	\$16
Rental Payments to GSA (23.1)	\$261	\$263	\$263	\$1
Rental Payments to Others (23.2)	\$851	\$855	\$855	\$4
Communications, Utilities, and Misc. Charges (23.3)	\$1,063	\$1,068	\$1,068	\$4
NTWK Use Data TRANSM SVC (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$79	\$79	\$79	\$0
Other Contractual Services (25):	<u>\$311,247</u>	<u>\$312,544</u>	<u>\$312,544</u>	<u>\$1,298</u>
Advisory and Assistance Services (25.1)	\$153,230	\$153,869	\$153,869	\$639
Other Services (25.2)	\$15,592	\$15,657	\$15,657	\$65
Purchases from Government Accounts (25.3)	\$61,272	\$61,527	\$61,527	\$255
Operation and Maintenance of Facilities (25.4)	\$22	\$22	\$22	\$0
Research and Development Contracts (25.5)	\$0	\$0	\$0	\$0
Medical Services (25.6)	\$202	\$203	\$203	\$1
Operation and Maintenance of Equipment (25.7)	\$80,928	\$81,266	\$81,266	\$337
Subsistence and Support of Persons (25.8)	\$0	\$0	\$0	\$0
Consultants, other and misc. (25.9)	\$0	\$0	\$0	\$0
Supplies and Materials (26.0)	\$16,592	\$16,662	\$16,662	\$69
Equipment (31.0)	\$9,738	\$9,778	\$9,778	\$41
Land and Structures (32.0)	\$0	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$195,650	\$196,466	\$196,466	\$816
Insurance Claims and Indemnities (42.0)	\$49,503	\$49,709	\$49,709	\$206
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
<b>Subtotal Non-Pay Costs</b>	<b>\$596,661</b>	<b>\$599,148</b>	<b>\$599,148</b>	<b>\$2,488</b>
<b>Total Budget Authority</b>	<b>\$715,224</b>	<b>\$718,206</b>	<b>\$718,206</b>	<b>\$2,982</b>
<b>Average Cost per FTE</b>				
<b>Civilian FTEs</b>	<b>274</b>	<b>22</b>	<b>22</b>	<b>-252</b>
Civilian Average Salary and Benefits	\$399	\$4,986	\$4,986	\$4,587
Percent change	N/A	1151%	0%	0%
<b>Military FTEs</b>	<b>28</b>	<b>8</b>	<b>8</b>	<b>-20</b>
Military Average Salary and Benefits	\$333	\$1,172	\$1,172	\$838
Percent change	N/A	251%	0%	0%
<b>Total FTEs</b>	<b>302</b>	<b>30</b>	<b>30</b>	<b>-272</b>
<b>Average Salary and Benefits</b>	<b>\$393</b>	<b>\$3,969</b>	<b>\$3,969</b>	<b>\$3,576</b>
<b>Percent change</b>	<b>N/A</b>	<b>911%</b>	<b>0%</b>	<b>0%</b>

<sup>1</sup> FY 2024 and FY 2025 reflect reimbursable ceiling estimates.

## DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

	FY 2023			FY 2024			FY 2025		
	Civilian	CC	Total	Civilian	CC	Total	Civilian	CC	Total
<b>Immunization and Respiratory Diseases</b>	<b>936</b>	<b>73</b>	<b>1,009</b>	<b>1,027</b>	<b>73</b>	<b>1,100</b>	<b>1,027</b>	<b>73</b>	<b>1,100</b>
Direct	932	73	1,005	1,027	73	1,100	1,027	73	1,100
Reimbursable	4	-	4	-	-	-	-	-	-
<b>HIV/AIDS, Viral Hepatitis, STI and TB Prevention</b>	<b>1,059</b>	<b>60</b>	<b>1,119</b>	<b>1,083</b>	<b>61</b>	<b>1,144</b>	<b>1,083</b>	<b>61</b>	<b>1,144</b>
Direct	1,058	60	1,118	1,083	61	1,144	1,083	61	1,144
Reimbursable	1	-	1	-	-	-	-	-	-
<b>Emerging and Zoonotic Infectious Diseases</b>	<b>1,514</b>	<b>124</b>	<b>1,638</b>	<b>1,507</b>	<b>141</b>	<b>1,648</b>	<b>1,522</b>	<b>141</b>	<b>1,663</b>
Direct	1,438	117	1,555	1,507	134	1,641	1,522	134	1,656
Reimbursable	76	7	83	-	7	7	-	7	7
<b>Chronic Disease Prevention and Health Promotion</b>	<b>832</b>	<b>44</b>	<b>876</b>	<b>885</b>	<b>42</b>	<b>927</b>	<b>907</b>	<b>42</b>	<b>949</b>
Direct	830	44	874	885	42	927	907	42	949
Reimbursable	2	-	2	-	-	-	-	-	-
<b>Birth Defects, Developmental Disabilities, Disability and Health</b>	<b>200</b>	<b>9</b>	<b>209</b>	<b>214</b>	<b>8</b>	<b>222</b>	<b>214</b>	<b>8</b>	<b>222</b>
Direct	200	9	209	214	8	222	214	8	222
Reimbursable	-	-	-	-	-	-	-	-	-
<b>Environmental Health</b>	<b>453</b>	<b>30</b>	<b>483</b>	<b>486</b>	<b>24</b>	<b>510</b>	<b>493</b>	<b>24</b>	<b>517</b>
Direct	410	29	439	486	24	510	493	24	517
Reimbursable	43	1	44	-	-	-	-	-	-
<b>Injury Prevention and Control</b>	<b>519</b>	<b>30</b>	<b>549</b>	<b>570</b>	<b>24</b>	<b>594</b>	<b>688</b>	<b>24</b>	<b>712</b>
Direct	496	29	525	570	24	594	688	24	712
Reimbursable	23	1	24	-	-	-	-	-	-
<b>Public Health Scientific Services</b>	<b>1,527</b>	<b>74</b>	<b>1,601</b>	<b>1,466</b>	<b>84</b>	<b>1,550</b>	<b>1,486</b>	<b>84</b>	<b>1,570</b>
Direct	1,455	72	1,527	1,445	84	1,529	1,465	84	1,549
Reimbursable	72	2	74	21	-	21	21	-	21
<b>Occupational Safety and Health</b>	<b>972</b>	<b>75</b>	<b>1,047</b>	<b>991</b>	<b>72</b>	<b>1,063</b>	<b>993</b>	<b>72</b>	<b>1,065</b>
Direct	969	75	1,044	991	72	1,063	993	72	1,065
Reimbursable	3	-	3	-	-	-	-	-	-
<b>Global Health</b>	<b>1,239</b>	<b>141</b>	<b>1,380</b>	<b>1,320</b>	<b>124</b>	<b>1,444</b>	<b>1,320</b>	<b>124</b>	<b>1,444</b>
Direct	1,189	125	1,314	1,319	123	1,442	1,319	123	1,442
Reimbursable	50	16	66	1	1	2	1	1	2
<b>Public Health Preparedness and Response</b>	<b>438</b>	<b>55</b>	<b>493</b>	<b>433</b>	<b>51</b>	<b>484</b>	<b>447</b>	<b>51</b>	<b>498</b>
Direct	438	54	492	433	51	484	447	51	498
Reimbursable	-	1	1	-	-	-	-	-	-
<b>Cross-Cutting Activities and Program Support</b>	<b>2,262</b>	<b>41</b>	<b>2,302</b>	<b>2,304</b>	<b>48</b>	<b>2,352</b>	<b>2,304</b>	<b>48</b>	<b>2,352</b>
Direct	2,262	41	2,302	2,304	48	2,352	2,304	48	2,352
BA	596	32	628	594	21	615	594	21	615
WCF	1,665	9	1,674	1,710	27	1,737	1,710	27	1,737
<b>CDC Total<sup>1,2</sup></b>	<b>11,950</b>	<b>756</b>	<b>12,706</b>	<b>12,288</b>	<b>752</b>	<b>13,040</b>	<b>12,486</b>	<b>752</b>	<b>13,238</b>
<b>CDC Direct Total</b>	<b>11,676</b>	<b>728</b>	<b>12,404</b>	<b>12,266</b>	<b>744</b>	<b>13,010</b>	<b>12,464</b>	<b>744</b>	<b>13,208</b>
<b>CDC Reimbursable Total</b>	<b>274</b>	<b>28</b>	<b>302</b>	<b>22</b>	<b>8</b>	<b>30</b>	<b>22</b>	<b>8</b>	<b>30</b>

<sup>1</sup> CDC FTE only. Excludes ATSDR.

<sup>2</sup> FTE displayed reflect updated actual levels for FY 2023, which may differ from the system of record.

## DETAIL OF POSITIONS<sup>1,2,3,4</sup>

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget
<b>Executive Level<sup>4</sup></b>			
Executive level I			
Executive level II			
Executive level III			
Executive level IV			
Executive level V			
<b>Subtotal</b>			
<b>Total-Executive Level Salary</b>			
ES-6			
ES-5			
ES-4			
ES-3			
ES-2			
ES-1			
<b>Total - SES</b>	<b>43</b>	<b>40</b>	<b>38</b>
<b>Total - SES Salary</b>	<b>\$7,438,301</b>	<b>\$7,442,314</b>	<b>\$7,593,080</b>
GS-15	942	913	897
GS-14	2,742	2,665	2,627
GS-13	4,086	3,919	3,844
GS-12	2,027	1,917	1,882
GS-11	849	771	757
GS-10	28	23	24
GS-9	437	431	426
GS-8	53	50	48
GS-7	329	300	240
GS-6	15	14	14
GS-5	172	81	74
GS-4	4	3	3
GS-3	1	1	1
GS-2	3	1	1
GS-1	0	0	0
<b>Subtotal</b>	<b>11,688</b>	<b>11,089</b>	<b>10,838</b>
<b>Total - GS Salary</b>	<b>\$1,243,129,531</b>	<b>\$1,316,828,692</b>	<b>\$1,331,095,897</b>
<b>Average ES level</b>			
<b>Average ES salary</b>			
<b>Average GS grade</b>	12.0	12.0	12.0
<b>Average GS salary</b>	\$106,359	\$118,751	\$122,817
<b>Average Special Pay Categories</b>			
<b>Average Comm. Corps Salary</b>	\$134,186	\$146,667	\$150,154
<b>Average Wage Grade Salary</b>	\$70,198	\$76,162	\$81,634

<sup>1</sup> Includes special pays and allowances.

<sup>2</sup> Totals do not include reimbursable FTEs.

<sup>3</sup> This table reflects "positions" not full-time equivalent(s) (FTEs).

<sup>4</sup> Executive level data not available.

## CDC FULL TIME EQUIVALENTS FUNDED BY THE AFFORDABLE CARE ACT, P.L. 111-148

(dollars in millions)																							
ACA Sec.	2015 Total	2015 FTEs	2016 Total	2016 FTEs	2017 Total	2017 FTEs	2018 Total	2018 FTEs	2019 Total	2019 FTEs	2020 Total	2020 FTEs	2021 Total	2021 FTEs	2022 Total	2022 FTEs	2023 Total	2023 FTEs	2024 Total	2024 FTEs	2025 Total	2025 FTEs	
<b>PPHF Program <sup>1,2</sup></b>																							
Healthcare-associated Infections (HAI)	4002	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4	\$12.0	6.4
Million Hearts	4002	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1	\$4.0	2.1
National Early Care Collaboratives	4002	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0	\$4.0	1.0
Public Health Workforce	4002	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0
Antibiotic Resistance Initiative	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<b>Total</b>		<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>	<b>\$20.0</b>	<b>9.5</b>

<sup>1</sup>Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.

<sup>2</sup>CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.

(dollars in millions)																							
ACA Sec.	2015 Total	2015 FTEs	2016 Total	2016 FTEs	2017 Total	2017 FTEs	2018 Total	2018 FTEs	2019 Total	2019 FTEs	2020 Total	2020 FTEs	2021 Total	2021 FTEs	2022 Total	2022 FTEs	2023 Total	2023 FTEs	2024 Total	2024 FTEs	2025 Total	2025 FTEs	
<b>ACA Program <sup>1,2</sup></b>																							
Childhood Obesity PL 114-10	4306	\$0.0	1.1	\$0.0	0.0	\$10.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0
Medical Monitoring in Libby, MT	1032 3	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9	\$4.0	0.9
<b>Total</b>		<b>\$4.0</b>	<b>2.0</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$14.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>	<b>\$4.0</b>	<b>0.9</b>

<sup>1</sup>Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.<sup>2</sup>CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.

## PHYSICIANS' COMPARABILITY ALLOWANCE (PCA) WORKSHEET

1) Department and component:

Centers For Disease Control and Prevention

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

*(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

CDC has found that SES salaries do not meet the threshold to attract top level senior officials for critical science-focused positions who are appointed under SES. The use of PCA is critical, as it allows CDC to recruit and retain top level senior officials who possess requisite scientific expertise, and whose national/international stature command salaries which exceed the SES salary level.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2023 (Actual)	CY 2024 (Estimates)	BY* 2025 (Estimates)
3a) Number of Physicians Receiving PCAs	2	1	1
3b) Number of Physicians with One-Year PCA Agreements	1	1	1
3c) Number of Physicians with Multi-Year PCA Agreements	1	0	0
4a) Average Annual PCA Physician Pay (without PCA payment)	183,300	183,500	183,500
4b) Average Annual PCA Payment	22,000	14,000	14,000

\*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

The use of PCA has enabled successful recruitment of physicians to key positions at CDC. It is anticipated that the failure to offer PCA to CDC physicians could would have a negative impact on CDC's global mission.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

The need will remain to pay PCA to any new physicians appointed under SES. Market pay will be utilized for all new accessions for physicians appointed under Title 5.

## RESOURCES FOR CYBER ACTIVITIES

*(Dollars in thousands)*

Cyber Category	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Cyber Human Capital.....	0.281	0.562	0.562	+0.281
Planning Roles and Responsibilities.....	0.000	0.000	0.000	--
Sector Risk Assessment, Management, and Operations.....	0.000	0.000	0.000	--
Sector Coordination.....	0.000	0.000	0.000	--
<b>Other NIST CSF Capabilities:</b>	<b><u>84.103</u></b>	<b><u>82.801</u></b>	<b><u>83.807</u></b>	<b><u>- 0.296</u></b>
Detect.....	11.182	11.518	11.518	+0.336
Identity.....	38.867	39.687	40.397	+1.530
Protect.....	28.607	25.986	26.282	- 2.325
Recover.....	1.016	1.046	1.046	+0.030
Respond.....	4.431	4.564	4.564	+0.133
<b>Total Cyber Request.....</b>	<b><u>84.384</u></b>	<b><u>83.363</u></b>	<b><u>84.369</u></b>	<b><u>- 0.015</u></b>
<i>Technology Ecosystems (non-add).....</i>				
<i>Zero Trust Implementation (non-add).....</i>	3.100	29.867	43.847	+40.747



## CUSTOMER EXPERIENCE FUNDING TABLE

*(Dollars in thousands)*

Customer Experience Activities	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
CDC-Office of Public Health Data, Surveillance, and Technology.....	4.900	5.000	5.000	+0.100

The American people rely on CDC to support and provide public health data that promote timely, evidence-based public health decision-making; however, transformation of public health data and information technology remains limited by the lack of a digital service organization in support of public health data modernization goals. These resources support approximately 16 FTE from the U.S. Digital Service, which support CDC’s goal of implementing a dedicated set of digital service capabilities throughout CDC’s operational structure and to help bridge gaps in skills and capacities needed to effectively deliver the data and technology solutions that CDC programs, federal partners, and STLT health departments need to combat health threats and disease crises quickly and accurately.

## FY 2019-2025 CONSOLIDATED CDC GRANTS TABLE

These funds are awarded by formula. Δ  
 These funds are not awarded by formula. •  
 These funds are awarded partially by formula. †

(dollars in millions)	FY 2019 Final	FY 2020 Final	FY 2021 Final	FY 2022 Final	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 PB +/- FY 2023 Final	% Formula
<b>Immunization Cooperative Agreements</b>									Δ
- Number of Awards	64	64	64	64	64	64	64	0	
- Total Awards	\$369.77	\$301.54	\$369.77	\$438.50	\$320.465	\$320.69	\$320.69	0	
<b>Enhancing Reviews and Surveillance to Eliminate Maternal Mortality Grants</b>									•
- Number of Awards	N/A	24*	30	40	46	59	59	13	
- Total Awards		\$9.076	\$11.17	\$14.20	\$20.60	\$26.80	\$29.80	+\$9.00	
<b>Behavioral Risk Factor Surveillance System (BRFSS) Grants</b>									•
- Number of Awards	57	57	56	56	56	56	56	0	
- Total Awards	\$13.47	\$14.39	\$22.44	\$22.49	\$24.60	\$24.60	\$24.60	0	
<b>National Notifiable Diseases Surveillance System (NNDSS) Grants</b>									•
- Number of Awards	63	58	64	64	64	64	64	0	
- Total Awards	\$9.72	\$10.00	\$8.85	\$8.85	\$11.04	\$11.04	\$11.04	0	
<b>Tracking Network Grants</b>									•
- Number of Awards	26	26	26	26	33	33	33	0	
- Total Awards	\$22.61	\$20.15	\$19.63	\$16.25	\$20.00	\$20.00	\$20.00	0	
<b>State Biomonitoring Cooperative Agreements</b>									•
- Number of Awards	N/A	N/A	N/A	6	6	7	7	1	
- Total Awards				\$5.00	\$5.00	\$5.00	\$5.00	0	

<b>Newborn Screening Cooperative Agreements</b>									•
- Number of Awards	N/A	N/A	N/A	5	5	1	1	-4*	
- Total Awards				\$1.99	\$1.99	\$1.00	\$1.00	0	
<b>Asthma Grants to Health Departments</b>									•
- Number of Awards	25	25	25	25	25	25	25	0	
- Total Awards	\$15.70	\$15.70	\$15.70	\$15.70	\$15.70	\$15.70	\$15.70	0	
<b>Building Resilience Against Climate Effects (BRACE) Cooperative Agreement</b>									•
- Number of Awards	N/A	N/A	N/A	11	11	11	11	0	
- Total Awards				\$4.30	\$4.30	\$4.30	\$4.30	0	
<b>ELC Cooperative Agreements</b>									•
- Number of Awards	N/A	N/A	N/A	64	64	64	64	0	
- Total Awards				\$197.04	\$173.00	TBD	TBD	TBD	
<b>ALS Research Grants</b>									•
- Number of Awards	N/A	N/A	N/A	7	8	8	8	0	
- Total Awards				\$3.10	\$3.20	\$3.20	\$3.20	0	
<b>Public Health Emergency Preparedness Cooperative Agreements</b>									Δ
- Number of Awards	N/A	N/A	N/A	62	62	62	62	0	
- Total Awards				\$651.79	\$661.34	\$661.34	\$661.34	0	
<b>Childhood Lead Poisoning Prevention Grants</b>									•
- Number of Awards	48	48	62	62	73	73	96	+23	
- Total Awards	\$14.97	\$19.97	\$23.98	\$23.98	\$36.00	\$36.00	\$40.60	+\$4.60	
<b>Rape Prevention and Education Grants</b>									Δ
- Number of Awards (State Health Departments)	55	55	53	53	53	TBD	TBD	TBD	
-Number of Awards (Sexual Violence Coalitions)	N/A	N/A	N/A	N/A	49	TBD	TBD	TBD	
- Total Awards	\$34.14	\$39.00	\$42.87	\$42.87	\$46.38	TBD	TBD	TBD	

<b>National Violent Death Reporting System (NVDRS) Grants</b>									Δ
- Number of Awards	41	52	52	52	52	TBD	TBD	TBD	
- Total Awards	\$10.64	\$16.26	\$16.83	\$16.83	\$16.83	TBD	TBD	TBD	
<b>Overdose Data to Action: State and OD2A: Local Grants</b>									●
- Number of Awards	43	101	66	66	90	TBD	TBD	TBD	
- Total Awards	\$72.15	\$244.19	\$258.13	\$290.00	\$279.50	TBD	TBD	TBD	
<b>Core State Violence and Injury Prevention Program Grants</b>									●
- Number of Awards	23	23	23	23	26	TBD	TBD	TBD	
- Total Awards	\$6.72	\$6.72	\$6.72	\$6.72	\$7.40	TBD	TBD	TBD	
<b>Occupational Safety and Health Grants</b>									●
- Number of Awards	136	147	145	145	145	145	145	0	
- Total Awards	\$46.99	\$90.09	\$94.14	\$94.14	\$97.34	\$97.34	\$97.34	0	
<b>National Syndromic Surveillance Program Grants</b>									●
- Number of Awards	31	31	51	51	51	51	51	0	
- Total Awards	\$6.56	\$6.56	\$6.56	\$6.56	\$6.00	\$6.00	\$6.00	0	
<b>Public Health Infrastructure and Capacity</b>									●
- Number of Awards	N/A	N/A	N/A	107	106	106	106	0	
- Total Awards	N/A	N/A	N/A	\$140.00	\$245.00	\$245.00	\$245.00	0	
<b>Environmental Health Capacity Cooperative Agreement</b>									●
-Number of Awards	N/A	N/A	N/A	N/A	29	29	29	0	
-Total Awards	N/A	N/A	N/A	N/A	\$2.46	\$2.46	\$2.46	0	

\* In 2024, CDC will transition to a Centers of Excellence (COE) model for the Newborn Screening cooperative agreement. The COE will collaborate with CDC and other state public health laboratories to improve newborn screening capacity by developing methods, harmonizing biochemical and molecular data, and sharing best practices with the newborn screening community.

# CDC SPECIFIC ITEMS

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## CDC DRUG CONTROL PROGRAM AGENCY

### Resource Summary

<i>(Dollars in Millions)</i>	FY 2023 Final	FY 2024 CR	FY 2025 Request
<b>Drug Resources by Function</b>			
Prevention	\$459.579	\$459.579	\$460.079
Harm Reduction	\$69.000	\$69.000	\$69.000
<b>Total Drug Resources by Function</b>	<b>\$528.579</b>	<b>\$528.579</b>	<b>\$529.079</b>
<b>Drug Resources by Decision Unit</b>			
Opioid Overdose Prevention and Surveillance	\$505.579	\$505.579	\$506.079
Infectious Diseases and the Opioid Epidemic <sup>1</sup>	\$23.000	\$23.000	\$23.000
<b>Total Drug Resources by Decision Unit</b>	<b>\$528.579</b>	<b>\$528.579</b>	<b>\$529.079</b>
<b>Drug Resources Personnel Summary</b>			
Total FTEs (Direct Only) <sup>2</sup>	201	201	202
Opioid Overdose Prevention and Surveillance	193	193	194
Infectious Diseases and the Opioid Epidemic	8	8	8
<b>Drug Resources as a Percent of Budget</b>			
Total Agency Budget <sup>3,4</sup>	\$9,184.132	\$9,184.132	\$9,683.332
Drug Resources Percentage	5.8%	5.8%	5.5%

<sup>1</sup> Infectious Diseases and the Opioid Epidemic supports CDC in reducing morbidity, mortality, and incidence of infectious diseases associated with drug use.

<sup>2</sup> Includes vacancies.

<sup>3</sup> Excludes ATSDR and mandatory programs; includes funding from the Prevention and Public Health Fund and PHS Evaluation Transfers.

<sup>4</sup> FY 2023 Final and FY 2024 CR Level are comparably adjusted to reflect \$21.9 million within CDC’s total for HHS Protect. The FY 2023 Joint Explanatory Statement provided \$21.9 million from the Public Health and Social Services Emergency Fund (PHSSEF) for HHS Protect, to support activities implemented by CDC. The FY 2025 Budget proposes directly appropriating funding to CDC for HHS Protect/Response Ready Enterprise Data Integration platform (RREDI).

### Program Summary

#### Mission

The Centers for Disease Control and Prevention (CDC) serves as the nation’s public health agency and exercises expertise in developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States.

CDC supports the National Drug Control Strategy through its surveillance activities and by advancing data-driven prevention strategies to address drug use and overdose. CDC works to prevent overdose and other substance use-related harms under its five strategic priorities:

- Monitoring, analyzing, and communicating trends.
- Building state, local, tribal, and territorial capacity.
- Supporting providers, health systems, payers, and employers.
- Partnering with public safety and community organizations.
- Raising public awareness and reducing stigma.

Foundational to CDC’s work are the six guiding principles of promoting health equity, addressing underlying factors, partnering broadly, taking evidence-based action, advancing science, and driving innovation. CDC uses data to tailor prevention activities that address drug overdoses as well as other negative health effects of the epidemic. For example, in response to the rise in deaths attributable to illicit opioids, stimulants, and

other emerging substance threats, CDC is improving the timeliness and comprehensiveness of drug overdose data. CDC is also strengthening partnerships with public safety and scaling up public health and harm reduction strategies, including syringe services programs (SSPs), to expand access to evidence-based treatment to assist in sustaining long-term recovery and reduce substance use-related harms, such as the rising rates of infectious diseases such as hepatitis C and HIV, as well as stigma. Across the agency, CDC has dedicated efforts to reach disproportionately affected populations (e.g., people from racial and ethnic minority groups and rural communities) with a focus on advancing racial equity and ensuring all communities have an equitable opportunity to prevent overdose and substance use-related harms in addition to fighting the overdose crisis.

### **Methodology**

CDC determined the drug control budget using the relevant amounts under the Consolidated Appropriations Act, 2023, P.L. 117-328. CDC is committed to an approach that protects the public's health and prevents drug overdose and substance use-related harms.

### **Budget Summary**

CDC's FY 2025 request of **\$529,079,000** for CDC's total drug resources is **\$500,000** above the FY 2023 final level, which reflects funding by decision units - Opioid Overdose Prevention and Surveillance and Infectious Diseases and the Opioid Epidemic. Activities within these decision units support multiple initiatives included in ONDCP Policy Priorities and the National Drug Control Strategy.

To effectively advance activities within each of the five strategic priorities, timely, high-quality data are necessary for public health officials and decision makers. Data can help policymakers and the public understand the extent of the problem, how various populations are being affected, focus resources, and evaluate the effectiveness of prevention and response efforts. CDC plays a critical role in improving data collection by helping states improve their surveillance systems to better monitor the overdose crisis and optimize evidence-based prevention efforts. CDC helps build state, local, and territorial capacity to prevent overdose through its [Overdose Data to Action \(OD2A\) program](#). [OD2A](#) supports states, localities, and territories to advance understanding of the drug overdose epidemic and to scale up surveillance and prevention strategies. This overarching support is made up of two distinct cooperative agreements: Overdose Data to Action in States (OD2A-S), which supports state health departments and Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (LOCAL), which supports local and territorial health departments, to help ensure broad resources and support to respond to the evolving overdose crisis at all levels of government. Both programs support 5-year cooperative agreements to expand and strengthen overdose surveillance and prevention efforts to reduce fatal and nonfatal overdoses involving opioids and/or stimulants and polysubstance use. OD2A is underpinned by a data-to-action framework that reinforces the use of surveillance and other data to inform and drive prevention efforts and policies, with an emphasis on addressing health equity and reducing health disparities.

CDC-supported surveillance improvements have helped public health experts adapt to the rapidly changing crisis, such as identifying communities at risk and implementing tailored strategies to link individuals to evidence-based harm reduction, care, and treatment. Data have also equipped communities with the necessary information to help save lives in cases of nonfatal overdose and emerging substances. For example, Indiana increased awareness of overdose related events across the state by adding alert systems that support stakeholders, the media, and public health partners to discuss, promote, and inform overdose prevention and response efforts in local communities.

CDC's State Unintentional Drug Overdose Reporting System (SUDORS), a module of the National Violent Death Reporting System, allows states to collect data on all unintentional or undetermined intent drug overdose deaths in one place. As a result, states can spot trends and understand factors leading up to overdose deaths. Data collected by SUDORS include valuable contextual information from death scene investigations, detailed information on toxicology and drugs contributing to death, the route of administration, decedent demographics,



and other risk factors associated with fatal overdose. States are providing mortality data for SUDORS 6-12 months after the death occurs, beginning in year 2 of the Notice of Funding Opportunity (NOFO). This is a critical data system that allows communities to spot trends and understand contextual and environmental factors leading up to overdose deaths, with the end goal of preventing overdose and related harms while expanding access to treatment and long-term recovery. For example, Nevada linked statewide SUDORS fatal overdose data with available Prescription Drug Monitoring Program data. The data linkage project identified missed opportunities for prescribers to intervene prior to an overdose.

CDC's Drug Overdose Surveillance and Epidemiology (DOSE) system was developed to analyze data from syndromic surveillance systems to rapidly identify outbreaks and provide situational awareness of changes in drug overdose-related emergency department (ED) visits at the local, state, and regional level. The DOSE System includes two complementary types of data that are collected and analyzed separately: near real-time ED syndromic data captured by health departments to gather aggregate data on ED visits involving suspected all drug, all opioid, heroin, and all stimulant overdoses, and quarterly discharge data from final ED and billing records. Aggregate data include demographic characteristics of those who overdosed, such as sex, age, and county of patient residence. The OD2A-S timeline for syndromic surveillance reporting is monthly, with a one-month lag, either by uploading data using a secure server or allowing DOSE staff access to their data in CDC's National Syndromic Surveillance Program's (NSSP) BioSense platform.<sup>321</sup> The number of jurisdictions included in the calculations of monthly and annual percent change estimates in rates will vary over time. Comparisons between jurisdictions should not be made because of variations in data quality, completeness, and reporting across jurisdictions. In 2023, CDC enhanced DOSE to include more states (i.e., from 32 states + DC to 47 states + DC), additional drug indicators (suspected all drug, all opioid, heroin, fentanyl, benzodiazepine, all stimulant, methamphetamine, and cocaine) and asked health departments to share available data more quickly. Both syndromic and discharge data are readily accessible and updated each month with a one-month lag (syndromic) and quarterly (discharge) in interactive dashboards<sup>322</sup> that can be used to improve coordination and strategic planning for intervention and response efforts. As a complement to DOSE, CDC has also enhanced the data collected in EDs to include overdose-related EMS transports using biospatial data, urine drug tests from Quest and Millennium Health, and comprehensive toxicology testing of left-over urine samples from individuals following an acute overdose to uncover emerging substances.

This, along with other initiatives within CDC's response to drug overdose prevention, interventions to prevent infectious diseases associated with injecting drug use, and support of primary prevention strategies aimed at youth support the Administration's drug policy priorities across all seven priority areas.

CDC supports providers and healthcare systems with resources to support and increase safe and effective pain care, maximize the use of prescription drug monitoring programs (PDMP), and advance insurer and health systems interventions at the federal, state, and local level. Pain, particularly chronic pain, can lead to impaired physical functioning, poor mental health, and a reduced quality of life. CDC provides patient resources, clinician guidance, continuing medical education, and other health professional training to advance better pain care, supported by the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain. CDC continues to leverage the Guideline to help healthcare systems integrate best practices and associated quality improvement (QI) measures into their clinical practice, including managing long-term opioid therapy. The [2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain](#) also describes evidence about long-standing health disparities that exist in the treatment of pain, such as geographic disparities and disparities in treatment due to access and affordability. It also highlights the importance of attention to health inequities related to race and ethnicity, as a guiding principle for implementation. The 2022 Clinical Practice Guideline considers and incorporates these important issues into and throughout the Guideline to support clinicians in their efforts to provide safe and effective pain care for all patients.

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<sup>321</sup> <https://www.cdc.gov/nssp/index.html>

<sup>322</sup> <https://www.cdc.gov/drugoverdose/nonfatal/dashboard/index.html>

CDC collaborates with multiple public health and public safety organizations to strengthen and improve efforts to reduce drug overdoses. These partnerships allow for effective implementation of programs and help advance promising strategies that address the overdose epidemic. CDC also works with public safety and harm reduction organizations that serve people from racial and ethnic minority groups to develop, disseminate, and evaluate educational and communications materials to reduce adverse health outcomes related to opioid use disorder. These tools use a trauma-informed, recovery-oriented approach to address the social determinants of health and incorporate real-world “how to” steps to implement the recommendations. CDC’s partnership with the Office of Justice Program’s Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Use Program (BJA COSSUP) provides financial and technical assistance to states, local government, and Indian tribal governments to develop, implement, or expand comprehensive efforts to identify, respond to, treat, and support those impacted by illicit opioids, stimulants, and other drugs. The [Overdose Response Strategy \(ORS\)](#) is a unique collaboration between CDC and the [High Intensity Drug Trafficking Areas \(HIDTA\)](#) program designed to enhance public health and public safety partnerships. The ORS is a national program that helps communities reduce fatal and non-fatal drug overdoses by connecting public health and public safety agencies, sharing information, and supporting evidence-based interventions. For example, CDC funds the North Carolina Harm Reduction Coalition (NCHRC) to continue, and expand upon, its jail-based overdose prevention education and naloxone distribution project. This ORS pilot project has led to the creation of a standardized overdose education training toolkit, recruiting and training for outreach specialists, overdose education and naloxone distribution in two NC county jails, and the development of a jail staff training focused on reducing stigma and increasing referrals.

To raise awareness about the risks of overdose, CDC provides individuals and their employers resources and information they need to make informed choices. CDC’s four evidence-based campaigns, known together as [Stop Overdose](#), are meant to prevent and reduce drug overdose in young adults ages 18 to 34. The campaigns address the risks of polysubstance use, the dangers of fentanyl, the life-saving power of naloxone, and stigma around treatment and recovery for substance use disorder.

As the nation continues to respond to the overdose epidemic, we must also stop the rising infectious diseases associated with drug use, such as hepatitis C and HIV, and other drug-use-associated skin and soft tissue infections.

CDC’s work to eliminate infectious diseases associated with drug use is built upon three key strategic priorities. First, CDC is strengthening the syringe services program (SSP) infrastructure nationwide and further integrating SSPs into the U.S. public health system. SSPs are harm reduction programs where syringes and other sterile equipment are distributed to prevent disease transmission and collected for safe disposal. These programs are often implemented with other medical and social services vital to improve the health of people who use drugs. In FY 2023, CDC invested nearly \$8.9 million to strengthen 65 SSPs across 31 jurisdictions through the [Strengthening Syringe Services Programs](#) cooperative agreement. These efforts build on investments from supplemental funding from FY 2018-2021, in which nine jurisdictions tested almost 50,000 people in high-risk settings for hepatitis B or hepatitis C infections and linked 90 percent (almost 5,000) of people with infections to care and treatment. In addition, CDC invests in efforts to ensure that SSPs offer effective, evidence-based harm reduction programs, practices, and policies – both by researching and disseminating science about drug user health, as well as offering robust technical assistance and consultation through programs such as the [National Harm Reduction Technical Assistance Center \(NHRTAC\)](#), in partnership with SAMHSA. CDC invests approximately \$1.1 million in this NHRTAC, which provides free assistance to those providing (or planning to provide) harm reduction services to their community. This may include SSPs, health departments, programs providing treatment for substance use disorder, as well as prevention and recovery programs.

Second, CDC is working to decrease stigma experienced by people who use drugs to increase access to services that save lives and improve health. Stigma prevents people from seeking help for substance use disorders (including stigma experienced in healthcare settings). CDC reduces stigma by addressing misinformation,

endorsing non-stigmatizing language, and promoting awareness of stigma's impact including among populations disproportionately affected by substance use and overdose. In FY 2023, CDC invested approximately \$4.9 million to support evidence-based services that reduce morbidity and mortality of infectious diseases associated with drug use, and reduce associated stigma, in high-impact settings such as hospital emergency departments and correctional settings, as well as SSPs.

Finally, CDC is establishing coordinated surveillance and monitoring systems for infectious disease indicators associated with drug use. By better understanding people who use drugs and the programs that serve them, our nation can better stop infectious diseases associated with drug use and improve the health of people who use drugs. CDC advances this work through CDC's National HIV Behavioral Surveillance cycle with people who inject drugs, as well as other surveys, such as the annual National Survey of SSPs.