Outside Witness Testimony – Fiscal Year 2023 LHHS Appropriations

Submitted by: J. Nadine Gracia, MD, MSCE, President & CEO
Trust for America's Health
Prepared for: United States Senate Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Addressing: U.S. Department of Health and Human Services (HHS): Centers for Disease Control and Prevention (CDC); Public Health and Social Services Emergency Fund (PHSSEF)
May 11, 2022

Trust for America's Health (TFAH) is pleased to submit this testimony on the fiscal year (FY) 2023 Labor, Health and Human Services, Education, and Related Agencies (LHHS) appropriations bill. TFAH is a non-profit, non-partisan organization that promotes optimal health for every person and community. We are funded by philanthropic organizations and do not accept government funding and support evidence-based investments that strengthen public health, disease prevention, and health equity. The pandemic has demonstrated the impact of chronic underfunding of public health and prevention. Communities across the country have responded to the pandemic with a depleted public health infrastructure and workforce, while also responding to longstanding issues due to increases in chronic diseases, substance misuse and suicide, health disparities, and environmental health risks. While Congress has allocated billions of dollars to address COVID-19, this funding is short-term and largely for use in response to the pandemic. It follows a familiar but inefficient pattern of underfunding core public health and then providing significant infusions of emergency funding when a disaster hits. This short-term funding cannot build cross-cutting capacity or strengthen the underlying infrastructure and workforce needed for effective program implementation and emergency response. Now is the time to fix an underfunded system so we can ensure every community has the chance for health and wellbeing. Bold action is needed to strengthen and modernize public health. TFAH urges Congress to fund **the Centers for Disease Control and Prevention (CDC)** at **$11 billion for the FY2023 budget,** including investing in these effective public health programs:

Emergency Preparedness: The COVID-19 response was hindered in part because the CDC's emergency preparedness funding had been repeatedly cut, reducing essential training and expert personnel. The **Public Health Emergency Preparedness (PHEP) cooperative agreement** has enabled great strides in our nation's all-hazards preparedness, but the pandemic has renewed the urgency in expanded investment in domestic health security. Yet, PHEP appropriations has been cut significantly from $918 million in FY2002 to $715 million in FY2022, or 51 percent when accounting for inflation. The PHEP cooperative agreement supports 62 state, local, and territorial recipients to develop and strengthen core public health preparedness capabilities. **TFAH recommends at least $824 million for the PHEP, the level authorized in 2006, to rebuild capacity to respond to an escalating number of emergencies.**

The pandemic has also demonstrated the impact of failing to invest in comprehensive readiness and surge capacity of the healthcare delivery system. Funding for the **Hospital Preparedness Program (HPP)**, administered by the Assistant Secretary for Preparedness and Response at HHS, supports the readiness of the healthcare delivery system for emergencies. HPP provides critical funding and technical assistance to health care coalitions (HCCs) across the country to

meet the disaster healthcare needs of communities, but funding has been cut drastically from $515 million in FY2003 to $296 million in FY2022. **TFAH recommends at least $474 million for HPP (PHSSEF), the level authorized in 2006, to build capacity for the healthcare system to save lives during disasters.**

Healthy Outcomes in Schools: Specialized efforts are needed within certain age groups as well. CDC's **Division of Adolescent and School Health (DASH)** provides evidence-based health promotion and disease prevention education for less than $10 per student. Through school-based surveillance, data collection, and skills development, DASH collaborates with state and local education agencies to increase health surveillance and services, promote protective factors, and reduce risky behaviors. A February 2022 study found that these programs resulted in significant decreases in sexual risk behaviors, violent experiences, and substance use, as well as improvements in mental health and reductions in suicidal thoughts and attempts.[1] During the COVID-19 pandemic, DASH has also leveraged its programs to improve student connections to mental health services during virtual learning. **TFAH recommends at least $100 million for DASH to expand its work to around 25 percent of all U.S. students and enable them to become healthy adults.**

Suicide Prevention: The COVID-19 pandemic appears to have heightened the risk for suicide among certain groups, including girls aged 12-17 years,[2] Black youth,[3] and Latino males.[4] Concerningly, the recent CDC Adolescent Behaviors and Experiences Survey also found that almost 20 percent of youth respondents had seriously considered attempting suicide, and 9 percent actually attempted suicide.[5] The complex nature of suicide requires a comprehensive program that focuses on disproportionately affected populations, data collection to inform efforts, and research on risk factors. CDC's work helps identify and disseminate effective strategies for preventing suicide, from strengthening access and delivery of suicide care to promoting policies and programs that reduce risk. CDC programs consist of multisector partnerships, using data to identify populations of focus and risk and protective factors, rigorous evaluation efforts, and filling gaps through complementary strategies and effective communications. **TFAH recommends at least $40 million to expand innovative prevention activities to at least 25 sites and support state health departments as they expand comprehensive suicide prevention and syndromic surveillance.**

Adverse Childhood Experiences: As the number of adverse childhood experiences (ACEs) an individual experiences increases, so does the risk for negative health outcomes such as asthma, diabetes, cancer, substance use, and suicide in adulthood. CDC estimates that 61% of adults report having experienced at least one ACE in their lifetime, and the prevention of ACEs could reduce cases of depression in adults by 44% and avoid 1.9 million cases of heart disease.[6] To help address these issues, CDC has worked to build the evidence base by supporting innovative research and evaluation, support surveillance and data innovation, and identify strategies and build capacity and awareness to prevent ACEs across the country.[7] CDC currently supports six state-level offices, institutes, or departments that are implementing two or more strategies from its *Preventing ACEs* guidance document, including economic assistance to families, efforts to connect youth to care, and short-term and long-term interventions to reduce harms.[8] **TFAH recommends at least $15 million to expand surveillance and innovative ACEs prevention activities to additional states.**

Obesity and Chronic Disease Prevention: The COVID-19 pandemic has been exacerbated by preventable, chronic health conditions, including obesity. In 2018, 42.4 percent of adults had obesity.[9] Even though obesity accounts for nearly 21 percent of U.S. healthcare spending, funding for CDC's **Division of Nutrition, Physical Activity, and Obesity (DNPAO)** is only equal to about 31 cents per person.[10] This Division funds state health departments to protect the health of all Americans by promoting healthy eating, active living, and obesity prevention in early care and education facilities, hospitals, schools, worksites and neighborhoods; building capacity of state health departments and national organizations to prevent obesity; and conducting research, surveillance, and evaluation studies. However, DNPAO only has enough money to implement its State Physical Activity and Nutrition Programs (SPAN) in 16 states. **TFAH recommends at least $125 million for DNPAO to expand SPAN to all 50 states and territories and build state-level capacity.**

Additionally, inequities in social and economic conditions facing people of color and Tribal Nations continue to negatively impact health outcomes. Among the programs that are effective in reducing racial and ethnic health disparities are **Racial and Ethnic Approaches to Community Health (REACH)** program and **Healthy Tribes (**previously referred to as Good Health and Wellness in Indian Country). CDC's REACH program, within DNPAO, works in 40 communities across the country by supporting innovative, community-centered approaches to develop and implement evidence-based and culturally tailored programs that reduce health disparities. The REACH program will be going through a re-compete in FY23, and increased funding is needed to meet the overwhelming need for the program, with over 260 approved but unfunded applications. **The Healthy Tribes** program represents CDC's largest investment in American Indian/Alaska Native health by coordinating three separate programs: the Good Health and Wellness in Indian Country (GHWIC), Tribal Epidemiology Centers for Public Health Infrastructure (TECPHI), and Tribal Practices for Wellness in Indian Country (TPWIC). Healthy Tribes supports holistic approaches to chronic disease prevention while also allowing tribal leaders to direct public health interventions most effective for their communities. **TFAH recommends at least $102.5 million for the total REACH funding line (CDC), with $75.5 million directed to REACH and $27 million for Healthy Tribes.**

Social Determinants of Health: Social determinants of health (SDOH) such as housing, employment, food security, and education have a major influence on individual and community health,[11] contributing to an estimated 80-90% of a person's health outcomes.[12] Public health agencies are uniquely situated to build collaborations across sectors, identify SDOH priorities in communities, and promote cost-saving interventions that prevent chronic health conditions. Currently most public health departments lack funding and tools to support such cross-sector efforts and are limited by disease-specific federal funding. Aligned with the President's budget request, **TFAH recommends at least $153 million to further develop CDC's Social Determinants of Health Program and enable grants to all states and territories.** CDC is also building out the evidence-base for these interventions. In a review of existing multi-sector partnerships addressing SDOH, 29 organizations projected a savings of $566 million over 20 years from saved medical costs and increased productivity levels.[13]

Environmental Health: Not all emergencies are caused by infectious disease. Many occur due

to environmental factors. Since CDC's **National Environmental Public Health Tracking Network** began in 2002, grantees have taken over 400 data-driven actions to eliminate risks to the public. Data includes asthma, drinking water quality, lead poisoning, flood vulnerability, and community design. State and local health departments use this data to conduct targeted interventions in communities with environmental health concerns. Currently, 25 states and one city are funded to participate in the Tracking Network. With a $1.44 return in health care savings for every dollar invested, [14] the Tracking Network is a cost-effective program that examines and combats harmful environmental factors. Yet only half the states receive funding. **TFAH recommends at least $54 million for National Environmental Public Health Tracking Network (CDC), which would enable fifteen additional states to join the network.**

Age-Friendly Public Health: The COVID-19 outbreak has shown that collaboration between the public health and aging sectors is vital. Every day 10,000 Americans turn 65 years of age, yet there have been limited public health approaches to healthy aging. Public health interventions play a valuable role in optimizing the health and well-being of older adults by prolonging their independence, reducing their use of expensive health care services, coordinating existing multi-sector efforts, and identifying gap areas, as well as disseminating and implementing evidence-based policies. Yet as of now, there is no comprehensive health promotion program for older adults. **We recommend the Committee provide CDC at least $50 million to administer and evaluate an Age Friendly Public Health program to promote and address the public health needs of older adults and collaborate with partners in the aging sector.**

---

[1] Robin L, Timpe Z, Suarez NA, et al. "Local Education Agency Impact on School Environments to Reduce Health Risk Behaviors and Experiences Among High School Students." Journal of Adolescent Health, February 2022. https://www.sciencedirect.com/science/article/abs/pii/S1054139X21004006. https://www.liebertpub.com/doi/10.1089/lgbt.2021.0133.

[2] Yard E, Radhakrishnan L, Ballesteros, M, et al. "Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021." Morbidity and Mortality Weekly Report, 70(24);888-894, June 18, 2021. https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm.

[3] Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. U.S. Surgeon General, December 7, 2021. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-healthadvisory.pdf.

[4] Ehlman D, Yard E, et al. "Changes in Suicide Rates – United States, 2019 and 2020." Morbidity and Mortality Weekly Report, 71(8);306-312, February 25, 2022. https://www.cdc.gov/mmwr/volumes/71/wr/mm7108a5.htm.

[5] Everett Jones S, Ethier K, et al. "Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021." Morbidity and Mortality Weekly Report, 71(3);16–21, April 1, 2022. https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm?s_cid=su7103a3_w.

[6] Justification of Estimates for Appropriations Committees. Centers for Disease Control and Prevention, 2022. https://www.cdc.gov/budget/documents/fy2023/FY-2023-CDC-congressional-justification.pdf.

[7] Adverse Childhood Experiences Prevention Strategy FY2021-FY2024. In Centers for Disease Control and Prevention, September 2020. https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf

[8] Preventing Adverse Childhood Experiences: Data to Action. In Centers for Disease Control and Prevention, updated August 19, 2021. https://www.cdc.gov/violenceprevention/aces/preventingacedatatoaction.html.

[9] *State of Obesity 2021*. Trust for America's Health. Sept 2021. https://www.tfah.org/report-details/state-of-obesity-2021/

[10] J. Cawley and C. Meyerhoefer, "The Medical Care Costs of Obesity: An Instrumental Variables Approach," *Journal of Health Economics* 31, no. 1 (2012): 219-30, doi: 10.1016/j.jhealeco.2011.10.003.

[11] Taylor, L et.al, "Leveraging the Social Determinants of Health: What Works?" Yale Global Health Leadership Institute and the Blue Cross and Blue Shield Foundation of Massachusetts, June 2015

[12] S. Magnan. Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine, Oct 9, 2017. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

[13] CDC, SDOH Evaluation. https://www.cdc.gov/chronicdisease/programs-impact/sdoh/pdf/GFF-eval-brief-508.pdf

[14] *Return on Investment of Nationwide Health Tracking*, Washington, DC: Public Health Foundation, 2001.