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Testimony on Behalf of CSTE for the House Appropriations Committee Subcommittee on Labor, Health and Human Services, Education and Related Agencies In Support of FY 2026 Funding for CDC, Public Health Data Modernization, and Epidemiology and Laboratory Capacity Program

Chair Aderholt, Ranking Member DeLauro, and members of the Subcommittee, thank you for the opportunity to testify in support of at least $11.581 billion for the Centers for Disease Control and Prevention, $340 million for CDC's Public Health Data Modernization, and $120 million for CDC's Epidemiology and Laboratory Capacity (ELC) base funding line in FY 2026. I am Theresa Sokol, State Epidemiologist at the Louisiana Department of Health (LDH), and Executive Board member of the Council of State and Territorial Epidemiologists (CSTE). CSTE represents more than 3,600 public health epidemiologists nationwide working on the front lines to save lives by detecting and responding to every emerging threat to public health—including food-borne illness, Ebola, Marburg, lead poisoning, measles, influenza, opioid overdoses, Zika, occupational threats like silicosis, and more.

I am an epidemiologist—or as we like to call ourselves, a disease detective. My job is to keep Louisianans safe and prevent the spread of infections and disease. I lead a team of epidemiologists at the LDH and the budget for our entire department is more than 90 percent from federal dollars—specifically from the CDC. These financial resources and the unmatched public health expertise we get from the CDC make my job possible—I cannot do it without them.

One of the most important aspects of the work of an epidemiologist is data. In public health, data can come from many places—from conversations with individual people, from health care providers (when you go to your doctor or an emergency room), from laboratories, from mosquito control offices, from nursing homes, from schools, from restaurants, from other states where you traveled, from other countries, from the CDC. And all these data points tell a story about an individual person—you, your baby, your mom, your grandfather—and my job is to put these data together to protect individuals and communities from getting sick. In Louisiana and public health departments across the country, we are working to get better, faster, actionable data that can help us make decisions to directly improve public health and safety in our communities. Thanks to investments from Congress in recent years, we have made tremendous improvements to our public health data systems. In my home state of Louisiana, this funding is making a difference.

In 2021 Hurricane Ida hit Louisiana and the New Orleans area lost power for about three weeks. For an entire week, our infectious disease data system in New Orleans was out of commission, which meant no notifications of diseases from local health care providers—severely limiting our public health response. Thankfully, we have been able to start the process of moving our state public health data to a more modern cloud-based infrastructure that will be safe during a natural disaster; but this move is not a one-time investment and we need to ensure we have resources to finish and maintain the project or the initial investments will go to waste, like a construction project vacated after only the foundation and walls are up. Furthermore, we must continue to support our system both financially and with the trained staff to use and maintain it. This progress in Louisiana has been made possible in part by CDC's data modernization efforts.

While our progress has been impressive, there is work still to be done. Unfortunately, across the country, systems have only been partially upgraded, remain in dire need of security enhancements, and lack sufficient trained personnel to keep them operational. In some situations,

public health is still relying on paper-based systems, phone calls, spreadsheets, and faxes, requiring data entry by hand, leaving us woefully behind and ill-equipped to combat the spread of infectious disease and other public health threats.

Five years ago, CSTE initiated and led the call for improved public health data systems. With our partners at the Data: Elemental to Health Campaign, we called on Congress to provide the first ever dedicated funding for Public Health Data Modernization, with the goal of building a 21st century public health data superhighway. Thanks to the work of this Subcommittee, Congress answered the call and has provided more than $1 billion to date through both annual funding and emergency supplemental funding for CDC's Public Health Data Modernization. This funding is making a critical difference. You can see a snapshot of successes on the CSTE Stories From the Field website (stories.cste.org) featuring more than 180 stories from nearly every state. While these successes are remarkable, we are at a crossroads. Unfortunately, pandemic-era resources that were allocated to states and were still being used to support public health activities like disease detection were recently clawed back by the administration and across the country states have lost millions of dollars and in some instances were forced to lay off critical staff or discontinue system maintenance contracts. Funding disruptions like this are painful as they put communities at risk as health departments scramble to continue business as usual.

To continue to build the modern data systems our country needs, jurisdictions need sustained, annual resources. As technology evolves and becomes more central to supporting and maintaining our health, our public health data systems will continue to need updates, software patches, security vulnerability protection, and upgrades, and the staff supporting these critical systems will need ongoing training. Investments to date will be wasted if we don't continue to support and update system infrastructure.

Public Health Data Modernization is a commitment to building the next generation of data workforce and systems that the public expects for daily operations and that are 'response-ready' for the next public health emergency with capacity to scale. While we are grateful for the investments made by Congress to date, we know the real need is much bigger. If we are going to truly modernize our public health data systems—like we did for health care modernization with the introduction and standardization of electronic health records—we estimate it will cost at least $7.84 billion over five years at the state, territorial, local and Tribal (STLT) levels alone.

Data modernization is built on a set of guiding principles: An **enterprise approach** to data exchange supporting getting data to state and then federal levels; **interoperability** between public health and health care systems to ensure health care professionals can spend more time seeing patients and public health can spend more time acting on the data rather than digitizing it; **security to protect patient data**; a **workforce** empowered to build and maintain the systems; and **public-private partnerships** to drive innovation.

The public health data modernization enterprise approach has five key interconnected pillars that support *all* diseases and conditions—acute, chronic, and emerging health threats; they are:

- Electronic Case Reporting (eCR)
- National Notifiable Disease Surveillance System (NNDSS)
- Electronic Vital Records System
- Syndromic Surveillance
- Laboratory Information Systems including Electronic Laboratory Reporting (ELR)

These pillars require investment across each public health jurisdiction along with support for a highly skilled workforce to lead local implementation and state-level management. A skilled workforce and upgraded data systems at the jurisdictional level are necessary to ensure that data can flow seamlessly into state systems where it is immediately used to improve health and support communities to thrive.

We need **eCR** to give health care providers a means to seamlessly communicate with public health. eCR will help guarantee that when providers see patients—in any setting—patient demographics, clinical information, and test results for all reportable conditions are rapidly shared with state and local public health and then able to be seamlessly incorporated into CDC's National NNDSS. Public Health Data Modernization investments in eCR are making a difference. Now, nearly 52,000 facilities in all 50 states are actively sending electronic initial case reports to public health using eCR. Every report that is sent via eCR represents a report that a provider does not have to enter manually, leaving more time for patient care.

Resources are needed to make improvements in **NNDSS** and rapid data submission from states to CDC. For example, in the multistate measles outbreak STLT health department staff serve as disease detectives contacting and interviewing patients and gathering detailed information to learn how and where they may have become infected. These data are submitted to CDC where the national picture and impact is put together.

We need **electronic laboratory results** to be shared immediately with public health epidemiologists to launch a rapid public health response. ELR, functioning across the country, enables states, localities, territories, Tribes, and the federal government to have timely information on laboratory results, often forming the initial pieces of information to initiate case investigations and immediate response action at STLT health departments. Without ELR, public health would not be able to support timely life-saving measures and know what is happening in virtually every place across Louisiana. In Louisiana, and many jurisdictions, this information is transmitted and ready for analysis in near real time.

We need improvements to our **electronic vital records systems** to ensure real-time transmission of birth and death data for statistical and monitoring purposes. We must make sure systems are interoperable so physicians, coroners, medical examiners, and funeral directors can seamlessly report deaths through their existing electronic records systems—eliminating delays and reducing errors.

Standards-based interoperability will also help to identify threats as they emerge. As it stands, 80 percent of emergency department visits are reported to the **National Syndromic Surveillance Program**, which helps detect, monitor, control and prevent emerging diseases.

These five pillars are interwoven, and each plays a key role in moving the United States from an outdated and burdensome patchwork of systems to a 21st century public health data infrastructure that provides complete, accurate, and instantaneous data. Public health data modernization will help break down siloes and ensure all systems are integrated and interoperable, and states like Louisiana can more efficiently use data for public health action and communicate data to CDC.

Equally important to upgrading our data systems, is a skilled workforce that includes epidemiologists, public health informaticists, data scientists, and other experts—all of whom work together so that the public health surveillance system can detect and monitor current threats and be ready for the next pandemic. **The Epidemiology and Laboratory Capacity (ELC) program** strengthens epidemiologic and lab capacity in all 50 states and eight territories. CSTE has been collecting national data since 2001 on the epidemiology capacity in states through the national Epidemiology Capacity Assessment. Most people don't realize on average, more than 80 percent of health department epidemiology funds are provided by the federal government. The most recent ECA estimates that an additional 2,537 epidemiologists (above the current 5,706) are needed in state health departments to meet basic public health needs. The number of epidemiologists is currently below the need and states and territories anticipate losing nearly one fifth (more than 1,000) of existing staff with the end of pandemic-era funding, much of which was recently terminated despite states' plans to use it until its expiration in FY 2027.

As the nation responds to a dangerous H5N1 avian flu (bird flu) outbreak, the identification of bird flu in rural communities is one more example where our public health disease detection systems are not resourced to keep pace with a rapidly moving threat. In January, unfortunately, Louisiana reported the first human death related to H5N1. The patient got sick after exposure to a backyard flock. Because of ELC support, LDH enacted an extensive investigation, including daily coordination with the hospital to prevent transmission of bird flu to health care workers and hospital patients. We actively monitored nearly 30 people for possible person-to-person transmission of bird flu—thankfully, in large part due to our efforts, no further transmission occurred. However, bird flu continues to spread, and states need sufficient resources to respond.

In my state of Louisiana, we also use ELC funds to combat other unexpected public health threats, including rapidly spreading infectious disease threats, food-borne illnesses, and public health threats that intersect with national security efforts when Louisiana hosts large scale events, like the Super Bowl and Mardi Gras. These funds are critical not only to responding to emerging diseases, but to also keep our communities safe from outside threats like bioterrorism.

Base ELC funding supported a disease investigation that impacted a boy scout troop in Baton Rouge. 15 out of 23 scouts who participated in a geocaching exercise at camp reported experiencing illness; nine sought medical care; five visited the emergency room; and, unfortunately, 3 were hospitalized. Our epidemiologists funded by ELC's base funding were able to mobilize immediately to investigate and identify the disease—histoplasmosis, a fungal infection—and its source. Being able to act this quickly allowed our health department staff to alert health care providers, immediately halt further transmission.

The ELC program currently has a base funding line of $40 million from the Prevention and Public Health Fund (PPHF) and is the only source of core infectious disease epidemiology and laboratory capacity in state and local health departments across the U.S. These funds are awarded to 65 state, local and territorial health departments to efficiently address urgent infectious disease threats, with the flexibility to meet community-specific needs**. The ELC program awards 94 percent of the PPHF funding received directly to state and local health departments.** These investments support approximately **500 highly skilled public health professionals**, serving as the front line in protecting our communities and allowing them to rapidly detect and respond to infectious disease threats.

In addition to the ELC base funding line, which provides foundational funding to the ELC program to support jurisdictions to hire and retain flexible response ready epidemiologists, more resources are needed for the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) to fund up to $500 million of existing requests from health departments to the ELC program to support disease detection and response. Disease specific NCEZID funding supports capacity within specific disease program areas (e.g., vector-borne disease, foodborne illness, antibiotic resistance, and health care-acquired infections), and is distributed by the ELC program to jurisdictions. However, this funding is tied to specific diseases, and when a new threat emerges funding is not immediately available for response.

Increased funding will enhance core epidemiological response by supporting response-ready epidemiologists who can immediately respond to any outbreak, like welder's Anthrax in shipyard workers. The base ELC funding line is critical to STLT health departments' ability to combat infectious diseases as it is the principal funding source for emerging infectious disease prevention and control. **In closing, to protect the health of our communities and ensure they thrive, we need commitment and support for better, actionable data and systems and epidemiology capacity. We respectfully request the Subcommittee provide funding of $11.581 billion for the CDC, $340 million for Public Health Data Modernization and $120 million for the base ELC funding line at CDC in Fiscal Year 2026.**