Documents for the Record

Subcommittee on Health Hearing
"Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?"
July 23, 2024

Majority:

- July 22, 2024 – Statement submitted by Apprise Health Insights
- July 22, 2024 – Statement submitted by Richard Hamburg, Executive Director of Safe States Alliance
- July 22, 2024 – Statement submitted by the National Safety Council
- July 23, 2024 – Document submitted by Rep. Bucshon, M.D.
- July 23, 2024 – Statement submitted by Alzheimer's Association and Alzheimer's Impact Movement
- July 23, 2024 – Statement submitted by the American Society of Health-System Pharmacists

Minority:

- July 22, 2024 – Letter submitted by Hawai'i Health & Harm Reduction Center
- July 22, 2024 – Letter submitted by HepFree 2030
- July 23, 2024 – Coalition letter on Labor, Health and Human Services FY25 Appropriations
- July 23, 2024 – Letter submitted by IC&RC
- July 23, 2024 – Letter submitted by the Injury and Violence Prevention Network and allied organizations
- July 23, 2024 – Statement of Faces & Voices of Recovery

July 22, 2024

The Honorable Brett Guthrie
2434 Rayburn House Office Building
Washington, D.C. 20515

RE: Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Connectivity Initiative Hospital Bed Capacity Project

Chairman Guthrie, Ranking Member Eshoo, and Members of the Energy and Commerce Health Subcommittee:

Apprise Health Insights, an Oregon-based small business that provides real-time data analytics and tools to first responders and hospitals, appreciates the opportunity to provide comments in support of funding for the Centers for Disease Control and Prevention (CDC) and its National Healthcare Safety Network (NHSN) Connectivity Initiative Hospital Bed Capacity Project.

With the support of federal funding, Apprise has worked in partnership with the state of Oregon and its 61 hospitals since 2020 to develop and deploy the Healthcare Capacity System (HCS). Oregon became the first state in the nation to utilize real-time data on statewide hospital bed capacity, rates of hospitalizations related to respiratory illnesses, and other key metrics. Using the best available technology, HCS captures data directly from hospitals' electronic health records and updates a shared dashboard every 15 minutes without accessing any personal health information.

Funding for this program is critical for national preparedness and local resiliency efforts. The Connectivity Initiative Hospital Bed Capacity Project is working to provide "more accurate and timely tracking of hospitalizations, improved collaboration among decision-makers to optimize and mitigate resource constraints, tracking health system inventories in real-time, and a better understanding of healthcare system capacity across the nation."[1]

In response to lessons learned during the COVID-19 pandemic, this program aims to fill gaps so local communities are ready and have access to actionable data from hospital capacity to personal protective equipment (PPE). The goal of this effort is to use data to support "faster decision-making and better response management during crisis, disaster

[1] NHSN Connectivity Initiative: Hospital Bed Capacity Project presentation, slide 11
https://www.cdc.gov/nhsn/pdfs/training/D1_Connectivity-Initiative_-Hospital-Bed-Capacity-Project_508c.pdf

and public health emergencies,"[2] while reducing reporting burden on providers so they can spend more time on patient care.

Due to success in our state, the CDC recognized Oregon as a national model and extended funding for more states to begin using the HCS tool. To date Maryland, Delaware, Hawaii and 100 acute care hospitals in California have joined the HCS network, with the goal of all states eventually having access to this critical health information through NHSN's Connectivity Initiative Hospital Bed Capacity Project.

Having access to this data in real-time is improving care delivery and collaboration in our state. It is helping hospital staff coordinate care across health systems and is enabling emergency service providers to quickly identify the nearest emergency department with capacity to take patients. It is providing a window into what is happening on the ground in our health systems, so government and policymakers can more nimbly respond to emerging issues that could impact community health. HCS is helping ensure that patients in rural and underserved communities are able to access sometimes lifesaving care when every second counts.

Thanks to federal investments, we are seeing real, tangible improvements in care delivery and emergency preparedness in states utilizing HCS. In Oregon, for example HCS is:

- **Freeing up staff to focus on patient care instead of administrative tasks**: Hospitals reported a 98% decrease in time spent (from eight hours per day to just 10 minutes) finding information about bed census data, staffed beds, emergency department census, medical, surgical, and critical care unit capacity, and personal protective equipment availability—
- **Cutting down the time patients wait for lifesaving care:** Oregon Medical Coordination Center reported the average time for a critical care patient to be transferred to another hospital for a higher level of care dropped from 22 hours before HCS was implemented to an average of just four hours.
- **Making it easier for first responders to get patients into emergency care:** Multnomah County, the state's largest population center, reported a 90% drop in emergency medical services radio traffic due to access to real-time hospital emergency department capacity data.
- **Streamlining emergency response efforts:** In September 2020, five simultaneous "megafires" and twelve other fires resulted in the need to evacuate four hospitals and prepare for the evacuation at several others. HCS allowed Oregon's hospitals to know in real-time where specific types of inpatient beds were available and then quickly evacuate and transfer the patients safely.

[2] NHSN Connectivity Initiative: Hospital Bed Capacity Project presentation, slide 6
https://www.cdc.gov/nhsn/pdfs/training/D1_Connectivity-Initiative_-Hospital-Bed-Capacity-Project_508c.pdf

Here in Oregon and the states utilizing HCS, we have seen firsthand how access to real-time data can transform care delivery, support emergency preparedness, critical resource allocation, and first responder priorities. We believe that every state should be afforded the same opportunity. Our mission is transparency across the health care continuum because at the center of our work is the patient experience. The success of HCS offers opportunities across other settings such as post-acute care and community behavioral health to support patient care and achieve this goal.

We urge you to continue to fund this NHSN initiative to support the expansion of HCS nationwide. This is just one example of how the CDC is working with partners to improve timely information sharing and best position local leaders to recognize and respond to issues impacting community health.

Sincerely,

Andy Van Pelt
CEO, Apprise Health Insights

CC:

The Honorable Cathy McMorris Rodgers, Chair of Energy and Commerce Committee
The Honorable Frank Pallone, Ranking Member of Energy and Commerce Committee

SAFE STATES

An Alliance to Strengthen the Practice of Injury and Violence Prevention

Statement of
Richard Hamburg, Executive Director
Safe States Alliance

Hearing on "Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?"

To: U.S. House of Representatives Committee on Energy and Commerce Health Subcommittee

Safe State Alliance, an 850+ member national organization dedicated to strengthening the practice of injury and violence prevention, expresses its strong support for the Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control (NCIPC).

Injuries and violence are the leading cause of death for children and adults aged 1 to 44 with a total economic cost of $4.2 trillion. Injuries and violence take form in many ways – from drug overdoses to community violence and youth drownings. The CDC's Injury Center is at the forefront of injury and violence prevention, using surveillance, research, programs and partnerships to:

- Build national data systems to track trends in violent deaths and overdose
- Conduct research on critical issues, including adverse childhood experiences and suicide
- Fund national programs on important topics such as Rape Prevention and Education and Drug Free Communities
- Support health departments, research institutions, community-based organizations, and American Indian and Alaska Native Communities

The Injury Center has played a key role in preserving America's public health for 30 years, and the elimination of the Center, as proposed in the recent House Appropriations Committee-passed Labor/HHS measure (see attached sign-on letter), would leave the nation vulnerable to leading causes of death, including overdoses (Americans ages 18-44), suicide (Americans ages 10-34), and drowning (American children ages 1-4). Such an action would also mean a loss of expertise, resources, and data, shuttering world-class data collection, analysis and surveillance.

We urge you to strongly support the Injury Center, the breadth of its work and impact, and its critical role as part of the CDC. The Center brings unparalleled data systems, scientific and technical expertise and community support to preventing leading causes of death. Please don't hesitate to contact us if you have any questions.

National Safety Council

Statement of National Safety Council
to
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on
"Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?"
July 23, 2024

Dear Chair Rogers, Ranking Member Pallone, Chair Guthrie, and Ranking Member Eshoo:

Thank you for allowing the National Safety Council (NSC) to submit this Statement for the Record in advance of today's House Energy and Commerce Subcommittee on Health hearing titled: "Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?" Given the myriad public health challenges in the United States, NSC believes it is imperative the United States Centers for Disease Control and Prevention (CDC) is adequately resourced to sustain its critical, lifesaving mission. Specifically, the National Center for Injury Prevention and Control (Injury Center) provides vital resources used by employers and advocacy organizations to eliminate ongoing epidemics including workplace injuries, opioid overdoses, and workplace violence.

NSC is America's leading nonprofit safety advocate and has been for 110 years. As a mission-based organization, we work to eliminate the leading causes of preventable death and injury, focusing our efforts on the workplace and roadways. We create a culture of safety to keep people safer at work and beyond so they can live their fullest lives. Our more than 13,000 member companies represent nearly 41,000 U.S. worksites.

The opioid epidemic continues to ravage communities across the United States. However, we are making progress. New provisional data from the CDC show opioid overdose deaths in 2023 fell for the first time since 2018.[1] While the overall number of overdose deaths are declining, workplace deaths continue to rise. Currently, 9.6% of all workplace deaths are the result of a drug overdose.[2] Since 2011, deaths from overdose on the job have increased by 619%.[3]

[1] https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2024/20240515.htm#:~:text=The%20new%20data%20show%20overdose,psychostimulants%20(like%20methamphetamine)%20increased.
[2] https://www.bls.gov/news.release/pdf/cfoi.pdf
[3] https://injuryfacts.nsc.org/work/safety-topics/overdose-deaths/

Housed in the Injury Center, the Division of Overdose Prevention (DOP) "monitor[s], prevent[s], reduce[s], and respond[s] to overdose."[4] This essential public health approach allows the Federal government to remain vigilant in surveilling trends in substance use and implementing evidenced-based strategies to eliminate the harm of substance use and overdose in the United States. DOP administers the Overdose Data to Action (OD2A) program, which provides state-based and local community grant funding to health departments in an effort to build capacity and better respond to overdose. Successes of this program include:

- Rural and underserved community naloxone distribution and saturation in Arizona
- Actionable response plans for overdose spikes in Illinois
- Illicit drug supply messaging and public safety campaigns in Massachusetts[5]

NSC vigorously disagrees with the sentiment expressed in the FY25 Labor, Health and Human Services, Education, and Related Agencies report that the work of the Injury Center is "duplicative of other programs, projects, and activities at other agencies."[6] In its justification for eliminating Injury Center funding, the House Appropriations Committee eyes the Department of Justice (DOJ) and the Substance Abuse and Mental Health Services Administration (SAMHSA) as better homes for the efforts of the Injury Center.[7] This could not be further from the truth. While the CDC administers and measures programs from a national, and at times global, public health lens, DOJ and SAMHSA administer and measure programs from law enforcement and broader behavioral health lenses. The Injury Center's focused expertise in overdose, injury and violence prevention provides a necessary balance against the missions of both DOJ and SAMHSA.

In September 2019, The White House announced $1.8 billion dollars in grant funding to help "States fight the opioid crisis and to help prevent more American lives from being lost to overdose."[8] The current administration continued this historic all-of-government approach to addressing the opioid epidemic by incorporating opioid overdose response efforts in his Unity Agenda.[9] Each perspective that a federal agency brings to combating this crisis is welcome, but the public health perspective must never be discounted. The CDC, through the Injury Center, must continue to surveil emerging threats to the successes the United States has begun to document in its response to the nation's overdose epidemic.

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[4] https://www.cdc.gov/injury/divisions-offices/about-division-of-overdose-prevention.html
[5] https://www.cdc.gov/overdose-prevention/php/od2a/impact.html
[6] https://docs.house.gov/meetings/AP/AP00/20240710/117503/HMKP-118-AP00-20240710-SD002.pdf
[7] Ibid.
[8] https://trumpwhitehouse.archives.gov/briefings-statements/president-donald-j-trump-dedicated-administration-fighting-back-opioid-crisis/
[9] https://www.whitehouse.gov/briefing-room/statements-releases/2023/02/07/fact-sheet-in-state-of-the-union-president-biden-to-outline-vision-to-advance-progress-on-unity-agenda-in-year-ahead/#:~:text=During%20his%20first%20State%20of,veterans%3B%20tackling%20the%20mental%20health

The Division of Violence Prevention (DVP) and the Division of Injury Prevention (DIP) also leverage evidence-based public health strategies to positively affect societal ills. DVP works to:

- Monitor violence-related behaviors, injuries, and deaths.
- Conduct research on the factors that put people at risk for or protect them from violence.
- Create and evaluate the effectiveness of violence prevention programs, practices, and policies.
- Help state and local partners plan, implement, and evaluate violence prevention efforts.
- Promote the effective adoption and dissemination of violence prevention strategies.[10]

This need is great. Violence from assault is the fifth leading cause of work-related deaths.[11] From 2021-2022, assault resulted in 57,610 Days Away from Work, Job Restriction, or Transfer (DART) cases which includes 41,270 Days Away from Work (DAFW) cases and 524 fatalities in 2022.[12] Violence alters communities and has a sizable impact on the economy. This impact is understood by multiple federal agencies, including the Department of Transportation (DOT). DOT is beginning a process to understand how harassment and assault unfairly keep women from actively embarking on a career in trucking.[13] DVP programs to implement and evaluate violence prevention efforts will contribute greatly to the reduction of assaults in the workplace.

Injuries are another public health challenge in the United States. In 2022, there were 227,039 preventable injury-related deaths, a 0.9% increase over 2021 figures.[14] This is also an increase of 162% over the past 30 years.[15] Outside of fatalities, 63 million people – about one in five U.S. residents – sought medical attention for an injury.[16] DIP has a role to play in eliminating injuries by connecting data with scientific research to apply evidence-based mitigation practices. Through this action, best practices are created and sustained to eliminate the threats of injuries.

Current research and programmatic efforts by DIP include:

- Leveraging its expertise in data analysis and suicide prevention to help communities prioritize the most impactful ways to prevent suicide.

[10] https://www.cdc.gov/injury/divisions-offices/about-division-of-violence-prevention.html
[11] https://injuryfacts.nsc.org/work/safety-topics/assault/
[12] Ibid.
[13] https://www.federalregister.gov/documents/2024/02/08/2024-02539/request-for-information-concerning-the-study-of-sexual-assault-and-sexual-harassment-in-the
[14] https://injuryfacts.nsc.org/all-injuries/overview/
[15] Ibid.
[16] https://injuryfacts.nsc.org/all-injuries/overview/

National Safety Council

- Investing grant funds into communities to help implement and evaluate a comprehensive public health approach to suicide prevention.
- Researching the knowledge, attitudes, and behaviors that motivate older adults to adopt evidence-based strategies for fall prevention.[17]
- Synthesizing public health research to understand differences in and prevention strategies for impaired driving (i.e., alcohol-, drug-, and polysubstance-impaired) especially among populations disproportionately affected by impaired driving.[18]

As evidenced by the data above, the public health challenges facing the United States and workplaces are many and varied. NSC believes this is not the appropriate time to eliminate funding to the Injury Center or shift their priorities to another government agency. Each agency endeavoring to examine and implement solutions to our shared challenges has a welcome remit. NSC encourages the Subcommittee on Health to support CDC and Injury Center efforts to eliminate overdose deaths, injuries and violence.

CC The Honorable Tom Cole, Chair, House Committee on Appropriations
CC The Honorable Rosa DeLauro, Ranking Member, House Committee on Appropriations and Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
CC The Honorable Robert Aderholt, Chair, House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

[17] https://www.cdc.gov/injury/pdfs/researchpriorities/Research_Priorities_-_Older_Adult_Falls.pdf
[18] https://www.cdc.gov/injury/pdfs/researchpriorities/NCIPC_Research-Priorities_Transportation_Safe.pdf

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Characterization of the Federal Workforce at the Centers for Disease Control and Prevention

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Scientific Education and Professional Development Program Office (Drs Coronado, Glynn, Massoudi, and Koo and Ms Polite), and Human Capital and Resources Management Office (Mr Sohani), Centers for Disease Control and Prevention, Atlanta, Georgia.

Abstract

Context: Studies characterizing the public health workforce are needed for providing the evidence on which to base planning and policy decision making both for workforce staffing and for addressing uncertainties regarding organizing, financing, and delivering effective public health strategies. The Centers for Disease Control and Prevention (CDC) is leading the enumeration of the US public health workforce with an initial focus on CDC as the leading federal public health agency.

Objective: To characterize CDC's workforce, assess retirement eligibility and potential staff losses, and contribute these data as the federal component of national enumeration efforts.

Methods: Two sources containing data related to CDC employees were analyzed. CDC's workforce was characterized by using data elements recommended for public health workforce enumeration and categorized the occupations of CDC staff into 15 standard occupational classifications by using position titles. Retirement eligibility and potential staffing losses were analyzed by using 1-, 3-, and 5-year increments and compared these data across occupational classifications to determine the future impact of potential loss of workforce.

Results: As of the first quarter of calendar year 2012, a total 11 223 persons were working at CDC; 10 316 were civil servants, and 907 were Commissioned Corps officers. Women accounted for 61%. Public health managers, laboratory workers, and administrative-clerical staff comprised the top 3 most common occupational classifications among CDC staff. Sixteen percent of the workforce was eligible to retire by December 2012, and more than 30% will be eligible to retire by December 2017.

Conclusions: This study represents the first characterization of CDC's workforce and provides an evidence base upon which to develop policies for ensuring an ongoing ability to fulfill the CDC mission of maintaining and strengthening the public's health. Establishing a system for continually monitoring the public health workforce will support future efforts in understanding workforce shortages, capacity, and effectiveness; projecting trends; and initiating policies.

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The authors declare no conflicts of interest.

Keywords

health manpower; public health workforce

Public health measures have contributed remarkably to the overall health improvement of US residents during the last century.[1] However, the public health practice landscape is rapidly changing and is being influenced by advances in technology and science, emerging and reemerging public health threats that know no geographic boundaries, and reductions in staff because of limited budgets, funding cuts, and personnel retirements.[2–4] Understanding how the existing public health workforce can meet the challenges posed by this changing landscape requires concrete data about the size, composition, and skill set of this workforce, yet neither these data nor accurate models to produce useful estimates are available.[2] Consequently, there are no answers to questions regarding the size of the workforce, much less how many personnel are needed, in what jobs and functions, and whether the necessary skills are present to provide adequate public health services. Studies characterizing the public health workforce are required both for providing foundational evidence on which to base planning and policy decision making related to workforce needs and for identifying and addressing critical uncertainties about how best to organize, finance, and deliver effective public health strategies for all Americans.[1,5,6] Enumerating the US public health workforce is a necessary prerequisite for improving our ability to identify gaps, forecast future workforce trends and needs, guide public health workforce development and related policy, and ultimately to strengthen the US health workforce infrastructure.

The imperative to plan for present and future public health workforce needs underscores the importance of performing an enumeration on an ongoing basis; however, implicit challenges exist in characterizing this workforce. The public health workforce encompasses diverse occupational groups often working across disciplines. Occupational groups or position titles might not be related to or require specific training, education, or certification, unlike other health professions. For example, a person working as an epidemiologist might hold a medical or veterinary degree with training in the Centers for Disease Control and Prevention (CDC) Epidemic Intelligence Service. This is one factor that makes characterizing the public health workforce challenging. A myriad of nongovernmental partners, community-based workers, and contractors add to the diversity to be considered when counting public health workers.[1,7] Finally, no comprehensively applied taxonomy and standards exist for occupational definitions, worker classifications, or data collection methods used by the different organizations attempting to characterize the public health workforce.

To address these challenges, CDC is leading the implementation of a systematic ongoing approach for enumerating the US governmental public health workforce. To advance this effort, CDC supported the work of the Centers of Excellence in Public Health Workforce at the University of Michigan and the University of Kentucky in developing consensus-based strategies to enumerate this workforce, specifically to reach consensus on a working definition of “governmental public health workforce” and a standard classification of public health occupations. The governmental public health workforce is defined for this initiative as “all persons responsible for providing any of the 10 Essential Public Health Services who

are employed in federal, state, or local governmental public health agencies and those providing environmental health and public health laboratory services." This definition has been limited so that occupations and functions can be accurately tracked as *public health* across time by using existing data sources, while recognizing that this definition likely underestimates the overall public health workforce.[8]

The Centers of Excellence recommended using 15 standard occupational classifications for enumerating the public health workforce to allow comparisons across different government agencies.[8] These occupational classifications match those developed by the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) for use in their periodic profile studies.[9,10] The ASTHO and NACCHO profile studies are considered the core data sources for information regarding the structure and function of their respective health constituencies. These 15 occupational classifications, hereafter referred to as the "recommended occupational classifications," support categorization of the public health workers at state and local public health agencies and link to the occupational series set used by the US Office of Personnel Management (OPM), the primary personnel data source for all federal civil service employees (civil servants) at the US Department of Health and Human Services (HHS). Consequently, these standard occupational classifications can be used to provide a comprehensive description of the combined federal, state, and local governmental public health workforce. However, accessible information regarding public health workers is primarily about those in state and local public health agencies, with only limited information available about the federal workforce.[11] Although the standard occupational classifications provide a mechanism for linking federal, state, and local public health workforce data, no enumeration of the federal component of the public health workforce is ongoing.[8]

CDC initiated an enumeration of the federal component of the public health workforce, with an initial focus on CDC as the leading public health agency in the United States. Determining the size and composition of CDC's workforce is a critical step in understanding its capacity and serves as an evidence base upon which to develop policies that ensure an ongoing ability to fulfill CDC's mission of maintaining and strengthening the public's health. This study characterizes the CDC federal workforce by using the 15 recommended occupational classifications, assesses retirement eligibility and potential staff losses, and contributes CDC information to the federal component of national enumeration efforts.

Methods

The CDC workforce comprises civil servants, US Public Health Service Commissioned Corps (CC) officers, and contractors. Contractors are not included in the OPM workforce count, and data regarding contractors using the official HHS system of record are incomplete; therefore, contractors cannot be included in the federal public health workforce enumeration. CDC federal employees support the agency's mission and provide essential public health services; consequently, all civil servants and CC officers meet the definition of a public health worker and are therefore included in this study. To enumerate CDC's workforce, we used 2 data sources with maximum validity, reliability, completeness, inclusiveness, and accessibility to data elements of interest. The primary data source was the

HHS system of record, Capital Human Resources, in which individual-level data regarding civil servants and CC officers are maintained. The HHS system of record, however, does not include complete demographic and occupational information regarding CC officers, necessitating use of a second data source, the CC database, which provides demographic and occupational information for active CC officers and information about the occupational categories used by the CC system. Because these data sources are official personnel records, data are captured on an ongoing basis and are essentially complete. To integrate data, both data sources were merged and sorted by CC officers' birth date, and duplicate records were removed.

The CDC workforce was characterized by using Centers of Excellence–recommended data elements for the public health workforce (eg, demographic information, educational background, and job characteristic)[8]; we also assessed location (domestic vs international) and supervisory responsibility status. Race/ethnicity was reported as a single, combined variable within the databases used and thus was recorded as such for this analysis rather than by using the White House Office of Management and Budget format of separate fields for race and ethnicity.

To categorize the occupations of CDC staff into the 15 recommended occupational classifications, we applied 2 methods. In the first method, the OPM occupational series was mapped to the recommended occupational classifications. None of the OPM series mapped to 3 of the recommended occupational classifications (ie, emergency preparedness staff, epidemiologists, and public health informatics specialists); therefore, we applied a second method, mapping CDC-assigned position title to the recommended occupational classifications. Because position titles are usually entered in free text in the HHS reporting system, and therefore not in a standard format, this mapping required manually collapsing and grouping position titles into a comparable single position title. For example, if part of a position title included "epid" (eg, epidemiology, epidemiolo-gist, or nurse epidemiologist), the position was classified as Epidemiologist. As an additional example, positions listed as "ADMIN ASST," "Administrative Assistant," or "Admint Asst." were classified as Administrative/Clerical Personnel. Mapping of CDC occupations by using the second method, position titles, proved more useful. Using the more granular description of position titles more accurately reflected job functions of the workforce and captured positions of employees working in the 3 occupational classifications not captured by the OPM. Classifications used to further characterize the CDC workforce, therefore, are based on position titles and their mappings to the recommended occupational classifications.

Retirement eligibility and potential staffing losses were analyzed by using 1-, 3-, and 5-year increments and were based on workers' retirement designations. Retirement designations differ for civil servants and CC officers; moreover, within the civil service, 2 retirement systems exist for permanent civilians: the Federal Employee Retirement System and the Civil Service Retirement System. Calculations for retirement eligibility were based on the parameters of the applicable retirement system. Retirement eligibility was compared within occupational classifications to determine the future impact of potential loss of workforce within different occupations.

First quarter of calendar year 2012 CDC workforce data were analyzed using SAS v9.3 (SAS Institute Inc, Cary, North Carolina). Descriptive statistics were calculated for all variables. The authors had access to deidentified information only. This project was reviewed by CDC for human subjects protection and deemed to be nonresearch.

Results

As of the first quarter of calendar year 2012, a total of 18 346 persons were working at CDC; 10 316 were civil servants and 907 were CC officers (Table 1). An additional 7123 contractors were identified, but they are not included in this analysis because of previously noted limitations of these data. Women accounted for 6821 of 11 223 employees (61%) included in our analyses. Among 11 061 employees (99%) with known race/ethnicity, 6795 (61%) were white, 2912 (26%) black, and 955 (8.6%) Asian/Pacific Islanders. The race/ethnicity distribution of civil servants and CC officers were similar among whites, Asians, and Hispanics. Proportionally, 2.4 times more black civil servants than black CC officers and 2.5 times more American Indian CC officers than American Indian civil servants worked at CDC. Sixty percent of the entire CDC workforce was 45 years or older (median age, 48 years; range, 18–91 years); 53% of the CC officers were 44 years or younger. Fifty-nine percent of the CDC workforce had a graduate-level degree.

Approximately 90% of the workforce was located at CDC offices throughout the United States (ie, Atlanta [CDC headquarters], Anchorage, Cincinnati, Fort Collins, Hyattsville, Morgantown, Pittsburgh, and Puerto Rico). A total of 145 CC officers (16%) and 757 civil servants (7%) were assigned to domestic locations outside of CDC offices (ie, state and local health departments). In addition, 48 CC officers (5%) and 232 civil servants (2%) were assigned to international locations. Thirty-one percent of the CDC workforce (n = 3489) was located in operational units focusing on noninfectious diseases, 27% on infectious diseases (n = 3062), and the remainder on crosscutting offices, including 24% on crosscutting science (eg, the Office of Surveillance, Epidemiology, and Laboratory Services or the Center for Global Health) and 18% on crosscutting support (eg, the Office of State, Tribal, Local, and Territorial Support or the Office of the Director) (Table 1).

Among CDC staff, persons in 159 individual OPM occupational series were identified and grouped into the recommended occupational classifications; however, OPM occupational series codes did not capture the roles of emergency preparedness staff, epidemiologists, or public health informatics specialists (Table 2). By using the single-position title approach as described in the “Methods” section, we identified 928 individual position titles, collapsed them into 230 comparable single-position titles, and then grouped them into one of the standard occupational classifications, successfully capturing the 3 missing occupations. The balance of the results presented is based on classifications that used this second approach.

Public health managers, laboratory workers, and administrative-clerical staff comprised the top 3 most common occupational classifications among CDC staff (Table 2). Persons placed in the Other Public Health Professional category accounted for 28% of the 11 223 person workforce, representing 124 of the 230 comparable single-position titles (54%). Characteristics of the most common scientific occupational classifications (ie, environmental

health workers, epidemiologists, laboratory workers, and public health managers) are displayed in Table 3. Among these 4 occupational classifications, women represented 54% or more, with the exception of environmental health workers (34%); more than 50% were white. Epidemiologists accounted for 9% of the overall CDC federal workforce, 5% of whom were civil servants and 50% CC officers. Among the established occupational classifications, the proportion of workers 55 years or older was larger than the proportion of workers aged 34 years or younger. Graduate-level degrees were held by 95% of epidemiologists, 70% of laboratory workers, 63% of environmental health workers, and 44% of public health managers. The supervisor-to-nonsupervisor ratio for epidemiologists, public health managers, and environmental health workers was 1:5, whereas the ratio for laboratory workers was 1:14.

Sixteen percent of the CDC workforce was eligible to retire by December 2012, and more than 30% will be eligible to retire by December 2017 (Table 4). Among CC officers, more than 40% were eligible to retire within 5 years, and an additional 8% faced mandatory retirement within the next 5 years (data not shown). Approximately 19% of the workforce in operational units focusing on noninfectious diseases was eligible to retire in 2012, and 15% of the workforce in crosscutting scientific areas was eligible to retire within 5 years (Figure). Positions critical for fulfilling the CDC mission, including 23% of public health physicians, 25% of environmental health workers, and 16% of epidemiologists, were eligible to retire by December 2012. Public health nurses, public health physicians, environmental health workers, health educators, and administrative-clerical staff are among the occupational classifications that might lose 30% or more of their workforce within the next 5 years (Figure).

Discussion

Although research is being conducted on staffing patterns of health departments and workforce competencies, these efforts have been hampered considerably by a lack of data regarding the public health workforce overall.[12,13] Describing and counting the public health workforce acknowledges the vital role of public health as part of the entire US health system, especially as public health and clinical health care evolve in complementary ways to address and improve population health. However, challenges to enumerating the public health workforce are mirrored by similar obstacles to enumerating the larger health workforce. This study is the first to characterize the CDC workforce and represents a substantial contribution to understanding the size and composition of the governmental federal public health enterprise; furthermore, our findings reveal implications for the broader national public health enumeration efforts. Monitoring the size and composition of the public health workforce is an essential first step in determining how to develop and maintain workforce competency and effectiveness and in ensuring that health agencies have a capable and qualified workforce necessary for providing essential public health services, a priority outlined by the *Healthy People* initiative.[14]

CDC has a large, highly educated, and diverse workforce that seeks to accomplish the agency's mission through collaboration with nationwide and global partners to improve the public's health. Our profile of the CDC workforce used data from existing personnel

systems capturing information about the workforce on an ongoing basis and was based on data elements recommended for workforce surveillance (eg, demographic and education and training background).[8] Combining these data with those of enumeration efforts from state and local public health departments collected through the ASTHO and NACCHO profile studies can provide a more complete and arguably representative picture of the public health workforce. The 2 profile studies do not collect demographic information or education and professional training characteristics of their workforce, and including the minimum elements recommended for monitoring the workforce in these studies and related occupational surveys should facilitate substantial progress in national efforts to characterize the public health workforce. Integrating these elements into their respective surveys or into a structured and systematic data collection method will permit (1) profiling the local, state, and federal public health population in quantitative terms; (2) presenting trends that allow reflecting on the diversity of the workforce trends and understanding the degree to which this workforce reflects the characteristics of the continually changing US population; (3) identifying disparities in worker qualifications; and (4) using these data to raise policy concerns in preparation, continuing education, recruitment, and retention.[11]

An accurate description of the job functions of persons working in public health is crucial to determining whether adequate numbers and types of staff are employed in positions that enable public health agencies to meet the needs of protecting the public health over time. Although the OPM provides extensive data regarding the federal civilian workforce, including demographic information, employment trends, and retirement statistics, the majority of occupational series do not reflect public health workers' job functions as accurately as position titles.[8,12,15] Position titles provide more granularity for classification into the corresponding occupational classification, but they do not consistently provide an accurate reflection of the educational preparation or the work performed by a person[11]; furthermore, at CDC, not all position titles correspond to workers' job functions or education and training background (eg, a physician who trained as an epidemiologist but serves in a management position). Additional variations among how public health worker job titles are listed in state, local, and federal governments limit our ability to compare our findings with those of other public health agencies. Implementing a standardized system for classifying public health workers among the different public health groups collecting workforce data or mapping current position titles to a standardized classification system is key to developing a profile of the national public health workforce derived from data from multiple sources.

The public health workforce is a complex mixture of health care professionals.[11] In our study, all CDC staff were grouped into one of the recommended occupational classifications by using position titles, from which we observe that more than 40% were classified as public health managers, laboratory workers, and epidemiologists. Workers classified in the Other Public Health Professional category, however, accounted for approximately 30% of the CDC workforce. This finding is consistent with the 29% of local public health workers enumerated but not categorized by the most recent NACCHO profile survey,[10] although it is somewhat lower than the 46% of ASTHO public health workers not categorized during their last survey.[9] At any level of government, the Other Public Health Professional category includes public health workers who are either in occupational classifications other than those

recommended for data collection or otherwise uncategorized because of missing data; at CDC, 124 different comparable position titles (eg, health scientists, veterinarians, or economists) were classified into this category. To provide a more refined characterization of a greater proportion of the public health workforce, assessing the Other Public Health Professional category is essential for determining whether we are systematically not capturing a discipline or occupation and thus the need to add additional occupational classifications to better characterize the public health workforce.

As one mechanism of responding to this challenge, CDC and public health partners, including ASTHO and NACCHO, are developing a taxonomy for occupational classifications to provide a detailed, more comprehensive, and accurate representation of the public health workforce. This taxonomy will help future studies determine whether the public health system has adequate numbers of staff working in the right job functions and assist the public health sector in efforts to hire and train a workforce that can deliver and measure the essential public health services.

Current and projected personnel shortages in the public health workforce are well documented, and reports indicate that 25% of the public health professionals are eligible to retire.[2] Our study indicates that more than 30% of the CDC workforce will be eligible to retire by 2017, and with their retirement, staff experience necessary for effectively delivering public health services also will be lost. Furthermore, our study indicates that CDC workers are an average age of 48 years, essentially the same as other public health workers outside the federal system and 8 years older than the rest of the US workforce.[16] These finding are consistent with other reports and reveal that the public health workforce is aging at a higher rate than the general workforce or that fewer workers at the younger end are being recruited; as older, more experienced workers retire, a substantial gap in leadership is anticipated. Although CDC has educational and training programs implemented to encourage careers in public health,[17] hiring limitations at federal, state, and local health agencies might constrain the number of trained workers entering the field of public health. That a field as important as public health might be left without sufficient workforce in the next 5 years is a wake-up call at all levels.[16] Addressing the looming workforce shortage should be approached strategically by developing workforce planning models for public health agencies that include monitoring and evaluation of the workforce,[18] along with succession planning, as critical steps in ensuring key public health positions are maintained. Workforce models can help to identify and implement strategies for maintaining and increasing competency in these positions beginning with the Institute of Medicine recommendation for all students to have access to public health education.[7] These and other targeted efforts should emphasize reevaluation of retention practices, preparing talent within the organization, and planning recruitment activities for external candidates.[13]

In its 2003 report, *The Future of the Public's Health in the 21st Century*, the Institute of Medicine recommended periodic assessments of the preparedness of the public health workforce to document the training necessary for meeting basic competency expectations and to advise on the funding necessary to provide such training.[7] Implementing a systematic process for characterizing the size and composition of the public health workforce is essential both for maintaining and strengthening the US public health infrastructure and for

understanding the capacity, projecting trends, and developing policies regarding the future workforce. CDC is facilitating the implementation of strategies for enumerating the US governmental public health workforce by using a systematic, ongoing, surveillance-like approach. This ongoing enumeration will monitor and leverage existing data sources and resources to provide a comprehensive picture of the numbers and variety of disciplines and functions that, combined, form the public health workforce. A single data source capturing workforce data across public health agencies does not exist, and existing data streams are neither compatible nor necessarily comparable[8]; however, standardizing job titles and consistently collecting data elements recommended for workforce surveillance can support combining the 3 most representative systems (the NACCHO and ASTHO periodic profile surveys and CDC's ongoing collection of personnel data) and analyzing them as a single data source system on an ongoing basis to provide an adequate, if not a complete, picture of the public health workforce. Accurate and timely enumeration data can lay the groundwork for workforce development efforts that include understanding gaps and future needs in the public health system, competency measurement, certification and credentialing, compliance with performance standards, and tracking progress toward *Healthy People* objectives.[19]

Our findings provide an understanding of the complex and diverse CDC workforce, and the methods used in our study can be applied to continually monitor US governmental agencies contributing to public health, especially those within the HHS system. This contribution represents a critical baseline measure that will help support studies to identify the needs of different public health professions. Nevertheless, enumeration efforts are only one part of a larger initiative to strengthen the public health and health workforce to improve the public's health. Under this initiative, CDC has adopted shared leadership with such key partners as ASTHO, NACCHO, and the University of Michigan, among others, to advance systems for measurement, evaluation, and continuous improvement by enhancing the education system at multiple levels, improving pathways to public health careers, and increasing the capacity and capability of the existing workforce.

Limitations

One limitation of our study was that our assessment did not include contract employees, considered a substantial contribution to the federal workforce and almost 30% of CDC's workforce. Contractors are counted through their home organization, not captured in the OPM data system, and therefore not classified as federal workers (ie, company A contractor working at CDC in a public health capacity is reported and counted as a company A employee). Second, because position titles lack standardization when entered into the personnel systems, our effort to manually collapse and group them into position titles similar in roles might have resulted in potential misclassification with under- or overcounting for certain disciplines. However, because of the specificity of job titles when compared with the use of OPM occupational series, our findings still provide useful insight into the CDC workforce. Third, our study measured retirement eligibility and potential staff losses but did not assess personnel influx. Evidence exists, however, that the growth of the general public health workforce might be slowing or even reversing.[20] In addition, categorization of certain CDC operational divisions into crosscutting, infectious disease, or noninfectious disease areas might not completely represent the activities within those units; for example, we

classified the Center for Global Health as a crosscutting science organization, yet it also includes disease-specific components (eg, the global HIV/AIDS and malaria programs). Consequently, we might have underestimated the proportion of CDC staff working in the infectious diseases area. Fourth, CDC workforce data were only available in real time; therefore, it did not allow for retrospective analyses and trends over time. Finally, CDC does not comprise the entirety of the public health workforce at the federal level. Because it is the leading public health agency in the US government, however, examining the composition of CDC workforce serves as a useful proxy for the federal component in the national public health workforce enumeration effort.

Conclusions

This study represents the first characterization of the CDC workforce and provides a valuable contribution to the national public health workforce enumeration. The methods used in our study can be applied to other HHS agencies and serve as the beginning of a systematic approach for enumerating the federal public health system. Establishing a system for continually monitoring the public health workforce is the method by which the characterization of this workforce will be possible, which, in turn, can help efforts regarding understanding workforce shortages, capacity, and effectiveness, projecting trends, and implementing policies.

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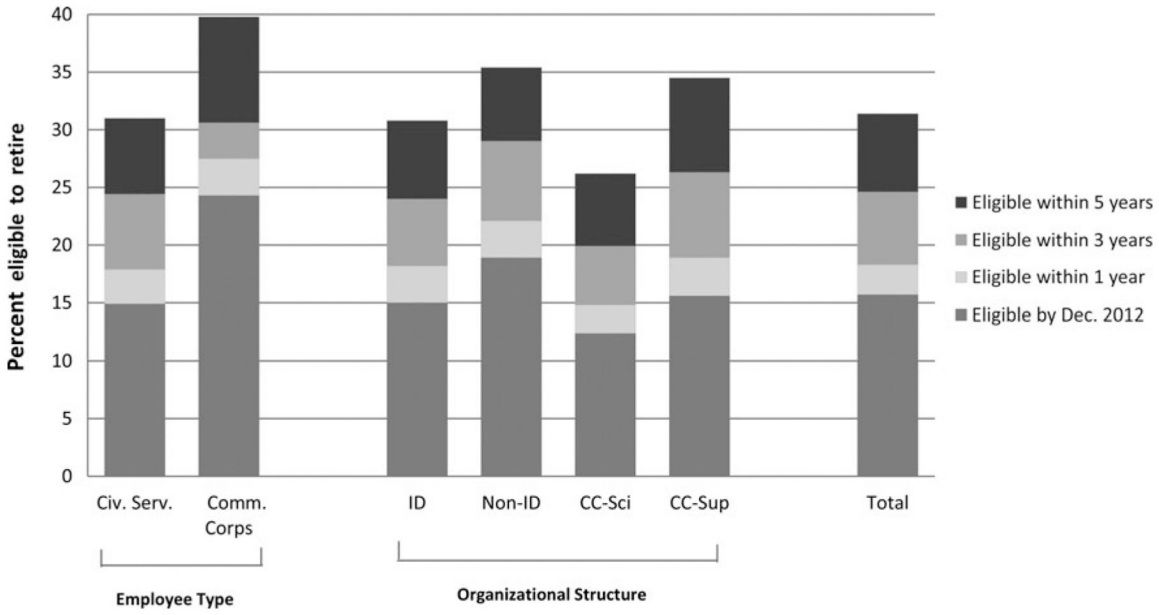

FIGURE. Retirement Status of the Centers for Disease Control and Prevention Federal Workforce, by Employee Type and Organizational Structure,[a] First Quarter Calendar Year 2012

Abbreviations: Employee Type—Civ. Serv., Civil Service employees; Comm. Corps., Commissioned Corps officers. Organizational structure—CC-Sci, crosscutting science; CC-Sup, crosscutting support; ID, infectious disease; NID, noninfectious disease.

[a]CDC Organizational Structure—Infectious disease: Office of Infectious Disease. Noninfectious Disease: Office of Noncommunicable Diseases, Injury, and Environmental Health; National Institute of Occupational Safety and Health; and Coordinating Center for Environmental Health and Injury Prevention. Crosscutting science: Center for Global Health; Coordinating Office for Terrorism Preparedness and Emergency Response; Office of Public Health Preparedness and Response; and Office of Surveillance, Epidemiology, and Laboratory Services. Crosscutting support: Office of the Chief Operating Officer; Office of the Director; and Office of State, Tribal, Local, and Territorial Support.

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TABLE 1

Characteristic of the Centers for Disease Control and Prevention Federal Workforce, First Quarter Calendar Year 2012[a]

Characteristic	Civil Service Employees, n (%)	Commissioned Corps Officers, n (%)	Total, n (%)
Sex			
Women	6 316 (61.2)	505 (55.7)	6 821 (60.8)
Men	4 000 (38.8)	402 (44.3)	4 402 (39.2)
Race/ethnicity			
Black	2 810 (27.2)	102 (11.2)	2 912 (25.9)
American Indian	37 (0.4)	9 (1.0)	46 (0.4)
Asian/Pacific Islander	871 (8.4)	84 (9.3)	955 (8.5)
White	6 274 (60.8)	521 (57.4)	6 795 (60.5)
Hispanic	324 (3.1)	29 (3.2)	353 (3.1)
Unknown	0 (0)	162 (17.9)	162 (1.4)
Age group, y			
≤24	139 (1.3)	0 (0)	139 (1.2)
25–34	1 316 (12.8)	164 (18.1)	1 480 (13.2)
35–44	2 525 (24.5)	324 (35.7)	2 849 (25.4)
45–54	3 404 (33.0)	295 (32.5)	3 699 (33.0)
55–64	2 529 (24.5)	119 (13.1)	2 648 (23.6)
≥65	403 (3.9)	5 (0.6)	408 (3.6)
Education level			
Less than bachelor's degree	1 938 (18.8)	0 (0)	1 938 (17.3)
Bachelor's degree	2 591 (25.1)	97 (10.7)	2 688 (24.0)
Master's degree	3 373 (32.7)	178 (19.6)	3 551 (31.6)
Doctoral degree	2 410 (23.4)	626 (69.0)	3 036 (27.1)
Unknown	4 (<0.1)	6 (0.7)	10 (<0.1)
Location			
Headquarters	9 327 (90.4)	709 (78.2)	10 036 (89.4)
Other domestic locations	757 (7.3)	145 (16.0)	902 (8.0)
International	232 (2.3)	48 (5.3)	280 (2.5)
Unknown	0 (0)	5 (0.5)	5 (<0.1)

Characteristic	Civil Service Employees, n (%)	Commissioned Corps Officers, n (%)	Total, n (%)
Organizational structure[b]			
Infectious disease	2 733 (26.5)	329 (36.3)	3 062 (27.2)
Noninfectious disease	3 228 (31.3)	261 (28.8)	3 489 (31.1)
Crosscutting science	2 371 (23.0)	278 (30.7)	2 649 (23.6)
Crosscutting support	1 984 (19.2)	39 (3.4)	2 023 (18.0)
Total	10 316 (100.0)	907 (100.0)	11 223 (100.0)

[a]Percentages might not sum to 100% because of rounding.

[b]Organizational Structure—Infectious disease: Office of Infectious Disease. Noninfectious disease: Office of Non-Communicable Diseases, Injury, and Environmental Health; National Institute of Occupational Safety and Health; and Coordinating Center for Environmental Health and Injury Prevention. Crosscutting science: Center for Global Health; Coordinating Office for Terrorism Preparedness and Emergency Response; Office of Public Health Preparedness and Response; and Office of Surveillance, Epidemiology, and Laboratory Services. Crosscutting support: Office of the Chief Operating Officer; Office of the Director; and Office of State, Tribal, Local, and Territorial Support.

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TABLE 2

Recommended Occupational Classifications, by OPM Occupational Series and Position Title, Centers for Disease Control and Prevention, First Quarter Calendar Year 2012[a]

Recommended Occupational Classifications for Public Health Workforce[b]	Total	
	By OPM Occupational Series,[c] n (%)	By Position Title,[d] n (%)
Administrative/Clerical Personnel	1 596 (14.2)	1 147 (10.2)
Behavioral Health Professional	233 (2.1)	233 (2.1)
Emergency Preparedness Staff	0 (0)	115(1.0)
Environmental Health Worker	266 (2.4)	354 (3.2)
Epidemiologist	0 (0)	961 (8.6)
Health Educator	176 (1.6)	176 (1.6)
Laboratory Worker	1 110 (10.0)	1 118 (10.0)
Nutritionist	1 (<0.1)	1 (<0.1)
Public Health Dentist	9 (<0.1)	5 (<0.1)
Public Health Informatics Specialist	0 (0)	67 (0.6)
Public Health Manager	2 416 (21.5)	2 867 (25.5)
Public Health Nurse	55 (0.5)	31 (0.3)
Public Health Physician	787 (7.0)	418(3.7)
Public Information Specialist	556 (5.0)	553 (4.9)
Other Public Health Professional	4 018 (35.8)	3 177 (28.3)
Total	11 223 (100.0)	11 223 (100.0)

Abbreviation: OPM, US Office of Personnel Management.

[a] Percentages might not sum to 100% because of rounding.

[b] From University of Michigan/Center of Excellence in Public Health Workforce Studies, University of Kentucky/Center of Excellence in Public Health Workforce Research and Policy.[8]

[c] *OPM occupational series* refers to the designations set forth by the OPM that fall into the corresponding recommended occupational classifications.

[d] *Position title* refers to the use of individual position titles that correspond to the recommended occupational classifications.

TABLE 3

Characteristics of the Most Common Scientific Occupational Classifications, Centers for Disease Control and Prevention, First Quarter Calendar Year 2012[a]

Characteristic	Environmental Health Workers, n (%)	Epidemiologists, n (%)	Laboratory Workers, n (%)	Public Health Managers, n (%)
Sex				
Women	122 (34.5)	596 (62.0)	602 (53.8)	2089 (72.9)
Men	232 (65.5)	365 (38.0)	516 (46.2)	778 (27.1)
Race/ethnicity				
American Indian	3 (0.8)	6 (0.6)	3 (0.3)	15 (0.5)
Asian/Pacific Islander	20 (5.6)	140 (14.6)	197 (17.6)	113 (3.9)
Black	38 (10.7)	75 (7.8)	128 (11.4)	1123 (39.1)
Hispanic	9 (2.5)	36 (3.7)	38 (3.4)	102 (3.6)
White	268 (75.7)	639 (66.5)	752 (67.3)	1469 (51.2)
Unknown	15 (4.2)	65 (6.8)	0 (0)	43 (1.5)
Age group, y				
≤24	0 (0)	1 (0.1)	6 (0.5)	110 (3.8)
25–34	46 (13.0)	158 (16.4)	186 (16.6)	401 (14.0)
35–44	84 (23.7)	345 (35.9)	321 (28.7)	744 (26.0)
45–54	138 (39.0)	302 (31.4)	332 (29.7)	1023 (35.7)
55–64	79 (22.3)	142 (14.7)	234 (20.9)	541 (18.9)
≥65	7 (2.0)	13 (1.4)	39 (3 5)	48 (1.7)
Education level[a]				
Less than bachelor's degree	22 (6.2)	2 (0.2)	42 (3.8)	642 (22.4)
Bachelor's degree	105 (29.7)	45 (4.7)	295 (26.4)	948 (33.1)
Master's degree	145 (41.0)	274 (28.5)	253 (22.6)	1166 (40.7)
Doctoral degree	79 (22.3)	640 (66.6)	527 (47.1)	107 (3.7)
Supervisory status[a]				
Nonsupervisor	304 (86.2)	807 (84.0)	1044 (93.4)	2384 (83.1)
Supervisor	49 (13.8)	154 (16.0)	74 (6.6)	481 (16.8)
Total	354 (100.0)	961 (100.0)	1118 (100.0)	2867 (100.0)

[a]Percentages might not sum to 100% because of rounding.

TABLE 4

Retirement Eligibility Information, by Occupational Classification, Centers for Disease Control and Prevention, First Quarter Calendar Year 2012[a]

Recommended Occupational Classifications for Public Health Workforce[b]	Dec 2012,[c] n (%)	1–3 y,[c] n (%)	>3–5 y,[c] n (%)	Future,[c] n (%)	Total, n (%)
Administrative/Clerical Personnel	208 (18)	131 (11)	101 (9)	707 (62)	1 147 (100)
Behavioral Health Professional	20 (9)	12 (5)	14 (6)	187 (80)	233 (100)
Emergency Preparedness Staff	3 (3)	14 (12)	7 (6)	91 (79)	115 (100)
Environmental Health Worker	87 (25)	43 (12)	27 (8)	197 (56)	354 (100)
Epidemiologist	149 (16)	65 (7)	74 (8)	673 (70)	961 (100)
Health Educator	24 (14)	26 (15)	13 (7)	113 (64)	176 (100)
Laboratory Worker	175 (16)	81 (7)	67 (6)	795 (71)	1 118 (100)
Nutritionist	0 (0)	0 (0)	0 (0)	1 (100)	1 (100)
Public Health Dentist	2 (40)	2 (40)	0 (0)	1 (20)	5 (100)
Public Health Informatics Specialist	6 (9)	2 (3)	5 (7)	54 (81)	67 (100)
Public Health Manager	431 (15)	287 (10)	193 (7)	1 956 (68)	2 867 (100)
Public Health Nurse	9 (29)	6 (19)	3 (10)	13 (42)	31 (100)
Public Health Physician	94 (23)	53 (13)	36 (9)	223 (53)	418 (100)
Public Information Specialist	67 (12)	64 (12)	28 (5)	394 (71)	553 (100)
Other Public Health Professional	475 (15)	256 (8)	194 (6)	2 251 (71)	3 176 (100)
Total	1 762 (16)	1 042 (9)	762 (7)	7 657 (68)	11 222 (100)

[a] Percentages might not sum to 100% because of rounding.

[b] Civil Service data using the Centers of Excellence classifications are available for 10 315 employees; 1 is missing.

[c] December 2012 = On or before December 31, 2012; 1–3 years = January 1, 2013-December 31, 2015; >3–5 years = January 1, 2016-December 31, 2017; Future = Beyond January 1, 2018.

Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

United States House Committee on Energy and Commerce, Health Subcommittee Hearing on "Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?"

July 23, 2024

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the United States House Committee on Energy and Commerce, Health Subcommittee legislative hearing on "Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?". The Association and AIM thank the Subcommittee for holding this hearing to consider issues important to the millions of people living with Alzheimer's and other dementia and their caregivers.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Millions of Americans living with dementia often face the challenge of navigating complex care landscapes without adequate support, leading to poorer health outcomes, high rates of hospitalization, and significant caregiver stress. According to the Alzheimer's Association's 2024 Facts and Figures and Special Report, nearly 7 million Americans are living with Alzheimer's. By 2050, that number will approach 13 million. Sixty percent of health care workers believe that the U.S. health care system is not effectively helping patients and their families navigate dementia care. A majority of caregivers (70 percent) report that coordinating care is stressful, and two in three (66 percent) have difficulty finding resources and support for their needs. Unfortunately, our work is only growing more urgent.

The BOLD Infrastructure for Alzheimer's Reauthorization Act (H.R. 7218/S. 3775) and the CDC

We are also grateful to Subcommittee Chairman Brett Guthrie and Committee member Congressman Paul Tonko for their leadership on the bipartisan 2018 Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act (P.L. 115-406), and recent efforts to reauthorize this important law through the bipartisan BOLD Infrastructure for Alzheimer's Reauthorization ACt (H.R. 7218/S. 3775). The BOLD Act, funded by appropriated funds through the CDC, has enabled communities nationwide to implement public health strategies that promote brain health, increase early detection, address dementia, and support people living with dementia and their caregivers. The BOLD Act provides an avenue for the activation of advances in knowledge to be integrated into our public health infrastructure. Public health can integrate brain health messages into existing, relevant public health campaigns, acknowledging the growing evidence that healthy living can reduce the risk of cognitive decline and may reduce the risk of dementia. Public health can also undertake public awareness campaigns to promote

early detection and diagnosis, and can educate medical professionals about assessment tools, which is critical to ensuring access to treatment. Public health can also increase access to care and services by ensuring providers are trained in evidence-based care guidelines, and people living with dementia and their caregivers have the support and resources they need in their communities.

We also thank the CDC for prioritizing BOLD implementation in a way that benefits people living with Alzheimer's, and their caregivers and families. Since its enactment, the CDC has made 66 awards to 45 state, local, and tribal public health departments. These award recipients are working to implement public health strategies tailored to local populations as well as create, update, and operationalize state plans to address Alzheimer's disease. The CDC has also awarded funding to three Public Health Centers of Excellence each focusing on a priority public health area of need: dementia risk reduction, early detection of dementia, and dementia caregiving. Together, this infrastructure helps implement strategies from *The Healthy Brain Initiative: State and Local Road Map for Public Health* (HBI Road Map) and *Healthy Brain Initiative Road Map for Indian Country*, which provide a framework for BOLD award recipients to lead with urgency and act for impact in their communities to improve brain health across the life course and support caregivers.

The BOLD Act continues to make a significant impact on communities across the country. For example, in Kentucky, BOLD funding is increasing the state's capacity to operationalize its Kentucky State Alzheimer's Plan. Kentucky's initial investment in Alzheimer's disease and other dementia led to the creation of a full-time state agency Dementia Services Coordinator staff position which was a catalyst for their application to the BOLD Program award. In September 2023, the Kentucky Department for Public Health was awarded a BOLD Public Health Program Component 1 award to develop strategic statewide strategies to address Alzheimer's disease. This funding is already allowing the state to support the work of Kentucky's Office of Dementia Services.

Using the HBI Road Map, the state of Washington has expanded its public health infrastructure to increase the populations served and discuss dementia throughout the continuum of disease, from risk reduction to the late stages of the disease. For example, the Washington State Department of Health released guidance to local health departments on effective ways to use the HBI Road Map and conducted an internal agency evaluation to assess its ability and identify potential gaps in addressing Alzheimer's and caregiving needs. The state has also allocated funding to support the statewide expansion of dementia-specific public awareness efforts at the Memory and Brain Wellness Center at the University of Washington and to other state-led public awareness efforts aimed at reducing the stigma surrounding dementia as well as educating physicians about the importance of the early detection and diagnosis of Alzheimer's. This work led to the CDC awarding the Washington State Department of Health with the state's BOLD Public Health Program Component 2 award in September 2023, which will allow the state to expand upon these actions.

In September 2020, Wisconsin received a BOLD Public Health Program Component 1 award, and, through this grant, the Wisconsin Department of Health Services is utilizing existing public health infrastructure to increase early detection and diagnosis, reduce the risk of developing dementia, and support dementia caregiving. Wisconsin is in the process of implementing the Wisconsin State Dementia Plan: 2019–2023, its third state dementia plan. The current state plan has four areas of focus: care provided in communities where people live; improving how health care providers diagnose and care for people with dementia; responding to crises involving people with dementia; and care provided in assisted living, nursing homes, and other

residential facilities. Further, a steering committee, led by the Department of Health Services, was established to ensure the state plan is implemented with the assistance of four “leadership teams” (work groups) that are responsible for assisting the Steering Committee in each of the four focus areas: care in the communities, health care, crisis response, and facilities-based care. The CDC awarded Wisconsin with its second BOLD award in September 2023, which will allow the state to continue building upon the great progress made thanks to its first award in 2020.

California recognized its need for a comprehensive Alzheimer’s public health infrastructure and used the resources provided by the federally funded Healthy Brain Initiative (HBI) as a framework to establish the California Healthy Brain Initiative. For this, six local health departments across the state produced action plans, and educational outreach materials and conducted 101 media campaigns for the public. Furthering implementation of the actions in the 2018 HBI Road Map, California appropriated funds to the state Medicaid program to establish Dementia Care Aware in 2021, a statewide program providing primary care providers with the information and tools needed to successfully administer cognitive health assessments and determine the appropriate next steps for the patients. In 2020, the County of Los Angeles received a BOLD Public Health Program Component 1 award, and in September 2023, the county received a BOLD Public Health Program Component 2 award to continue this work. The California State Department of Public Health received its first BOLD Public Health Program Award in September 2023, when the CDC awarded the state with a BOLD Public Health Program Component 2 award to amplify its existing efforts to address Alzheimer’s disease.

The Vermont Department of Health received a BOLD Public Health Program Component 2 award from the CDC in September 2020, and, in September 2021, the department launched a virtual Project ECHO series to help build capacity for dementia diagnosis and care. Over 80 participants joined the first session of this monthly telementoring program run through the Area Health Education Center at the University of Vermont’s (UVM) Larner College of Medicine. The Department of Health also offers monthly "Dementia Corner Consults" for primary care providers and their teams, led by the medical director of the UVM Memory Program. Additionally, in October 2021, the Vermont Department of Health published a data brief on Risk Factors for Subjective Cognitive Decline in Vermonters. The CDC awarded Vermont with its second BOLD award in September 2023, which will allow the state to continue building upon the great progress made thanks to its first award in 2020.

Underscoring the importance of a public health approach to addressing Alzheimer’s and dementia in our communities, while New Jersey does not currently receive BOLD funding, the state is active in developing Alzheimer’s public health initiatives. For example, the New Jersey Alzheimer’s Disease Study Commission was established in 2011 to study the current and future impact and incidence of Alzheimer’s within the state. The New Jersey Alzheimer’s Disease Study Commission Report was published in August 2016 and examined services within the state to meet the needs of those affected by Alzheimer’s. Most recently in 2023, the New Jersey Department of Health participated in a public health program called Data for Action, a project of the HBI designed to support the integration of data on brain health and caregiving into public health planning efforts. This has allowed the health department to produce state-specific data on risk factors for Alzheimer’s and other dementia as well as identify links between cognitive changes and other chronic conditions and health behaviors. New Jersey now plans to use their work to educate members of the public and inform key decision-makers on how to advance public health action on brain health.

These are just a few of the many examples of the innovation stemming from Alzheimer’s

investment across the country. BOLD has clearly led to great progress in building and strengthening the Alzheimer's public health infrastructure nationwide. However, this important program is set to expire this year. The bipartisan BOLD Infrastructure for Alzheimer's Reauthorization Act of 2024 (H.R. 7218/S. 3775), introduced by Subcommittee Chairman Brett Guthrie and Committee member Congressman Paul Tonko, would extend this important law until 2029 and authorize $33 million annually for five years, to reflect the program's current appropriated level. In May, the BOLD Reauthorization Act passed out of this Committee It is vital that Congress passes this bill and continues to invest in a nationwide Alzheimer's public health response that will help further population-level improvements, achieve a higher quality of life for those living with the disease and their caregivers, and reduce associated costs.

Conclusion

The Alzheimer's Association and AIM appreciate the Subcommittee's steadfast support and commitment to advancing issues important to the millions of individuals living with Alzheimer's and other dementia, as well as their caregivers. We look forward to continuing to work with the Subcommittee and other members of Congress in a bipartisan way to reauthorize and extend these laws through the BOLD Infrastructure for Alzheimer's Reauthorization Act (H.R. 7218/S. 3775). It is important that this law be reauthorized and fully funded, so the CDC can continue to advance Alzheimer's public health infrastructure and reinforce Congress' sustained commitment to a strategic approach to combating Alzheimer's disease and supporting caregivers nationwide while enabling further strides in understanding, treating, and ultimately preventing Alzheimer's and other dementia. Doing so will provide much-needed hope for the millions of families affected by this devastating disease.

July 23, 2024

The Honorable Chairman Brett Guthrie
House Energy and Commerce Committee
Health Subcommittee
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Anna Eshoo
House Energy and Commerce Committee
Health Subcommittee
272 Cannon House Office Building Office
Washington, DC 20515

Re: Hearing on Whether the CDC's Priorities are Restoring Public Trust and Improving the Health of the American People?

Dear Chair Guthrie and Ranking Member Eshoo:

Thank you for holding today's hearing on whether the Centers for Disease Control and Prevention's (CDC) priorities are restoring public trust in the agency and improving health of Americans. The CDC offers essential infrastructure to our public health system. The American Society of Health-System Pharmacists (ASHP) appreciates the CDC's understanding of the unique role of pharmacists as a critical partner within that infrastructure. ASHP is the collective voice of pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. Our organization's more than 60,000 members include pharmacists, student pharmacists, and pharmacy technicians. For more than 80 years, ASHP has been at the forefront of efforts to promote medication safety and address the nation's public health needs.

ASHP supports the mission of the CDC to save lives and protect Americans from health threats. The CDC is the nation's preeminent organization that supports public health preparedness, prevention, and control to improve patient health and well-being. We appreciate that the agency recognizes the pharmacist's role as medication experts and healthcare extenders in communities for vaccinations, point-of-care testing, and acute and chronic disease management. For example, the CDC leverages pharmacists to expand vaccination efforts through the Vaccine for Children program and Federal Retail Pharmacy Program. Further, the CDC has utilized pharmacists to address chronic care issues through numerous programs and initiatives. Examples are the National Diabetes Prevention Program in community pharmacies and the Heart Disease and Stroke Prevention Program. Lastly, the agency realizes the importance of pharmacists on disease surveillance, prevention and treatment such as CDC Core Elements of Antibiotic Stewardship and antimicrobial use and resistance reporting through the National Healthcare Safety Network.

While these efforts are important to the CDC's mission and outreach, the agency could further use pharmacists to address public health issues. For example, pharmacists play a key role in substance use disorder treatment through collaboration with other interprofessional team members. With the elimination of the X-waiver, pharmacists are uniquely positioned to improve patient access and adherence to medications for opioid use disorder (MOUDs). Similarly, pharmacists are in a unique position to support access to human immunodeficiency virus infection screening, prevention, and treatment. We encourage CDC to leverage pharmacists as patient care providers to address these national public health needs.

ASHP thanks you for holding this hearing and we look forward to working with you on this and other CDC issues. If you have any questions or if ASHP can assist your office in any way, please contact Frank Kolb at [redacted].

Sincerely,

Tom Kraus
American Society of Health-System Pharmacists

REDUCING HARM,
PROMOTING HEALTH,
CREATING WELLNESS,
AND FIGHTING STIGMA
IN HAWAI'I AND
THE PACIFIC

HAWAI'I HEALTH
& HARM REDUCTION
CENTER

677 Ala Moana Blvd.
Suite 226
Honolulu, HI 96813

(808) 521-2437
www.hhhrc.org

Letter of Support

July 22, 2024

Chairman Brett Guthrie
2434 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Anna Eshoo
202 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo,

As you prepare for your hearing on Tuesday, July 23, entitled "Are CDC's Priorities Restoring Public Trust and Improving the Health of the American People?" We wish to bring to your attention the work that the CDC has done to fight the overdose epidemic in our country.

For over a decade, we have watched as our government has sought solutions to the overdose epidemic, which has claimed millions of lives in that span. Overdoses continue to be a leading cause of accidental death in our country- yet recently, after years upon years of investing in the fight against it, we finally began to see progress as numbers began to trend downward, for the first time in recent memory.

Now that we are finally beginning to see progress, the House of Representatives Committee on Appropriations now seeks to eliminate the $500 million Overdose Division at the Centers for Disease Control. This is an utterly baffling decision. The role of the CDC Overdose division is to fund surveillance activities that help track overdoses, **emerging drug threats, and associated risk factors,** and enhance biosurveillance and data linkage. Its prevention activities promote evidence-based strategies aligned with **rapid shifts in overdose trends, including changes in the illegal drug supply and a rise in stimulant and polysubstance use.** To achieve this, CDC funds 49 state health departments and the District of Columbia to expand drug overdose surveillance and prevention efforts.

Overdose Data to Action (OD2A) in States was designed to empower jurisdictions to collect data around **community characteristics**, including race/ethnicity, and conduct analyses that consider social determinants of health and use a health equity lens. It uses this data to **inform and tailor prevention strategies**, with an emphasis on reaching groups disproportionately affected by the overdose epidemic. This way, we can ensure the implementation of culturally relevant interventions and equitable delivery of prevention services.

Often overlooked in the battle against overdoses are the factors that contribute to substance use disorders, as well as the other complications that arise from SUD. These include trauma, adverse childhood experiences, and a plethora of other maladies. As a result, we are disturbed by the proposed cuts to other areas of the

REDUCING HARM,
PROMOTING HEALTH,
CREATING WELLNESS,
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IN HAWAI'I AND
THE PACIFIC

CDC Injury Prevention Center as well. The elimination of programs aimed at tobacco prevention, ending HIV, suicide prevention, and rape prevention, will all impact the effort to reduce overdoses adversely.

HHHRC's mission is to *reduce harm, promote health, create wellness, and fight stigma in Hawaii and the Pacific.* We focus our efforts on those disproportionately affected by social determinants of health, including but not limited to: people living with and/or affected by HIV, hepatitis, substance use, transgender, LGBQ, and the Native Hawaiian communities.

Congress has been unified in its message that this issue is bipartisan and needs to continue as a major priority. Eliminating over half a billion dollars, and programs aimed at reducing overdose, seems to us a bizarre way to accomplish the task in front of us. Every other disease we have beaten, or we are on the road to defeating- whether it be HIV, COVID, SARS, cancer, or diabetes- has been stunted and turned back as a result of multi-billion-dollar investments by the federal government. It is time to do the same for substance use disorders and addiction. We ask you to put aside the political rhetoric about the border and invest in the health of our nation. We call on every member of this committee- and every member of Congress- to support a robust CDC, a strong Injury Prevention Center, and a serious investment in overdose prevention. This can begin by offering your support to the CDC and its mission.

Sincerely,

Heather Lusk, LCSW
Executive Director
Hawai'i Health & Harm Reduction Center

HAWAI'I HEALTH
& HARM REDUCTION
CENTER

677 Ala Moana Blvd.
Suite 226
Honolulu, HI 96813

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Letter of Support

July 22, 2024

Chairman Brett Guthrie
2434 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Anna Eshoo
202 Cannon House Office Building
Washington, D.C. 20515

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Now that we are finally beginning to see progress, the House of Representatives Committee on Appropriations now seeks to eliminate the $500 million Overdose Division at the Centers for Disease Control. This is an utterly baffling decision. The role of the CDC Overdose division is to fund surveillance activities that help track overdoses, **emerging drug threats, and associated risk factors,** and enhance biosurveillance and data linkage. Its prevention activities promote evidence-based strategies aligned with **rapid shifts in overdose trends, including changes in the illegal drug supply and a rise in stimulant and polysubstance use.** To achieve this, CDC funds 49 state health departments and the District of Columbia to expand drug overdose surveillance and prevention efforts.

Overdose Data to Action (OD2A) in States was designed to empower jurisdictions to collect data around **community characteristics**, including race/ethnicity, and conduct analyses that consider social determinants of health and use a health equity lens. It uses this data to **inform and tailor prevention strategies**, with an emphasis on reaching groups disproportionately affected by the overdose epidemic. This way, we can ensure the implementation of culturally relevant interventions and equitable delivery of prevention services.

Often overlooked in the battle against overdoses are the factors that contribute to substance use disorders, as well as the other complications that arise from SUD. These include trauma, adverse childhood experiences, and a plethora of other maladies. As a result, we are disturbed by the proposed cuts to other areas of the CDC Injury Prevention Center as well. The elimination of programs aimed at tobacco prevention, ending HIV, suicide prevention, and rape prevention, will all impact the effort to reduce overdoses adversely.

Hep Free Hawai'i's mission is to promote liver health and wellness by raising awareness and increasing access to the prevention, diagnosis, and treatment of liver disease. We focus our efforts on those disproportionately affected by social determinants of health, including but not limited to: people living with and/or affected by HIV, hepatitis, substance use, transgender, LGBQ, and the Native Hawaiian communities.

Congress has been unified in its message that this issue is bipartisan and needs to continue as a major priority. Eliminating over half a billion dollars, and programs aimed at reducing overdose, seems to us a bizarre way to accomplish the task in front of us. Every other disease we have beaten, or we are on the road to defeating- whether it be HIV, COVID, SARS, cancer, or diabetes- has been stunted and turned back as a result of multi-billion-dollar investments by the federal government. It is time to do the same for substance use disorders and addiction. We ask you to put aside the political rhetoric about the border and invest in the health of our nation. We call on every member of this committee- and every member of Congress- to support a robust CDC, a strong Injury Prevention Center, and a serious investment in overdose prevention. This can begin by offering your support to the CDC and its mission.

Sincerely,

Heather Lusk, LCSW
Co-Director
Hep Free Hawai'i

The Honorable Robert Aderholt
Chair
House Appropriations Committee
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
Washington, D.C. 20515

The Honorable Rosa DeLauro
Ranking Member
House Appropriations Committee
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
Washington, D.C. 20515

Dear Chair Aderholt and Ranking Member DeLauro,

The 164 undersigned medical, public health, non-profit, and research organizations, representing the Injury and Violence Prevention Network and allied organizations, write to express our strong opposition to the proposed $1.8 billion in cuts in the House FY 2025 Labor, Health and Human Services, Education and Related Agencies Appropriations bill to the Centers for Disease Control and Prevention (CDC). These cuts, which would slash the CDC's funding by 22 percent, include the elimination of the National Center for Injury Prevention and Control (Injury Center), which would severely weaken our public health infrastructure, putting millions at risk. We call on Congress to reject these harmful reductions that would threaten the health of safety of the nation.

Our organizations are committed to a vision of a nation free from injury and violence, so that individuals, no matter who they are or where they reside, are safe where they live, work, travel, and play, and the CDC's Injury Center plays a primary role in that effort.

Injuries and violence are critical public health threats facing the United States today. According to the CDC, in the first half of life, more Americans die from violence and injuries — such as motor vehicle crashes, falls, suicides, homicides, or opioid overdoses — than from any other cause, including cancer, HIV, or the flu. Yet injuries and violence are predictable and preventable.

Robust investment in the CDC and its diverse array of programming is vital to America's health and well-being. The Injury Center provides distinct primary prevention programming, research, and evaluation that is not duplicative to programs across other agencies, and the proposed cuts would effectively undo decades of progress toward a safe and healthy future.

The recently released bill text is a misguided threat to programs and services that protect our communities and families. We call on leadership to oppose the following:

- A 22% decrease in CDC funding, $2.3 billion less than the President's budget request, and $1.8 billion below the FY24 enacted level; and
- Elimination of funding for the National Center for Injury Prevention and Control, a cut of $761 million below the 2024 level and $943 million below the President's FY 2025 request, which would in turn eliminate several key programs addressing:
    - Firearm injury and mortality prevention research
    - Opioid overdose prevention and surveillance
    - Rape prevention
    - Suicide prevention
    - Traumatic Brain Injury (TBI) prevention
    - Drowning prevention
    - Elder fall prevention
    - Domestic and Sexual Violence Prevention
    - Child Sexual Abuse Prevention
    - Adverse Childhood Experience (ACEs) prevention

We call on the Congress to prioritize injury and violence prevention programs that protect our nation's public health by rejecting the FY 2025 House Labor, Health and Human Services, Education and Related Agencies Appropriations bill.

Sincerely,

Safe States Alliance
Adams County Health Department (Colorado)
AIDS United
American Academy of HIV Medicine
American Academy of Pediatrics
American Association for Dental, Oral, and Craniofacial Research
American Association of Colleges of Pharmacy (AACP)
American Foundation for Suicide Prevention
American Psychological Association Services
American Public Health Association
American School Health Association
American Trauma Society
APHL
Arkansas Coalition Against Sexual Assault
Association of American Medical Colleges
Association of Maternal & Child Health Programs
Big Cities Health Coalition
Brain Injury Alliance of Nebraska
Brain Injury Association of America

California Consortium of Addiction Programs & Professionals
California Partnership to End Domestic Violence
CAWS North Dakota
Center for Popular Democracy
Children's Wisconsin
Colorado Coalition Against Sexual Assault
Columbia University Irving Medical Center
Community Catalyst
Community Justice Action Fund
Connecticut Children's
Connecticut Coalition Against Domestic Violence
Connecticut Harm Reduction Alliance
Consortium of Forensic Science Organizations
Council of State and Territorial Epidemiologists
CUNY Graduate School of Public Health & Health Policy
DC Coalition Against Domestic Violence
Delaware Coalition Against Domestic Violence (DCADV)
Drug Policy Alliance
Eating Disorders Coalition for Research, Policy, & Action
End Domestic Abuse Wisconsin
Faces & Voices of Recovery
Florida Harm Reduction Collective
ForsMArsh
Futures Without Violence
Geisinger Medical Center
Georgia Clinicians for Gun Safety (GC4GS)
Georgia Coalition Against Domestic Violence
Harm Reduction Michigan
Hawai'I Health & Harm Reduction Center (HHHRC)
Health Alliance for Violence Intervention
Hep Free Hawai'I (HFH)
Illinois Coalition Against Domestic Violence
Illinois Public Health Association
Indiana Coalition Against Domestic Violence, Inc.
Injury and Violence Prevention Center | CU Anschutz Medical Campus
Injury Free Coalition for Kids
Injury Prevention Research Center at Emory
Intercambios Puerto Rico, Inc.
International Association of Forensic Nurses
International Certification & Reciprocity Consortium
Iowa Coalition Against Domestic Violence
Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence
Johns Hopkins University
Joyful Heart Foundation

Just Solutions
Kansas Coalition Against Sexual & Domestic Violence
Kapi'olani Medical Center for Women & Children
Kids in Danger (KID)
Legal Momentum
Louisiana Coalition Against Domestic Violence
Louisiana Foundation Against Sexual Assault (LaFASA)
Maryland Coalition Against Sexual Assault
Maryland Network Against Domestic Violence
Medical College of Wisconsin
Memorial Hermann Health System
Minnesota Coalition Against Sexual Assault
Mississippi Coalition Against Domestic Violence
Missouri Coalition Against Domestic and Sexual Violence
NAESV
National Alliance for Eye and Vision Research
National Alliance of State and Territorial AIDS Directors
National Association of Councils on Developmental Disabilities
National Association of State Head Injury Administrators
National Behavioral Health Association of Providers
National Center on Domestic and Sexual Violence
National Center on Domestic Violence, Trauma, and Mental Health
National Compadres Network
National Council on Aging (NCOA)
National Domestic Violence Hotline
National Harm Reduction Coalition
National Network of Public Health Institute
National Network to End Domestic Violence
National Organization for Women (Columbia, MO Chapter)
National Organization for Women (Missouri Chapter)
National Organization for Women (Montgomery County, MD Chapter)
National Organization for Women (Northern Colorado Chapter)
National Prevention Science Coalition to Improve Lives
National Resource Center on Domestic Violence
National Safety Council
Nationwide Children's Hospital
NC Coalition Against Sexual Assault
Nebraska Coalition to End Sexual and Domestic Violence
Nevada Coalition to End Domestic and Sexual Violence
New Hampshire Coalition Against Domestic and Sexual Violence
New Mexico Coalition Against Domestic Violence
New York State Coalition Against Domestic Violence
New York State Coalition Against Sexual Assault
Ni-Ta-Nee NOW
Not One More Anonymous Death, Inc. (NOMAD)

Ohio Domestic Violence Network
OHSU Gun Violence Prevention Research Children
Pacific Institute for Research and Evaluation
Pascow County NOW
Peer Initiative
Penn Injury Science Center
Pennsylvania Coalition Against Domestic Violence
Pennsylvania Coalition to Advance Respect
Prevent Child Abuse America
Prevent Child Abuse Arizona
Prevent Child Abuse Louisiana (PCAL)
Prevention Institute
Public Health-Seattle & King County
Rape Crisis Center of Robeson County
Ray E. Helfer Society
Respect Together
Rhode Island Coalition Against Domestic Violence
Robert Wood Johnson University Hospital Trauma and Injury Prevention Department
Safe Kids Oakland County
Safe Kids Pennsylvania
Safe Kids Wisconsin
Sandy Hook Promise
Santa Fe NOW
SC Coalition Against Domestic Violence and Sexual Assault
Seattle Children's
Smoky Mountain Harm Reduction
Society for Public Health Education
Society to Advance Injury Research
South Dakota Network Against FV & SA
Tahirih Justice Center
Tennessee Coalition to End Domestic and Sexual Violence
Texas Council on Family Violence
The Action Lab at the Center for Health Policy & Law, Northeastern University School of Law
The Center for Safe Alaskans
The Child Injury Prevention Alliance
The Moore Center for the Prevention of Child Sexual Abuse
The University of Vermont Medical Center
Trauma Research Education Foundation (TREF) of San Diego
Trust for America's Health
Ujima, The National Center on Violence Against Women in the Black Community
University of Michigan Injury Prevention Center (IPC)
University of North Carolina at Chapel Hill
Utah Domestic Violence Coalition

VALOR
Vermont Network Against Domestic & Sexual Violence
VIA LINK
Violence Free Minnesota
Violence Policy Center
Violence Prevention Institute at Tulane University
Viriginia Harm Reduction Coalition
Washington State Coalition Against Domestic Violence
Washington State Sexual Assault Policy Working Group
Wisconsin Coalition Against Sexual Assault
Wyoming Coalition Against Domestic Violence and Sexual Assault
YMCA of the USA
YWCA USA

Chairman Brett Guthrie
2434 Rayburn House Office Building
Washington, D.C. 20515

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Now that we are finally beginning to see progress, the House of Representatives Committee on Appropriations now seeks to eliminate the $500 million Overdose Division at the Centers for Disease Control. This is an utterly baffling decision. The role of the CDC Overdose division is to fund surveillance activities that help track overdoses, **emerging drug threats, associated risk factors,** and enhance biosurveillance and data linkage. Its prevention activities promote evidence-based strategies aligned with **rapid shifts in overdose trends, including changes in the illegal drug supply and a rise in stimulant and polysubstance use.** To achieve this, CDC funds 49 state health departments and the District of Columbia, as well as 40 city, county, and territorial health departments to expand drug overdose surveillance and prevention efforts.

Overdose Data to Action (OD2A) in States was designed to empower jurisdictions to collect data around **community characteristics**, including race/ethnicity, and conduct analyses that consider social determinants of health and use a health equity lens. It uses this data to **inform and tailor prevention strategies**, with an emphasis on reaching groups disproportionately affected by the overdose epidemic. This way, we can ensure implementation of culturally relevant interventions and equitable delivery of prevention services. OD2A LOCAL (Limiting Overdose Through Collaborative Actions in Localities) is structured to provide resources to improve and create local prevention activities informed by local data and direct community experiences.

Often overlooked in the battle against overdoses are the factors that contribute to substance use disorders, as well as the other complications that arise from SUD. These include trauma, adverse

childhood experiences, and a plethora of other maladies. As a result, we are disturbed by the proposed cuts to other areas of the CDC Injury Prevention Center as well. The elimination of programs aimed at tobacco prevention, ending HIV, suicide prevention, and rape prevention, will all impact the recovery community adversely.

Congress has been unified in its message that this issue is bipartisan and needs to continue as a major priority. Eliminating over half a billion dollars, and programs aimed at reducing overdose, seems to us a bizarre way to accomplish the task in front of us. Every other disease we have beaten, or we are on the road to defeating- whether it be HIV, COVID, SARS, cancer, or diabetes- has been stunted and turned back as a result of multi-billion-dollar investments by the federal government. It is time to do the same for substance use disorders and addiction. It is time to put aside the political rhetoric about the border and invest in the health of our nation. We call on every member of this committee- and every member of congress- to support a robust CDC, a strong Injury Prevention Center, and a serious investment in overdose prevention. This can begin by offering your support to the CDC and its mission.

Sincerely,

IC&RC
AIDS United
American College of Preventive Medicine
Association of Maternal & Child Health Programs
Big Cities Health Coalition
Faces and Voices of Recovery
Foundation for Drug Policy Solutions
Mental Health America
National Behavioral Health Association of Providers
SMART Recovery
Smart Approaches to Marijuana
Song for Charlie
Society for Public Health Education

Statement of Faces & Voices of Recovery
House Energy & Commerce Committee
Health Subcommittee Hearing

July 23, 2024

For too long, people most affected by alcohol and other drug problems were absent from the public policy conversation. Although Faces & Voices of Recovery has changed quite a bit over the years, one thing remains unchanged: our commitment to fighting stigma by putting a face and a voice on recovery.

Today, the recovery community is unifying around key priorities like getting access to resources, eliminating barriers, and ending discrimination against people in recovery. Recovery should be a right for every American that wants it and every family it touches. Today's children and future generations stand to benefit in life-changing ways.

Faces & Voices is the leading voice for people in recovery and the community organizations they have founded.

We have watched as Congress has fought the overdose epidemic for over a decade, and millions of lives have been lost despite their efforts. And even though overdose continues to be a leading cause of accidental death in our country, it was only recently, after *years* of investing in the fight against it, that we finally began to see incremental progress. Overdose deaths began to trend downward for the first time in recent memory.

But just as real progress is being made, the House of Representatives Committee on Appropriations seeks to *eliminate* the $500 million Overdose Division at the Centers for Disease Control.

This is an utterly baffling decision.

The role of the CDC Overdose Division is to fund surveillance activities that help track overdoses, **emerging drug threats, associated risk factors,** and enhance bio surveillance and data linkage.

Its prevention activities promote evidence-based strategies aligned with **rapid shifts in overdose trends, including changes in the illegal drug supply and a rise in stimulant and polysubstance use.** The CDC currently funds 49 state health departments and the District of Columbia to expand drug overdose surveillance and prevention efforts.

10 G St. NE Suite 600, Washington, DC 20002 | www.facesandvoicesofrecovery.org
info@facesandvoicesofrecovery.org | 202.737.0690

FACES & VOICES OF RECOVERY

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The factors that contribute to substance use disorders – and other complications like trauma and adverse childhood experiences (ACES) – are often overlooked in the battle against the overdose epidemic.

Faces & Voices of Recovery is disturbed by the proposed cuts that would have cascading impacts on other areas of the CDC Injury Prevention Center. Eliminating programs aimed at ending HIV, suicide prevention, rape prevention, and tobacco use prevention would gravely affect the recovery community.

Congress' message has, to this point, been unified and clear: overdose prevention is a bipartisan issue and a major priority for the American people.

Eliminating over half a billion dollars already designated for life-saving programs seems antithetical to that message.

All the progress we have made against life-threatening diseases like HIV, COVID, SARS, cancer, and diabetes has been possible because of multi-billion-dollar investments by the federal government.

It is time to do the same for substance use disorders and addiction.

It is time to put aside the political rhetoric about the border and invest instead in the health of our nation.

We call on every member of this Committee and every member of Congress to support a robust investment in overdose prevention. Start by offering support to the CDC.

Sincerely,

10 G St. NE Suite 600, Washington, DC 20002 | www.facesandvoicesofrecovery.org
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FACES & VOICES OF RECOVERY

Patty McCarthy, CEO

About Faces & Voices of Recovery

Faces & Voices of Recovery was founded in 2001 at the Alliance Project's Faces & Voices of Recovery Summit in St. Paul, Minnesota after more than two years of work on bringing focus to an advocacy force made of people in recovery from addiction to alcohol and other drugs (and their families, friends, and allies).

This statement is endorsed by the following organizations:

AIDS United
Community Catalyst
Drug Policy Alliance
Entertainment Industries Council
Foundation for Drug Policy Solutions
IC&RC
Mothers Against Prescription Drug Abuse
National Association of Addiction Treatment Providers
National Association of State AIDS Direcrectors
National Behavioral Health Association of Providers
National Council for Mental Wellbeing
Overdose Prevention Initiative at the Global Health Advocacy Incubator
SMART Recovery
Smart Approaches to Marijuana
Song for Charlie
Treatment Communities of America

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Statement of Faces & Voices of Recovery
House Energy & Commerce Committee
Health Subcommittee Hearing

July 23, 2024

For too long, people most affected by alcohol and other drug problems were absent from the public policy conversation. Although Faces & Voices of Recovery has changed quite a bit over the years, one thing remains unchanged: our commitment to fighting stigma by putting a face and a voice on recovery.

Today, the recovery community is unifying around key priorities like getting access to resources, eliminating barriers, and ending discrimination against people in recovery. Recovery should be a right for every American that wants it and every family it touches. Today's children and future generations stand to benefit in life-changing ways.

Faces & Voices is the leading voice for people in recovery and the community organizations they have founded.

We have watched as Congress has fought the overdose epidemic for over a decade, and millions of lives have been lost despite their efforts. And even though overdose continues to be a leading cause of accidental death in our country, it was only recently, after *years* of investing in the fight against it, that we finally began to see incremental progress. Overdose deaths began to trend downward for the first time in recent memory.

But just as real progress is being made, the House of Representatives Committee on Appropriations seeks to *eliminate* the $500 million Overdose Division at the Centers for Disease Control.

This is an utterly baffling decision.

The role of the CDC Overdose Division is to fund surveillance activities that help track overdoses, **emerging drug threats, associated risk factors,** and enhance bio surveillance and data linkage.

Its prevention activities promote evidence-based strategies aligned with **rapid shifts in overdose trends, including changes in the illegal drug supply and a rise in stimulant and polysubstance use.** The CDC currently funds 49 state health departments and the District of Columbia to expand drug overdose surveillance and prevention efforts.

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Overdose Data to Action (OD2A) in the States was designed to empower jurisdictions to collect data about **community characteristics**, including race/ethnicity, and conduct analyses that consider social determinants of health through a health equity lens. It uses this data to **inform and tailor prevention strategies**, with an emphasis on reaching groups disproportionately affected by the overdose epidemic. This ensures implementation of culturally relevant interventions and equitable delivery of prevention services.

The factors that contribute to substance use disorders – and other complications like trauma and adverse childhood experiences (ACES) – are often overlooked in the battle against the overdose epidemic.

Faces & Voices of Recovery is disturbed by the proposed cuts that would have cascading impacts on other areas of the CDC Injury Prevention Center. Eliminating programs aimed at ending HIV, suicide prevention, rape prevention, and tobacco use prevention would gravely affect the recovery community.

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