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

Chair Capito, Ranking Member Baldwin, members of the Subcommittee, thank you for the opportunity to submit testimony in support of at least \$11.581 billion for the Centers for Disease Control and Prevention (CDC), \$340 million for CDC's Public Health Data Modernization, and \$120 million for CDC's Epidemiology and Laboratory Capacity (ELC) base funding line in FY 2026. The Council of State and Territorial Epidemiologists (CSTE) represents more than 3,500 public health epidemiologists nationwide working on the front lines to save lives by detecting and responding to every emerging threat to public health—food-borne illness, Ebola, Marburg, lead poisoning, measles, influenza, opioid overdoses, Zika, occupational threats like silicosis, and more.

Since FY 2020, federal investments in data modernization have significantly improved public health data systems, enhancing every state's ability to detect and respond to health threats. With this federal funding, states have improved their ability to identify and respond to drug overdoses by using hospital emergency department data accessed through the National Syndromic Surveillance Program. These data improved the speed and accuracy of detection and response. Real-time data now supports quicker investigations, clinical notifications, and public health action. For example, Maine has been heavily impacted by opioid use. It is a crisis, and the state is working hard to reverse the trend. The Maine Center for Disease Control and Prevention collects information on fatal and non-fatal overdoses from Emergency Medical Services and from hospital emergency departments. They put that information on a public website for those interested in learning more about opioid overdoses, like community organizations that distribute Naloxone and educational materials. Maine CDC send out alerts when we see a cluster of overdose activity to help reinforce these important messages about preventions. These tools are integral to overdose response and are vital to protecting the health of Maine residents and visitors.

At the heart of these advances are the data that epidemiologists rely on every day. Public health data comes from many sources—health care visits, labs, schools, nursing homes, mosquito control, wastewater, even travel—and each data point tells a critical part of the story about how your child, your parent, or your neighbor became ill and key information to understand how to prevent more illnesses. The job of an epidemiologist is to piece that story together to prevent illness and protect communities. Across the country, health departments are working to get better, faster, more actionable data to guide public health decisions. Thanks to Congressional support in recent years, we are closer than ever to making that a reality.

In 2021, Hurricane Ida hit Louisiana, and the New Orleans area lost power for nearly three weeks. For an entire week, the city's infectious disease data system was offline, meaning local health care providers couldn't send disease notifications—severely limiting the public health response. The disruption exposed just how vulnerable critical systems are during natural disasters. Since then, Louisiana is beginning the process of moving its state public health data to a more modern, cloud-based infrastructure that can remain operational during emergencies. But this shift is not a one-time investment. Without resources to finish and maintain the project, the initial progress risks being lost—like a construction site abandoned after only the foundation and walls are built. Continued investment is essential, not just in the system itself, but also in the trained workforce needed to

operate and sustain it. This progress in Louisiana has been made possible in part through CDC's data modernization efforts.

While progress in every state has been impressive, there is work still to be done. Unfortunately, across the country, systems have only been partially upgraded, remain in dire need of security enhancements, and lack sufficient trained personnel to keep them operational. In some situations, public health is still relying on paper-based systems, phone calls, spreadsheets, and faxes, requiring data entry by hand, leaving us woefully behind and ill-equipped to combat the spread of infectious disease and other public health threats.

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

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

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

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

The public health data modernization enterprise approach has five key interconnected pillars that support *all* diseases and conditions—acute, chronic, and emerging health threats. **The five pillars are Electronic Case Reporting (eCR); National Notifiable Disease Surveillance System (NNDSS); Electronic Vital Records System; Syndromic Surveillance; and Laboratory Information Systems including Electronic Laboratory Reporting (ELR).**

These pillars require investment across each public health jurisdiction along with support for a highly skilled workforce to lead local implementation and state-level management. A skilled

workforce and upgraded data systems at the jurisdictional level are necessary to ensure that data can flow seamlessly into state systems where it is immediately used to improve health and support communities to thrive.

We need **eCR** to give health care providers a means to seamlessly communicate with public health. eCR will help guarantee that when providers see patients—in any setting—patient demographics, clinical information, and test results for all reportable conditions as designated by state laws are rapidly shared with the corresponding state and local public health and then a subset of those data are seamlessly incorporated into **CDC's NNDSS** to provide a national picture of when and where diseases and condition are occurring. Public Health Data Modernization investments in eCR are making a difference. Now, more than 56,000 facilities in all 50 states are actively sending electronic initial case reports to public health using eCR. Every report that is sent via eCR represents a report that a provider does not have to enter manually, leaving more time for patient care; however, thousands more facilities are waiting to be brought online.

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

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

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

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

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

Equally important to upgrading our data systems, is a skilled workforce that includes epidemiologists, public health informaticists, data scientists, and other experts—all of whom work together so that the public health surveillance system can detect and monitor current threats and be ready for the next pandemic.

The Epidemiology and Laboratory Capacity (ELC) program strengthens epidemiologic and laboratory capacity in all 50 states and eight territories. CSTE has been collecting national data since 2001 on the epidemiology capacity in states through the national [Epidemiology Capacity Assessment](#). Most people don't realize that on average, more than 85-95 percent of health department epidemiology funds are provided by the federal government. The most recent ECA

estimates that an additional 2,537 epidemiologists (above the current 5,706) are needed in state health departments to meet basic public health needs including responding to daily outbreaks to keep our food and water safe. The number of epidemiologists is currently below the need and states and territories anticipate losing nearly one fifth (more than 1,000) of existing staff with the end of pandemic-era funding, much of which was recently terminated despite states' plans to use it until its expiration in FY 2027.

Across the country, ELC supports an average of eight dedicated staff in each of the 65 funded health departments, forming the backbone of infectious disease response. These include epidemiologists, laboratorians, microbiologists, informaticians, and public health veterinarians who can respond rapidly when outbreaks occur. Their ability to pivot quickly is especially critical in health departments that are often understaffed or overwhelmed by larger-than-expected outbreaks.

These cross-trained teams respond not only to routine threats like tuberculosis and rabies, but also to emerging diseases such as dengue, Marburg virus, and mpox. Their work is essential for identifying and containing outbreaks through testing, data analysis, and public communication. From creating dashboards and syndromic surveillance reports to interpreting lab results in real time, these professionals provide the timely insights communities need to protect themselves. Without continued investment, this national response capacity would be severely diminished.

The ELC program currently receives \$40 million from the Prevention and Public Health Fund and is the sole source of core infectious disease epidemiology and laboratory capacity in state and local health departments. **We support the President's FY 2026 budget proposal to shift ELC to discretionary budget authority to ensure more stable, reliable funding.**

These funds are awarded to 65 state, local and territorial health departments to efficiently address urgent infectious disease threats, with the flexibility to meet community-specific needs. **The ELC program awards 94 percent of the PPHF funding received directly to state and local health departments.** These investments support approximately **500 highly skilled public health professionals in states**, serving as the front line in protecting our communities and allowing them to rapidly detect and respond to infectious disease threats.

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

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