DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2013

Centers for Disease Control and Prevention

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE DIRECTOR

As Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR), I am pleased to present the agency's budget request for Fiscal Year (FY) 2013. This budget request reflects the Administration's priorities in support of key Department of Health and Human Services goals that will help people live healthy, safe, and productive lives.

For 65 years, CDC has served as a public health leader throughout the United States and the world. CDC is dedicated to protecting health and promoting quality of life by preventing and controlling disease, injury, and disability, as well as reducing the health and economic burden of the leading causes of disease, disability, and death.

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

- Excellence in surveillance, epidemiology, and laboratory services
- Support for state, tribal, local, and territorial public health
- Global health impact, before diseases cross borders
- Scientific and program expertise to advance policy change that promotes health
- Prevention of illness, injury, disability, and death

The FY 2013 budget request prioritizes essential investments. The request also streamlines our approach, as we continue our commitment to be efficient, effective stewards of the American people's resources. Maintaining critical agency investments in FY 2013 will allow CDC to continue its important work and build public health capacity at the local, state, and international levels to protect and promote health.

I believe this budget request will sustain CDC's key efforts to preserve and protect the lives of Americans, and strengthen CDC's ability to carry out its critical mission.

Sincerely,

Thomas R. Frieden, MD, MPH

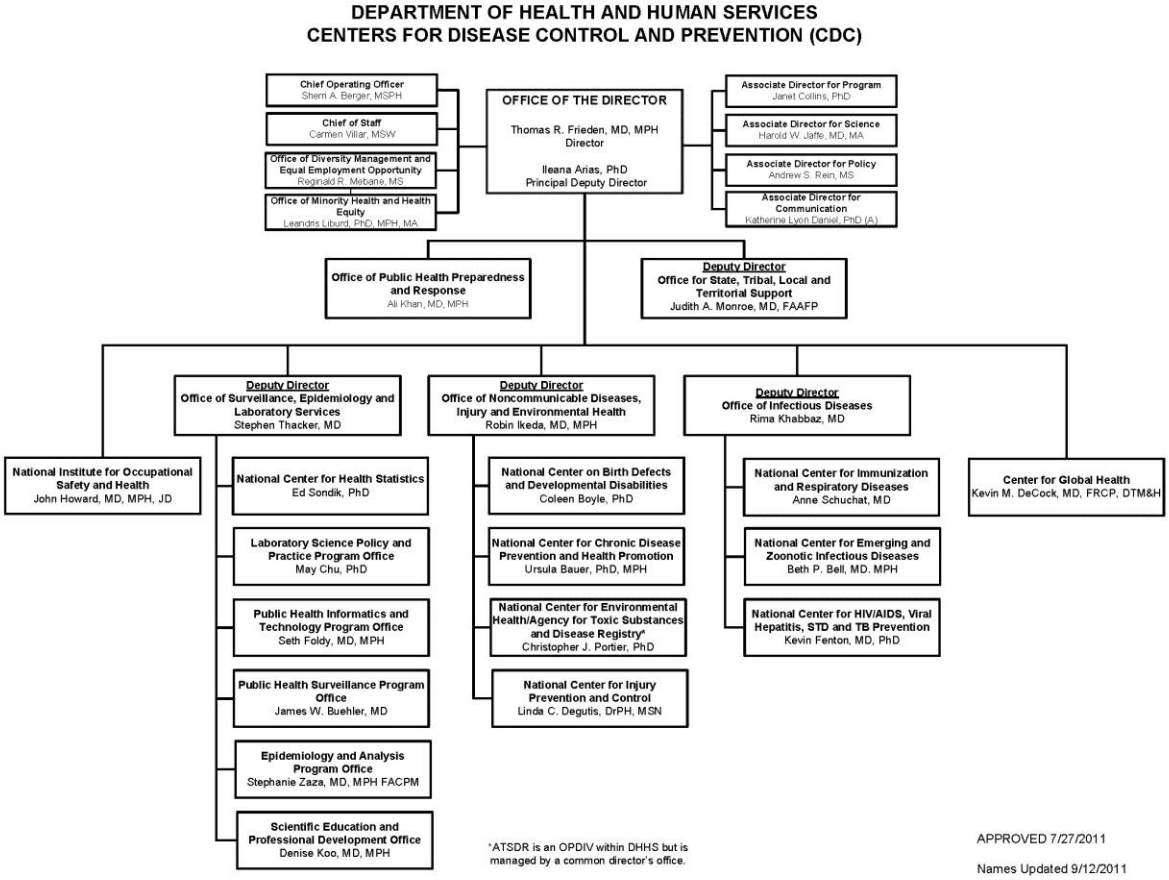
Director, Centers for Disease Control and Prevention

Administrator, Agency for Toxic Substances and Disease Registry

This page intentionally left blank

TABLE OF CONTENTS

ORGANIZATIONAL CHART



This page intentionally left blank

PERFORMANCE BUDGET OVERVIEW

INTRODUCTION AND MISSION

The Centers for Disease Control and Prevention (CDC) is an operating division of the Department of Health and Human Services (HHS). Since 1946, CDC has served as the leading public health agency, monitoring, investigating, and taking action to resolve complex health problems in the United States and abroad. CDC carries out its mission by collaborating with local, state, and international partners to:

- monitor health,
- detect and investigate health problems and events,
- conduct research to enhance prevention,
- measure the effectiveness of public health policies,
- implement prevention strategies,
- promote healthy behaviors,
- foster safe and healthful environments, and
- provide leadership and training.

CDC's Mission:
Collaborating to create the expertise, information, and tools that people and communities need to protect their health—through health promotion; prevention of disease, injury, and disability; and preparedness for new health threats.

These functions form the foundation of CDC's mission, and each CDC program draws on these functions to carry out comprehensive public health activities and programs. These programs provide partners and Americans with the essential health information they need to make decisions that protect and advance health. CDC's highly trained staff is essential in providing the national leadership and scientific expertise to carry out these programs in support of the agency's mission.

CDC is committed to reducing the health and economic consequences of the leading causes of death and disability and helping to ensure our nation's citizens are safer, healthier people.

OVERVIEW OF BUDGET REQUEST

The fiscal year (FY) 2013 President's Budget request includes a total program level of $11.236 billion in discretionary authority, mandatory funding, Public Health Service (PHS) Evaluation funds, transfers from the Public Health and Social Services Emergency Fund (PHSSEF), and the Affordable Care Act (ACA) Prevention and Public Health Fund for CDC and ATSDR. The FY 2013 budget request includes an increase of $78.210 million for CDC from the ACA Prevention and Public Health Fund, for a total of $903.210 million of the $1.250 billion available in the Fund. This is an overall program level increase of $39.475 million above FY 2012.

CDC remains committed to maximizing the impact of every dollar entrusted to the agency. The FY 2013 budget request maintains investments in key programs, while identifying strategic reductions that will allow CDC to advance our core public health mission in the most cost-effective way in this challenging fiscal environment.

INCREASED PROGRAM INVESTMENTS

Increases described in this section represent overall program level increases for CDC, as compared to FY 2012, including budget authority, PHSSEF, and PHS Evaluation funds, as well as resources from the ACA Prevention and Public Health Fund.

Vaccines for Children – Mandatory Funding (+$261.955 million)

The FY 2013 budget request includes an increase of $261.955 million above the FY 2012 estimate for the Vaccines for Children (VFC) program. The FY 2013 estimate includes an increase for vaccine purchase and a decrease for vaccine management business improvement plan contractual support. Taken together with CDC's Section 317 Immunization activities, these programs provide vaccines and necessary program support to reach uninsured and underinsured populations.

Coordinated Chronic Disease Prevention and Health Promotion (+$128.699 million)

The FY 2013 budget request includes an increase of $128.699 million for CDC's consolidation of heart disease and stroke, nutrition, physical activity, obesity prevention, school health, diabetes, comprehensive cancer control, arthritis, and other chronic disease activities into a single grant program, the Coordinated Chronic Disease Prevention and Health Promotion Program. These increased resources will allow CDC to increase the average awards to states from approximately $2.6 million to approximately $4.5 million and will permit states, tribes, and territories to support a broader range of programs targeting the leading causes of chronic disease-related death and disability and associated risk factors.

Affordable Care Act Prevention and Public Health Fund (+$78.210 million)

The FY 2013 budget request includes an increase of $78.210 million for CDC from the ACA Prevention and Public Health Fund, for a total of $903.210 million of the $1.250 billion available in the Fund. These activities invest in prevention and public health programs to improve health and restrain growth in health care costs. More information on this allocation can be found in the ACA section following the Overview. In some programmatic areas, these increases relate to decreases in budget authority.

Domestic HIV/AIDS Prevention and Research (+$40.231 million)

The FY 2013 budget request includes an increase of $40.231 million above the FY 2012 level for Domestic HIV/AIDS Prevention and Research. This increase provides additional funding to achieve the goals of the National HIV/AIDS Prevention Strategy. These goals include supporting health departments to improve linkage to and retention in care, increasing prevention services, and supporting successful treatment among persons with HIV. Additionally, CDC will use these investments to expand HIV testing and linkage to care for men who have sex with men (MSM). CDC's goals are to identify previously unrecognized HIV infections, improve health outcomes, and reduce HIV transmission. Of this increase,

CDC will also use $10.096 million to increase funding to state and local education and health agencies to implement school-based HIV prevention activities, increase funding to national nongovernmental organizations (NGOs) that support HIV prevention efforts serving youth in high prevalence communities, and expand surveillance and monitoring to collect national data to monitor priority health risk behaviors and school health programs and policies.

Health Statistics (+$23.150 million)

The FY 2013 budget request includes a $23.150 million increase in PHS Evaluation Funds for vital statistics system enhancement. This increase will enable CDC to phase in full implementation of the electronic death records in as many jurisdictions as possible, with an initial target of 15 to 17 states. This investment will enhance the nation's vital statistics system, including increased accuracy and availability of key public health data.

This increase will also support enhancements to health surveys. CDC will include new questions on sexual orientation in the new National Health Interview Survey data collection, pending successful pretesting and developing and implementing new sample designs for population-based surveys using 2010 Census data. CDC will also use these resources to improve and expand survey data collection methods. This investment will provide the data needed to support initiatives to identify and reduce disparities in health and health care by sexual orientation status.

Food Safety (+$16.735 million)

The FY 2013 budget request includes an increase of $16.735 million above the FY 2012 level for foodborne disease and food safety activities. This increase will enable CDC to move forward implementation of CDC's provisions of the Food Safety Modernization Act (FSMA), including enhancing and integrating surveillance systems, upgrading the PulseNet system, improving outbreak detection and response timeliness, improving timeliness in responding to state and local partners through the FoodCORE program, attributing illnesses to specific food commodity groups to aid in prevention efforts, monitoring food safety prevention measure effectiveness, and supporting the FSMA's Integrated Food Safety Centers of Excellence. These investments will help restore state and local capacity to monitor foodborne illness and respond to outbreaks.

Polio Eradication (+$15.079 million)

The FY 2013 budget request includes an increase of $15.079 million above the FY 2012 level for CDC's global immunization work to accelerate polio eradication efforts. This increase will provide augmented support, through more frequent and intense technical assistance, in the remaining four polio-endemic countries of Afghanistan, India, Nigeria, and Pakistan, as well as the re-infected countries of Angola, Chad, and the Democratic Republic of Congo. CDC will also amplify technical assistance to other countries at risk for polio infection or transmission. These efforts will support the U.S. Government-endorsed Global Polio Eradication Strategic Plan with the goal of eradicating polio within India by the end of 2013 and achieving global certification of polio eradication by the end of FY 2015.

National Healthcare Safety Network (+$12.628 million)

The FY 2013 budget request includes an increase of $12.628 million above the FY 2012 level for the National Healthcare Safety Network (NHSN). This increase will allow CDC to modernize the NHSN information technology platform to accommodate the Centers for Medicare and Medicaid Services' Value-Based Purchasing program requirements for NHSN reporting of additional types of healthcare-associated infections (HAIs), such as *C. difficile* and MRSA infections, and from additional healthcare settings, such as long-term acute care, ambulatory surgical centers, and rehabilitation centers. These investments will also support state data validation, electronic reporting, and data quality activities for HAI reporting, including implementing national standards for reporting laboratory data and developing methods for automatic HAI detection. This increase will also support accelerated prevention research to

address scientific gaps in HAI prevention and develop innovative ways to detect and prevent HAIs through the Prevention Epicenters.

Tobacco (+$6.040 million)

The FY 2013 request includes an increase of $6.040 million for tobacco prevention and control. CDC will use this increase in resources to expand the reach of a national tobacco education campaign and its tobacco cessation quitline capacity support.

Preparedness and Response Capability (+$8.730 million)

The FY 2013 budget request includes an increase of $8.730 million above the FY 2012 level for building CDC's preparedness and response capability. CDC will use this increase to rebuild internal capacity to protect the nation's health security with a particular focus on the nation's ability to detect and respond to public health emergencies, specifically, resuming the nation's ability to detect and respond to chemical, biological, and nuclear terrorism. This includes developing improved laboratory methods to detect chemical, biological, and radiologic agents.

PROGRAM DECREASES AND ELIMINATIONS

Decreases and eliminations described in this section represent overall program level decreases for CDC, as compared to FY 2012, including budget authority, PHS Evaluation funds, PHSSEF transfers, and transfers from the ACA Prevention and Public Health Fund.

Preventive Health and Health Services Block Grants (-$79.545 million)

The FY 2013 budget request proposes eliminating the Preventive Health and Health Services Block Grant program, which received $79.545 million in FY 2012. Through CDC's existing and expanding activities, there is substantial funding to state health departments. These activities will be more effectively and efficiently implemented through CDC's new Chronic Disease Prevention and Health Promotion Grant Program, as well as state and local ACA Prevention and Public Health Fund investments. Elimination of this program provides an opportunity to find savings while expanding core public health infrastructure at the state level through the ACA Prevention and Public Health Fund.

Community Transformation Grants (-$79.660 million)

The FY 2013 budget request includes a decrease of $79.660 million below the FY 2012 level in ACA Prevention and Public Health Fund investments for Community Transformation Grants (CTG). This decrease will have no impact on grants supported in FY 2011, which will be continued in FY 2013. New grants will be fully funded in FY 2012 for up to four years. In FY 2013, the CTG program will continue to amplify efforts to promote healthy behaviors that control health care costs.

Section 317 Immunization (-$57.986million)

The FY 2013 budget request for the Section 317 immunization program reflects a program level decrease of $57.986 million below the FY 2012 level. This level reduces funding for one-time investments to assist programs with health insurance reforms, such as Immunization Information Systems and adult immunization. The FY 2013 budget request will continue to provide vaccine purchase for at-need populations and immunization program operations, including support for implementing billing systems for immunization services at public health clinics to sustain high levels of vaccine coverage, and support for the scientific evidence base informing immunization policies. Health reform expansion will further increase access to immunizations and decrease the number of uninsured and underinsured individuals served by the Section 317 Program, resulting in cost savings.

Racial and Ethnic Approaches to Community Health (-$53.940 million)

The FY 2013 budget request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program, funded at $53.940 million in FY 2012. The Community Transformation

Grants (CTG) program, which builds on past program successes and lessons learned, marks the next stage of CDC's community-based programs. The CTG program will integrate best practices and lessons learned from the REACH program into its new approach, amplifying the dissemination of these best practices and lessons learned to communities across the nation.

Strategic National Stockpile (-$47.572 million)

The FY 2013 budget request reflects a program level decrease of $47.572 million to the Strategic National Stockpile (SNS) below FY 2012. The SNS is a key resource in maintaining public health preparedness and response; however, the current fiscal climate necessitates scaling back. The Public Health Emergency Countermeasures Enterprise (PHEMCE) will re-prioritize those public health threats for which the SNS holds emergency medical countermeasures (MCM) to ensure the maximum possible protection against some threats that could create a public health emergency. PHEMCE will accomplish this by examining the SNS formulary to determine a reduced or re-balanced level of current MCM, as well as purchases of new and replacement of expiring MCM, given available funds.

Occupational Safety and Health (-$43.224 million)

The FY 2013 budget request for occupational safety and health includes an overall decrease of $43.224 million below the FY 2012 level. This reduction includes the elimination of the Education and Research Centers (ERCs), funded at $24.268 million, and elimination of the Agricultural, Forestry, and Fishing (AgFF) sector of the National Occupational Research Agenda (NORA) at $19.642 million. Given the limited federal resources in a resource-constrained environment, the ERC program is a lower priority program across CDC. AgFF is one of ten sectors that CDC has been focused on over several years and there have been positive accomplishments from this program. However, given the relation to CDC's mission and the ability to have a national impact on improved health outcomes, the AgFF program has been designated as a low-priority program and proposed for elimination in a limited resource environment.

Business Services and Support (-$26.153 million)

The FY 2013 budget request includes a decrease to Business Services and Support (BSS) of $26.153 million below the FY 2012 level. This decrease represents a return to funding levels prior to FY 2012. CDC plans to expand funds from a two-year account to continue base funding for BSS for all of CDC's programs. Any funds not expended will be used in subsequent years to finance capital investments, excluding buildings and facilities capital investments, or provide the initial capital for a working capital fund.

Buildings and Facilities (-$24.946 million)

The FY 2013 budget request reflects a decrease of $24.946 million below the FY 2012 level for buildings and facilities activities. CDC will use carryover balances to support critical repairs and improvements to maintain the condition of CDC's portfolio of assets.

State and Local Public Health Preparedness and Response (-$15.501 million)

The FY 2013 budget request includes a decrease of $15.501 million below the FY 2012 level for state and local preparedness and response. This reduction includes the elimination of the Academic Centers for Public Health Preparedness and funds designated for CDC's programmatic operating costs to provide oversight, guidance, and management of the Public Health Emergency Preparedness program. In FY 2013, the funds for the programmatic operating costs will come from the State and Local Preparedness and Response Capability budget. The Academic Centers for Public Health Preparedness have not resulted in the return on investment or significant public health impact on public health hoped at the program's outset. CDC will offer technical guidance to the Academic Centers to ensure that efforts in developing strategies for public health preparedness continue.

Birth Defects and Developmental Disabilities (-$11.722 million)

The FY 2013 budget request includes a decrease of $11.722 million for Birth Defects and Developmental Disabilities activities below the FY 2012 level. This decrease includes reduced funding for Health and Development for People with Disabilities, Child Health and Development, and Blood Disorders, CDC will transition these activities from disease-specific approaches to a consolidated approach of unified budget lines to maximize public health impact.

Environmental Health Activities (-$7.326 million)

The FY 2013 budget request includes an overall decrease for environmental health activities of $7.326 million, including a decrease of $6.000 million in Prevention and Public Health Fund investments for environmental health tracking, below the FY 2012 level. This decrease includes the elimination of Built Environment activities. CDC will integrate aspects of Built Environment activities into the Community Transformation Grants, supported by the ACA Prevention and Public Health Fund investments, to have a more integrated, comprehensive approach to promoting healthy communities.

The overall reduction also decreases funding for climate change activities. CDC will consolidate existing research efforts and streamline CDC's surveillance and early warning system capacity.

In addition, the request includes a decrease for the Environmental Health Tracking Network, which will focus on capacity building assistance for existing grants. CDC will also discontinue overlapping funding to study the environmental causes of disease and to develop tools and methods states use to inform and respond to community concerns regarding environmental hazards.

Johanna's Law (-$4.972 million)

The FY 2013 budget request eliminates funding for Johanna's Law activities, funded at $4.972 million at the FY 2012 level. CDC will continue to support gynecologic cancer education and awareness activities, targeting both the public and health care providers. CDC will also continue to work with and provide existing campaign materials through partner organizations and health care providers. CDC will also continue to disseminate gynecologic cancer educational materials through other programs, such as the National Breast and Cervical Cancer Early Detection Program and the National Comprehensive Cancer Control Program, as well as other agencies, such as the HHS Office of Women's Health.

Tuberculosis (-$4.607 million)

The FY 2013 budget request includes a decrease of $4.607 million below the FY 2012 level for tuberculosis prevention activities. CDC will work with partners to implement this reduction in a way that maintains a focus on tuberculosis control for the most urgent cases, especially outbreaks that have already resulted in deaths or permanent neurological or other damage to health as well as cases that are multi-drug resistant. Greater flexibility provided through the new appropriations language could allows both states and CDC to direct up to 10 percent of CDC's total HIV/AIDS, STDs, TB and Hepatitis funding to Tuberculosis activities to address the overlapping epidemic of these diseases.

World Trade Center (-$3.718 million)

The FY 2013 budget request includes a decrease of $3.718 million below FY 2012 in mandatory funding for the World Trade Center program. The mandatory funding represents the Federal share of estimated obligations. This reduction is for one-time administrative activities that were used for startup costs for the World Trade Center program.

Prevention Research Centers (-$2.900 million)

The FY 2013 budget request includes a program level decrease of $2.900 million in below the FY 2012 level. CDC will implement this decrease by streamlining prevention research efforts through the Prevention Research Center program's Comprehensive Centers, which have the established capacity and

partnerships necessary to optimally conduct and disseminate core research on chronic disease prevention strategies and ways to reduce health care costs.

Emerging Infectious Diseases (-$2.425 million)

The FY 2013 budget request includes a decrease of $2.425 million for emerging infectious diseases below the FY 2012 level. This request includes funds to focus on necessary activities for prion disease and reflects a reduction due to a decrease in global public health risk of variant Creutzfeldt-Jakob disease. Due to completion of population-based studies to address Chronic Fatigue Syndrome, the proposal also includes reduced funding that will shift focus of CDC's activities to patient and provider education and clinic-based studies.

KEY PROGRAMMATIC CHANGES

Coordinated Chronic Disease Prevention and Health Promotion

The FY 2013 budget request consolidates CDC's heart disease and stroke; nutrition, physical activity, and obesity prevention; school health (excluding HIV/AIDS prevention school health activities); diabetes; comprehensive cancer control; and arthritis and other chronic disease activities into a single, streamlined grant program, the Coordinated Chronic Disease Prevention and Health Promotion Program. The approach will enable CDC to create a coordinated, national response to chronic disease, maximizing program effectiveness, reducing interrelated risk factors, and accelerating health improvements. This will also provide states with additional flexibility to address the leading causes of chronic disease and disability, while increasing accountability and improving health outcomes through performance incentives.

Birth Defects and Developmental Disabilities

In the FY 2013 budget request, CDC proposes consolidating birth defects and developmental disabilities activities into three budget lines: *Child Health and Development, Health and Development for People with Disabilities, and a Public Health Approach to Blood Disorders*. By consolidating activities into unified budget lines, CDC is afforded the latitude to more aggressively track birth defects and developmental disabilities, expand its effort to improve the lives of people with disabilities by focusing on the most critical public health treats to these populations, and widen the scope of CDC's efforts to mitigate the unnecessary morbidity and mortality associated with non-malignant blood disorders in the United States.

Healthy Home and Community Environments/Asthma

The FY 2013 budget request consolidates the Healthy Homes/Childhood Lead Poisoning and Asthma programs into the new Healthy Homes and Community Environment Program. CDC is transitioning to a new healthy homes approach that addresses and mitigates not only lead and asthma, but also an expanded range of home-based hazards, such as the presence of radon, smoke, lead, and asthma triggers.

AFFORDABLE CARE ACT: PREVENTION AND PUBLIC HEALTH FUND

The FY 2013 budget request includes an increase of $78,210,000 for CDC from the Affordable Care Act Prevention and Public Health Fund for a total of $903,210,000 of the $1,250,000,000 available. These investments in prevention and public health programs will improve individual and population health and can help restrain the rate of growth in public and private sector health care costs.

The Prevention and Public Health Fund (Prevention Fund) helps win the future in health by empowering communities to support longer, healthier, more productive lives by preventing heart attacks, strokes, cancer, and other disabling, costly, deadly conditions; improving health protection agencies' capacity to detect and control threats; and identifying and monitoring the health system's successes and challenges.

CDC's approach to Prevention Fund is to ensure that each every dollar spent has the greatest possible impact. To achieve this end, some Prevention Fund program dollars will be used to jointly to fund activities also supported through CDC's regular appropriation to provide the greatest possible return on this investment in our Nation's health. Many of these activities will be described in greater detail in the program narratives that follow in the Narrative by Activity Section later in this Congressional Justification.

PREVENTING THE LEADING CAUSES OF DEATH

(dollars in millions)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Preventing Leading Causes of Death	**$391.950**	**$618.050**	**$692.260**
Community Transformation Grants (CTGs)	$145.000	$226.000	$146.340
Million Hearts	$0.000	$0.000	$5.000
Tobacco	$50.000	$83.000	$89.000
National Prevention Strategy	$1.000	$1.000	$1.000
Racial Ethnic Approaches to Community Health Grant Program (REACH)	$25.000	$40.000	$0.000
Immunization	$100.000	$190.000	$72.460
Workplace Wellness	$10.000	$10.000	$4.000
Hospitals Promoting Breastfeeding	$0.000	$7.050	$2.500
National Youth Fitness Survey	$6.000	$0.000	$0.000
Promoting Obesity Prevention	$0.750	$0.000	$0.000
Let's Move/ Healthy Weight Task Force Obesity Activities	$0.000	$5.000	$4.000
Cancer Prevention and Control	$0.000	$0.000	$260.871
Chronic Disease Grants to States	$52.200	$0.000	$0.000
Nutrition, Physical Activity, and Obesity	$0.000	$10.000	$0.000
Prevention, Education, and Outreach	$2.000	$26.000	$0.000
Diabetes	$0.000	$10.000	$0.000
Viral Hepatitis	$0.000	$10.000	$0.000
Birth Defects	$0.000	$0.000	$107.089

CDC is requesting $692,260,000 from the Prevention Fund to support Community Transformation Grants (CTG) and other activities to address the leading causes of death, disability, and chronic disease. CDC's largest Prevention and Public Health Fund investment to date is to prevent the leading causes of death by targeting their risk factors. The leading causes of death account for nearly two-thirds of all preventable

deaths in the United States. To prevent heart attacks, strokes, other cardiovascular diseases, and cancers, we must address risk factors such as tobacco use, nutrition, and physical activity and ensure people have access to community and clinical preventive services such as behavioral interventions, disease screening and treatment. The Prevention Fund will enable communities and health departments to maximize prevention by supporting changes to the way services are provided, reducing redundancies across the health care and public health systems and bridging successful programs from clinic to community. The Prevention Fund will enable communities to target their priorities and invest in interventions proven to improve health outcomes.

The Prevention Fund empowers communities to support residents' efforts to live longer, healthier lives. Effective, evidence-based community, environmental, and infrastructure interventions can help make healthy choices easier for individuals, families, and communities. The Prevention Fund will also enable health departments to implement effective programs to mitigate chronic diseases, which account for seven out of 10 deaths and three of four U.S. health care dollars spent. Funds will support activities that expand access to community and clinical preventive services, connecting people with clinical care and community programs to control blood pressure, prevent diabetes, and stop using tobacco.

The focus on reducing cardiovascular disease and other leading causes of death is specifically supported by the Community Transformation Grants (CTGs), tobacco programs, cancer prevention and control programs, and the Million Hearts program. CTGs aim to empower communities to choose science-based policy, environmental, programmatic, and infrastructure changes to achieve their intended outcomes, including weight change, proper nutrition, physical activity, tobacco use prevalence, high blood pressure, and psychological well-being.

The PPHF-funded components of the Million Hearts program are strategically designed to complement CTG's cardiovascular disease prevention activities by promoting medication management and adherence, using more direct nurse counseling and pharmacy support services. In addition, investments will support a network of model electronic health record-based registries and feedback systems to track blood pressure and cholesterol control. This network will provide sentinel surveillance data on regional progress in these areas, tracking progress and highlighting areas for improvement.

Preventing tobacco use, which accounts for over 440,000 deaths each year, not only saves lives but also reduces direct health care costs and improves productivity. In FY 2013, CDC will continue to implement strategic, comprehensive counter-marketing efforts that will result in significant reductions in initiation and prevalence of tobacco use.

CDC will use PPHF resources to invest in programs that will improve the health of mothers and infants by providing funds to states that will support efforts to encourage hospitals to promote breastfeeding to new mothers. Since breastfeeding significantly reduces health risks for infants, which in turn reduces medical care needs and health care costs, this investment of Prevention Fund resources will save health care costs through prevention and reduced medical visits.

Finally, CDC will use PPHF resources to support the First Lady's Let's move Initiative and the HHS Healthy Weight Task Force activities. Together, these activities target obesity prevention and promoting healthy weight among children. These programs will focus on encouraging children to adopt healthy habits, especially in nutrition and physical activity.

IMPROVING PUBLIC HEALTH DETECTION AND RESPONSE

(dollars in millions)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Improving Public Health Detection and Response	**$151.950**	**$151.950**	**$165.950**
National Public Health Improvement Initiative	$40.200	$40.200	$40.200
Public Health Workforce	$25.000	$25.000	$25.000
Epidemiology and Laboratory Capacity (ELC) / Emerging Infections Program (EIP)	$40.000	$40.000	$40.000
Healthcare-Associated Infections	$11.750	$11.750	$11.750
Environmental Public Health Tracking	$35.000	$35.000	$29.000
Laboratory Improvement Initiative	$0.00	$0.00	$20.000

CDC is requesting $165,950,000 from the Prevention Fund to support select investments to strengthen federal, state, local, tribal, and territorial public health detection and response capacity, our nation's first line of defense against health threats. The Prevention Fund will improve health agencies' capacity to manage scarce resources and continue to detect and respond rapidly to outbreaks and natural disasters and manmade harms. Investments will improve efficiencies and performance in federal, state, and local public health laboratories; support surveillance and health tracking systems, and fund training that increases state and local public health capacity and develops the next generation of public health leaders. CDC will use Prevention Funds to invest in core programs, such as the Epidemiology and Laboratory Capacity program and the Emerging Infections Program that bolster state and local capacity to detect and respond to infectious diseases, including those caused by pertussis, influenza, rotovirus, health care-associated infections, and foodborne pathogens. This will increase the percentage of laboratories (commercial and hospital) sharing information via electronic laboratory reporting, allowing for faster detection and analysis of disease-causing agents. Additionally, in FY 2013 CDC proposes a new Laboratory Improvement Initiative using Prevention Fund resources to help assure that public laboratories in all US communities have the capacity to address infectious disease outbreaks, mitigate environmental and hazardous health threats, and communicate high quality test results rapidly to public health and clinical care decision makers.

CDC will also continue investing Prevention Fund resources toward its successful Environmental Public Health Tracking program which strengthens state and local public health agencies abilities to prevent and control diseases and health conditions that may be linked to environmental hazards. Data from this program can be used by state and local public health agencies to better understand the scope of threats to public health in their area and what can possibly be done to abate them.

The Prevention Fund will also build on CDC's substantial progress in reducing health care-associated infections, which now affect one out of every 20 hospital patients. Proven practices save lives, reduce treatment costs, and prevent costly hospital readmissions. CDC-trained epidemiology, laboratory, informatics, and other public health professionals will work side-by-side with state and local partners to investigate outbreaks, assist with prevention program development, implementation, and evaluation, and provide continuing education for those state and local public health workers to ensure they remain current with research and program breakthroughs.

USING INFORMATION FOR ACTION

(dollars in millions)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Information for Action	**$67.000**	**$55.000**	**$45.000**
Community Guide	$7.000	$10.000	$10.000
Healthcare Statistics/ Healthcare Surveillance	$30.000	$35.000	$35.000
Prevention Research Centers	$10.000	$10.000	$0.000
Public Health Prevention Research	$10.000	$0.000	$0.000
Emergency Preparedness	$10.000	$0.000	$0.000

CDC is requesting $45,000,000 from the Prevention Fund to support select investments that will aid in characterizing the people's health, wellness, and disease, with a special emphasis on vulnerable populations at increased risk of illness. The Prevention Fund will be used to increase the efficiency and effectiveness of public health investments by monitoring and evaluating health system performance to identify top-performing prevention programs. We will increase our knowledge by strengthening the systems for gathering, analyzing, and communicating health data and ensuring they produce accurate and timely information for action.

CDC will use Prevention Fund resources to collect and analyze health data and produce accurate and timely information for action on health outcomes, risk factors for poor health, and best practices that improve health. We will conduct systematic reviews of public health interventions to prevent disability, disease, and death, and disseminate the results to the public, clinicians, health officials, and community leaders. Resources from the Prevention Fund will support up to 17 Community Guide systematic reviews in 2013, leading to increased implementation of evidence-based practices and policies and an increase in the availability of relevant information to assist decision makers and practitioners in prioritizing interventions for implementation. We will continue to make investments in surveys designed and executed by the National Center for Health Statistics and provide local-level data to aid in decision making about clinical and community changes to increase opportunities to prevent disease and injury. The Health Statistics funding will support $2.5 million in FY 2012 and $2.5 million in FY 2013 to fully implement electronic birth records in the 8 remaining states and jurisdictions. Lastly, we will use funds to continue to learn more about what works to improve individual and population health.

OVERVIEW OF PERFORMANCE

As the nation's prevention agency and a leader in improving public health around the world, CDC is committed to protecting health and reducing the leading causes of death, disability and injury. CDC staff work every day around the world to save lives, protect people, and save money through prevention. To achieve maximum public health impact, CDC implements strategic, evidence-based efforts in science, programs, policy and education, and ongoing data collection and monitoring. To prevent the leading causes of death and disability and further CDC's vision for a safer, healthier world, CDC focuses its work on the following strategies:

- Ensure excellence in surveillance, epidemiology and laboratory services
- Strengthen support for state, tribal, local, and territorial public health
- Increase global health impact
- Use scientific and program expertise to advance policy change that promotes health

As we continue to expand and strengthen our collection and use of data, we gain greater knowledge and insight about the extent of our biggest health problems, which populations are most affected by them, and what we need to do to solve them. Information is power — and this power makes it possible for us to implement programs that fulfill our promise to keep Americans healthy and our nation strong.

– Dr. Tom Frieden, Director, CDC

Performance in each of these areas and in all of CDC's work is strengthened through rigorous and ongoing performance metrics and the use of program evaluation data to monitor program effectiveness, while ensuring progress is being made against performance targets. The accomplishments described below highlight the importance of investing in public health, preventing disease, and protecting health.

HIGHLIGHTS OF AGENCY ACCOMPLISHMENTS

- Expanded detection of antiviral resistance in 20 U.S. public health laboratories by providing equipment, reagents, and technical assistance in collaboration with the Association of Public Health Laboratories.
- Provided tens of thousands of specimens from CDC's extensive and unique collections to researchers in the private sector, academic institutions, and programs for research that supports development of new vaccines, diagnostic tests, and health interventions on diseases and conditions such as HIV, SARS, Hantavirus, Legionnaire's disease, and lead poisoning.
- Assigned 124 Public Health Associates to state, tribal, local, and territorial health agencies in FY 2011 as part of a two-year assignment aimed at training them for future public health-related careers. These associates serve on the frontlines of public health providing screening services, individual and community education, infectious disease investigation, and support for emergency responses to outbreaks including foodborne diseases, seasonal diseases like influenza, and natural disasters that put communities at high risk for diseases.
- Responded to major epidemics, including the 2010–2011 cholera outbreak in Haiti, as well as ensured ongoing protection of health domestically through the response to 2,186 reports of illness at U.S. ports of entry and distribution of 631 vials of lifesaving biologic medicines.

- Responded promptly to the largest epidemic of dengue ever recorded in Puerto Rico, managing the disease surveillance system and training over 8,000 physicians in the diagnosis and management of cases. CDC also responded to epidemics of yellow fever, plague and other vector-borne pathogens in Africa, Asia and the Americas.
- Improved prevention of mother-to-child transmission outcomes in select hospitals in Ethiopia's Oromia Region, increasing the percentage of infected mothers delivering in a medical setting from 23 percent to 56 percent, and the percentage of infected partners being tested for HIV/AIDS in from 13 percent to 51 percent.
- Contributed to the vaccination of one billion children as a co-founder of the Measles Initiative, and a reduction of 81 percent in global measles mortality in all ages from an estimated 733,000 deaths in 2000 to an estimated 139,000 deaths in 2010.
- Expanded the National Healthcare Safety Network (NHSN) from 3,400 health care facilities in in October 2010 to 5,000 as of November 2011. Approximately 260 hemodialysis facilities are now enrolled in NHSN and approximately 270 long-term acute care facilities as of November 2011. Demonstrated a 60 percent reduction of methicillin-resistant *Staphylococcus aureus* (MRSA) in Veteran's Administration (VA) facilities through a prevention initiative. Initially implemented as a pilot project at the local level, it now has been adopted by regional and national programs.
- Achieved rapid identification of cantaloupes as the source of the 2011 *Listeria monocytogene* outbreak through CDC's PulseNet. This was the deadliest foodborne disease outbreak in the United States in nearly 90 years. Although 29 deaths resulted from the outbreak, the number of deaths would have been higher had it not been for an effective, coordinated response by the CDC, state and local health departments, and the Food and Drug Administration (FDA). Lives were saved because the outbreak was detected, its source was identified, and a national warning was issued – all in just a matter of days.
- Conducted more than 2.8 million tests and newly diagnosed over 18,000 persons with HIV infection from 2007-2010. Of the new positives, for which follow-up data were available, at least 91 percent received their test results, 75 percent were linked to medical care, and 83 percent were referred to partner services.
- Reached all state and local health departments and over 95 percent of local boards of health with evidence-based recommendations from the Community Guide. Evidence from the Community Guide recommendations on the effectiveness of health communications that include mass media and health-related product distribution was used by the New York General Assembly when it considered eliminating the media budget of the New York tobacco control program.
- Demonstrated with most recent data (2009) the sustained impact of pneumococcal conjugate vaccine (PCV7) in reducing the risk of invasive bacterial diseases caused by vaccine serotypes by 99 percent in children targeted by vaccine, and by over 90 percent among older age groups (greater than 18 years of age) who are protected by herd immunity.
- Reached over one million people with the first 12 editions of CDC Vital Signs, which provides a call to action each month concerning a single, important public health topic. Copies have been distributed to state and local health departments, schools, and other public health partners.

AGENCY PERFORMANCE MANAGEMENT

CDC strives for continuous quality improvement through priority and goal setting, performance measurement, and program evaluation. In recent years, CDC has established a performance management system which is critical to the achievement of this cycle.

CDC's Quarterly Program Reviews (QPR) reflect a systematic process for monitoring program goals, strategy, and progress through increased measurement of and communication between program leadership and CDC senior leadership. The purpose of the QPR process is to set clear standards for performance and monitor progress over time. Three primary questions frame the QPR process: What health outcomes are programs focused on improving? How will programs accomplish their goals? How does CDC know that progress is being made?

The process includes semi-annual written materials and formal meetings between program staff and CDC senior leaders. QPR materials provide information on program goals, initiatives for accomplishing goals, and indicators of progress for each CDC division. CDC's QPR process yields useful information on a regular basis that enables leadership and management to make timely decisions regarding program design and allows for potential shifts in program strategy or resource allocation.

ALIGNMENT TO ADMINISTRATION PRIORITIES AND INITIATIVES

CDC is committed to supporting the national priorities set by the Administration. For example, CDC has supported the implementation of the President's National HIV/AIDS Strategy (NHAS) goals of reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities through domestic HIV programs.

In alignment with the First Lady's *Let's Move* campaign to combat the childhood obesity epidemic and the President's Task Force on Childhood Obesity, CDC funds school health programs to improve food and beverage options and increase physical activity.

In support of the National Prevention, Public Health, and Health Promotion Council (National Prevention Council) chaired by the Surgeon General, CDC is helping to lead the implementation of the National Prevention Strategy by providing technical and content expertise, participating in stakeholder engagement, and assisting in the development and review of recommendations and actions.

CDC is a significant partner in The Million Hearts initiative, a national public-private initiative designed to prevent one million heart attacks and strokes from January 2012 to January 2017. Million Hearts represents the first time there will be a system-wide—governmental and non-governmental—commitment to drastically improve cardiovascular disease prevention.

CDC also provides substantial support to Healthy People (HP) 2020. CDC is committed to the success of the Healthy People process and to assisting in prioritizing and achieving HP 2020 goals and objectives, as well as supplying the bulk of the data used to measure progress. Through engagement in the development process and CDC's integration of HP 2020 measures into our strategic and operational planning efforts, CDC is strategically aligned with and responsive to the health objectives for the nation.

CDC also actively supports the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* by helping to eliminate persistent health disparities in the leading causes of death and disability through effective and scalable public health interventions through CDC-funded programs and related efforts, including:

- National Tobacco Control Networks, which help advance the science and practice of tobacco control related to specific populations in the United States; and
- The Motor Vehicle Injury Tribal Initiative, which has been expanded to include seven more tribes to gain a more representative experience of the 564 federally recognized tribes in the United States. CDC works with grantees to design, implement, and evaluate programs to reduce motor vehicle-related injuries and deaths among members of their communities.
- The Minority HIV/AIDS Research Initiative, which works directly with and in highly-affected minority communities in research projects that engage study participants directly in HIV education, prevention, testing and, if HIV-positive, linkage to care.

Many of these areas of alignment are captured in the HHS Strategic Plan and the inaugural FY 2013 HHS Performance Plan as well as three High Priority Performance Goals (HPG) in which CDC is a significant partner. CDC owns nine measures in the 2010-2015 HHS Strategic Plan and 10 measures in the FY 2013 HHS Performance Plan. These are represented through the following: 1) transforming health care coverage, cost, and quality outcomes; 2) strengthening public health surveillance and epidemiology; 3) enhancing support of the public health infrastructure at the state, tribal, local, and territorial levels; 4) addressing obesity through childhood nutrition, food labeling, and physical fitness; 5) protecting Americans in public health emergencies; 6) increasing impact in global health; 7) preventing and controlling use of tobacco; 8) enhancing food safety; and 9) mitigating and preventing infectious and chronic diseases.

Building on CDC's FY 2010-2011 completed High Priority Performance Goals, CDC plays a significant role in three HPGs for FY 2012-2013: 1) preventing tobacco consumption, 2) reducing healthcare associated infections, and 3) improving food safety in the United States. In partnership with other federal agencies, CDC contributes its expertise in surveillance and promotion of evidence-based practices and policies towards accomplishing these goals.

ALL PURPOSE TABLE

CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2013 President's Budget
(Dollars in Thousands)

Revised Budget Activity/Description	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 President's Budget +/- FY 2012
Immunization and Respiratory Diseases	$748,257	$778,947	$721,129	($57,818)
Immunization and Respiratory Diseases - BA	$479,049	$576,083	$583,855	$7,772
Immunization and Respiratory Diseases - PHS Evaluation Transfer	*$12,864*	*$12,864*	*$13,765*	*$901*
Immunization and Respiratory Diseases - PPHF	*$100,000*	*$190,000*	*$72,460*	*($117,540)*
Immunization and Respiratory Diseases - PHSSEF	*$156,344*	*$0*	*$51,049*	*$51,049*
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	$1,115,995	$1,109,934	$1,145,678	$35,744
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	$1,115,995	$1,099,934	$1,145,678	$45,744
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PPHF	$0	$10,000	$0	($10,000)
Emerging and Zoonotic Infectious Diseases	$304,193	$304,226	$331,227	$27,001
Emerging and Zoonotic Infectious Diseases - BA	$252,443	$252,476	$279,477	$27,001
Emerging and Zoonotic Infectious Diseases - PPHF	$51,750	$51,750	$51,750	$0
Chronic Disease Prevention and Health Promotion	$1,074,937	$1,183,427	$1,144,730	($38,697)
Chronic Disease Prevention and Health Promotion - BA	$773,987	$756,377	$608,019	($148,358)
Chronic Disease Prevention and Health Promotion - PHS Eval	$0	$0	$25,000	$25,000
Chronic Disease Prevention and Health Promotion - PPHF	$300,950	$427,050	$511,711	$84,661
Birth Defects, Developmental Disabilities, Disability and Health	$136,072	$137,287	$125,565	($11,722)
Birth Defects, Developmental Disabilities, Disability and Health - BA	$136,072	$137,287	$18,476	($118,811)
Birth Defects, Developmental Disabilities, Disability and Health - PPHF	$0	$0	$107,089	$107,089
Environmental Health	$169,855	$139,998	$132,672	($7,326)
Environmental Health - BA	$134,855	$104,998	$103,672	($1,326)
Environmental Health - PPHF	$35,000	$35,000	$29,000	($6,000)
Injury Prevention and Control	$143,714	$137,693	$137,754	$61
Injury Prevention and Control - BA	$143,714	$137,693	$137,754	$61
Injury Prevention and Control - PPHF	$0	$0	$0	$0
Public Health Scientific Services	$467,564	$461,741	$505,069	$43,328
Public Health Scientific Services - BA	$147,795	$143,972	$35,695	($108,277)
Public Health Scientific Services - PHS Evaluation Transfer	*$247,769*	*$247,769*	*$379,374*	*$131,605*
Public Health Scientific Services - PPHF	$72,000	$70,000	$90,000	$20,000
Occupational Safety and Health	$316,079	$292,588	$249,364	($43,224)
Occupational Safety and Health - BA	$224,355	$181,864	$0	($181,864)
Occupational Safety and Health - PHS Evaluation Transfer	*$91,724*	*$110,724*	*$249,364*	*$138,640*
Global Health	$340,265	$347,594	$362,889	$15,295
Public Health Preparedness and Response	$1,415,416	$1,329,479	$1,275,136	($54,343)
Public Health Preparedness and Response - BA	$1,336,901	$1,299,479	$1,228,360	($71,119)
Public Health Preparedness and Response - PPHF	$10,000	$0	$0	$0
Public Health Preparedness and Response - PHSSEF	$68,515	$30,000	$46,776	$16,776
Cross-Cutting Activities and Program Support	$604,739	$659,113	$528,848	($130,265)
Cross-Cutting Activities and Program Support - BA	$563,539	$617,913	$487,648	($130,265)
Cross-Cutting Activities and Program Support - PPHF	$41,200	$41,200	$41,200	$0
Total CDC, Budget Authority -	*$5,648,970*	*$5,655,670*	*$4,991,523*	*($664,147)*
Total CDC, (Budget Authority & PHS Evaluation Transfers) -	*$6,001,327*	*$6,027,027*	*$5,659,026*	*($368,001)*
Program Level (includes BA, PHS Eval, PHSSEF & PPHF) -	*$6,837,086*	*$6,882,027*	*$6,660,061*	*($221,966)*
Agency for Toxic Substances and Disease Registry	*$76,638*	*$76,215*	*$76,300*	*$85*
Public Health and Social Services Emergency Fund (Transfer) (non-add)	*$224,859*	*$30,000*	*$97,825*	*$67,825*
Affordable Care Act- Prevention and Public Health Fund Transfer (non-add)	*$610,900*	*$825,000*	*$903,210*	*$78,210*
Vaccines for Children [1]	$3,952,677	$4,005,941	$4,271,015	$265,074
Energy Employees Occupational Illness Compensation Program Act (EEOICPA)	$55,358	$55,358	$55,358	$0
World Trade Center (Mandatory) [2]	$71,000	$174,354	$170,636	($3,718)
PHS Evaluation Transfers (non-add)	$352,357	$371,357	$667,503	$296,146
Other User Fees	*$2,226*	*$2,226*	*$2,226*	*$0*
Total, CDC/ATSDR Program Level -	*$10,994,985*	*$11,196,121*	*$11,235,596*	*$39,475*

1. The FY 2011 level reflects actual obligations. The FY 2012 level represents the anticipated transfer from Medicaid and does not include $3.1 million in prior year recoveries and refunds, for a total program level of $4,009.060 million. The FY 2013 level represents the anticipated transfer from Medicaid.

2. The FY 2011 level reflects the Federal government's share of actual obligations. The FY 2012 and FY 2013 levels reflect the Federal government's share of estimated obligations.

This page intentionally left blank

SUPPORTING EXHIBITS

APPROPRIATIONS LANGUAGE

CENTERS FOR DISEASE CONTROL AND PREVENTION

Immunization and Respiratory Diseases

For carrying out titles II, III, VII, XVII, and XXI, and section 2821 of the PHS Act, titles II and IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act, with respect to immunization and respiratory diseases, *$583,855,000***[**$579,375,000**]**: *Provided*, That in addition to amounts provided herein, **[**$12,864,000**]***$13,765,000* shall be available from amounts available under section 241 of the PHS Act to carry out the National Immunization Surveys.

HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention

For carrying out titles II, III, VII, XVII, XXIII, and XXVI of the PHS Act with respect to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis prevention, *$1,145,678,000***[**$1,105,995,000**]**: *Provided, That Centers for Disease Control and Prevention and State grant recipients may transfer up to ten percent of funds appropriated for Centers for Disease Control and Prevention HIV/AIDS, sexually transmitted disease, hepatitis, and tuberculosis activities to address the overlapping epidemics of these diseases by improving program collaboration and providing integrated services in accordance with priorities identified by the Centers for Disease Control and Prevention: Provided further, That with respect to the previous proviso, grantees shall submit a plan in writing to the Centers for Disease Control and Prevention and obtain the approval of the Centers for Disease Control and Prevention to transfer such funds.*

Emerging and Zoonotic Infectious Diseases

For carrying out titles II, III, VII, and XVII**[**,**]** and section 2821 of the PHS Act, titles II and IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act, with respect to emerging and zoonotic infectious diseases, *$279,477,000***[**$253,919,000**]**, *of which $1,000,000 shall remain available until expended to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under federal or state quarantine laws*.

Chronic Disease Prevention and Health Promotion

For carrying out titles II, III, VII, XI, XV, XVII, and XIX of the PHS Act *and Section 4201 of the Patient Protection and Affordable Care Act,* with respect to chronic disease prevention and health promotion, *$608,019,000***[**$760,700,000**]**: *Provided, That in addition to the amounts provided herein, $25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the Prevention Research Centers: Provided further*, That funds appropriated under this account may be available for making grants under section 1509 of the PHS Act for **[**not less than**]***up to* 21 States, tribes, or tribal organizations.

Birth Defects, Developmental Disabilities, Disabilities and Health

For carrying out titles II, III, VII, XI, and XVII of the PHS Act with respect to birth defects, developmental disabilities, disabilities and health, *$18,476,000***[**$138,072,000**]**.

Public Health Scientific Services

For carrying out titles II and III of the PHS Act with respect to health statistics, surveillance, informatics, and workforce development, *$35,695,000***[**$144,795,000**]**: *Provided*, That in addition to amounts provided herein, **[**$247,769,000**]** *$379,374,000* shall be available from amounts available under section 241 of the PHS Act to carry out Public Health Scientific Services.

Environmental Health

For carrying out titles II, III, VII, and XVII of the PHS Act with respect to environmental health, *$103,672,000***[**$105,598,000**]**.

Injury Prevention and Control

For carrying out titles II, III, VII, and XVII of the PHS Act with respect to injury prevention and control, *$137,754,000***[**$138,480,000**]***: Provided, That funds appropriated under this heading may be used to fund evaluation, research and pilot programs for sexual violence prevention programs*.

[National Institute for] Occupational Safety and Health

For carrying out titles II, III, VII, and XVII of the PHS Act, sections 101, 102, 103, 201, 202, 203, 301, 501, and 514 of the Federal Mine Safety and Health Act, section 13 of the Mine Improvement and New Emergency Response Act, and sections 20, 21, and 22 of the Occupational Safety and Health Act, with respect to occupational safety and health, **[**$182,903,000: *Provided*, That in addition to amounts provided herein, $110,724,000**]***$249,364,000* shall be available from amounts available under section 241 of the PHS Act.

Energy Employees Occupational Illness Compensation Program

For necessary expenses to administer the Energy Employees Occupational Illness Compensation Program Act, $55,358,000, to remain available until expended**[**, of which $4,500,000 shall be for use by or in support of the Advisory Board on Radiation and Worker Health (``Board'') to carry out its statutory responsibilities, including obtaining audits, technical assistance, and other support from the Board's audit contractor with regard to radiation dose estimation and reconstruction efforts, site profiles, procedures, and review of Special Exposure Cohort petitions and evaluation reports**]**: *Provided*, That this amount shall be available consistent with the provision regarding administrative expenses in section 151(b) of division B, title I of Public Law 106-554.

Global Health

For carrying out titles II, III, VII and XVII of the PHS Act with respect to global health, *$362,889,000***[**$349,547,000**]**, of which **[**$118,023,000**]***$117,119,000* for international HIV/AIDS shall remain available through September 30, **[**2013**]***2014*: *Provided*, That funds may be used for purchase and insurance of official motor vehicles in foreign countries.

Public Health Preparedness and Response

For carrying out titles II, III, VII, and XVII of the PHS Act with respect to public health preparedness and response, and for expenses necessary to support activities related to countering potential biological, nuclear, radiological, and chemical threats to civilian populations, *$1,228,360,000***[**$1,306,906,000**]**, of which *$439,444,000***[**$509,486,000**]** shall remain available until expended for the Strategic National Stockpile under section 319F-2 of the PHS Act.

CDC-Wide Activities and Program Support

For carrying out titles II, III, VII, XVII and section 2821 of the PHS Act and for cross-cutting activities and program support that supplement activities funded under the headings ``Immunization and Respiratory Diseases'', ``HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention'', ``Emerging and Zoonotic Infectious Diseases'', ``Chronic Disease Prevention and Health Promotion'', ``Birth Defects, Developmental Disabilities, Disabilities and Health'', ``Environmental Health'', ``Injury Prevention and Control'', ‘‘[National Institute for ]Occupational Safety and Health'', ``Employees Occupational Illness Compensation Program Act'', ``Global Health'', ``Public Health Preparedness and Response'', and ``Public Health Scientific Services'', *and for carrying out section 4001*

of the Patient Protection and Affordable Care Act, **[**$621,445,000**]***$487,648,000* of which **[**30,000,000**]** $*368,529,000* shall be available until September 30, **[**2013**]***2014*, for business services, **[**of which $25,000,000 shall be available until September 30, 2016, for equipment, construction and renovation of facilities][, and of which $80,000,000 shall be for the Preventive Health and Health Services Block Grant Program:**]** *Provided*, That paragraphs (1) through (3) of subsection (b) of section 2821 of the PHS Act shall not apply to funds appropriated under this heading and in all other accounts of the Centers for Disease Control and Prevention (referred to in this title as ``CDC''): *Provided further*, That funds appropriated under this heading and in all other accounts of CDC may be used to support the purchase, hire, maintenance, and operation of aircraft for use and support of the activities of CDC: *Provided further*, That employees of CDC or the Public Health Service, both civilian and commissioned officers, detailed to States, municipalities, or other organizations under authority of section 214 of the PHS Act, or in overseas assignments, shall be treated as non-Federal employees for reporting purposes only and shall not be included within any personnel ceiling applicable to the Agency, Service, or HHS during the period of detail or assignment: *Provided further*, That CDC may use up to $10,000 from amounts appropriated to CDC in this Act for official reception and representation expenses when specifically approved by the Director of CDC: *Provided further*, That in addition, such sums as may be derived from authorized user fees, which shall be credited to the appropriation charged with the cost thereof: *Provided further*, That with respect to the previous proviso, authorized user fees from the Vessel Sanitation Program shall be available through **[**September 30, 2013**]***2014*: *Provided further*, That of the funds made available under this heading, up to $1,000 per eligible employee of CDC shall be made available until expended for Individual Learning Accounts: **[***Provided further*, That CDC may establish a Working Capital Fund, with the authorities equivalent to those provided in 42 U.S.C. 231, to improve the provision of supplies and service.**]** *Provided further, That the Director may transfer funds between any of the accounts of CDC with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer: Provided further, That no such account shall be decreased by more than 3 percent by any such transfer.*

APPROPRIATIONS LANGUAGE ANALYSIS

Language Provision	Explanation
HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED DISEASES, AND TUBERCULOSIS PREVENTION	
Provided, That Centers for Disease Control and Prevention and State grant recipients may transfer up to ten percent of funds appropriated for Centers for Disease Control and Prevention HIV/AIDS, sexually transmitted disease, hepatitis, and tuberculosis activities to address the overlapping epidemics of these diseases by improving program collaboration and providing integrated services in accordance with priorities identified by the Centers for Disease Control and Prevention: Provided further, That with respect to the previous proviso, grantees shall submit a plan in writing to the Centers for Disease Control and Prevention and obtain the approval of the Centers for Disease Control and Prevention to transfer such funds.	CDC requests authority to allow CDC and grant recipients to transfer up to 10 percent of funds across HIV/AIDS, VH, STD, and TB prevention activities to enhance program coordination and service integration (PCSI) and strengthen collaborative work across disease areas and integrate services that are provided by related programs at the client level. Because these disease conditions share many social, environmental, behavioral, and biological determinants and are often managed by the same or similar organizations, public health efforts to prevent their occurrence require a syndemic orientation. This orientation provides a way of thinking about public health work that focuses on connection among health activities with other avenues for social change to foster conditions in which all people can be healthy. This allows grantees to provide services in a more comprehensive manner. PCSI is aimed at making small changes in the way prevention services are delivered in order to make a dramatic difference by reaching a larger population with more services. It can also improve efficiency, cost-effectiveness and health outcomes.
EMERGING AND ZOONOTIC INFECTIOUS DISEASES	
of which $1,000,000 shall remain available until expended to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under federal or state quarantine laws.	The isolation and quarantine of travelers can occur across fiscal years. This language gives CDC the ability to pay the necessary expenses for any persons quarantined by the Federal Government under Title III of the Public Health service Act should they be quarantined during the crossover period between fiscal years.
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION	
Provided, That in addition to the amounts provided herein, $25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the Prevention Research Centers	Language added to reflect the transfer of PHS Evaluation funds (PHS Act 241) to fund the Prevention Research Centers.
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH	
[$182,903,000: *Provided*, That in addition to amounts provided herein, $110,724,000**]**	This language was removed to reflect the fact that the entire account is now funded from transfers available from PHS Evaluation Funds (PHS Act 241)

***ENERGY* EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM**	
[, of which $4,500,000 shall be for use by or in support of the Advisory Board on Radiation and Worker Health (``Board'') to carry out its statutory responsibilities, including obtaining audits, technical assistance, and other support from the Board's audit contractor with regard to radiation dose estimation and reconstruction efforts, site profiles, procedures, and review of Special Exposure Cohort petitions and evaluation reports**]**	This language was removed to make it consistent with other HHS operating divisions' appropriation language sections.
CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT	
[of which $25,000,000 shall be available until September 30, 2016, for equipment, construction and renovation of facilities][, and of which $80,000,000 shall be for the Preventive Health and Health Services Block Grant Program:**]**	This language authorizing and funding buildings and facilities and the Preventive Health and Health Services Block Grant Program was deleted due to their funding elimination from the FY 2013 budget.
[*Provided further*, That CDC may establish a Working Capital Fund, with the authorities equivalent to those provided in 42 U.S.C. 231, to improve the provision of supplies and service.**]**	This language establishing the working capital fund is unnecessary to repeat in FY 2013, as the Working Capital Fund is now authorized.
Provided further, That the Director may transfer funds between any of the accounts of CDC with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer: Provided further, That no such account shall be decreased by more than 3 percent by any such transfer.	CDC requests this limited transfer authority in order to improve the provision of services and activities between accounts following congressional notification.

AMOUNTS AVAILABLE FOR OBLIGATION

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
DISEASE, CONTROL, RESEARCH AND TRAINING
AMOUNTS AVAILABLE FOR OBLIGATION [1, 2, 3]

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget Request
Discretionary Appropriation:			
Annual[1]	$5,660,291,000	$5,657,023,000	$4,991,523,000
HHS Secretary's Transfer	($11,320,582)	($1,353,000)	$0
Subtotal, adjusted Appropriation	**$5,648,970,418**	**$5,655,670,000**	**$4,991,523,000**
Mandatory and Other Appropriations:			
Transfers from Other Accounts[3]	$611,218,500	$825,000,000	$903,210,000
Receipts from CRADA	$2,378,193	$2,000,000	$2,000,000
Receipts from Royalties	$1,486,697	$0	$0
Appropriation (EEOICPA)	$55,358,000	$55,358,000	$55,358,000
Subtotal, adjusted Mandatory and Other Appropriations	**$670,441,390**	**$882,358,000**	**$960,568,000**
Recovery of prior year Obligations	$20,293,844	$0	$0
Unobligated balance start of year	$283,198,327	($193,193,284)	($193,193,284)
Unobligated balance expiring	$3,341,028	$0	$0
Unobligated balance end of year	$193,193,284	$193,193,284	$193,193,284
Total Obligations	**$ 6,622,903,979**	**$ 6,538,028,000**	**$ 5,952,091,000**

[1] Excludes Vaccine for Children.

[2] Excludes the following amounts for reimbursements: FY 2011 $575,000,000; FY 2012 $774,000,000 and FY 2013 $774,000,000

[3] Includes Health Reform

SUMMARY OF CHANGES

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SUMMARY OF CHANGES
(DOLLARS IN THOUSANDS)

	Dollars	FTEs
FY 2013 Budget (Program Level)	**$6,660,061**	**10,613**
FY 2012 Enacted (Program Level)	**$6,882,027**	**10,623**
Net Change	**$221,966**	**(10)**

	FY 2012 Appropriation		Change from Base	
	FTE		FTE	
Increases:				
Immunization & Respiratory Diseases	---		---	
Influenza Planning and Response		$158,775		$168
HIV/AIDS, Viral Hepatitis, STD, & TB Prevention	---		---	
Domestic HIV/AIDS Prevention and Research	---	$786,176	---	$40,231
Viral Hepatitis	---	$29,672	---	$22
Sexually Transmitted Infections (STIs)	---	$153,788		$98
Emerging and Zoonotic Infectious Diseases	---		---	
Food Safety	---	$27,113	---	$16,735
National Healthcare Safety Network	---	$14,840	---	$12,628
Quarantine	---	$25,866	---	$63
Chronic Disease Prevention, Health Promotion, & Genomics	---		---	
Tobacco Prevention and Control	---	$191,077	---	$6,040
Oral Health	---	$14,644	---	$9
Safe Motherhood and Infant Health	---	$43,803	---	$45
Chronic Diseases Prevention and Health Promotion Grants	---	N/A	---	$138,699
Environmental Health	---		---	
Environmental Health Lab	---	$42,383	---	$11
Healthy Home and Community Environments		$27,293		$23
Injury Prevention and Control	---		---	
Injury Prevention and Control	---	$137,693	---	$61
Public Health Scientific Services	---		---	
Health Statistics	---	$138,683	---	$23,150
Surveillance, Epi., and Informatics	---	$217,129	---	$412
State/Local Efficiency and Sustainability	---	*$0*	---	$20,000
Occupational Safety & Health				
All Other Occupational Safety & Health		$156,954		$686
Global Health				
Global Immunization Program	---	$160,287		$15,130
Other Global	---	$187,307		$165
Public Health Preparedness & Response	---		---	
CDC Preparedness and Response Capability	---	$138,269	---	$8,730
Total Increases	**N/A**	**$2,651,752**	**N/A**	**$283,106**

FY 2013 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF CHANGES (Cont.) (DOLLARS IN THOUSANDS)				
	FY 2012 Appropriation		Change from Base	
	FTE		FTE	
Decreases:				
Immunization & Respiratory Diseases				
Section 317 Immunization Program/Program Implementation and	---	$620,172	---	-$57,986
HIV/AIDS, Viral Hepatitis, STD, & TB Prevention				
Tuberculosis (TB)	---	$140,298	---	-$4,607
Emerging and Zoonotic Infectious Diseases				
Core Infectious Diseases	---	$184,657	---	-$2,425
Chronic Disease Prevention, Health Promotion, & Genomics				
Cancer Prevention and Control	---	$348,304	---	-$4,440
Racial and Ethnic Approaches to Community Health (REACH)	---	$53,940	---	-$53,940
Prevention Research Centers	---	$27,900	---	-$2,900
Other ACA/PPHF	---	$284,050		-$122,210
Birth Defect, Developmental Disabilities, Disability & Health				
Birth Defects, Developmental Disabilities, Disability and Health - BA	---	$137,287	---	-$11,722
Environmental Health				
Environmental Health Activities	---	$35,322	---	-$1,360
Environmental and Health Outcome Tracking Network (PPHF)	---	$35,000	---	-$6,000
Public Health Scientific Services	---		---	
Public Health Workforce Capacity - BA	---	$35,929		-$234
Occupational Safety & Health				
Educational and Research Centers	---	$24,268	---	-$24,268
NORA - Ag. Sector	---	$111,366	---	-$19,642
Public Health Preparedness & Response				
State and Local Preparedness and Response Capability	---	$657,418	---	-$15,501
Strategic National Stockpile	---	$533,792	---	-$47,572
Cross-Cutting Activities and Program Support	---		---	
Preventive Health and Health Services Block Grants	---	$79,545	---	-$79,545
Other Cross Cutting Activities	---	$538,368	---	-$50,720
Total Decreases	**N/A**	**$3,977,894**	**N/A**	**($505,072)**
Built-In:				
1. Annualization of Jan - 2012 Pay Raise	---	---	---	$1,379
2. FY 2013 Pay Increases	---	---	---	$3,765
3. Changes in Day of Pay	---	---	---	$3,826
4. Within-Grade Increases	---	---	---	$0
5. Rental Payments to GSA and Others	---	---	---	$538
Total Built-In	**10,623**	**$6,862,027**	**(10)**	**$9,508**
1. Absorption of Current Services	---	---	---	($9,508)
Total	---	---	---	($9,508)
Total Increases (Program Level)	**10,623**	**$6,862,027**	**(10)**	**$292,614**
Total Decreases (Program Level)	**N/A**	**N/A**	**0**	**($514,580)**
NET CHANGE - L/HHS/ED Program Level	**10,623**	**$6,862,027**	**(10)**	**($221,966)**
Program Level Changes				
1. Vaccines for Children	---	$4,005,941	---	$265,074
2. World Trade Center	---	$174,354	---	-$3,718
3. ATSDR	---	$76,215	---	$85
Total - Program Level Net Increase	**10,623**	**$4,005,941**	**(10)**	**$261,441**
NET CHANGE: BUDGET AUTHORITY & PROGRAM LEVEL	**10,623**	**$10,867,968**	**(10)**	**$39,475**

BUDGET AUTHORITY BY ACTIVITY

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
BUDGET AUTHORITY BY ACTIVITY (APT)
(DOLLARS IN THOUSANDS)

Budget Activity/Description	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 President's Budget +/- FY 2012
Immunization and Respiratory Diseases - BA	$479,049	$576,083	$583,855	$7,772
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	$1,115,995	$1,099,934	$1,145,678	$45,744
Emerging and Zoonotic Infectious Diseases - BA	$252,443	$252,476	$279,477	$27,001
Chronic Disease Prevention and Health Promotion - BA	$773,987	$756,377	$608,019	($148,358)
Birth Defects, Developmental Disabilities, Disability and Health - BA	$136,072	$137,287	$18,476	($118,811)
Environmental Health - BA	$134,855	$104,998	$103,672	($1,326)
Injury Prevention and Control - BA	$143,714	$137,693	$137,754	$61
Public Health Scientific Services - BA	$147,795	$143,972	$35,695	($108,277)
Occupational Safety and Health - BA	$224,355	$181,864	$0	($181,864)
Global Health - BA	$340,265	$347,594	$362,889	$15,295
Public Health Preparedness and Response - BA	$1,336,901	$1,299,479	$1,228,360	($71,119)
Cross-Cutting Activities and Program Support - BA	$563,539	$617,913	$487,648	($130,265)
Total CDC, Budget Authority -	***$5,648,970***	***$5,655,670***	***$4,991,523***	***($664,147)***

AUTHORIZING LEGISLATION

Dollars in Millions	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2012 Amount Authorized	FY 2013 Presidents Budget
Immunization and Respiratory Diseases	Indefinite	$778.947	Indefinite	$721.129
PHSA §§ 301, 307, 310, 311, 317, 317(a), 317(j), 317(k), 317(l), 317(m), 317N, 317S, 319, 319C, 319E, 319F, 322, 325, 327, 340C, 352, 2102(a)(6), 2102(a)(7), 2125, 2126, 2127, 2821 Immigration and Nationality Act §§ 212 (8 U.S.C. 1182), 232 (8 U.S.C. 1222) Social Security Act § 1928 (42 U.S.C. 1396s) Pandemic and All-Hazards Preparedness Act of 2006 (P.L. 109-417)				
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	Indefinite	$1,109.934	Indefinite	$1,145.678
PHSA §§ 301, 306, 307, 308, 310, 311, 317, 317E, 317N, 317P, 317T, 318, 318A, 318B, 322, 325, 327, 352, 1701, 1704, 2315, 2320, 2341; Title II of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1995 (P.L. 103-333) Section 212 of the Consolidated Appropriations Act, 2012 (P.L. 112-74, Division F)				
Emerging Zoonotic Infectious Diseases	Indefinite	$304.226	Indefinite	$331.227
PHSA §§ 301, 304, 307, 308(d), 310, 311, 317, 317P, 317R, 317S, 319, 319D, 319E, 319F, 319G, 321, 322, 325, 327, 352, 353, 361–369, 399G, 1102, 2821; P.L. 96-517; P.L. 111-5 Immigration and Nationality Act §§ 212, 232 (8 U.S.C. 1182, 8 U.S.C. 1222)				
Chronic Disease Prevention, Health Promotion	Indefinite	$1,183.427	Indefinite	$1,144.730
PHSA §§ 301, 307, 310, 311, 317, 317D, 317H, 317K, 317L, 317M, 330E, 399B–399D, 399E, 399W–399Z, 1501–1508,				

Dollars in Millions	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2012 Amount Authorized	FY 2013 Presidents Budget
1702, 1703, 1704, 1706 Fertility Clinic Success Rate And Certification Act of 1992 (P.L. 102-493) The Patient Protection and Affordable Care Act of 2010, § 4201 (P.L. 111-148) Comprehensive Smoking Education Act of 1984, P.L. 98-474 (15 U.S.C. 1335(a) and 15 U.S.C. 1341) Comprehensive Smokeless Tobacco Health Education Act of 1986 (P.L. 99-252)				
Birth Defects, Developmental Disabilities, Disabilities & Health	Indefinite	$137.287	Indefinite	$125.565
PHSA §§ 301, 304, 307, 308D, 310, 311, 317, 317C, 317J, 317K, 317L, 317Q, 327, 352, 399G, 399M, 399Q, 399S, 399T, 399AA, 399BB, 399CC, 1102,1108-1115				
Environmental Health	Indefinite	$139.998	Indefinite	$132.672
PHSA §§ 301, 307, 310, 311, 317, 317A, 317B, 317I, 327, 352, 361, 366, 1102; Toxic Substances Control Act. The Toxic Substances Control Act, § 405(c) (15 U.S.C. 2685)				
Injury Prevention and Control	Indefinite	$137.693	Indefinite	$137.754
PHSA §§ 214, 215, 301, 304, 307, 308D, 310, 311, 317, 319, 319D, 327, 352, 391, 392, 393, 393A, 393B, 393C, 393D, 394, 394A, 399G, 399P, 1102; Safety of Seniors Act of 2007 (P.L. 110-202) Traumatic Brain Injury Act of 2008 (P.L. 110-206) Family Violence Prevention and Services Act § 413 (42 U.S.C. 10418)				
Public Health Scientific Services	Indefinite	$461.741	Indefinite	$505.069
PHSA §§ 241, 301, 304, 306, 307, 308, 317, 317G, 318, 319, 319A, 353, 391, 399V, 778, 1102, 2315, 2341, 2521; P.L. 107-347, Title V (44 U.S.C. 3501				

Dollars in Millions	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2012 Amount Authorized	FY 2013 Presidents Budget
note) Intelligence Reform and Terrorism Prevention Act of 2004 § 7211 (P.L. 108-458) Food, Conservation, And Energy Act of 2008 § 4403 (7 U.S.C. 5311a) P.L. 101-445 § 5341 (7 U.S.C. 5341) The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)				
Occupational Safety and Health	Indefinite	$292.588	Indefinite	$249.364
PHSA §§ 301, 304, 306, 307, 308d, 310, 311, 317A, 317B, 319, 327, 352, 399G, 399M, 1102, 2695; Bayh-Dole Act of 1980 (P.L. 96-517) Occupational Safety and Health Act of 1970 §§20–22, P.L. 91-596 as amended by PL 107-188 and 109-236 (29 U.S.C. 669–671) Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164 and P.L. 109-236 (30 U.S.C. 811–813, 842, 843–846, 861, 951–952, 957, 962, 963, 964) Black Lung Benefits Reform Act of 1977 § 19, P.L. 95-239 (30 U.S.C. 902) Bureau of Mine Act, as amended by P.L. 104-208 (30 U.S.C. 1 note, 3, 5) Radiation Exposure Compensation Act, §§ 6 and 12 (42 U.S.C. 2210 note) Energy Employees Occupational Illness Compensation Program Act as amended (42 U.S.C. 7384, et seq) Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 §§ 3611, 3612, 3623, 3624, 3625, 3626, 3633 of P.L. 106-398 National Defense Authorization Act for Fiscal Year 2006, P.L. 109-163 Toxic Substances Control Act, P.L. 94-469 as amended by 102-550, (15 U.S.C. 2682, 2685) Ryan White HIV/AIDS Treatment Extension Act of 2009 § 2695, P.L. 111-				

Dollars in Millions	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2012 Amount Authorized	FY 2013 Presidents Budget
87 (42 U.S.C. 300ff-131) James Zadroga 9/11 Health and Compensation Act (2010), P.L.111-347				
Global Health	Indefinite	$347.594	Indefinite	$362.889
PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 361–369, 2315, 2341; Foreign Assistance Act of 1961 §§ 104, 627, 628; Federal Employee International Organization Service Act § 3 International Health Research Act of 1960 § 5 Agriculture Trade Development and Assistance Act of 1954 § 104; Economy Act 38 (38 U.S.C. 707); Foreign Employees Compensation Program (22 U.S.C. 3968); International Competition Requirement Exception (41 U.S.C. 253); The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L.108-25); Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act (P.L.110-293); Consolidated Appropriations Act, 2012 (P.L. 112-74)				
Public Health Preparedness and Response	Indefinite	$1,329.479	Indefinite	$1,275.136
PHSA §§ 301, 307, 311, 317, 319, 319C-1, 319D, 319F, 319F-2, 319G, 351A, 352, 369				
CDC-Wide Activities and Program Support	Indefinite	$659.113	Indefinite	$528.848
PHSA §§ 301, 304, 306, 307, 308, 308D, 310, 311, 317, 317F, 319, 319A, 319D, 321 322, 325, 327, 352, 361–369, 391, 399G, 1102, 2821				
Total Appropriation		**$6,882.027**		**$6,660.061**

APPROPRIATIONS HISTORY

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION[1]
APPROPRIATION HISTORY TABLE
DISEASE CONTROL, RESEARCH, AND TRAINING

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2004 2	4,157,330,000	4,538,689,000	4,494,496,000	4,367,165,000
2005 [2, 3]	4,213,553,000	4,228,778,000	4,538,592,000	4,533,911,000
2005 Labor/HHS Reduction`	--	--	--	(1,944,000)
2005 Rescission	--	--	--	(36,256,000)
2005 Supplemental [3]	--	--	--	15,000,000
2006 [2, 4]	3,910,963,000	5,945,991,000	6,064,115,000	5,884,934,000
2006 Rescission	--	--	--	(58,848,000)
2006 Suplemental [5]	--	--	--	275,000,000
2006 Supplemental [6]	--	--	--	218,000,000
2006 Section 202 Transfer to CMS	--	--	--	(4,002,000)
2007 [4, 5, 7]	5,783,205,000	6,073,503,000	6,095,900,000	5,736,913,000
2008 [4]	5,741,651,000	6,138,253,000	6,156,169,000	6,156,541,000
2008 Rescission [4]	--	--	--	(106,567,000)
2009	5,618,009,000	6,202,631,000	6,313,674,000	6,283,350,000
2009 American Reinvestment & Recovery Act [8]				300,000,000
2009 H1N1 Influenza Supplemental, HHS [9]	473,000,000	--	--	473,000,000
2010 H1N1 Influenza Supplemental, CDC [9]	200,000,000	--	--	200,000,000
2010 Public Health Prevention Fund [10]	--	--	--	191,800,000
2010	6,312,608,000	6,313,032,000	6,733,377,000	6,390,387,000
2011	6,265,806,000	--	6,527,235,000	5,648,970,000
2011 Public Health Prevention Fund	610,900,000	--	--	610,900,000
2012	5,817,412,000	--	5,765,915,000	5,655,670,000
2012 Public Health Prevention Fund	752,500,000	--	848,000,000	825,000,000
2013	4,991,523,000	--	--	--
2013 Public Health Prevention Fund	903,210,000	--	--	--

[1] Does not include funding for ATSDR

[2] FY 2004, FY 2005, FY 2006, funding levels for the Estimate reflect the Proposed Law for Immunization.

[3] FY 2005 includes a one time supplemental of $15,000,000 for avian influenza through the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005.

[4] Beginning in FY 2006, Terrorism funds are directly appropriated to CDC instead of being appropriated to the Public Health and Social Service Emergency Fund (PHSSEF). As a result, FY 2006 House, Senate, and Appropriation totals include Terrorism funds. Terrorism funding is included in CDC Appropriation after 2006.

[5] FY 2006 includes a one-time supplemental of $275 million for pandemic influenza and World Trade Center activities through P.L.109-141, Department of Defense Emergeny Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006

[6] FY 2006 includes a one time supplemental of $218 million for pandemic influenza, mining safety, and mosquito abatement through P.L. 109-234, Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006.

[7] The FY 2007 appropriation amount listed is the FY 2007 estimated CR level based on a year long Continuing Resolution.

[8] FY 2009 Appropriation amount displays $300M Section 317 funds for American Reinvestment & Recovery Act (P.L. 111-5)

[9] FY 2009 H1N1 influenza supplemental, Supplemental Appropriations Act, 2009 (P.L. 111-32). $473M transferred from HHS's Public Health and Social Services Emergency Fund to CDC; $200M directly appropriated to CDC.

[10] The Affordable Care Act passed on March 23, 2010, after the FY 2010 appropriation. Therefore, CDC did not request Prevention and Public Health (PPH) funds from Congress, but from HHS. The amounts here reflect CDC's request and final amount alloted from the PPH Fund to CDC from HHS.

APPROPRIATIONS NOT AUTHORIZED BY LAW

Program (dollars in millions)	Last Year Of Authorization	Authorization Level	Appropriations In Last Year Of Authorization	Appropriations In FY 2012
Sexually Transmitted Diseases Grants	FY 1998	Such Sums…	$113.671	$153.788
WISEWOMAN	FY 2003	Such Sums…	$12.419	$20.745
National Center for Health Statistics	FY 2003	Such Sums…	$125.899	$138.683
Safe Motherhood/Infant Health Promotion	FY 2005	Such Sums…	$44.738	$43.803
Oral Health Promotion	FY 2005	Such Sums…	$11.204	$14.644
Asthma Prevention	FY 2005	Such Sums…	$32.422	$25.298
Lead Poisoning Prevention	FY 2005	Such Sums…	$36.474	$1.995
Injury Prevention and Control	FY 2005	Such Sums…	$138.237	$137.693
Strategic National Stockpile	FY 2006	Such Sums…	$524.700	$533.792
Birth Defects, Developmental Disability, Disability and Health	FY 2007	Such Sums…	$122.242	$137.287

NARRATIVE BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$479.049	$576.083	$583.855	+$7.772
PHS Evaluation Transfer	$12.864	$12.864	$13.765	+$0.901
PHSSEF Transfer	$156.344	$0.000	$51.049	+$51.049
ACA/PPHF	$100.000	$190.000	$72.460	-$117.540
Total	**$748.257**	**$778.947**	**$721.129**	**-$57.818**
FTEs	669	666	666	0

Authorizing Legislation: PHSA §§ 301, 307, 310, 311, 317, 317(a), 317(j), 317(k), 317(l), 317(m), 317N, 317S, 319, 319C, 319E, 319F, 322, 325, 327, 340C, 352, 2102(a)(6), 2102(a)(7), 2125, 2126, 2127, 2821; Immigration and Nationality Act §§ 212 (8 U.S.C. 1182), 232 (8 U.S.C. 1222); Social Security Act § 1928 (42 U.S.C. 1396s); Pandemic and All-Hazards Preparedness Act of 2006 (P.L. 109-417)

FY 2013 Authorization……Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $721,129,000 for immunization and respiratory diseases, including $72,460,000 from the Affordable Care Act Prevention and Public Health Fund, $51,049,000 from the Public Health and Social Services Emergency Fund, and $13,765,000 in PHS Evaluation resources, is an overall decrease of $57,818,000 below the FY 2012 level. The FY 2013 request includes a decrease of $57,986,000 for the Section 317 Immunization Program.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Section 317 Immunization	$425.571	$367.870	$426.839	+$58.969
Program Implementation	$63.005	$62.302	$62.887	+$0.585
PHS Eval Transfer (non-add)	$12.864	$12.864	$13.765	+$0.901
Influenza Planning and Response	$159.681	$158.775	$158.943	+$0.168
PHSSEF Transfer (non-add)	$156.344	$0.000	$51.049	+$51.049
ACA/PPHF	$100.000	$190.000	$72.460	-$117.540
Total	**$748.257**	**$778.947**	**$721.129**	**-$57.818**

CDC focuses on the prevention of disease, disability, and death of children, adolescents, and adults through immunization and by control of respiratory and related diseases. Childhood vaccination coverage rates are at near record high levels, and as a result, cases of most vaccine-preventable diseases in the United States are at or near record lows. Maintaining and enhancing high vaccination coverage is critical for preventing recurrent epidemics of diseases that could result in preventable illness, disability, and death. For example, the over 200 measles cases in 2011 that were primarily import-related and the outbreaks of pertussis in the United States serve as reminders that we must maintain high coverage rates in order to keep disease rates low. In addition, acute respiratory infections are a critical public health, humanitarian, and security concern. CDC provides technical expertise in implementing immunization programs; preparedness planning for pandemic influenza; and epidemiology and laboratory capacity to detect, prevent, and respond to vaccine-preventable, respiratory, and related infectious disease threats.

- CDC administers the two primary federal programs that support immunization for the underinsured and uninsured populations in the United States—the discretionary Section 317 Immunization Program and the mandatory Vaccines for Children (VFC) Program.
- CDC ensures a safe and effective vaccine delivery system by providing core support for state and local program operations and infrastructure via Section 317 funding. This infrastructure is critical to support successful VFC Program implementation.
- CDC invests in disease surveillance, laboratory capacity, and scientific studies to evaluate vaccine effectiveness and program impact to provide essential information to inform the nation's immunization policies and programs.
- CDC is the nation's lead public health agency for maintaining a safe, effective vaccine supply for all children, adolescents, and adults in the United States by monitoring vaccine safety and conducting research to address gaps in scientific knowledge about vaccine-associated adverse events.
- CDC's public health surveillance, laboratory infrastructure, and response capacity protect against existing and emerging respiratory diseases, including influenza and pneumonia, that threaten the health and safety of every person in the country.

Through these investments, CDC aims to prevent vaccine-preventable diseases by assuring high immunization coverage levels, and to control respiratory and related diseases such as influenza.

FUNDING HISTORY[1]

Section 317 Immunization	
Fiscal Year	**Dollars (in millions)**
2003	$502.765
2004	$468.789
2005	$493.032
2006	$517.199
2007	$512.804
2008	$527.359
2009	$557.359
2009 (ARRA)	$300.000
2010	$561.459
2011	$488.576
2011 (ACA/PPHF)	$100.000
2012	$430.172
2012 (ACA/PPHF)	$190.000

Immunization and Respiratory Diseases	
Fiscal Year	**Dollars (in millions)**
2008	$684.634
2009[2]	$716.048
2010	$721.180
2011	$648.257
2011 (ACA/PPHF)	$100.000
2012	$588.947

Immunization and Respiratory Diseases	
Fiscal Year	**Dollars (in millions)**
2012 (ACA/PPHF)	$190.000

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

[2]Amount does not include $200,000,000 for Pandemic Influenza from the Public Health and Social Services Emergency Fund.

The table below reflects the sources of VFC funding and estimates of total VFC obligations. The FY 2013 estimate is a net increase of $261,955,000 above the FY 2012 estimate. The FY 2013 estimate includes an increase for vaccine purchase and a decrease for vaccine management business improvement plan contractual support. The increase in vaccine purchase is based on price and forecast changes for vaccines.

VFC	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate
Unobligated Balances Brought Forward/Recoveries	$7M	$3M[2]	N/A
Non-expenditure Transfer from CMS	$3,937M	$4,006M	$4,271M
Total VFC Obligations[1]	$3,953M	$4,009M	$4,271M

[1]In FY 2011, total VFC obligations did not equal total available resources.

[2]Unobligated balances were returned to the Centers for Medicare & Medicaid Services (CMS). Amount reflects prior year recoveries and refunds. The FY 2013 net increase of estimated total obligations, inclusive of prior year recoveries and refunds brought into FY 2012, totals $261,955,000; the FY 2013 net increase of the non-expenditure transfer from CMS, exclusive of prior year recoveries and refunds brought into FY 2012, totals $265,074,280.

SECTION 317 IMMUNIZATION PROGRAM AND PROGRAM IMPLEMENTATION AND ACCOUNTABILITY BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$475.712	$417.308	$475.961	+$58.653
PHS Evaluation Transfer	$12.864	$12.864	$13.765	+$0.901
ACA/PPHF	$100.000	$190.000	$72.460	-$117.540
Total	**$588.576**	**$620.172**	**$562.186**	**-$57.986**

Program Overview: The Section 317 Immunization Program aims to improve access to immunization services by funding the purchase and delivery of vaccines to vulnerable populations, including underinsured children and adolescents, underinsured and uninsured adults, and special populations at high risk for vaccine-preventable diseases. Section 317 provides evidence-based recommendations, technical assistance, capacity-building, and infrastructure support for 64 grantees, including the 50 states, six large cities (including Washington, D.C.), and eight territories and former territories to implement immunization programs.

The passage and implementation of the Affordable Care Act (ACA) includes new prevention provisions that create health insurance reforms. Since September 23, 2010, new health plans are required to cover recommended preventive services without charging a deductible, copayment, or coinsurance. This reform includes coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) when these services are provided by an in-network provider. In 2011, HHS estimated that 41 million people enrolled in new health plans benefitted from these new prevention provisions. This estimate is expected to increase to 88 million by 2013. As health reform expands prevention services, the

size of the uninsured and underinsured populations served by Section 317 is expected to be reduced and cost savings to Section 317 Vaccine Purchase are likely to occur. Savings will also be realized from Section 317 billing projects that will fund additional state and local health department clinics to develop the capacity to bill health insurance plans for services provided to insured members. These savings will be used by states to increase outreach to at-risk populations with unmet needs, as prioritized by each state.

A strong public health infrastructure is vital to ensuring high vaccination coverage levels and low incidence of vaccine-preventable diseases, as well as maintaining adequate public health preparedness for response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. Regardless of whether a vaccine is publically or privately purchased, public health at the federal, state, and local levels plays a critical role in ensuring a safe and effective national immunization system. Ongoing safety monitoring, vaccine effectiveness studies, and coverage assessments help to ensure maximum impact of immunization policies, programs, and investments.

CDC's post-licensure immunization safety activities include: monitoring adverse events following immunization, evaluating adverse events that result in a safety concern to assess the possibility of causal association with immunization, assessing risk factors for specific adverse events, and communicating vaccine risks and benefits to health care providers and the public. A robust and transparent immunization safety monitoring and research system must exist to ensure safe and effective vaccines and maintain public confidence in immunizations.

Recent accomplishments:

- Documented increases in adolescent vaccination coverage rates through the National Immunization Survey-Teen. Vaccination coverage among adolescents aged 13 through 15 years increased for all three of the routinely administered adolescent vaccines from 2009 to 2010: Tetanus, Diphtheria, Pertussis (Tdap) from 62 percent to 74 percent; meningococcal conjugate vaccine (MCV) from 55 percent to 65 percent; and for girls who received at least one dose of human papillomavirus (HPV) vaccine from 41 percent to 46 percent.

- Enhanced interoperability of Electronic Health Records (EHRs) and Immunization Information Systems (IIS) by funding 20 Section 317 immunization grantees with Health Information Technology for Economic and Clinical Health (HITECH) and American Recovery and Reinvestment Act (ARRA) funds, which allowed more than 80 percent of grantees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions. HL7 messaging standards are recommended by the National Vaccine Advisory Committee as one of the core IIS functions or minimum functional standards for data exchange.

- Documented that in the 2007–2009 timeframe, after introduction of rotavirus vaccine in 2006, there was a reduction of nearly 65,000 hospitalizations from diarrhea and direct medical savings of approximately $280 million. The sustained declines in diarrhea hospitalizations and costs reaffirm the benefits of the U.S. rotavirus vaccination program.

- Provided critical scientific evidence that informed the ACIP's new adolescent recommendation for a booster dose of meningococcal conjugate vaccine (MCV4) at age 16 to assure protection through the high-risk college years. CDC's vaccine effectiveness study demonstrated declining effectiveness of MCV4 within three years of vaccination.

- Assessed a potential safety concern regarding increased risk of febrile seizures in young children associated with the 2010–2011 trivalent inactivated influenza vaccine; preliminary findings of this rapid assessment were presented at the February 2011 ACIP meeting for discussion and consideration of next steps.

Budget Proposal: CDC's FY 2013 request of $562,186,000 for the Section 317 Immunization Program and immunization program implementation and accountability, including $72,460,000 from the

Affordable Care Act Prevention and Public Health Fund and $13,765,000 in PHS Evaluation resources, is an overall decrease of $57,986,000 below the FY 2012 level. This represents reductions from one-time investments supported by the Prevention and Public Health Fund (PPHF). The FY 2013 budget request will continue to provide vaccine purchase for at-need populations, immunization program operations—including support for implementing billing systems for immunization services at public health clinics to sustain high levels of vaccine coverage, and support for the scientific evidence base informing immunization policies. Health reform expansion will further increase access to immunizations and decrease the number of uninsured and underinsured individuals served by the Section 317 Program, resulting in cost savings. FY 2011 and FY 2012 funding supported activities to assist with the transition to full implementation of the health insurance reforms, such as IIS and adult immunization. FY 2013 PPHF funding includes $25,000,000 to continue progress with public health departments directly billing insurers for immunization services. The FY 2013 request also includes an increase of $901,000 in PHS Evaluation resources for the National Immunization Survey.

In FY 2013, CDC will:

- Support immunization for priority populations served in non-traditional venues, such as pharmacies and retail-based clinics where providers can appropriately bill insurers.
- Expand the billables program to allow public health departments to have the capacity to bill private insurers for immunization services. This will help public health departments in transitioning to health reform by 2014.
- Continue to provide funding and technical assistance to immunization grantees to develop, enhance, and maintain IIS capable of identifying individuals in need of immunization, measuring vaccination coverage rates, producing reminder and recall notices, and interfacing with EHRs.
- Increase national public awareness and provider knowledge about vaccine-preventable diseases and immunization recommendations using an array of media and culturally appropriate tools and resources to support informed decision-making about vaccination.
- Improve methods to assess vaccination coverage levels across the lifespan to identify groups at risk of vaccine-preventable diseases, monitor racial and ethnic disparities in vaccine coverage, evaluate the effectiveness of programs designed to increase coverage levels, monitor uptake of new vaccines, assess differential impact of vaccine shortages, measure performance by various types of providers, and provide greater understanding of socio-demographic and attitudinal factors associated with vaccination.
- Strengthen the scientific evidence base for the nation's immunization policies and programs through investments in disease surveillance, laboratory capacity, outbreak response, and scientific studies to evaluate vaccine effectiveness and program impact.
- Continue to ensure a safe immunization program through the implementation of CDC's vaccine safety priority studies, strengthening vaccine safety surveillance capacity for rare, immunization-associated vaccine adverse events, improvement of adverse-event reporting through electronic reporting, and the development of vaccine safety profiles for each newly licensed vaccine in collaboration with the Food and Drug Administration (FDA) to support FDA's mandates.

Section 317 Immunization Grant Table [1,2]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	64	64	64
Average Award	$7.477	$8.032	$7.188
Range of Awards	$0.404–$54.582	$0.484–$63.099	$0.433–$56.457

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of New Awards	0	0	0
Number of Continuing Awards	64	64	64

[1]This table includes Section 317 budget authority and Prevention and Public Health Funds.

[2]Includes immunization operations grants and vaccine direct assistance.

INFLUENZA PLANNING AND RESPONSE BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$3.337	$158.775	$107.894	-$50.881
PHSSEF Transfer	$156.344	$0.000	$51.049	+$51.049
Total	**$159.681**	**$158.775**	**$158.943**	**+$0.168**

Program Overview: Seasonal influenza remains a formidable public health challenge due to the substantial health and economic burden throughout the world and the potential for rapid emergence and spread of new influenza virus strains. Influenza seasons are unpredictable in timing and severity. Over a period of 30 years, between 1976 and 2006, annual estimates of influenza-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people, with an average of more than 200,000 hospitalizations per year. A study published in 2007 estimated that seasonal influenza contributed an estimated $10.4 billion annually in direct medical costs in the United States.[1]

The 2009 H1N1 influenza pandemic demonstrated that threats of pandemics from novel influenza viruses against which few people have natural immunity represent a critical on-going public health hazard. The United States was fortunate in 2009. Systems in the United States and substantial international investments in influenza surveillance and diagnostics, put in place largely with U.S. Government funding, discovered the disease and identified the virus quickly, produced an effective vaccine in record time, and made antiviral medications widely available. Public health measures substantially mitigated the health impact of the pandemic, particularly among those younger than 65 years of age, including pregnant women. The United States was also fortunate that many older adults had existing immunity to the virus. However, influenza viruses are constantly evolving, and the next pandemic could present more serious challenges and could occur at any time.

CDC maintains a wide, diverse network that supports core capabilities to protect the public from influenza, including international partners, policymakers, tribal leaders, state and local health departments, the medical community, private sector partners, academic institutions, and other parts of the federal government. The program supports influenza prevention and control in all U.S. states, the Global Influenza Surveillance and Response System, the United Nations Global Initiative to Combat Avian Influenza, and the Global Initiative on Sharing All Influenza Data. Funding supports activities in CDC's global health, public health scientific services, vaccine coverage and safety monitoring, vaccine distribution, health care surge planning, and quarantine programs.

[1]Molinari NA, Ortega-Sanchez IR, Messonnier ML, Thompson WW, Wortley PM, Weintraub E, et al. "The Annual Impact of Seasonal Influenza in the US: Measuring Disease Burden and Costs". Vaccine 2007 Jun 28;25(27):5086–96. Epub 2007 Apr 20.

CDC works to improve influenza prevention, control, monitoring, and response by developing and deploying vaccines to prevent disease and antiviral medications to treat illness, using its surveillance and laboratory capabilities to determine which viruses pose a pandemic threat, what viruses are causing disease, and the effectiveness of these interventions. CDC evaluates interventions and educates health care providers and the public to improve acceptance of public health interventions. The impact of CDC's focus on influenza to build generic international health capacity is substantial. Globally, public health is applying these influenza accomplishments to support diagnosis, response, and surveillance for other infectious diseases, as well as disaster events. For example, in building capacity for influenza, CDC has helped develop capacity and technical competence in the same laboratories that have also been activated to support work during Ebola outbreaks and anthrax diagnoses.

Recent accomplishments:

- Data from surveys with pregnant women have shown that the most significant motivator for women to be vaccinated against influenza is the recommendation and offer of vaccine by their obstetricians. During the 2009 H1N1 pandemic, CDC worked closely with professional obstetric provider groups to encourage vaccination of pregnant women. As a result, vaccination among pregnant women increased from less than 15 percent before the pandemic to nearly 50 percent during the 2009–2010 (pandemic) season, and these gains were sustained during the 2010–2011 season. During the 2011–2012 influenza season, CDC is building on this successful effort by continuing to work with these professional organizations with the goal of making influenza vaccination a part of routine obstetric care.

- Utilized new systems during the 2010–2011 and 2011–2012 influenza seasons to monitor vaccine coverage. These systems have allowed public information about vaccine knowledge and coverage among the U.S. population to be shared in early December—earlier than information has been available in past seasons—resulting in opportunities for increased awareness in local areas and with important groups such as pregnant women and health care personnel.

- Distributed influenza test reagents to record numbers of state public health laboratories, Department of Defense laboratories, and over 100 National Influenza Centers globally during the 2011–2012 influenza season in the Northern and Southern Hemispheres to monitor influenza disease, develop new vaccine candidates, and detect emerging influenza viruses with pandemic potential.

- Enhanced preparedness and response capabilities globally through activities in more than 40 countries, including cooperative agreements with in-country and international partners, intramural research, and technical support. Assessment and review tools show that significant improvements from 2008–2010 continue for 2011 for critical capabilities such as clinical management guidance, resource management for antiviral treatment and personal protective equipment, and communicating surveillance information. Assessment and review tools include: the International Influenza Laboratory Capacity Review Tool, the International Influenza Surveillance Assessment Tool, and the National Inventory of Core Capabilities for Pandemic Influenza Preparedness and Response which will be formally reported next in FY 2012.

Budget Proposal: CDC's FY 2013 request of $158,943,000 for influenza planning and response, including $51,049,000 from the Public Health and Social Services Emergency Fund, is an increase of $168,000 above the FY 2012 level.

Influenza Prevention and Response to Outbreaks

In FY 2013, CDC will:

- Continue promotion of the 2010–2011 ACIP influenza season recommendation that every American six months and older be vaccinated. Vaccination is the primary means of preventing influenza.
- Determine optimal vaccine strategies that incorporate new vaccine approaches.
- Promote vaccination through traditional primary care settings and clinics, while expanding support for school-located vaccination activities. CDC will continue special efforts to reach high-risk individuals, such as pregnant women, and provide further outreach to subspecialty medical providers to increase vaccination of persons at especially high risk of severe illness or death from influenza.
- Extend the reach of vaccination by working with partners to promote non-traditional venues as vaccination sites. CDC is accomplishing this through initiatives with non-traditional vaccine providers, such as retail pharmacies and other commercial sites, to extend the efforts of clinicians and to increase access to vaccine services outside of typical clinic hours.
- Capitalize on the progress made since FY 2010 in increasing influenza vaccination among vulnerable and special populations, including expanded efforts to increase influenza vaccination among minority populations. In addition, CDC will work to capitalize on influenza vaccination efforts and systems to improve the coverage of recommended vaccines for other diseases.
- Improve U.S. health security by providing support to other countries and international partners to expand influenza immunization globally in conjunction with increased global vaccine production capacity and supply.
- Refine and implement recommended interventions and countermeasures in addition to vaccines and antiviral medications to protect individuals from influenza, such as promoting hand washing and covering coughs and sneezes. Interventions and countermeasures for an influenza pandemic also could include promoting social distancing when one is sick with influenza-like symptoms, and developing a nationwide system of nurse triage/call centers to reduce burden on hospitals, health care facilities, and public health facilities.
- Sustain the nation’s ability to respond to influenza pandemics by ensuring that well-trained staff are in place for pandemic response, and by providing technical assistance where feasible to help CDC’s Public Health Emergency Preparedness (PHEP) Cooperative Agreement and HHS’ Hospital Preparedness Program (HPP) Cooperative Agreement grantees meet all hazard requirements of the Pandemic and All Hazards Preparedness Act.

Detection and Monitoring of Influenza

In FY 2013, CDC will:

- Improve CDC's ability as a World Health Organization (WHO) Collaborating Center to rapidly detect, identify, and characterize emerging influenza viruses so that seed strains used to produce vaccines for seasonal and novel viruses can be selected rapidly and with precision. A crucial ingredient of effective influenza control is to shorten the interval between the identification of novel influenza viruses and the delivery of effective vaccines. CDC will accomplish this by:
    - Improving the use of new diagnostics at public health laboratories;
    - Working with the FDA to bring new point-of-care influenza virus detection tests to clinician offices; and
    - Promoting use of national electronic messaging standards for automated reporting of influenza laboratory data.

- Provide support to states, territories, and countries through the Epidemiology and Laboratory Capacity (ELC) grant for enhanced surveillance and laboratory testing capacity of influenza viruses. This activity determines which influenza viruses are circulating, identifies and prepares viruses for use in vaccines, monitors for vaccine mismatch during influenza seasons, detects the emergence of novel influenza strains, and determines the effectiveness of antiviral drug treatment for circulating viruses.
- Enhance the capability of state and local health departments to conduct influenza laboratory testing by increasing the number of public health laboratories that can perform testing for resistance to antiviral medications from 12 in FY 2012 to 15 in FY 2013, and maintaining the number of state and local laboratories that participate in CDC evaluations of new influenza diagnostic tests.
- Continue work with domestic and international partners in the intersection of human and animal health to improve surveillance, conduct swift outbreak responses, and complete threat assessments for emerging influenza viruses with pandemic potential.
- Monitor influenza viruses and infections to:
    - Determine the health security and economic impacts of influenza-associated clinic visits, hospitalizations, and deaths; and
    - Refine methods to demonstrate the health security and economic impacts of annual influenza recommendations.
- Conduct research to better understand the complex factors that determine how influenza is transmitted and causes illness.
- Support the international monitoring of influenza and continue to evaluate countries' core capacities to conduct surveillance, perform laboratory testing, and prepare for and be ready to respond to influenza pandemics that can occur at any time. CDC will place special emphasis on expanded virus sample sharing among countries to produce vaccines and develop tests to detect influenza viruses that have pandemic potential.

Education of Health Care Providers and the Public

In FY 2013, CDC will:

- Continue effective influenza communication and education that is crucial for successful preparedness for and response to seasonal and pandemic influenza. CDC will lead efforts to improve clinician and public awareness and acceptance of CDC's influenza prevention, testing, and treatment recommendations.
- Strengthen communication and education strategies to reach vulnerable populations, including pregnant women and others with special needs.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$100.000**	**$190.000**	**$72.460**	**-$117.540**

The following activities are included:

- Immunization – $72,460,000 (included in the Immunization narrative)

PERFORMANCE

Efficiency Measure for the National Center for Immunization and Respiratory Diseases

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
1.E.1: Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S. (Efficiency)	FY 2011: 98% reduction (Target Met)	Maintain 98% reduction in inventory depots	Maintain 98% reduction in inventory depots	Maintain

Program: Section 317 Immunization Program and Program Implementation and Accountability

Performance Measures for Long Term Objective: Ensure that children and adolescents are appropriately vaccinated.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
1.2.1c: Sustain immunization coverage in children 19 to 35 months of age for one dose of Measles, Mumps, and Rubella (MMR) vaccine (Intermediate Outcome)	FY 2010: 92% (Target Exceeded)	90%	90%	Maintain
1.2.1h: Achieve immunization coverage of at least 90% in children 19-35 months of age for at least 4 doses pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2010: 83% (Target Not Met but Improved)	90%	87%	-3%
1.2.1i: Achieve immunization coverage of at least 60% in children 19- to 35-months of age for 2-3 doses of rotavirus (Intermediate Outcome)	FY 2010: 59% (Target Exceeded)	60%	60%	Maintain
1.2.2a: Achieve or sustain immunization coverage of at least 70% in adolescents 13 to 15 years of age for 1 dose Tdap (tetanus and diphtheria toxoids and acellular pertussis) (Intermediate Outcome)	FY 2010: 74% (Target Exceeded)	70%	73%	+3%

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
1.2.2b: Achieve or sustain immunization coverage of at least 70% in adolescents 13 to 15 years of age for 1 dose meningococcal conjugate vaccine (MCV4) (Intermediate Outcome)	FY 2010: 65% (Target Exceeded)	70%	73%	+3%
1.C**:** Number of states (including the District of Columbia) achieving 65% coverage for 1 birth dose hepatitis B vaccine (19–35 months of age) (Output)	FY 2010: 32 (Target Exceeded)	40	42	+2
1.D: Number of states (including the District of Columbia) achieving 30% coverage for influenza vaccine (6–23 months of age) (Output)	FY 2010: 27 (Target Exceeded)	29	31	+2
1.E: Number of states (including the District of Columbia) achieving 25% coverage for ≥ 3 doses human papillomarivus vaccine (13–17 years of age) (Output)	FY 2010: 45 (Target Exceeded)	40	42	+2
1.F: Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose Tdap vaccine (13–17 years of age) (Output)	FY 2010: 49 (Target Exceeded)	46	48	+2
1.G: Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose meningococcal conjugate vaccine (13–17 years of age) (Output)	FY 2010: 44 (Target Exceeded)	40	42	+2

Performance Measures for Long Term Objective: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
1.3.1a: Increase the rate of influenza vaccination in persons 65 years of age and older (Intermediate Outcome)	FY 2010: 66% (Target Not Met)	75%	78%	+3%
1.3.1b: Increase the rate of pneumococcal vaccination in persons 65 years of age and older (Intermediate Outcome)	FY 2010: 60% (Target Not Met)	67%	70%	+3%
1.3.2a: Increase the rate of influenza vaccination among adults ages 18 to 64 (Intermediate Outcome)	FY 2010: 28% (Target Not Met but Improved)	36%	40%	+4%
1.3.2b: Increase the rate of pneumococcal vaccination among non-institutionalized high-risk adults ages 18 to 64 (Intermediate Outcome)	FY 2010: 28% (Target Not Met but Improved)	31%	34%	+3%

Performance Trends: Immunization continues to be one of the most cost-effective public health interventions. CDC supports the implementation of state-based immunization programs making vaccines available to vulnerable children, adolescents, and adults. Since the adoption of this strategy, the U.S. experienced record high childhood vaccination levels and record low levels of vaccine-preventable diseases. For each 2009 birth cohort vaccinated against 13 diseases (diphtheria, haemophilus influenzae type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella) in accordance with the routine childhood immunization schedule, the U.S. saved $13.6 billion in direct medical costs and 42,000 lives and prevented 20 million cases of disease. Overall, an estimated $10.20 for every $1 invested (Table 1).

Table 1: Cost-effectiveness of Childhood Vaccines

Vaccine:	Cost Savings: for every $1 spent on an individual vaccine
Diphtheria-Tetanus-acellular Pertussus (DTaP)	saves $47.80
Measles, Mumps, and Rubella (MMR)	saves $23.30
Hepatitis B	saves $2.40
Varicella	saves $2.00
Inactivated Polio (IPV)	saves $8.60
Haemophilus influenza type b (Hib)	saves $4.90
Pneumococcal (PCV7)	saves $1.50
Childhood series (9 vaccines) [1]	saves $10

[1] Includes DTaP, Hib , hepatitis A, hepatitis B, MMR, PCV7, IPV, rotavirus, and varicella vaccines; hepatitis A and rotavirus vaccines are cost-effective, but not cost saving..

CDC made significant progress in improving and sustaining immunization coverage of children 19–35 months of age with appropriate vaccinations. In 2010, coverage levels were near or above the national Healthy People 2010 targets of 90 percent or higher among children 19–35 months of age for most of the routinely recommended childhood vaccines. Of the three performance measures for vaccination coverage in children 19-35 months of age, two measures exceeded the 2010 target and one, while very close to meeting the target, showed improvement over the 2009 rate. Coverage for MMR vaccine increased from 90 percent in 2009 to 92 percent in 2010; rotavirus vaccine increased by 15 percentage points from 44 percent in 2009 to 59 percent in 2010; and while coverage with pneumococcal conjugate vaccine did not meet the 2010 target of 84 percent, it increased from 80 percent in 2009 to 83 percent in 2010 (Measures 1.2.1).

Adolescent vaccination coverage rates showed significant progress in meeting immunization targets. Both adolescent performance measures significantly exceeded their targets. Vaccination coverage for Tetanus, Diphtheria, Pertussis (Tdap) increased from 62 percent in 2009 to 74 percent in 2010 and MCV4 coverage increased from 55 percent in 2009 to 65 percent in 2010 (Measures 1.2.2).

During the past decade, vaccination coverage levels among older adults increased slightly as CDC implemented national strategies and worked with state and local public health departments to promote adult immunization among healthcare providers and state and local governments. However, CDC did not meet the 2010 targets for adult vaccination. Influenza vaccination among the adults ages 65 and older remained at 66 percent and pneumococcal vaccination decreased from 61 percent in 2009 to 60 percent (Measures 1.3.1). For adults ages 18 to 64, influenza vaccination increased from 27 percent in 2009 (baseline) to 28 percent and pneumococcal vaccination among high risk populations increased from 17 percent in 2009 to 28 (Measures 1.3.2). Addressing barriers to adult immunization and increasing adult vaccination rates will require a different approach to the ones used to increase childhood coverage. Adult vaccination recommendations are not typically included in the routine adult preventive care schedule. Further, the types of providers where adults receive care are more diverse and may not always be experienced in delivering vaccines. CDC is working on a number of strategies to improve adult vaccination coverage rates, including patient and provider education to increase demand, system changes

in the office setting to reduce missed opportunities, evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations, expanded provider education to reach the diversity of health care venues in which adults receive care, and implementation of vaccination programs in new venues.

Program: Influenza Planning and Response

Performance Measures for Long Term Objective: Protect Americans from infectious diseases – Influenza.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
1.6.1: Increase the number of public health laboratories monitoring influenza virus resistance to antiviral drugs (Output)	FY 2011: 9 (Target Met)	12	15	+3
1.6.2: Increase the percentage of corrective actions completed from Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees pandemic influenza improvement plans (Output)	FY 2010: 37% (Baseline)	60%	70%	+10%
1.6.3: Percentage of countries achieving an increase of five percent over last year's indicator score on CDC's National Inventory of Core Capacities for Pandemic Influenza Preparedness and Response (Output)	FY 2010: 94% (Target Exceeded)	75%	N/A[1]	N/A
1.L: Number of influenza diagnostic kits and virus reference panels distributed domestically and internationally. (Output)	FY 2011: 2,315 (Target Exceeded)	2,100	2,100	Maintain
1.M: Number of virus specimens received and characterized annually from global National Influenza Centers for use in determining vaccine strain selection. received and characterized (Output)	FY 2010: 9,487 (Historical Actual)	11,000	11,000	Maintain

[1] This indicator score is formally assessed every other year, and that the instrument may be reassessed and improved in FY 2013.

Performance Trends: CDC met the FY 2011 targets of having nine public health programs monitoring the influenza virus resistance to antiviral drugs and having 37 percent of pandemic influenza improvement plan corrective actions completed by Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees (Measures 1.6.1 and 1.6.2). Recent evaluation of preparedness and response capabilities of 44 countries participating in CDC's National Inventory of Core Capacities for Pandemic Influenza and Response demonstrated significant improvements for the reporting period 2008–2010 in clinical management guidance, resource management for antiviral treatment, personal protective equipment, and communication of surveillance information. CDC expects to achieve the FY 2011 interim target of 60 percent of countries achieving a five percent increase in indicator scores over the full two-year reporting period ending in FY 2012 (Measure 1.6.3).

In FY 2010 and FY 2011, CDC enhanced state and local capacity to gather influenza epidemiology and laboratory data essential for systematic, accurate surveillance of seasonal and novel influenza viruses by supporting the assignment of 93 ELC-funded laboratorians and influenza coordinators at state and local

health departments. CDC enhanced global capacity to monitor influenza viruses and to inform vaccine policy and antiviral treatment recommendations by serving as a WHO Collaborating Center for Influenza. In this capacity, CDC provided 2,315 influenza diagnostic kits and virus reference panels to ensure the availability of timely diagnostic resources domestically and globally in FY 2010 (Measure 1.L). In the fall of 2011, the FDA approved revisions configuration of diagnostic kits, which increased the products available and subsequently the number of kits shipped during the reporting timeframe. CDC exceeded the target and targets for future years were adjusted to reflect this change. In addition, CDC received and characterized 9,487 influenza virus specimens and expects to receive about 11,000 influenza virus specimens in FY 2010 (Measure 1.M). Characterization of these specimens from throughout the world is essential to the production of each season's influenza vaccine, as well as informing decisions regarding potential vaccines for novel influenza viruses with pandemic potential and informing vaccine policies and recommendations.

IT INVESTMENTS

CDC made several investments in information technology (IT) to improve efficiencies and effectiveness. These systems support various programs in the elimination of vaccine-preventable and respiratory diseases and infections. IT investments are developed to track and order vaccines; monitor the occurrence of vaccine-preventable diseases and disease outbreaks; provide electronic capabilities for gathering, storing, tracking, and analyzing critical surveillance data; support the development and dissemination of public health information; and oversee grants management. These systems improve CDC's understanding of the public health issues related to vaccine-preventable and respiratory diseases, and inform the design, implementation, and evaluation of public health practice for preventing and controlling disease. These systems include: the Grants Information Systems for Immunization (formerly Program Annual Progress Assessment), Administrative Support investments, Public Health Communication for Immunization and Respiratory Diseases, Public Health Monitoring for Immunization and Respiratory Diseases, Public Health Services for Immunization and Respiratory Diseases, Immunization Registries (Extramural), and the Vaccine Tracking System (VTrckS).

VTrckS is an enterprise system used to track federally contracted vaccine orders between manufacturers, distributor, and health care providers. The system went live on December 13, 2010, with four pilot grantees: two external registry system grantees (Michigan and Washington) and two VTrckS Provider Order Pilot (VPOP) grantees (Chicago and Colorado). Since the system went live, VTrckS has successfully processed all vaccine orders (approximately two million as of December 2011) generated from the old legacy system by non-pilot grantees, as well as orders entered directly into VTrckS by the pilot grantees. After go-live, pilot grantees, third party reviewers, and internal users provided significant feedback for the need for enhancements and optimizations before further scale up of the system. These optimizations will be released to the pilot grantees in February 2012. Further rollout to the non-pilot grantees will begin in February 2012, with rollout completion in June 2013.

STATE TABLES[1,2]

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program[1]				
State/City/Territory	**FY 2011 Appropriation**	**FY 2012 Enacted**	**FY 2013 President's Budget**	**FY 2013 +/- FY 2012**
Alabama	$8,617,358	$8,454,623	$7,565,663	-$888,960
Alaska	$4,417,966	$5,063,654	$4,527,935	-$535,719
Arizona	$11,248,386	$11,943,137	$10,688,946	-$1,254,191

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program[1]				
State/City/Territory	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Arkansas	$7,431,098	$4,535,736	$4,059,034	-$476,702
California	$54,581,732	$63,098,560	$56,457,479	-$6,641,081
Colorado	$9,348,914	$8,923,218	$7,985,780	-$937,438
Connecticut	$6,652,851	$5,903,580	$5,282,066	-$621,514
Delaware	$1,212,411	$1,453,520	$1,301,301	-$152,219
District of Columbia	$1,526,767	$1,819,236	$1,628,457	-$190,778
Florida	$24,376,881	$27,798,394	$24,874,066	-$2,924,329
Georgia	$12,294,516	$13,373,052	$11,969,681	-$1,403,371
Hawaii	$3,742,549	$3,339,335	$2,988,956	-$350,379
Idaho	$3,036,563	$3,572,914	$3,197,169	-$375,746
Illinois	$10,414,741	$12,211,871	$10,926,601	-$1,285,270
Indiana	$7,816,653	$8,751,190	$7,827,851	-$923,339
Iowa	$5,288,434	$5,191,251	$4,645,971	-$545,280
Kansas	$7,527,921	$5,233,112	$4,683,764	-$549,348
Kentucky	$4,641,112	$5,510,045	$4,931,749	-$578,296
Louisiana	$5,525,117	$6,421,128	$5,743,952	-$677,177
Maine	$4,410,056	$3,796,748	$3,399,521	-$397,226
Maryland	$7,847,550	$7,814,566	$6,995,304	-$819,261
Massachusetts	$13,974,520	$13,180,643	$11,788,862	-$1,391,782
Michigan	$15,568,191	$16,823,961	$15,053,713	-$1,770,248
Minnesota	$9,504,850	$9,717,704	$8,696,168	-$1,021,536
Mississippi	$5,101,609	$5,486,825	$4,911,083	-$575,743
Missouri	$9,835,236	$9,855,129	$8,816,993	-$1,038,137
Montana	$1,756,109	$2,088,388	$1,869,287	-$219,100
Nebraska	$3,271,984	$3,323,984	$2,975,684	-$348,300
Nevada	$4,100,914	$4,177,123	$3,737,532	-$439,591
New Hampshire	$2,237,442	$2,619,798	$2,343,982	-$275,816
New Jersey	$4,585,748	$4,584,977	$4,108,031	-$476,946
New Mexico	$3,371,657	$4,041,972	$3,618,674	-$423,297
New York	$15,727,951	$15,758,168	$14,107,615	-$1,650,553

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program[1]				
State/City/Territory	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
North Carolina	$12,245,952	$13,160,536	$11,775,458	-$1,385,078
North Dakota	$2,267,034	$2,377,799	$2,127,185	-$250,614
Ohio	$14,193,018	$16,164,366	$14,458,767	-$1,705,599
Oklahoma	$6,915,832	$6,907,641	$6,181,241	-$726,399
Oregon	$5,912,350	$6,287,161	$5,627,946	-$659,215
Pennsylvania	$12,688,305	$14,872,326	$13,306,920	-$1,565,406
Rhode Island	$2,377,608	$2,802,802	$2,508,170	-$294,632
South Carolina	$6,795,174	$7,230,527	$6,470,240	-$760,288
South Dakota	$2,335,765	$2,674,766	$2,391,726	-$283,040
Tennessee	$8,070,490	$9,541,057	$8,538,742	-$1,002,314
Texas	$30,733,189	$35,484,306	$31,751,602	-$3,732,704
Utah	$5,376,547	$5,728,690	$5,126,460	-$602,230
Vermont	$3,125,736	$2,731,991	$2,444,353	-$287,638
Virginia	$10,862,660	$12,023,827	$10,753,980	-$1,269,847
Washington	$10,531,250	$10,310,800	$9,225,574	-$1,085,226
West Virginia	$4,419,466	$3,653,389	$3,269,253	-$384,136
Wisconsin	$8,544,540	$9,089,063	$8,131,441	-$957,623
Wyoming	$1,952,032	$1,745,092	$1,562,044	-$183,047
Chicago	$4,661,699	$5,586,888	$5,001,761	-$585,126
Houston[2]	$2,087,960	$2,476,429	$2,220,233	-$256,196
New York City	$13,212,691	$15,691,126	$14,044,406	-$1,646,720
Philadelphia	$2,623,676	$3,156,108	$2,825,836	-$330,272
San Antonio	$2,353,652	$2,847,982	$2,550,341	-$297,640
American Samoa	$404,308	$484,024	$433,319	-$50,705
Guam	$957,601	$1,140,992	$1,021,338	-$119,654
Marshall Islands	$1,697,945	$1,967,340	$1,759,720	-$207,621
Micronesia	$2,743,502	$3,220,166	$2,881,329	-$338,837
Northern Mariana Islands	$711,123	$858,959	$769,154	-$89,804
Puerto Rico	$5,526,764	$6,530,978	$5,844,814	-$686,165
Republic Of Palau	$551,445	$639,632	$572,146	-$67,486
Virgin Islands	$641,648	$800,752	$717,629	-$83,123

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program[1]				
State/City/Territory	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Total States/Cities/Territories	**$478,516,746**	**$514,055,055**	**$460,001,999**	**-$54,053,056**
Other Adjustments[3]	$47,054,254	$43,814,945	$39,297,001	-$4,517,944
Total Resources[4,5]	**$525,571,000**	**$557,870,000**	**$499,299,000**	**-$58,571,000**

[1]Includes vaccine direct assistance and immunization infrastructure/operations grant funding.

[2]Immunization infrastructure/operations grant funding only; vaccine direct assistance for Houston is included with Texas.

[3]Other adjustments include vaccine that is in inventory at the centralized distribution center but has not been ordered by immunization providers, funds for centralized vaccine distribution activities, vaccine safety data link, PHS evaluation, special projects, and program support services.

[4]FY 2011 does not include American Recovery and Reinvestment Act funding.

[5]FY 2011 includes Section 317 request of $425,571,000 and Prevention and Public Health Fund (PPHF) request of $100,000,000. PPHF operations funding was awarded by a competitive funding opportunity announcement (not all Section 317 grantees applied or were awarded funds); FY 2012 includes Section 317 request of $367,870,000 and PPHF request of $190,000,000; FY 2013 includes Section 317 request of $426,813,000 and PPHF request of $72,460,000.

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 MANDATORY STATE/FORMULA GRANTS CFDA Number: 93.268/Vaccines for Children (VFC) Program[1]				
State/City/Territory	FY 2011 Appropriation	FY 2012 Appropriation	FY 2013 President's Budget	FY 2013 +/- FY 2012
Alabama	$55,388,691	$56,037,969	$60,009,310	$3,971,341
Alaska	$10,838,232	$10,991,361	$11,705,702	$714,340
Arizona	$80,154,471	$81,101,230	$86,832,734	$5,731,503
Arkansas	$39,795,202	$40,264,126	$43,112,145	$2,848,019
California	$508,084,654	$513,910,346	$550,621,737	$36,711,391
Colorado	$42,653,709	$43,168,929	$46,194,204	$3,025,275
Connecticut	$33,188,107	$33,608,334	$35,920,351	$2,312,017
Delaware	$10,418,907	$10,560,146	$11,265,792	$705,646
District of Columbia	$8,496,504	$8,618,201	$9,179,530	$561,329
Florida	$189,989,369	$192,195,855	$205,862,639	$13,666,784
Georgia	$135,952,153	$137,534,407	$147,306,813	$9,772,406
Hawaii	$14,087,536	$14,303,901	$15,203,013	$899,112
Idaho	$20,081,513	$20,323,939	$21,748,553	$1,424,614
Illinois	$92,332,721	$93,430,593	$100,017,170	$6,586,577
Indiana	$65,696,959	$66,480,695	$71,161,629	$4,680,933
Iowa	$25,077,633	$25,389,292	$27,149,021	$1,759,730
Kansas	$24,031,345	$24,331,778	$26,014,240	$1,682,462

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 MANDATORY STATE/FORMULA GRANTS CFDA Number: 93.268/Vaccines for Children (VFC) Program[1]				
State/City/Territory	FY 2011 Appropriation	FY 2012 Appropriation	FY 2013 President's Budget	FY 2013 +/- FY 2012
Kentucky	$44,492,516	$45,009,211	$48,209,819	$3,200,608
Louisiana	$67,213,177	$67,987,806	$72,835,674	$4,847,867
Maine	$10,461,885	$10,620,053	$11,293,205	$673,152
Maryland	$60,974,411	$61,685,606	$66,065,153	$4,379,547
Massachusetts	$60,252,712	$60,978,474	$65,256,398	$4,277,924
Michigan	$90,804,476	$91,882,493	$98,363,700	$6,481,207
Minnesota	$36,703,085	$37,150,158	$39,745,294	$2,595,137
Mississippi	$43,353,731	$43,856,837	$46,976,316	$3,119,480
Missouri	$56,417,831	$57,084,725	$61,117,830	$4,033,105
Montana	$7,418,976	$7,519,890	$8,021,617	$501,726
Nebraska	$21,377,061	$21,632,337	$23,154,903	$1,522,566
Nevada	$33,236,067	$33,641,371	$35,990,368	$2,348,997
New Hampshire	$8,336,866	$8,453,488	$9,010,309	$556,821
New Jersey	$75,849,599	$76,762,846	$82,148,978	$5,386,132
New Mexico	$35,091,101	$35,520,185	$37,997,778	$2,477,592
New York	$84,715,909	$85,789,722	$91,688,898	$5,899,176
North Carolina	$97,361,800	$98,511,513	$105,474,073	$6,962,560
North Dakota	$5,688,437	$5,765,089	$6,151,349	$386,260
Ohio	$98,675,172	$99,806,393	$106,936,523	$7,130,129
Oklahoma	$56,917,111	$57,598,041	$61,649,219	$4,051,178
Oregon	$31,959,508	$32,362,440	$34,592,633	$2,230,193
Pennsylvania	$79,909,132	$80,904,227	$86,507,217	$5,602,990
Rhode Island	$13,500,850	$13,678,455	$14,604,558	$926,103
South Carolina	$48,176,016	$48,764,745	$52,166,961	$3,402,216
South Dakota	$9,172,505	$9,290,611	$9,925,350	$634,738
Tennessee	$72,384,462	$73,231,212	$78,424,944	$5,193,732
Texas	$342,698,254	$346,691,051	$371,315,161	$24,624,110
Utah	$22,773,277	$23,062,512	$24,647,082	$1,584,570
Vermont	$6,055,559	$6,153,125	$6,529,731	$376,606
Virginia	$56,289,087	$56,938,856	$60,996,553	$4,057,698

CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2013 MANDATORY STATE/FORMULA GRANTS
CFDA Number: 93.268/Vaccines for Children (VFC) Program[1]

State/City/Territory	FY 2011 Appropriation	FY 2012 Appropriation	FY 2013 President's Budget	FY 2013 +/- FY 2012
Washington	$101,108,135	$102,343,898	$109,483,807	$7,139,910
West Virginia	$17,786,674	$18,005,112	$19,258,882	$1,253,770
Wisconsin	$45,571,882	$46,112,188	$49,366,451	$3,254,263
Wyoming	$5,728,464	$5,807,878	$6,192,043	$384,165
Chicago	$47,180,950	$47,769,251	$51,075,782	$3,306,532
Houston[2]	$739,395	$780,730	$762,988	($17,742)
New York City	$137,278,447	$138,880,858	$148,738,375	$9,857,517
Philadelphia	$27,268,035	$27,621,898	$29,502,881	$1,880,983
San Antonio	$25,033,172	$25,336,064	$27,110,467	$1,774,403
American Samoa	$844,197	$856,769	$911,237	$54,467
Guam	$2,179,805	$2,218,795	$2,345,017	$126,221
Northern Mariana Islands	$890,499	$906,603	$957,776	$51,173
Puerto Rico	$64,305,315	$65,069,630	$69,657,516	$4,587,886
Virgin Islands	$2,344,349	$2,405,882	$2,500,215	$94,333
Total States/Cities/Territories	**$3,512,787,595**	**$3,554,700,132**	**$3,804,965,615**	**$250,265,483**
Other Adjustments[3]	$439,889,106	$454,359,868	$466,049,385	$11,689,517
Total Resources[4]	**$3,952,676,701**	**$4,009,060,000**	**$4,271,015,000**	**$261,955,000**

[1]This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/.

[2]Funding for Houston only includes funding for operations, not the cost of vaccines. Funding for Texas includes the cost of vaccines for Houston.

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

[4]Total resources for FY 2011 reflect actual obligations. Total resources for FY 2012 and FY 2013 are based on the FY 2013 VFC President's Budget ten year table. The FY 2012 level represents estimated total obligations, including $3.119 million in prior year recoveries and refunds brought forward and $4.006 billion in transfer from CMS. The FY 2013 net increase of estimated total obligations, inclusive of prior year recoveries and refunds brought into FY 2012 totals $261,955,000; the FY 2013 net increase of the non-expenditure transfer from CMS, exclusive of prior year recoveries and refunds brought into FY 2012 totals $265,074,280.

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

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$1,115.995	$1,099.934	$1,145.678	+$45.744
ACA/PPHF	$0.000	$10,000	$0.000	-$10.000
Total	**$1,115.995**	**$1,109.934**	**$1,145.678**	**+$35.744**
FTEs	1,092	1,087	1,086	-1

Authorizing Legislation: PHSA §§ 301, 306, 307, 308, 310, 311, 317, 317E, 317N, 317P, 317T, 318, 318A, 318B, 322, 325, 327, 352, 1701, 1704, 2315, 2320, 2341; P.L. 103-333; Section 212 of the Consolidated Appropriations Act, 2012 (P.L. 112-74, Division F)

FY 2013 Authorization……..……..Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $1,145,678,000 for HIV/AIDS, viral hepatitis (VH), sexually transmitted infections (STIs), and tuberculosis (TB) prevention is an overall increase of $35,744,000 above the FY 2012 level. The request includes an increase of $40,231,000 for domestic HIV/AIDS prevention and research and a reduction of $4,607,000 for TB. The FY 2013 budget request reflects a substantial investment to continue implementing the National HIV/AIDS Strategy (NHAS).

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Domestic HIV/AIDS Prevention and Research	$800.445	$786.176	$826.407	+$40.231
Viral Hepatitis	$19.784	$19.672	$29.694	+$10.022
Sexually Transmitted Infections	$154.666	$153.788	$153.886	+$0.098
Tuberculosis	$141.100	$140.298	$135.691	-$4.607
ACA/PPHF	$0.000	$10.000	$0.000	-$10.000
Total	**$1,115.995**	**$1,109.934**	**$1,145.678**	**+$35.744**

CDC provides national leadership to prevent and control HIV/AIDS, VH, STIs, and TB in the United States.

- CDC is committed to achieving the goals of the President's *National HIV/AIDS Strategy* (NHAS) and the *HHS Action Plan to Combat Viral Hepatitis*, which aims to reduce the health consequences of hepatitis B virus (HBV) and hepatitis C virus (HCV) infection.
- CDC reduces the health consequences of STIs, such as infertility in women, adverse reproductive health outcomes, cancer, and HIV infection, by incorporating advances such as improved prevention service delivery, better screening tests and vaccines, while at the same time addressing growing threats such as antibiotic-resistant gonorrhea.
- CDC works to eliminate TB in the United States, building on the substantial achievements made in TB control in the United States in the past two decades.

- CDC monitors these infections and related risk factors; implements effective prevention and control programs; and conducts prevention research, demonstration projects, and evaluation efforts to refine prevention approaches. Program activities are conducted in partnership with health departments and other institutions in the United States and around the world.
- CDC's efforts focus on the populations most affected by these diseases, including racial and ethnic minorities; men who have sex with men (MSM) of all races; persons born outside the United States; and young, sexually active adults. Because these disease conditions share many social, environmental, behavioral, and biological determinants and are often managed by the same or similar organizations, public health efforts to prevent their occurrence require a syndemic orientation. Key approaches include a focus on sexual health, which provides an opportunity for a broader dialogue on prevention and wellness rather than disease incidence or avoidance, and social determinants of health approach, which considers the structural, contextual, and environmental factors, socioeconomic status, and health care service access and quality, in addition to individual risks.
- CDC has greatly advanced program collaboration and service integration (PCSI) across HIV, VH, STI, and TB prevention programs over the past several years through development of best practices, support for demonstration projects, and authorization of PCSI activities in its categorical programs. Through PCSI, CDC strengthens collaborative work across disease areas and integrates services at the client level. PCSI makes small changes in the way prevention services are delivered in order to reach a larger population with more services. It can also improve efficiency, cost effectiveness, and health outcomes. For example, CDC is working to consolidate certain funding announcements across disease areas to lessen the administrative burden on grantees (e.g., the Pacific Islands). CDC will continue to fund PCSI through its categorically funded programs and through cross-center efforts.
- CDC also requests authority to allow CDC and grant recipients to transfer up to 10 percent of funds across HIV/AIDS, VH, STI, and TB prevention activities to enhance PCSI; strengthen collaborative work across disease areas; and integrate services that are provided by related programs at the client level. The budget also includes new appropriations language that would provide CDC with the additional flexibility to transfer funds to across activities to address outbreaks.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$1,002.130
2009	$1,006.375
2010	$1,088.345
2010 (ACA/PPHF)	$30.367
2011	$1,115.995
2012	$1,099.934
2012 (ACA/PPHF)	$10.000

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

DOMESTIC HIV/AIDS PREVENTION AND RESEARCH BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
HIV Prevention by Health Department[1]	$394.809	$392.636	$402.447	+$9.811
National Programs to Identify and Reach High Risk Populations[1]	$365.636	$363.702	$384.026	+$20.324
HIV Adolescent and School Health[2]	$40.000	$29.838	$39.934	+$10.096
Total	**$800.445**	**$786.176**	**$826.407**	**+$40.231**

[1]FY 2011 and FY 2012 amounts for HIV Prevention by Health Department and National Programs to Identify and Reach High Risk Populations have been adjusted for comparability to the newly proposed FY 2013 Domestic HIV/AIDS Prevention sub-line structure.
[2]The FY 2011 Operating Plan reflected HIV School Health activities in the School Health budget line within the Chronic Disease Prevention and Health Promotion budget.

Program Overview: Important changes have occurred in the field of HIV prevention in the past two years that have created exciting, new opportunities to lower the number of new HIV infections that occur each year in the United States.

Significant research developments point to new, effective approaches for preventing new HIV infections. For example, in May 2011, researchers from the HIV Prevention Trials Network published a paper finding that successful treatment of HIV reduced an individual's risk of transmitting the virus to others by 96 percent. In July 2011, at the International AIDS Society meeting in Rome, Italy, CDC researchers provided preliminary evidence that taking a daily pill containing a combination of two antiretroviral medications can be effective in preventing acquisition of HIV infection among heterosexuals. The announcement followed a National Institutes of Health (NIH) announcement in late 2010 that a daily dose of an oral antiretroviral drug taken by HIV-negative gay and bisexual men reduced the risk of acquiring HIV infection by 43.8 percent and had even higher rates of effectiveness, up to 73 percent, among those participants who adhered most closely to the daily drug regimen. CDC has released interim guidance for the safe and effective use of pre-exposure prophylaxis (PrEP) among MSM, but conflicting results from some trials point to the need for additional data to confirm its efficacy in women. In November 2011, CDC researchers published a study in conjunction with World AIDS Day that described the delivery of HIV prevention and medical care services to persons living with HIV in the United States. These findings highlighted the fact that gaps in HIV diagnosis and delivery of medical services are placing the majority of people living with HIV in the United States at risk for disease progression and onward transmission of HIV. Of particular concern is the finding that only 28 percent of people living with HIV in the United States have an undetectable viral load. Finally, studies of cost effectiveness and models of efficacy are informing CDC and others about the best combination of prevention approaches needed to achieve the highest impact.

The NHAS, released in 2010, guides federal agencies, including CDC, in making the most of these changes and in utilizing prevention and treatment resources most effectively. It is focused on three overarching goals: 1) reducing the number of new HIV infections, 2) increasing access to care for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS set three specific metrics for measuring the nation's collective success at reducing new infections. Over the next five years, from 2010–2015, the United States aims to: 1) lower the annual number of new infections by 25 percent; 2) reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent; and 3) increase from 79 percent to 90 percent the percentage of people living with HIV who know their serostatus.

To achieve these aggressive but realistic targets, the NHAS identifies three specific action steps: 1) intensify HIV prevention efforts in communities where HIV is most heavily concentrated; 2) expand

targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches; and 3) educate all Americans about the threat of HIV and how to prevent it.

CDC, as the nation's lead HIV prevention agency, remains at the forefront of preventing new infections by providing leadership and guidance to other agencies, other levels of government, and community stakeholders. CDC has introduced a new, high-impact approach to HIV prevention that is designed to advance the prevention goals of the NHAS and maximize the effectiveness of current HIV prevention methods. This approach is based on the use of combinations of scientifically proven, cost-effective, and scalable interventions that are directed to the right populations in the right geographic areas. In addition to these targeted efforts, CDC will continue to support HIV education for young Americans.

CDC proposes to reduce the number of Domestic HIV/AIDS Prevention and Research budget lines from six lines to three lines to enable the agency to respond to emerging needs in a cost-effective manner while ensuring accountability. The proposed structure allows CDC to efficiently implement projects in response to evolving prevention interventions and technologies, emerging problems (such as outbreaks), newly developed national priorities (such as the NHAS), and changes in the operating environment (such as the identification of more cost-effective means to achieve programmatic results). For example, procurement regulations require that certain multi-year projects be fully funded in the first year of a contract. These non-severable contracts, such as those for research and demonstration projects, put great pressure on the budget in the year that they are funded, such that CDC may not support some worthy projects because it is unable to fund the project at a sufficient scale to have an impact. Having a smaller number of budget lines increases CDC's ability to fund a portfolio of projects at sufficient scale and increases the potential for administrative efficiencies.

The following budget lines represent the main areas of activity:

- *HIV Prevention by Health Departments*: CDC's largest prevention program that supports HIV prevention nationwide through the actions of health departments in every state, territory, and highly affected metropolitan area.
- *National Programs to Identify and Reach Highest Risk Populations*: Includes surveillance to monitor changes in the epidemic and identify populations and geographic areas in which most infections occur, focused prevention programs to reach those at highest risk, capacity-building assistance programs (CBAs), and research to improve prevention approaches.
- *HIV Adolescent and School Health*: CDC's program to help adolescents develop healthy behaviors and avoid HIV and STIs.

Budget Proposal: CDC's FY 2013 request of $826,407,000 for domestic HIV/AIDS prevention and research is an increase of $40,231,000 above the FY 2012 level. This amount includes funding to the HIV adolescent and school program, which was transferred to the National Center for HIV/AIDS, VH, STD, and TB Prevention in FY 2012, and provides additional funding to achieve the goals of the NHAS. CDC will continue to focus its HIV prevention resources to achieve NHAS goals, including funding to health departments to improve linkage to and retention in care and receipt of prevention services, as well as surveillance activities. Additionally, funds will expand HIV testing and linkage to care for MSM, with the goal of identifying previously unrecognized HIV infections and improving health outcomes and reducing HIV transmission. CDC will provide technical assistance to health departments and community-based organizations (CBOs) to support service delivery improvements and targeting of resources using programmatic data. Funds will also support research, evaluation, and implementation of high-impact prevention programs among HIV-affected populations. Funds will be used to increase funding to state and local education and health agencies to implement school-based HIV prevention activities, increase funding to national nongovernmental organizations (NGOs) that support HIV prevention efforts serving youth in high prevalence communities, and expand surveillance and monitoring to collect national data to monitor priority health risk behaviors and school health programs and policies. CDC will continue to

support recipients of its grants and cooperative agreements to address syndemics of HIV, VH, STIs, and TB through PCSI.

HIV Prevention by Health Departments

Program Overview: CDC's flagship HIV prevention program, with 67 state and local health departments, provides the foundation for HIV prevention and control nationwide. Successful execution of this program is essential to achieving the prevention goals of the NHAS, and funding supports all three primary NHAS goals. In FY 2012, this program was modified to incorporate the following specific NHAS strategies:

- Intensifying efforts in communities where HIV is most concentrated.
- Expanding targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.

Funding for the program is awarded using a need-based formula, phased in over a five-year period.

The goal of the program is to reduce HIV transmission by building health department capacity to implement high-impact HIV prevention efforts that include:

- Focusing HIV prevention efforts in communities and local areas where HIV is most heavily concentrated to achieve the greatest impact;
- Increasing HIV testing;
- Increasing access to care and improving linkage to continuous and coordinated quality care, medical, prevention, and social services;
- Increasing awareness and educating communities about the threat of HIV and how to prevent it;
- Expanding targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches, including delivery of integrated and coordinated biomedical, behavioral, and structural HIV prevention interventions;
- Reducing HIV-related disparities and promoting health equity; and
- Monitoring program activity for improvement and accountability.

State and local communities, as well as HIV-infected and affected persons, inform the domestic prevention approach in these cooperative agreements. Program components include: Category A, core prevention programs, which support core funding to all 67 jurisdictions; Category B, the expanded testing program in 34 jurisdictions with the highest numbers of African Americans, Hispanics and MSM living with HIV; and Category C, innovative demonstration projects awarded competitively to health departments to develop methods that improve the practice of prevention.

With core prevention funding, health departments design, implement, and evaluate comprehensive HIV prevention programs that are effective, scalable, and intended to yield maximum impact on reducing new HIV infections. Required core prevention components are HIV testing, comprehensive prevention with positives (services and programs to assist HIV-infected person in avoiding transmitting the virus), condom distribution, and policy initiatives. Programs may also support evidence-based HIV prevention interventions for HIV-negative persons at highest risk for acquiring HIV; social marketing, media, and mobilization; and activities to support PrEP and non-occupational post-exposure prophylaxis (nPEP) services. CDC encourages programs to focus on groups at highest risk for HIV.

HIV testing is one of the most important tools available to fight the HIV epidemic and is prominently featured in the NHAS. In addition to being unquestionably important to increasing access to care and improving health outcomes, HIV testing is an important strategy in reducing new HIV infections, as those who are aware of their infection are less likely to transmit HIV. CDC has a long history of providing

health departments and CBOs funding to conduct HIV testing. In 2007, these efforts were significantly increased through the Expanded Testing Program (ETP), which has led to a large increase in HIV testing in CDC-funded programs serving communities that are disproportionately affected by HIV. This increase in testing has resulted in increased diagnosis of previously undetected HIV infection and linkage to care and prevention services. In 2012, this program was continued as Category B of the flagship HIV prevention cooperative agreement to supplement core efforts to promote HIV testing.

CDC provides capacity-building and technical assistance to health departments to ensure that they have the information, training, and infrastructure support necessary to implement effective programs in their communities.

Recent accomplishments:

- Instituted a revised funding algorithm in 2012 to better align project funding according to disease burden nationally; provided more direction to grantees regarding effective HIV prevention activities, delineating those that are required and those that are recommended activities; and redirected funding within the cooperative agreements to achieve greater efficiency by shifting emphasis from individual and small group interventions that are difficult to take to scale to more scalable interventions and public health strategies that are more cost-effective.

- Continued the successful ETP, which in its first three years conducted more than 2.8 million tests and newly diagnosed over 18,000 persons with HIV infection in communities that are disproportionately affected by HIV. Of the new positives for which follow-up data were available, at least 91 percent received their test results, 75 percent were linked to medical care, and 83 percent were referred to partner services. Sixty percent of all those tested (and 70 percent of those newly diagnosed with HIV) were African American.

- Published a study examining the financial return on investment of CDC's ETP that demonstrated that the program was effective and realized positive returns on investment ($1.95 saved in direct medical costs for every $1 invested) due to reductions in transmissions from persons newly diagnosed with HIV infection. This program was estimated to have prevented 3,381 new HIV infections and to have saved the health care system more than $1.1 billion in lifetime HIV-related medical costs.

- Made available to the public plans developed by the 12 health jurisdictions participating in the Enhanced Comprehensive HIV Prevention Planning (ECHPP) initiative. These plans detail the locally developed strategies for increasing the impact of HIV prevention efforts, reducing new HIV infections, improving the health of people living with HIV, and reducing HIV-related disparities. The posting of these plans online furthers CDC's efforts to make information about HIV prevention funding, activities and outcomes more readily available to public health partners and the public. This program ended in 2012, but evaluations are ongoing.

Budget Proposal: CDC’s FY 2013 request for HIV Prevention by Health Department is $402,447,000, which includes increased resources to support health departments as they implement high-impact prevention services. These services will support the use of CD4 cell count, viral load, core HIV surveillance and programmatic data in order to improve testing, linkage, retention and re-engagement in care, and to reduce HIV risk behaviors.

In FY 2013, CDC will:

- Ensure a strong network of HIV prevention programs nationwide by providing technical and financial support to 67 health departments for HIV prevention. Through Category A (HIV Prevention Programs for Health Departments) of the flagship health department cooperative agreement, CDC will provide approximately two million HIV tests annually when the program is fully implemented nationwide.

- Provide technical assistance and training to staff of health departments on the implementation of recommendations for HIV testing, counseling, and linkage to health care in non-health care settings. CDC plans to publish the recommendations in 2012 and will monitor their uptake.
- Ensure that federal HIV prevention funding allocations go to jurisdictions with the greatest need by continuing to phase in revised funding allocations to health departments' prevention programs.
- Complete the evaluation of the implementation of enhanced HIV prevention plans developed by the 12 health jurisdictions with the greatest burden of HIV/AIDS, funded through the ECHPP project from FY 2010–FY 2012. These data will help CDC assess the community-level changes that occurred, including the delivery of HIV prevention services and programs, exposure to HIV prevention messages, HIV testing, and HIV risk behavior during the ECHPP implementation period and disseminate lessons learned to improve the delivery and effectiveness of HIV prevention programs in other health jurisdictions.
- Continue to support health departments as they shift from lower to higher impact activities. This would include: 1) shifting intervention activities to emphasize more scalable Diffusion of Effective Behavioral Interventions (DEBIs) and Public Health Strategies (PHSs), 2) implementing more cost-efficient strategies for community planning, and, 3) implementing more efficient strategies for HIV testing.
- Promote HIV testing and linkage to care, thereby reducing the undiagnosed prevalent HIV infection, improving awareness of serostatus, and reducing HIV transmission rates.
- Facilitate voluntary testing for STIs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB in conjunction with HIV testing, as medically appropriate.
- Support 34 health departments to increase testing among groups at highest risk for HIV acquisition (MSM, African Americans, injecting drug users [IDUs], and Latinos) through the ETP.
- Continue to provide HIV testing through the ETP to reach the goals of providing more than 1.3 million HIV tests and identifying at least 6,500 persons with newly diagnosed HIV infection annually.
- Continue implementation of "Scaling up HIV Testing among African American and Hispanic Men Who Have Sex with Men (MSM): The MSM Testing Initiative (MTI)," a project CDC began in 2011 to reach MSM at highest risk for HIV with testing and linkage-to-care services.
- Support local testing efforts, including those to secure reimbursement for HIV screening in collaboration with providers, health plans, state Medicaid boards, and other partners.
- Develop, distribute, and provide training on the operational guidelines to support routine HIV testing in substance abuse treatment centers (in collaboration with the Substance Abuse and Mental Health Services Administration), STI clinics, primary care and in-patient hospital settings, and non-health care settings.
- Collect national data to provide routine reports on program processes and impacts at the national and jurisdiction levels.

HIV Prevention with Health Departments Grant Table

(dollars in millions)	FY 2011 Appropriation[1]	FY 2012 Enacted[2]	FY 2013 Budget Request[2]
Number of Awards	95	67	67
Average Award	$3.323	$5.057	$5.057

(dollars in millions)	FY 2011 Appropriation[1]	FY 2012 Enacted[2]	FY 2013 Budget Request[2]
Range of Awards	$0.122–$27.000	$0.080–$21.001	$0.080–$21.001
Number of New Awards	0	67	0
Number of Continuing Awards	95	0	67

[1]In FY 2012, PS10-1001 (HIV Prevention Projects), PS10-1002 (HIV Prevention for the Pacific Islands), and PS10-10138 (Expanded HIV Testing) were consolidated into PS12-1201.

[2]Figures do not include awards for Category C - Demonstration Projects because those awards will not be made until March 1, 2012.

National Programs to Identify and Reach Highest Risk Populations

Program Overview: The NHAS requires special efforts to identify and reach those who are most at-risk for acquisition or transmission of HIV. CDC supports this NHAS imperative through national HIV surveillance, support of CBO prevention programs, capacity building, research, and social marketing activities to reach communities at highest risk for HIV transmission.

CDC's approach to surveillance is critical to successful HIV prevention efforts nationwide. CDC supports health departments to effectively track new HIV infections and diagnoses, deaths, access to care, and risk behaviors to characterize the domestic epidemic and inform public health actions. Central to this effort is financial and technical assistance to 65 state and local health departments to describe all reported cases of HIV in the United States. This is accompanied by behavioral surveillance for special risk groups, medical monitoring of persons who are infected, and HIV incidence surveillance to characterize the leading edge of the epidemic. Data from these efforts demonstrate continued and severe disparities by race, ethnicity, and risk behavior. They have guided national, state, and local testing programs; social marketing; and health education/risk reduction efforts focusing on severely impacted populations. CDC also works with jurisdictions to measure community viral load and other population-level markers for HIV transmission risk.

The NHAS recognizes the vital role voluntary and other private sector organizations play in reaching and mobilizing HIV-affected communities. CDC provides financial and technical assistance to CBOs to deliver HIV prevention interventions focused on populations disproportionately affected by HIV, particularly communities of color and MSM. CDC also works through national, regional, and other organizations to provide CBA to its directly-funded CBOs, to health departments and to other CBOs across the nation. CDC works to raise awareness among patients, providers, and the public about HIV. For example, the Act Against AIDS campaign seeks to raise awareness about the importance of talking about HIV testing, condom use, and myths and misperceptions about HIV with peers, partners, and families of all Americans.

The NHAS clearly describes the need to improve behavioral and biomedical interventions to better serve at-risk populations. CDC develops, identifies, and adapts biomedical and behavioral interventions and provides guidance to prevention partners on their use. CDC also supports demonstration projects that identify and document best practices, as well as laboratory and epidemiologic studies. Epidemiologic, policy, health services and operations research is conducted with the goal of increasing linkage to and retention in quality care. CDC works to provide appropriate preventive services for coinfections to at-risk persons. CDC reduces health disparities by supporting applied research to adapt and translate interventions for at-risk populations and to address syndemics. Activities are focused on populations and venues where integration efforts can fill gaps in services and include research on the effectiveness of the use of antiretroviral treatment for HIV prevention and medication adherence. CDC also develops scientific recommendations for HIV testing, the use of PrEP and, other prevention strategies.

Recent accomplishments:

- Implemented reporting of all CD4 cell counts and viral load test results in more than 25 CDC funded health jurisdictions, including undetectable data. CDC recommends this as a strategy for public health monitoring of the epidemic, as well as improving linkage to and retention in care for individuals. In 2011, CDC and the Health Resources and Services Administration (HRSA) hosted a consultation to assist the development of guidance related to the best use of these data for surveillance and monitoring as well as program activities related to linkage to care, quality of care, retention in care, and reducing viral load.

- Released data from the National HIV Behavioral Surveillance System that provided important information on testing, risk behaviors and HIV prevalence for populations at high risk for HIV infection, including IDUs, MSM, and heterosexuals at increased risk. In 2011, released the first national data from the Medical Monitoring Project, a nationwide sample of HIV-infected persons in care. The report included data on risk behaviors and health outcomes.

- Released research findings in 2011 that support the use of PrEP as a strategy for HIV prevention. The trial of the oral antiretroviral drug tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC, combined as TDF/FTC) for prevention of HIV infection among heterosexuals in Botswana found that infections were reduced by 63 to 78 percent. CDC also released interim guidance for the safe and effective use of PrEP among MSM.

- Evaluated and published in October 2011 the outcome findings of an HIV prevention intervention for Latina women ages 18–35 years (AMIGAS) which was adapted from an intervention for African American women (SiSTA). The intervention was efficacious in increasing consistent condom use among Latina women.

- Published research in February 2011 demonstrating that interventions proven to work in carefully controlled research studies are effective when delivered in real-world settings by CBOs. Reported decreased sexual risk behaviors over time, including fewer numbers of partners and episodes of any unprotected sex events at four months after the intervention by participants in two evidence-based interventions, VOICES/VOCES and Healthy Relationships. More pronounced reductions in sexual risk behaviors were seen for certain subgroups.

- Achieved more than two billion media impressions for HIV prevention messages through March 2011 with Act Against AIDS, while enhancing partnership networks, initiatives, and collaborations with private-sector organizations; websites and social media; public service advertising (transit, online, radio, television, print, and outdoor); news media; and interpersonal outreach. On World AIDS Day, 2011, launched Testing Makes Us Stronger, a campaign designed by black gay men to encourage HIV testing among black gay and bisexual men. Campaigns were launched in New York City and Atlanta in January 2012, with expansion to four additional cities planned.

- Expanded membership in CDC's Act Against AIDS Leadership Initiative (AAALI), a partnership with some of the country's leading national civic/social and media organizations in an effort to address HIV within the communities they serve. AAALI partners have hosted more than 1,000 events and facilitated HIV testing for more than 17,000 people.

- Contributed to the science base for HIV testing programs. Successfully evaluated dried blood spots in a pilot study as a cost-saving and field-friendly, non-clinical blood sample for incidence testing and drug resistance screening to support expanded HIV testing and surveillance. These efforts and others will serve as the foundation for updating and streamlining the HIV diagnostic testing algorithm in the United States. In addition, CDC initiated research on the use of self-administered rapid home tests for HIV screening and prevention.

- Published *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD, and TB Programs*, recommending standards to facilitate the secure collection, storage, and use of data while maintaining confidentiality. Adoption of these guidelines will help agencies improve the completeness of infection reporting and maximize use of data for public health action, including the provision of integrated and comprehensive services.

- Guided PCSI demonstration sites in completing comprehensive assessments that reviewed syndemic data, laws, policies, and procedures. These assessments allow these sites to address gaps and implement appropriate integrated services that make sense locally. Demonstration sites have completed surveillance registry matches to identify local syndemics and determine rates of co-infection by population groups. This data will be utilized to implement appropriate integrated screening.

Budget Proposal: CDC's FY 2013 request for National Programs to Identify and Reach High Risk Populations is $384,026,000, which includes increased resources to implement key NHAS action steps. The increase will provide additional support for core HIV surveillance to enable innovations necessary to support new prevention strategies, continue an internet-based survey to monitor rapid changes in risk behaviors and service utilization, provide technical assistance to health departments and CBOs to improve services, and support innovative research projects to improve prevention services and test prevention strategies.

In FY 2013, CDC will:

- Provide increased funding and support to health departments implementing CDC's core HIV surveillance system, which will begin a new project cycle in FY 2013. These funds will support efforts critical to the successful implementation of NHAS including case surveillance, CD4 cell count and viral load reporting, optional surveillance activities such as geocoding and linkage and perinatal exposure reporting, and incidence surveillance. These funds will stabilize HIV surveillance capacity in the states.

- Provide additional focused technical assistance to support health departments and community-based organizations as they implement NHAS action steps, using programmatic data to support service delivery improvements and improved targeting of resources.

- Support an additional project cycle for monitoring risk behaviors, access and use of services by MSM through an annual internet-based survey. This survey, begun in FY 2010, has yielded important surveillance data for MSM, with the goals of identifying unrecognized HIV infections, improving health outcomes, and reducing HIV transmission.

- Conduct innovative epidemiologic, health services and operational research projects to better understand and improve HIV prevention services or implement biomedical HIV prevention strategies.

- Initiate a new project cycle to provide support and technical assistance to 65 project areas to conduct and improve HIV case surveillance. All 50 states will have mature, name-based HIV reporting in 2012. The new cycle will build upon this achievement. As part of case surveillance, CDC will provide national leadership and technical assistance to localities to guide the collection of laboratory data, such as CD4 cell count and viral load test results, to enhance prevention and care efforts, as well as monitor the epidemic in terms of access to and quality of care.

- Estimate the annual number of new HIV infections in the United States so prevention activities can be appropriately targeted and progress towards national goals can be assessed. CDC will support 25 project areas to conduct HIV incidence surveillance.

- Continue to fund, as part of the National HIV Behavioral Surveillance System, 20 project areas to conduct surveillance for behavioral risks, HIV testing, prevention services use, and HIV prevalence among three different populations at increased risk for HIV infection (MSM, IDUs, and heterosexuals at increased risk).
- Continue to fund, as part of the Medical Monitoring Project, 23 project areas to conduct surveillance for clinical outcomes, behavioral risks, and exposure to and use of HIV prevention interventions among HIV-infected individuals who are receiving HIV medical care in the United States.
- Continue to monitor risk behavior, access and use of services by MSM through an annual internet-based survey.
- Provide data to HRSA and to the U.S. Department of Housing and Urban Development (HUD) to guide the allocation of over $2 billion in federal funding for HIV care, treatment, and housing programs.
- Conduct activities that ensure the implementation and evaluation of interventions, strategies, and technologies to increase testing, linkage to care, use of antiretroviral therapy (ART) and reductions in risk behaviors.
- Continue to fund 133 CBOs to conduct HIV counseling and testing and implement evidence-based prevention interventions among populations at greatest risk of HIV infection, particularly communities of color. Will continue to fund an additional 34 CBOs that serve young MSM of color and young transgender persons of color and their partners, in a program that emphasizes linkage to treatment and care for HIV-positive individuals and referrals to support services for both HIV-positive and HIV-negative individuals.
- Provide capacity-building assistance (CBA) to CBOs, health departments, and HIV prevention community stakeholders in the areas of organizational infrastructure development, evidence-based interventions, monitoring and evaluation, and community planning through a network of 30 CBA providers.
- Continue to implement the Act Against AIDS campaign, a five-year, multi-faceted national communication campaign to refocus national attention on the domestic HIV/AIDS epidemic, increase HIV awareness through social marketing campaigns and expanded social media initiatives to educate Americans about the continued threat of HIV in the U.S. and develop targeted campaigns with an emphasis on populations bearing a disproportionate burden of HIV/AIDS.
- Train staff from health departments and CBOs on evidence-based interventions for persons at highest risk of acquiring or transmitting HIV.
- Continue to direct research activities to biomedical and behavioral research projects that address significant unmet public health needs in disproportionately affected communities and that have the potential for greatest impact.
- Continue to conduct an open-label study of PrEP in Botswana to better understand efficacy and use of this prevention strategy in a setting that more closely resembles “real-world” settings than clinical trials. CDC will also continue to update PrEP guidelines as more study results become available for populations such as IDUs and heterosexuals.
- Provide financial and technical assistance to 24 state and local health departments to provide HIV testing to TB patients, which is a highly recommended intervention strategy as HIV dramatically increases the risk that someone infected with TB will develop active disease.

- Provide support to 69 state and local health departments for provision of HIV testing and partner services through STI programs.
- Update the *Compendium of Evidence-based HIV Prevention Interventions* and the *Compendium of Evidence-based HIV Medication Adherence Interventions* to expand the number of interventions identified and provide additional information regarding the impact of interventions and evidence of the probability that an intervention will reduce incidence of HIV or other STIs.
- Continue support to three jurisdictions to evaluate the yield and cost-effectiveness of enhanced partner notification and contact tracing techniques linked to acute HIV infection screening.
- Improve and field test, through cooperative agreements, rapid diagnostics for HIV infection to improve informing individuals of their infection status.
- Continue collaborations with NIH on safety and efficacy evaluations of candidate microbicides and other (non-vaccine) biomedical prevention products using the CDC-developed repeat low-dose (RLD) macaque simian immunodeficiency virus/simian human immunodeficiency virus infection model. This collaboration builds on CDC's expertise in using the RLD macaque model and NIH's support for basic, therapeutic, and prevention research and development.
- Monitor uptake of revised prevention with positives recommendations and educational materials regarding prevention strategies for persons living with HIV.
- Continue to collaborate with NIH to implement and evaluate prevention with positives program at HIV clinics with the goals of improving patients' health and reducing transmission of HIV through increasing the number of patients with undetectable viral load and the number who practice safer sex. CDC will support: 1) training of clinic staff to conduct the intervention; 2) computer-delivered risk assessment and intervention tools in the clinics to increase patients' retention in care, adherence to antiretroviral therapy, and safer sex; 3) recruitment of a cohort of HIV patients at each clinic followed across time to evaluate the effects of the intervention; and 4) transmittal of electronic medical chart data on patients' viral load, CD4 count, and attendance at clinic.
- Continue to conduct a multi-site clinical epidemiology cohort study designed to provide detailed characterization of the course of clinical HIV disease, treatment of HIV disease, factors associated with improved response to HIV therapy, and risk factors for medical complications related to the treatment of HIV infection and attendant prolonged survival.
- Continue to support PCSI activities in health departments, including integrated HCV testing and screening for syphilis and gonorrhea in HIV settings, enhanced collaboration of viral hepatitis and HIV sites to ensure integrated HIV and hepatitis screening where appropriate, and integration of HIV testing in TB clinics.
- Support PCSI through the development of models, identification of best practices, technical assistance to jurisdictions and incorporation of PCSI practices into standalone infectious disease programs. CDC will provide examples of best and promising practices in the field and data on program effectiveness.

HIV Adolescent and School Health

Program Overview: NHAS identifies education of all Americans about the threat of HIV and how to prevent it as a critical step in reducing new infections in the United States. CDC's main program to achieve this mandate is the HIV Adolescent and School Health program. In FY 2012, this program was transferred from CDC's National Center for Chronic Disease Prevention and Health Promotion in order to ensure closer collaboration with CDC's other HIV and STD prevention programs. The adolescent and

school health program supports school-based education to prevent HIV, STD, and teen pregnancy among adolescents.

Through this program, CDC provides national data on youth health risk behaviors and school-based health policies, programs, and practices. CDC also translates research findings, identifies effective policies and programs, and develops implementation tools for schools. Finally, CDC provides funding and technical assistance to agencies and organizations to plan and implement effective policies, programs, and practices.

Recent accomplishments:

- Released the 2012 School Health Profiles providing data related to HIV prevention education and HIV-related school health policies for 49 states, 19 large urban school districts, four territories and two tribal governments.
- Between 1991 and 2009 there was a 15 percent reduction in the proportion of students who had ever had sexual intercourse and a 32 percent increase in use of condom at last sexual intercourse. Rates of gonorrhea among persons 15–19 years old decreased for the second year in a row in 2009.
- Published *Youth Risk Behavior Surveillance—Sexual Minority Students, 2001–2009*, the most comprehensive report to date that describes the disproportionate rate of health risk behaviors among sexual minority students.
- Increased the percentage of middle schools and high schools in which health services staff provided HIV counseling, testing, and referrals from 11.8 percent to 39.1 percent between 2000 and 2006.

Budget Proposal: CDC's FY 2013 request for HIV Adolescent and School Health is $39,934,000, which includes an increase to assure progress toward NHAS objectives to educate all Americans about the threat of HIV and will be used to increase funding to state and local education and health agencies to implement school-based HIV prevention activities, increase funding to NGOs that support HIV-prevention efforts serving youth in high prevalence communities, and expand surveillance and monitoring to collect national data to monitor priority health risk behaviors and school health programs and policies.

In FY 2013, CDC will:

- Increase funding by 20 percent for cooperative agreements to states, cities, territories, and tribes to develop and implement health policies, programs, and practices and improve HIV prevention activities for youth across the country.
- Increase funding by 10 percent for cooperative agreements to states, cities, territories, and tribes to support implementation of the Youth Risk Behavior Survey.
- Restore funding for two NGOs to develop, deliver, and evaluate professional development activities and follow-up support to build the skills of NGO staff members to effectively implement programmatic efforts for all funded partners.
- Support the National Association of State and Territorial AIDS Directors (NASTAD) to assist state and local education agencies with developing and implementing effective policies and practices to prevent HIV, other STIs, and unintended pregnancy among students.
- Restore funding for one NGO to provide assistance to local education agencies and their health agency partners to assess, develop, evaluate, and maintain effective school health policies.
- Restore supplemental funding to five state education agencies to implement strategies to promote abstinence among teens and support youth development activities.

HIV Adolescent and School Health Grant Table[1]

(dollars in millions)	FY 2011 Appropriation[2]	FY 2012 Enacted[3]	FY 2013 President's Budget
Number of Awards	84	83	85
Average Award	$0.232	$0.170	$0.233
Range of Awards	$0.001–$0.637	$0.001–$0.327	$0.040–$0.640
Number of New Awards	0	0	85
Number of Continuing Awards	84	83	0

[1]Reflects funding to state, tribal, local and territorial education agencies.
[2]Missouri did not receive FY 2011 funding.
[3]Nevada did not request FY 2012 funding and Missouri did not receive any FY 2012 funding.

VIRAL HEPATITIS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2012 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$19.784	$19.672	$29.694	+$10.022
ACA/PPHF	$0.000	$10.000	$0.000	-$10.000
Total	**$19.784**	**$29.672**	**$29.694**	**+$0.022**

Program Overview: CDC provided critical assistance to the Assistant Secretary of Health at HHS in the development of the *HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis*. *The Plan was designed to respond to the growing* public health threat of VH, which infects between 3.5 and 5.3 million Americans. CDC continues to lead implementation of the Plan, working with state and local health departments to prevent VH through surveillance, screening with linkage to care, education, and vaccination. CDC continues to reduce the rates of new cases of hepatitis A virus (HAV) and hepatitis B virus (HBV) by supporting the vaccination of infants and at-risk populations (with funding from CDC's immunization program). Furthermore, CDC focuses particularly on hepatitis B elimination among infants born to women who are HBsAg+, because those infants are at highest risk for developing chronic HBV infection and later liver cancer. Vaccination efforts for HAV and HBV also focus on adults with behavioral risks for infection. With public health partners, CDC conducts outbreak investigations for VH. CDC also conducts epidemiologic studies and surveillance to identify populations most at risk, characterize sources of transmission, and monitor burden of disease and impact of CDC prevention recommendations. CDC supports laboratory research to assess the performance of new screening tests and monitor the circulation of variant strains that may not be prevented by current vaccines or responsive to therapies. CDC develops recommendations for HAV and HBV vaccination, as well as HBV and HCV screening with linkage to care and treatment. CDC supports implementation of these policies at the state and local levels. Funding recipients are supported to address syndemics of VH, HIV, and STI through program collaboration and service integration.

Recent accomplishments:

- Helped lead the development of the *HHS Viral Hepatitis Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis*, which provides a roadmap for national efforts to prevent the transmission of new infections and to mitigate the adverse health impact of chronic infections.
- Established a baseline estimate of the proportion of the estimated 3.9 million HCV-infected persons who are aware of their infection. This information will be used to monitor the effects of efforts to improve screening of at-risk persons.

- Supported increased surveillance of VH in 10 state and local health departments, and supported a national survey to assess knowledge and receipt of VH prevention services among racial and ethnic minority communities across the United States.
- Detected the re-emergence of HCV transmission among adolescents and young adults and HCV transmission among HIV-infected MSM.
- Revised CDC surveillance reports to report data regarding persons living with HBV and HCV infection, VH mortality, and outbreak investigations.

Budget Proposal: CDC's FY 2013 request of $29,694,000 for VH is an increase of $22,000 above the FY 2012 level. Funds will be used to address the goals in the *HHS Action Plan for Viral Hepatitis*. CDC will seek to: reduce VH related morbidity and mortality by expanding access to testing and vaccination, link infected persons to care and treatment, improve interventions to prevent HCV transmission among adolescents and young adults, revise hepatitis B vaccine recommendations, implement programs for at-risk adults and case management of infants born to HBV-infected mothers, and raise awareness about VH among at risk persons and their health care providers.

In FY 2013, CDC will:

- Detect VH transmission, monitor health disparities, and guide the implementation of recommended prevention services in up to 10 high-burden state and local health departments.
- Support adult viral hepatitis coordinators in all states and several large cities to provide local leadership in viral hepatitis prevention.
- Develop and implement science-based community education campaigns to address HBV health issues facing many Asian/Pacific Islanders and HCV health issues facing African Americans and Hispanics.
- Educate health care providers, public health professionals, and social service providers about prevention and testing strategies to reach persons at risk for chronic infection.
- Promote testing, counseling, and referrals to care for persons chronically infected with HBV and HCV.
- Identify and implement strategies to improve HAV and HBV vaccination coverage among vulnerable populations.
- Work to eliminate HBV transmission in the United States by promoting HBV screening of pregnant women, referring those who are infected to appropriate care, providing timely vaccination to their infants and family members, and vaccinating adults at risk of infection in public health settings.
- Implement revised recommendations to guide HCV screening and referral to care.
- Investigate outbreaks and modes of transmission of VH, as requested by states.
- Conduct prevention research to determine the long-term effectiveness of HAV and HBV vaccines, and to assess the role of vaccination in preventing transmission among populations not currently recommended to receive these vaccinations.
- Monitor access to and utilization of prevention services via national and multi-state surveys.
- Work with global partners to implement VH surveillance and prevention in high-burden countries.

SEXUALLY TRANSMITTED INFECTIONS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$154.666**	**$153.788**	**$153.886**	**+$0.098**

Program Overview: CDC reduces the domestic prevalence of sexually transmitted infections (STIs); such as chlamydia, gonorrhea, and syphilis, and their sequelae, including poor reproductive outcomes such as pelvic inflammatory disease, infertility, and increased risk of HIV infection, and reduces health disparities. CDC focuses on preventing infections among the two population groups with the highest burden of infection: adolescents and young adults, and MSM. CDC also addresses individual and social factors and other determinants of health that affect STI outcomes among disproportionately affected populations.

CDC monitors the national occurrence of STIs and conducts epidemiologic and health services research for STI prevention and control. CDC assures the provision of quality STI services in both the public and private sectors through technical assistance and training; education for providers, patients, and the public; serving as a national STI reference laboratory; and developing guidelines and recommendations for STI prevention and control nationally. CDC distributes funds to state and local STI programs through the Comprehensive STI Prevention Systems (CSPS) cooperative agreement. CDC supports funded recipients to address syndemics of HIV, VH, and TB through PCSI.

Through the National Infertility Prevention Project (IPP) CDC provides assistance to state and local STI prevention programs to prevent the spread of chlamydia and gonorrhea. If left untreated, these infections can lead to pelvic inflammatory disease, infertility in women, and ectopic pregnancy. Through IPP, CDC supports assessment of screening and laboratory services through surveillance and data management systems; and assures provision of services for poor, uninsured, young, sexually active women and their sexual partners by working with primary care providers in the community, including family planning clinics and community health centers.

Through the National Network of STI/HIV Prevention Training Centers (PTCs), CDC develops, delivers, and evaluates STI clinical and laboratory training courses, materials, and other activities on the diagnosis, treatment, and prevention of STIs and HIV in order to meet the training needs of public and private sector health professionals throughout the United States. PTCs are a group of regional centers, each created as a partnership between academic institutions and a state or local public health department. These investments in STI prevention, including screening and other prevention strategies, not only avert infections and improve the health outcomes of the nation, but are cost-effective because of the high—and increasing—economic burden associated with STIs and their sequelae.

Recent accomplishments:

- Developed a cephalosporin-resistant *N. gonorrhoeae* response plan. Elements of the plan include: 1) a surveillance case definition of cephalosporin-resistant gonorrhea, 2) a proposal to monitor treatment failures, 3) guidance for treatment of patients who experienced treatment failure, 4) guidance for partner management, and 5) outbreak investigation tools. The response plan was informed by a consultation with external partners and will be updated as new surveillance data are available.
- Collaborated with the WHO to develop estimates of the global burden of congenital syphilis using data from 77 countries. These new estimates include syphilis testing in pregnancy and were presented to the Child Health Epidemiology Research Group and published in the 2010 WHO progress report *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector*.

- Developed and disseminated coding guidelines and prepared a list of laboratories that are verified under the Clinical Laboratory Improvement Amendments to test rectal and pharyngeal specimens for chlamydia and gonorrhea using nucleic acid amplification tests in order to increase adoption of non-genital gonorrhea and chlamydia screening recommendations for MSM.
- Provided expert advice and analysis to the Advisory Committee on Immunization Practices to inform recommendations for HPV vaccination.
- Developed and published laboratory recommendations for the detection of infections caused by syphilis, chlamydia, and gonorrhea. These recommendations will provide information for laboratory directors to assist clinicians, laboratorians, and the STI public health workforce in the selection and use of appropriate laboratory tests, their interpretation, and any necessary adjunct or follow-up testing. This will allow laboratory results to be better used by clinicians and the STI public health workforce to identify infected persons for treatment, counseling, and follow-up as warranted.

Budget Proposal: CDC's FY 2013 request of $153,886,000 for STIs is an increase of $98,000 above FY 2012.

In FY 2013, CDC will:

- Increase emphasis on preventing infections among adolescents, young adults, and MSM.
- Expand domestic and global efforts to eliminate congenital syphilis.
- Provide financial and technical assistance to 65 state and local STI prevention programs to strengthen assessment (including surveillance and evaluation) and assurance capacity through the CSPS program.
- Reduce infertility caused by STIs by providing financial support and technical assistance to 65 state and local project areas to conduct assessment and assurance for chlamydia and gonorrhea screening and treatment through the IPP.
- Prevent reinfection with *C. trachomatis* and *N. gonorrhoeae* and increase options available to treat sexual partners of infected women by providing assistance to STI prevention programs with implementation of Expedited Partner Therapy (EPT).
- Monitor changing resistance and antimicrobial susceptibility patterns in *N. gonorrhoeae* in the United States by supporting a network of regional laboratories providing standardized testing on all isolates using a standard protocol.
- Implement a cephalosporin-resistant *N. gonorrhoeae* response plan.
- Support the WHO Gonococcal Antimicrobial Surveillance Programme (GASP) in the Western Pacific and Southeast Asia Regions to enhance global surveillance in regions where resistance is likely to first emerge.
- Assess effectiveness of various approaches to notify exposed partners of MSM (e.g., internet-based, patient-delivered) to improve STI prevention and control in areas of high STI and HIV morbidity among MSM.
- Enhance screening, partner services, and other evidence-based interventions in state and local areas with high levels of syphilis.
- Promote adoption of CDC recommendations for STI prevention and treatment services through work with other federal agencies and nonprofit and private partners.

- Increase health care providers' knowledge and skills in the areas of sexual and reproductive health by supporting state-of-the-art educational opportunities, including experiential learning through a network of STI/HIV Prevention Training Centers and developing guidelines for screening and treatment of STIs, STI diagnostics and laboratory practice, and partner management.
- Improve electronic reporting and collection of core data elements, including gender of sex partners and social determinants of health.
- Support 12 sites to participate in the STI Surveillance Network (SSuN), a sentinel clinic and population based surveillance system to monitor behavioral and clinical trends.
- Increase the use of nucleic acid amplification screening tests for non-genital chlamydia and gonorrhea, especially in the care of sexually active MSM, through clinical provider training and outreach.

Comprehensive STD Prevention Services Cooperative Agreement Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	65	65	65
Average Award	$1.558	$1.555	$1.555
Range of Awards	$0.044–$6.777	$0.043–$6.724	$0.043–$6.724
Number of New Awards	0	0	0
Number of Continuing Awards	65	65	65

TUBERCULOSIS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$141.100**	**$140.298**	**$135.691**	**-$4.607**

Program Overview: CDC controls the spread of TB in the United States and works to achieve its elimination. CDC's activities include providing technical assistance, training and education on TB control and elimination; monitoring the occurrence of TB in the United States; serving as a national reference laboratory for TB; assisting in outbreak investigations across the United States; and supporting epidemiologic, laboratory, and clinical research to identify factors associated with transmission and to develop and assess faster, shorter, and more reliable tests and treatments for TB. State and local TB programs are the vanguard against TB and drug-resistant TB in the United States. CDC provides funding and technical assistance to these programs to conduct TB surveillance, ensure treatment to cure (each case requires six to nine months of therapy and daily observation by specially trained workers with every dose of medicine), identify infected contacts, and provide community training and outreach. CDC will continue to support funding recipients to address syndemics of HIV, VH, and STIs through PCSI.

Recent accomplishments:

- Published in the *MMWR* new guidelines for isoniazid and rifapentine for the treatment of persons with latent TB infection (LBTI). These guidelines are based on ground-breaking research supported by CDC to develop a shorter therapy for LTBI. The new therapy offers a once weekly, 12-week regimen as an alternative to daily dosing over nine months for most persons with LTBI.
- Launched the new Tuberculosis Epidemiology Studies Consortium, funding 10 new sites and shifting research focus to LTBI.

- Implemented CDC's service to state health departments for molecular drug detection of drug resistance, shortening the time to results from 42 to two days and enabling providers to ensure that prescribed treatments are effective.
- Provided outbreak investigation assistance and program support in the Navajo Nation in Arizona; a Puerto Rico health care facility; Kane County, Illinois; and multidrug-resistant TB in the Republic of the Marshall Islands.
- Published the report of the clinical trial in Botswana demonstrating that 36 months of isoniazid is superior to six months of therapy for latent TB in HIV-infected persons, and successfully evaluated a screening algorithm in Southeast Asia to detect TB in HIV-infected persons. Both of these studies were crucial part of the evidence base for updated WHO policy recommendations for TB control.
- Developed and implemented the Quality Assurance for TB Surveillance Data Training to ensure excellence in program reporting of TB data for surveillance and epidemiology purposes.
- Updated and published "Core Curriculum on Tuberculosis: What the Clinician Should Know" to strengthen the knowledge of clinicians with responsibility for diagnosing and treating TB and LTBI.

Budget Proposal: CDC's FY 2013 request of $135,691,000 for TB is a reduction of $4,607,000 below the FY 2012 level. CDC will work with partners to implement this reduction in a way that maintains a focus on TB control for the most urgent cases, especially outbreaks that have already resulted in deaths or permanent neurological or other damage to health, as well as cases that are multi-drug resistant.

In FY 2013, CDC will:

- Support TB prevention, control, and laboratory programs in all 50 states, Washington D.C. and eight dependent areas.
- Assure an adequate supply of workers with training in TB diagnosis and treatment through support of four regional training and medical consultation centers.
- Support research to enhance programmatic approaches to TB and develop more effective and better tolerated drug regimens for curing LTBI to prevent future cases and disease. Support research to improve TB therapy in children, and in persons with HIV infection, diabetes, other co-morbidities, and drug-resistant TB.
- Build TB surveillance, program, laboratory, and health systems capacity in countries with high burdens of TB, TB/HIV, and drug-resistant TB, as well as countries of strategic interest for domestic TB elimination efforts, including countries in Latin America, Eastern Europe, Asia, and Africa.

TB Prevention and Control Cooperative Agreement Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	68	68	68
Average Award	$1.344	$1.344	TBD[1]
Range of Awards	$0.869–$8.599	$0.869–$8.599	TBD[1]
Number of New Awards	0	0	0
Number of Continuing Awards	68	68	68

[1]A new funding formula will take effect in FY 2013.

BUDGETARY OUTPUTS

Measures	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
HIV Prevention				
2.A: Areas funded for HIV prevention (Output)	FY 2011: 65	67	67	No Change
2.B: Number of jurisdictions funded for enhanced, comprehensive HIV prevention planning activities (Output)[1]	FY 2011: 12	12	0	-12
2.C: Areas funded for HIV/AIDS surveillance (Output)	FY 2011: 65	65	65	No Change
2.D: Number of areas funded to estimate HIV incidence (Output)	FY 2011: 25	25	25	No Change
2.H: Number of community-based organizations (CBOs) funded to support community level interventions (Output)[2]	FY 2011: 133	133	133	No Change
2.I: Number of jurisdictions funded for enhanced testing activities (Output)	FY 2011: 30	34	34	No Change

[1]The enhanced comprehensive HIV prevention planning program will end in 2012; therefore FY 2013 targets have been reduced to zero.
[2]Reflects CDC's main directly funded CBO program 10-003.

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Viral Hepatitis				
2.J: Number of states or cities funded for enhanced viral hepatitis surveillance (Output)	FY 2011: 9	9	9	No change
2.K: Number of states or cities funded for adult viral hepatitis prevention coordinators (Output)[1]	FY 2011: 55	55	55	No change

[1]This program will be recompeted in 2013; results may vary depending upon that competition

Measures	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Sexually Transmitted Infections				
2.L: Number of grantees receiving technical and financial assistance for sexually transmitted infection prevention (Output)	65	65	65	No change
2.M: Number of Syphilis Elimination Programs funded (Output)[1]	FY 2011: 37	37	37	No Change
2.N: Number of Regional Infertility Programs funded (Output)	FY 2011: 10	10[2]	10[2]	No Change
2.O: Number of STI/HIV Regional Prevention Training Centers funded (Output)	FY 2011: 10	8	Maintain	No change

[1]The number of programs funded annually for this activity is determined by a formula for which some data are not yet available.
[2]Estimated based on prior year results. The Regional Infertility Program will be recompeted in 2012 and the number of infertility programs to be funded is not yet finalized.

Measures	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Tuberculosis				
2.R: Number of cities, states, and territories provided financial and technical aid to conduct tuberculosis prevention and control activities and collect tuberculosis surveillance data (Output)	FY 2011: 68	68	68	No Change
2.S: Number of TB research consortia funded (Output)	FY 2011: 2	2	2	No Change

PERFORMANCE

Program: Domestic HIV/AIDS Prevention and Research

NHAS Performance Measures and CDC Contextual Indictors for Long Term Objective: Reduce new HIV infections

NHAS Measures	Most Recent Result	FY 2015 Target
2.1.1: Decrease the annual HIV incidence (Outcome)	FY 2009: 48,100 (Historical Actual)	36,450[1]
2.1.2: Reduce the HIV transmission rate per 100 persons living with HIV (Outcome)	FY 2006: 4.4% (Baseline)	3.1%[1]
2.1.3: Increase the percentage of people living with HIV who know their serostatus (Outcome)	FY 2008: 80.0%	90%

[1]Some results have been updated based on improved methodologies.

Performance Measures for Long Term Objective: Reduce new HIV infections

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.1.4: Increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AIDS) (Outcome)	FY 2009: 42.5% (Historical Actual)	46.0%	47.5%	+1.5%
2.1.7: Increase the proportion of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active[1] (Outcome)	FY 2009: 86.9% (Target Not Met)	N/A	86.9%	Maintain

[1] Targets and results are set and reported biennially.

NHAS Performance Measures and CDC Contextual Indictors for Long Term Objective: Increase access to care and improve health outcomes for people living with HIV

NHAS Measures	Most Recent Result	FY 2015 Target
2.2.1: Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis (Outcome)	FY 2007: 65.0% (Baseline)	85%

Performance Measures for Long Term Objective: Increase access to care and improve health outcomes for people living with HIV[1]

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.2.2: Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to Partner Services (Outcome)	FY 2009: 69.4% (Target Exceeded)	72.0%	73.5%	+1.5%

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.2.3: Increase the percentage of HIV-infected persons in CDC-funded counseling and testing sites who were referred to HIV prevention services (Outcome)	FY 2009: 57.8% (Target Not Met)	66.0%	68.0%	+2%
2.2.4: Increase the number of states that report all CD4 and viral load values for HIV surveillance purposes (Output)	FY 2010: 25 (Baseline)	31	36	+5
2.2.5: Increase the number of states with mature, name-based HIV surveillance systems (Output)	FY 2010: 46 (Target Met)	50	50	Maintain
2.2.6: Reduce the number of new AIDS cases among adults and adolescents per 100,000 (Outcome)	FY 2009: 13.5 (Baseline)	12.9	12.7	-0.2

[1]Results reflect, in part, impact of funding from ACA/PPHF.

Performance Trends: HIV interventions, such as HIV testing, HIV partner services, and counseling and education, demonstrate cost effectiveness and a reduced risk of HIV acquisition or transmission. For every HIV infection prevented, an estimated $367,000 is saved in the cost of providing lifetime HIV treatment[2]—a significant cost-savings for the federal government, which spent an estimated $14.1 billion on healthcare for persons living with HIV in 2011, with most costs attributed to Medicare and Medicaid.[3] Between 1992 and 2006, HIV prevention efforts in the U.S. averted more than 350,000 HIV infections and more than $125 billion in direct medical costs. For the estimated 50,000 newly infected persons with HIV annually, lifetime medical care and treatment total more than $18 billion. CDC estimates that, over a five-year time horizon, health department and community-based organization prevention programs are cost-saving, and preventing HIV infections saves more than $6.4 billion in medical costs.[4]

CDC slightly revised its HIV performance measures for FY 13, establishing long-term targets to better align with the National Health AIDS Strategy (NHAS) and incorporate lessons learned from monitoring its performance measures. CDC will refine methods to monitor other NHAS priorities, such as linkage and access to care (percentage of persons diagnosed with HIV who have a CD4 (cluster of differentiation 4) or viral load result reported within three months of diagnosis) and disparities in community viral load (percentage of HIV-diagnosed men who have sex with men (MSM), Blacks and Hispanics with undetectable viral load). CDC led national governmental efforts to prevent HIV from the outset of the epidemic. HIV incidence declined significantly from approximately 130,000 cases per year in the mid-1980s to approximately 50,000 cases per year today due to numerous federal, state, local government and community response efforts. While overall rates remained relatively stable for the past decade, rates declined among certain groups (e.g., injection-drug users (IDUs)), remained stable in others (high-risk heterosexual men and women of all races), and increased among young, African American

[2]Schackman BR, Gebo KA, Walensky RP, et al. The lifetime cost of current human immunodeficiency virus care in the U.S. *Med Care* 2006 Nov;44(11):990–97.

[3] Kaiser Family Foundation. U.S. Federal Funding for HIV/AIDS: The President's FY 2012 Budget Request. October 2011. Available at http://www.kff.org/hivaids/upload/7029-07.pdf. Accessed on 1/5/2012.

[4] Lasry, A., et al., A model for allocating CDC's HIV prevention resources in the U.S. *Health Care Manag Science,*2011. 14(1): 115-124.

MSM. HIV transmission rates declined by approximately 90 percent since the early 1980s and by about 33 percent over the last decade (from an estimated eight transmissions per 100 persons living with HIV in 1997 to 4.4 in 2006). CDC will achieve HIV incidence and transmission targets by refocusing its core prevention programs and by expanding efforts aimed at the most vulnerable populations (Measures 2.1.1, 2.1.2). These efforts are evidenced by changes to CDC funding announcements for health departments and community-based organizations to follow CDC's high-impact approach to HIV prevention (released in 2011).

Ensuring that those with HIV are aware of their infection is a key strategy for both improving the health of those infected and for preventing HIV transmission. The estimated proportion of HIV+ persons who are aware of their HIV status increased from 75 percent in 2003 to 80 percent in 2008. In 2009, CDC-funded programs conducted approximately 3.2 million HIV tests and expanded routine HIV testing in health care settings. One major CDC initiative to expand HIV testing in communities with a disproportionate burden of HIV/AIDS was evaluated, and results show that 2.8 million people were tested for HIV from 2007 to 2010. Through the initiative, CDC and its grantees newly diagnosed more than 18,000 persons with HIV infection, preventing an estimated 3,381 new HIV infections. This initiative was cost-saving, averting approximately $1.2 billion in direct medical costs.

CDC exceeded its 2008 targets for increasing the proportion of HIV-infected people in the U.S. who know they are infected and increasing the proportion of people with HIV diagnosed before progression to AIDS. CDC set new targets for knowledge of serostatus, consistent with NHAS and developed a better measure of early diagnosis (i.e., the percentage of persons diagnosed with HIV infection at earlier stages of disease [not CDC stage 3: AIDS]) (Measures 2.1.3, 2.1.4). CDC provided training to agencies to implement proven effective behavioral interventions, training 935 agencies in 2009.

Scientific reviews document that school health programs can positively impact health-risk behaviors, health outcomes, and educational outcomes. CDC-led studies demonstrate how school health programs can be cost effective. For example, every dollar invested in school HIV, STI, and pregnancy prevention efforts saves $2.65 in medical and social costs. These efforts address NHAS imperatives to provide age-appropriate HIV and STI education for all Americans. In FY 2009, 86.9 percent of adolescents in grades 9 to 12 abstained from sexual intercourse or used condoms if currently sexually active. Although CDC didn't meet its FY 2009 target, performance improved from the previous actual in FY 2007 of 86.7 percent. CDC strategies to improve performance for this measure focus on school health programs, which play a unique and important role in the lives of young people by improving their health knowledge, attitudes and skills, health behaviors and outcomes, educational outcomes, and social outcomes. CDC emphasizes a coordinated, comprehensive, and collaborative approach to school health that focuses on strengthening the health infrastructure of state and local education agencies and schools to address critical health issues including HIV/AIDS, STIs, and teen pregnancy prevention. In the long term, the program aims to increase the proportion of adolescents in grades 9 to 12 who abstain from sexual intercourse or use condoms if sexually active (Measure 2.1.7).

CDC targets are consistent with NHAS—to increase the proportion of newly diagnosed persons who are linked to clinical care within three months of their HIV diagnosis. Through its health department and directly funded community-based organization (CBO) programs that provide HIV testing, CDC ensures that persons living with HIV are linked to clinical care and referred to partner and prevention services. CDC also expands HIV testing in health care and other settings. In the new, recompeted CBO program (2010), CDC strengthened the requirement for directly funded CBOs to link individuals living with HIV to medical care (including screening for STIs, VH, and TB), partner services, prevention services, and other support services. Grantees must also implement a tracking system to determine whether individuals successfully accessed referral services in a timely manner. Newly available baseline data lay the foundation to track the progress of CDC-funded programs, and established targets will improve performance and guide technical assistance efforts. (Measures 2.2.1, 2.2.2, 2.2.3).

CDC monitors the HIV and AIDS epidemic through the national HIV surveillance system and uses the data to direct prevention efforts and provide researchers, policymakers, and the public with a timely understanding of the U.S. HIV epidemic . HIV and AIDS case surveillance data meet high standards for completeness of reporting (more than 80 percent of diagnosed cases are reported). Adopted by all 50 states, CDC's recommendation to conduct confidential, name-based HIV infection surveillance resulted in a more accurate picture of the epidemic in the U.S., better planning for prevention programs, and improved resource allocation. As states' reporting systems mature, CDC will incorporate HIV surveillance data from more states in its analyses. In FY 2010, 46 states used mature, name-based HIV surveillance systems, an increase of six states over the previous year (Measure 2.2.5). CDC continues to monitor the progression from HIV infection to AIDS among people living with HIV and will increase the availability of data on the health status of people living with HIV. In collaboration with state health departments, CDC will better monitor the effects of HIV medical care through expanded reporting of CD4 and viral load test results through HIV surveillance programs. CDC expects progress on these performance measures as surveillance of CD4 and viral load test results expands and more persons living with HIV are diagnosed earlier, linked to medical care, and retained in care. CDC expects this to lead to fewer AIDS cases , improve health among people living with HIV, reduce risk of HIV transmission as HIV viral load is reduced, and reduce health care costs. CDC set targets to reduce new AIDS cases among adults and adolescents, and its objective for all state HIV surveillance programs to report HIV diagnoses and CD4 and HIV viral load data reflects recognition of the importance of these key data for planning and monitoring prevention and medical care. (Measures 2.2.4, 2.2.6)

HIV causes significant disparities in health among affected populations, including new HIV infections and health outcomes, among those who are living with HIV. MSM, blacks, and Hispanics are especially affected. Also, there are disparities in health outcomes among people living with HIV, as blacks and Hispanics are less likely to receive the full benefits of HIV medical care and treatment. A nationally representative sample of people with HIV in medical care found that blacks and Hispanics were less likely than whites to be prescribed HIV antiretroviral therapy or to achieve very low HIV viral load levels. Efforts to increase HIV testing and improve linkage to medical care are critical to lowering HIV viral load and improving the health of people living with HIV. CDC builds the capacity of indigenous organizations; these organizations make important contributions to the substantial decreases in HIV transmission rates and improvements in knowledge noted above.

Program: Viral Hepatitis

Performance Measures for Long Term Objective: Reduce the rates of viral hepatitis in the United States.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.6.1: Reduce the rate of new cases of hepatitis A (per 100,000 population) (Outcome)	FY 2009: 0.6 /100,000 (Target Exceeded)	0.9 /100,000	0.5/100,000	-0.4
2.6.2: Reduce the rate of new cases of hepatitis B (per 100,000 population) (Outcome)	FY 2009: 1.1 /100,000 (Target Exceeded)	1.5 /100,000	1.4/100,000	-0.1
2.6.4: Increase the number of state and local health departments reporting acute viral hepatitis data of sufficient quality to be included in national surveillance reports (Output)	FY 2010: 9 (Target Met)	10	10	Maintain

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.6.5: Among minority communities experiencing health disparities, increase the portion of persons who have been tested for hepatitis B virus (Outcome)	FY 2010: 39% (Target Not Met but Improved)	44%	44%	Maintain

Performance Trends: In the U.S., illness from viral hepatitis (VH) is mainly caused by the hepatitis A, B, and C viruses (HAV, HBV, and HCV). Before the 1996 implementation of Advisory Committee on Immunization Practices (ACIP) recommendations for hepatitis A immunization, there were an estimated average of 271,000 infections an estimated 100 persons died as a result of acute liver failure attributed to HAV each year. Through the implementation of effective immunization strategies, HAV incidence decreased approximately 95 percent nationwide since 1995. The 2009 rate of 0.6 cases per 100,000 surpasses the Healthy People 2010 target of 2.4 cases per 100,000 and is the lowest rate of new cases recorded to date. CDC expects that the expansion of 2006 recommendations for routine hepatitis A vaccination, which now include all children in the U.S. aged 12–23 months, will reduce hepatitis A rates even further (Measure 2.6.1).

Similar declines in HBV incidence occurred among all age groups, but are greatest among children under 15 years of age. HBV incidence is well below the original Healthy People 2010 target of 4.5 cases per 100,000, and the 2009 rate of 1.1 cases per 100,000 (the latest available) is the lowest rate of new cases recorded. Declines over the past decade are linked to the successful vaccination strategy execution, as well as increases in screening and awareness. More than 95 percent of pregnant women in the U.S. are screened for HBV infection during pregnancy, reducing perinatal transmission risk. Even with declining incidence, 95 percent of new cases are now among adults, and the number of persons with chronic HBV infection remains high—(between 800,000 and 1.4 million). CDC provided technical analyses to the Advisory Committee on Immunization Practices (ACIP) to expand recommendations for adult HBV vaccination to include persons with diabetes aged 20-59. Chronic HBV infection is a significant cause of cirrhosis and liver cancer among disproportionately-affected populations. Published studies indicate that expanded screening of populations most affected is cost-effective. One such study indicates that expanded screening among Asian Americans would cost $40,000 per quality-adjusted life year (QALY) gained. For these reasons, CDC established targets to increase screening for HBV among minority populations (Measures 2.6.2, 2.6.5).

HCV incidence declined from 290,000 cases per year to an estimated 16,000 per year between 1989 and 2009, largely as a result of decreases in infections among IDUs, and successful efforts to screen the U.S. blood supply. However, transmission among IDUs and outbreaks of HCV related to health care settings remain an important transmission source . Further, between 2.7 and 3.9 million Americans have HCV, and most are unaware of their infection. Estimates from a CDC model indicate that, without enhanced interventions to identify and treat the estimated 2.8 million Americans in primary care who are chronically infected with HCV, 1.47 million will develop cirrhosis, 350,000 will develop liver cancer, and 897,000 will die from complications of hepatitis C. Preliminary projections from a CDC model indicate that expanding current HCV screening and care to include routine one-time screening of all persons born between 1945 to 1965 (compared with current risk-based screening) would reduce deaths due to HCV by 86,000 at a cost of $29,000 per QALY gained. To improve hepatitis prevention and control efforts, CDC is assisting states in improving viral hepatitis surveillance. Currently nine states completed the reporting needed for national reports, and CDC will increase this number by at least one state in 2012.

Program: Sexually Transmitted Infections

Performance Measures for Long Term Objective: Reduce pelvic inflammatory disease in the U.S.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.7.1: Reduce pelvic inflammatory disease in the U.S. (Outcome)	FY 2010: 113,000 (Target Not Met)	84,709	99,667	+14,958
2.7.2a: Reduce the percentage of high-risk women aged 16–20 infected with chlamydia (Outcome)	FY 2009: 13.08 % (Baseline)	12.98%	12.75%	-0.23
2.7.2b: Reduce the percentage of high-risk women aged 21–24 infected with chlamydia (Outcome)	FY 2009: 8.24 % (Baseline)	7.84%	7.7%	-0.14
2.7.4a: Reduce the rate of gonorrhea per 100,000 population in women aged 16–20 (Outcome)	FY 2009: 664.8 (Baseline)	714.56	708.4	-6.16
2.7.4b: Reduce the rate of gonorrhea per 100,000 population in women aged 21–24 (Outcome)	FY 2009: 491.7 (Baseline)	533.4	528.8	-4.6
2.7.5: Reduce the racial disparity of gonorrhea in women aged 16–24 (Outcome)	FY 2009: 14.6 :1 ratio (Baseline)	13.2 :1 ratio	12.9 :1 ratio	-0.3
2.7.6a: Increase the proportion of sexually active women aged 16–20 enrolled in Medicaid health plans who are screened for Chlamydia infections (Outcome)	FY 2010: 54.6 (Target Not Met but Improved)	60.0	61.8	+1.8
2.7.6b: Increase the proportion of sexually active women aged 16–20 enrolled in commercial health plans who are screened for Chlamydia infections (Outcome)	FY 2010: 40.8 (Target Not Met)	48.7	50.8	+2.1
2.7.6c: Increase the proportion of sexually active women aged 21–24 enrolled in Medicaid health plans who are screened for Chlamydia infections (Outcome)	FY 2010: 62.3 (Target Not Met but Improved)	69.4	72.1	+5.3
2.7.6d: Increase the proportion of sexually active women aged 21–24 enrolled in commercial health plans who are screened for Chlamydia infections (Outcome)	FY 2010: 45.7 (Target Not Met but Improved)	54.8	57.7	+2.9

Performance Measures for Long Term Objective: Eliminate congenital syphilis

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.9.1: Reduce the incidence of primary and secondary syphilis in women aged 15–44 (per 100,000 population) (Outcome)	FY 2009: 3.1 (Historical Actual)	3	2.97	-0.03
2.9.2: Reduce the incidence of congenital syphilis per 100,000 live births. (Outcome)	FY 2010: 8.7 /100,000 (Target Exceeded)	18.5 /100,000	9.97 /100,000	-8.53
2.9.3: Increase percentage of pregnant women screened for syphilis at least one month before delivery (Outcome)	FY 2008: 78.3% (Baseline)	80.6%	81.3%	+0.7%
2.Q: Percentage of STI Sentinel Surveillance Sites reporting gender of sex partner for gonorrhea and primary and secondary syphilis in men (Output)	FY 2009: 100% (Historical Actual)	100%	100%	Maintain

Performance Trends: CDC assures the provision of quality sexually transmitted infections (STI) services in both the public and private sectors through technical assistance and training. CDC provides technical and financial assistance to state and local programs to address sexually transmitted infections. CDC's long-term objectives are to reduce pelvic inflammatory disease (PID) and eliminate congenital syphilis. PID is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Infections due to *Chlamydia trachomatis* and *Neisseria gonorrhea* are major causes of PID. Data from a randomized controlled trial of Chlamydia screening in a managed care setting suggested that screening programs can lead to as much as a 60 percent reduction in the incidence of PID (Measures 2.7.1-2.7.6). Congenital syphilis is a preventable disease which could be eliminated through consistent and effective antenatal screening and treatment of infected pregnant women. Elimination of congenital syphilis would contribute to reductions of lost pregnancies, preterm/low birth weight infants, and prenatal death (Measure 2.9.1, 2.9.2, 2.9.3).

Improvements in screening and investments in other prevention strategies will not only avert infections and improve the health outcomes of the nation but will be cost-effective because of the high, and increasing, economic burden associated with STIs and their sequelae[5]. Reductions in gonorrhea and syphilis from 1990 to 2003 greatly reduced the economic burden of these diseases with $6.5 billion in estimated savings (2010 dollars). Published estimates of cost-effectiveness of Chlamydia screening in sexually active young women range from about $2,500–$37,000 per QALY.

Targeted STI prevention programs are successful in reducing disease. Between 2000 and 2009, Chlamydia screening of young women ages 16–25 enrolled in U.S. commercial or Medicaid health plans increased by 85.8 percent. Between 1988 and 2009, screening programs supported by CDC in HHS Region 10 (serving Alaska, Idaho, Oregon, and Washington) demonstrated a decline in Chlamydia positivity rate of 46 percent (from 11.1 percent to 6.0 percent) among 15 to 24 year-old women in

[5] Chesson HW, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. Perspectives on Sexual and Reproductive Health 2004, 36(1): 11–19. Also: Maciosek, M, et al. Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis. American Journal of Preventive Medicine, 2006; (31) 1, 52–61.

participating family planning clinics (Measure 2.7.6a-d). In addition, from 1999 to 2009, primary and secondary syphilis rates among females declined by 30 percent and rates of congenital syphilis declined by 32 percent (Measure 2.9.2). Screening and providing treatment is a key strategy to control treatable STIs. CDC works with partners to inform healthcare providers of screening recommendations and implements strategies to encourage adherence to recommendations. Monitoring progress in screening and reducing disease burden informs programmatic priorities and resource allocation.

Program: Tuberculosis

Performance Measures for Long Term Objective: Decrease the rate of cases of tuberculosis (TB) among U.S.-born persons in the U.S.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
2.8.1: Decrease the rate of cases of tuberculosis among U.S.-born persons (per 100,000 population) (Outcome)	FY 2010: 1.6 /100,000 (Target Exceeded)	1.7 /100,000	1.7 /100,000	Maintain
2.8.2: Increase the percentage of newly diagnosed TB patients who complete treatment within 12 months (where <12 months of treatment is indicated) (Outcome)	FY 2008: 84.6% (Target Not Met but Improved)	88%	88%	Maintain
2.8.3: Increase the percentage of culture-positive TB cases with initial drug susceptibility results reported(Outcome)	FY 2010: 95.8% (Target Exceeded)	95%	95%	Maintain
2.8.4: For contacts to sputum acid-fast bacillus smear-positive TB cases who have started treatment for newly diagnosed latent TB infection, increase the proportion of TB patients who complete treatment (Outcome)	FY 2008: 64.1% (Target Not Met)	75%	70%	-5%
2.T: Number of state public health laboratories participating in the TB Genotyping Network (Output)	FY 2010: 50 (Target Met)	50	50	Maintain

Performance Trends: Effective control efforts by CDC and its 68 state and local partners led to the lowest number of overall U.S. TB cases (estimates are 11,182 cases in 2010, or 3.6 per 100,000 population) since national reporting began in 1953. Reflecting program effectiveness, the U.S. consistently ranks among the lowest TB incidence countries in the world. Moreover, while TB drug resistance is increasing globally, with the World Health Organization (WHO) reporting 440,000 cases and 150,000 deaths in 2008, numbers of drug resistant cases in the U.S. remain stable at less than one percent of all cases (approximately 100 cases per year). CDC monitors key TB controls, including treatment completion within one year, timely laboratory reporting, and testing of all TB patients for HIV to ensure coordinated care and other prevention activities. CDC works with state and local TB programs to monitor these indicators performance, ensuring essential TB prevention, control, and laboratory activities are contributing to TB elimination (defined as a case rate of less than one case per million population). In 2008, 84.6 percent of patients completed a curative course of treatment for TB (Measure 2.8.2). Although a substantial increase over the 1994 baseline of 67.6 percent and an improvement from the previous year, CDC didn't meet its target. Because TB treatment completion is the most effective way to reduce the spread of TB and prevent its complications, this measure is the highest priority for CDC's TB program.

CDC adjusted targets to reflect progress achievable given current federal, state, and local funding for TB. Research funded by CDC through the TB Trials Consortium identified a new regimen for treatment for latent TB infection (LTBI). The new regimen requires three months of treatment, instead of nine and, therefore, is more likely to be completed. CDC published new guidelines for the regimen the day following the publication of research results. Treatment for LTBI to prevent TB disease costs a fraction of the cost of curing a case of TB disease. Direct medical costs of LTBI screening and treatment are approximately $261 to $390 per person (2010 dollars). The direct medical cost of curing TB disease is approximately $5,010 per case of drug susceptible TB disease, treated by directly observed therapy. Costs rise if the case of disease requires hospitalization ($23,800) and even more for treatment of a multidrug-resistant strain ($18,800 to $171,600), or for hospitalization of an extensively drug-resistant TB case (approximately $605,000 each). For individuals at high risk for TB, the benefits of screening for LTBI and completion of treatment outweigh the costs if treatment reduces the risk of—and costs associated with—TB disease and hospitalization.

IT INVESTMENTS

Information technology (IT) resources are an essential component of HIV, VH, STI, and TB prevention activities. Investment in IT builds the capacity of CDC and its grantees to gather, store, control, and disseminate valuable data for public health monitoring and program evaluation. Program funds support the operation of IT systems to monitor disease incidence and prevalence nationwide, analyze data for surveillance reports and other publications, monitor program effectiveness, and ensure efficient administration of business and support services.

CDC-WIDE HIV/AIDS FUNDING

Fiscal Year	Domestic HIV/AIDS Prevention and Research (Infectious Disease)	Other Domestic HIV Prevention	Global AIDS Program[1]	CDC-Wide HIV Total[2]
2004[2]	$667,940,000	$70,032,000	$266,864,000	$1,004,836,000
2005[3]	$662,267,000	$69,438,000	$123,830,000	$855,535,000
2006[4]	$651,657,000	$64,008,000	$122,560,000	$838,225,000
2007	$695,454,000	$62,802,000	$120,985,000	$879,241,000
2008[5]	$691,860,000	$40,000,000	$118,863,000	$850,723,000
2009	$691,860,000	$40,000,000	$118,863,000	$850,723,000
2010[6]	$799,270,000	$0	$118,961,000	$918,231,000
2011	$800,445,000	$0	$118,741,000	$919,186,000
2012 Appropriation[7]	$786,176,000	$0	$117,118,000	$903,294,000
2013 President's Budget	$826,407,000	$0	$117,156,000	$943,563,000

[1] Amount for Global AIDS Program does not include PEPFAR funding.

[2] From FY 2004 to FY 2009, CDC-wide HIV/AIDS funding was comprised of activities conducted by NCHHSTP, the National Center Chronic Disease Prevention and Health Promotion (NCCDPHP), and the National Center for Birth Defects and Developmental Disabilities (NCBDDD).

[3] In FY 2004, CDC's budget was restructured to separate actual program costs from the administration and management of those programs. Funding levels are not comparable to those of previous years. Also in that year, funding for the HIV lab activities was moved from the Infectious Disease budget activity to the Research and Domestic HIV Prevention sub-line in the HIV, STI and TB prevention budget activity.

[4] HIV/AIDS Basic Research was moved from the Infectious Disease budget activity to the CDC Research and Domestic HIV Prevention sub-line under HIV/AIDS, Viral Hepatitis, STI, and TB Prevention in FY 2006.

[5] In FY 2010, funds supporting hemophilia/HIV activities in NCBDDDP and for oral health/HIV, BRFSS/HIV, and Safe Motherhood/HIV activities in NCCDPHP have been removed from the HIV-wide table. FY 2008 and FY 2009 figures have been adjusted to become comparable to FY 2010 figures

[6] FY 2010 and FY 2011 funding levels have been made comparable to the budget realignment, reflecting a transfer of $40,000,000 from Chronic Disease Prevention and Health Promotion to HIV/AIDS Prevention and Research. Funding levels prior to FY 2010 have not been made comparable to the budget realignment. FY 2010 funding includes a $30,400,000 ACA/PPHF allocation.

[7] The FY 2012 appropriation included a transfer of $29,838,000 from the National Center for Chronic Disease Prevention and Health Promotion to the Domestic HIV//AIDS Prevention and Research line within the National Center for HIV/AIDS, Viral Hepatitis, STI, and TB Prevention (NCHHSTP). These funds have been moved in this table from the Other Domestic HIV Prevention column to the Domestic HIV/AIDS Prevention and Research column. This change has been reflected in the 2013 Request as well.

STATE TABLES[1]

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS*			TB ELIMINATION & LABORATORY PROGRAM	COMPREHENSIVE STI PREVENTION PROGRAM
	FY 2011 Prevention Projects	FY 2011 Surveillance	Total	FY 2011 Actual	FY 2011 Actual
Alabama[2 3 5 7]	$2,280,490	$1,068,213	$3,348,703	$1,212,506	$1,866,396
Alaska[1]	$1,460,584	$129,965	$1,590,549	$399,437	$426,843
Arizona[1]	$3,180,100	$978,961	$4,159,061	$1,379,549	$1,383,447
Arkansas[1]	$1,606,930	$197,586	$1,804,516	$607,747	$1,253,392
California[1 2 3 4 6]	$14,210,031	$2,878,044	$17,088,075	$8,248,160	$5,733,449
Colorado[1 2 3 4]	$4,447,445	$1,217,895	$5,665,340	$543,390	$1,113,650
Connecticut[1 2 3]	$6,072,583	$ 989,388	$7,061,971	$782,925	$761,120
Delaware[1 2 3]	$1,856,337	$ 278,718	$2,135,055	$281,176	$375,585
District of Columbia[2 3 4 5 6]	$5,990,780	$2,089,767	$8,080,547	$792,039	$1,242,024
Florida[2 3]	$19,765,008	$3,974,732	$23,739,740	$7,816,014	$4,526,781
Georgia[2 3 4 5 6]	$7,854,411	$1,197,380	$9,051,791	$3,115,060	$3,867,429
Hawaii[1 2 3]	$2,108,284	$252,688	$2,360,972	$1,009,398	$385,112
Idaho[2 6]	$830,716	$95,169	$925,885	$177,962	$423,404
Illinois[1]	$4,223,900	$587,320	$4,811,220	$1,373,373	$2,192,750
Indiana[1]	$2,647,377	$798,865	$3,446,242	$776,471	$1,766,420
Iowa[2 3 4 5]	$1,717,312	$250,537	$1,967,849	$352,894	$770,083
Kansas	$1,686,916	$193,735	$1,880,651	$408,412	$840,080
Kentucky	$2,008,327	$302,678	$2,311,005	$809,136	$965,774
Louisiana[2 3 4 5 6]	$5,347,107	$1,873,647	$7,220,754	$1,480,883	$2,308,900
Maine[2 3 6]	$1,630,436	$235,536	$1,865,972	$176,514	$304,400
Maryland[2 3 4 5 6]	$9,919,207	$1,843,480	$11,762,687	$1,288,056	$1,305,619
Massachusetts[1 2 3]	$8,878,171	$1,367,791	$10,245,962	$1,535,777	$1,589,334
Michigan[2 3 4 5 6]	$6,426,517	$1,766,370	$8,192,887	$961,472	$2,744,153
Minnesota[1 2 3 4 5 6]	$3,228,529	$479,202	$3,707,731	$1,067,824	$1,079,000
Mississippi[1 2 3 4 6]	$2,147,626	$463,297	$2,610,923	$850,183	$1,434,670
Missouri	$3,776,051	$701,036	$4,477,087	$647,310	$2,086,241

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS*			TB ELIMINATION & LABORATORY PROGRAM	COMPREHENSIVE STI PREVENTION PROGRAM
	FY 2011 Prevention Projects	FY 2011 Surveillance	Total	FY 2011 Actual	FY 2011 Actual
Montana	$1,312,214	$75,000	$1,387,214	$180,789	$309,762
Nebraska[2 3 4 6]	$1,359,043	$242,446	$1,601,489	$213,427	$457,345
Nevada[1 2 3 4 6]	$2,750,266	$678,855	$3,429,121	$638,661	$708,887
New Hampshire	$1,393,171	$111,000	$1,504,171	$231,862	$285,844
New Jersey[1 2 3]	$13,022,737	$3,181,550	$16,204,287	$4,485,777	$3,243,389
New Mexico[1]	$2,336,636	$284,163	$2,620,799	$420,448	$776,540
New York[1 2 3 4 5 6]	$27,063,398	$3,162,459	$30,225,857	$2,518,397	$2,985,946
North Carolina[1 2 3 4 6]	$3,324,770	$1,216,474	$4,541,244	$1,891,520	$2,972,176
North Dakota[2 3 5]	$745,179	$173,261	$918,440	$159,325	$263,557
Ohio[2 5 6]	$5,233,635	$878,301	$6,111,936	$1,284,603	$3,317,187
Oklahoma[2 3 4 5 6]	$2,430,267	$539,536	$2,969,803	$742,304	$1,175,471
Oregon[1]	$2,458,034	$295,268	$2,753,302	$616,701	$1,025,522
Pennsylvania[1 2 3 4 5 6]	$4,712,683	$939,949	$5,652,632	$996,525	$2,071,908
Rhode Island	$1,716,847	$224,293	$1,941,140	$319,722	$404,790
South Carolina[1 2 3 4 6]	$4,559,847	$1,239,771	$5,799,618	$1,406,212	$1,602,443
South Dakota[1]	$556,295	$74,670	$630,965	$238,389	$291,684
Tennessee[2 3 4 5 6]	$3,591,923	$1,103,635	$4,695,558	$1,595,030	$2,329,767
Texas[1 2 3 4 6]	$13,600,073	$2,379,466	$15,979,539	$8,104,874	$6,649,763
Utah[1 2 3 5 6]	$1,159,720	$521,321	$1,681,041	$282,821	$482,151
Vermont	$1,501,201	$95,000	$1,596,201	$153,000	$183,302
Virginia[1 2 3 4 5 6]	$4,662,557	$1,407,167	$6,069,724	$1,601,894	$1,909,604
Washington[1 2 3 4 6]	$3,526,778	$2,000,706	$5,527,484	$1,605,229	$2,582,156
West Virginia[1]	$1,549,184	$228,605	$1,777,789	$318,155	$712,233
Wisconsin[2 3 4 5]	$2,827,390	$520,323	$3,347,713	$477,245	$967,413
Wyoming[1]	$787,249	$74,969	$ 862,218	$189,938	$267,392
Subtotal, States	***$233,482,272***	***$47,860,188***	***$280,052,493***	***$68,766,516***	***$80,722,288***

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS*			TB ELIMINATION & LABORATORY PROGRAM	COMPREHENSIVE STI PREVENTION PROGRAM
	FY 2011 Prevention Projects	**FY 2011 Surveillance**	**Total**	**FY 2011 Actual**	**FY 2011 Actual**
Baltimore	–	–	–	$444,754	$1,459,810
Chicago[1 2 4 5 6]	$5,652,941	$1,136,136	$6,789,077	$1,922,523	$2,289,510
Detroit	–	–	–	$485,763	–
Houston[1 2 3 4 5 6]	$5,374,701	$1,749,212	$7,123,913	$2,348,408	–
Los Angeles[1 2 3 5 6]	$13,094,672	$2,635,215	$15,729,887	$8,248,160	$3,762,782
New York City[1 2 3 5]	$21,902,320	$5,252,956	$27,155,276	$9,019,999	$6,776,893
Philadelphia[1 2 3 4 6]	$6,201,666	$1,176,314	$7,377,980	$1,060,022	$2,563,668
San Diego	-	–	–	$2,210,979	–
San Francisco[2 3 4 5 6]	$9,143,991	$1,599,054	$10,743,045	$2,587,438	$1,545,109
Subtotal, Cities	***$61,370,291***	***$13,548,887***	***$74,919,178***	***$28,328,046***	***$18,397,772***
American Samoa[1]	$174,435	$9,000	$183,435	$85,525	$63,121
Guam	$510,922	$25,000	$535,922	$414,651	$116,844
Marshall Islands	$122,518	$18,042	$140,560	$135,734	$136,660
Micronesia[1]	$223,566	$5,903	$229,469	$171,542	$56,570
Northern Mariana Island	$292,058	$22,712	$314,770	$181,337	$119,549
Palau[1]	$232,630	$21,017	$253,647	$127,397	$43,522
Puerto Rico[2 3 4 5]	$3,933,190	$767,274	$4,700,464	$799,241	$1,422,617
Virgin Islands	$630,397	$140,371	$770,768	$86,938	$192,836
Subtotal, Territories	***$6,119,716***	***$1,009,319***	***$7,129,035***	***$2,002,364***	***$2,151,719***
TOTALS:	**300,972,279**	**$62,418,394**	**$363,390,673**	**$96,077,567**	**$101,271,779**

Notes: *Amounts reflect new funding only. Closeout for FY 2011 has not been finalized. Figures presented in this table are subject to change.

[1] In addition, this grantee received unobligated dollars from prior years to offset the new award.

[2] This grantee is one of 41 states that received supplemental funds for one or more HIV/AIDS Surveillance activities (see below for total supplemental funding).

[3] Award includes supplemental funds for HIV/AIDS Surveillance: Enhancing Lab Reporting Data Emphasis on CD4 and VL Test Results.

[4] Award includes supplemental funds for HIV/AIDS Surveillance: Geographic Information System (GIS).

[5] Award includes supplemental funds for HIV/AIDS Surveillance: Using Laboratory Data to Assess and Plan for Improved Prevention and Care.

[6] Award includes supplemental funds for HIV/AIDS Surveillance: Enhancing Security and Confidential Practices and Infrastructure.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$252.443	$252.476	$279.477	+$27.001
ACA/PPHF	$51.750	$51.750	$51.750	$0.000
Total	**$304.193**	**$304.226**	**$331.227**	**+$27.001**
FTEs	1,215	1,209	1,208	-1

Authorizing Legislation: PHSA §§ 301, 304, 307, 308(d), 310, 311, 317, 317P, 317R, 317S, 319, 319D, 319E, 319F, 319G, 321, 322, 325, 327, 352, 353, 361–369, 399G, 1102, 2821; P.L. 96-517; P.L. 111-5; Immigration and Nationality Act §§ 212, 232 (8 U.S.C. 1182, 8 U.S.C. 1222)

FY 2013 Authorization……..……..……..Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $331,227,000 for emerging and zoonotic infectious diseases, including $51,750,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of $27,001,000 above the FY 2012 level. The FY 2013 request includes a decrease of $2,425,000 for Core Infectious Diseases, an increase of $16,735,000 for Food Safety, and an increase of $12,628,000 for the National Healthcare Safety Network.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Core Infectious Diseases	$186.216	$184.657	$182.232	-$2.425
Food Safety	$25.323	$27.113	$43.848	+$16.735
National Healthcare Safety Network	$14.872	$14.840	$27.468	+$12.628
Quarantine	$26.032	$25.866	$25.929	+$0.063
Federal Isolation and Quarantine (non-add)	N/A	N/A	$1.000	N/A
ACA/PPHF	$51.750	$51.750	$51.750	$0.000
Total	**$304.193**	**$304.226**	**$331.227**	**+$27.001**

CDC is the global leader in protecting Americans and people around the world from infectious diseases. Recognized infectious agents are ubiquitous, changing constantly, and responsible for millions of illnesses and deaths. Working with partners at the local, state, national, and international levels, CDC provides technical epidemiologic and laboratory expertise to detect, prevent, and respond to known and newly identified infectious disease threats and develops evidence-based recommendations to protect people against illness and death from:

- Infectious diseases transmitted by mosquitoes, ticks, fleas, and other vectors, including Lyme disease.
- Infectious diseases caused by dangerous known or unknown infectious agents, often requiring evaluation in biosafety level (BSL)-3 and BSL-4 laboratories, including high-consequence pathogens, such as Ebola hemorrhagic fever.
- Infectious diseases of respiratory origin, including pneumococcal infections.
- Infectious microbes resistant to drug therapy (antimicrobial resistant).

- Healthcare-associated infections (HAIs): public health activities focused on patient safety; HAI outbreak investigations; HAI prevention guideline development; blood, organ, and tissue safety; and medical injection safety.
- Infections associated with and spread in healthcare settings tracked by the National Healthcare Safety Network (NHSN).
- Infectious diseases transmitted through contaminated food, including *Salmonella* and norovirus infections.
- Infectious diseases associated with global migration and travelers' health, including the prevention of diseases among immigrants, refugees, and international travelers, and to prevent spread to others.

Through these investments, CDC aims to protect Americans from a range of infectious agents and support states and other partners in detecting these agents and preventing their spread in communities.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$217.771
2009	$225.404
2009 (ARRA)	$40.000
2010	$261.174
2010 (ACA/PPHF)	$20.000
2011	$252.443
2011 (ACA/PPHF)	$51.750
2012	$252.476
2012 (ACA/PPHF)	$51.750

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

CORE INFECTIOUS DISEASES BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$186.216**	**$184.657**	**$182.232**	**-$2.425**

Program Overview: CDC houses our country's leading experts and gold standard laboratories to prevent and control infectious diseases. CDC experts and laboratories detect and track this enormous range of microbes, respond to outbreaks of known infectious threats to prevent further spread, and serve as an early warning system to quickly identify new infectious disease threats as they emerge. To accomplish this, CDC invests in a flexible and adaptable public health system at national, state, and local levels, including building a sufficient and competent public health workforce; creating and supporting tracking systems; supporting modern and efficient laboratory facilities with well-trained laboratory staff; preparing and equipping outbreak investigation and response teams; and developing epidemiologic, statistical, analytic, and communication tools needed to effectively respond to infectious disease problems. CDC also provides technical expertise and conducts public health research to further support state, local, national, and international infectious disease prevention efforts.

The state and local parts of this integrated public health system are supported primarily by means of two infectious disease platforms—the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Program and the Emerging Infections Program (EIP)—that assist states, localities, and territories in

tracking and responding to known infectious disease threats in their communities and maintaining core capacity to be our nation's eyes and ears on the ground to detect new threats as they emerge.

The ELC, which provides a single grant vehicle for multiple programmatic initiatives, currently supports all 50 states, six local health departments (Chicago, Houston, Los Angeles County, New York City, Philadelphia, and Washington, D.C.), Puerto Rico, and the Republic of Palau.

The EIP is a network of 10 state public health departments and their partners that is a national resource for surveillance, prevention, and control of emerging infectious diseases. This core EIP surveillance work generates reliable estimates of the incidence of certain infections and provides the foundation for a variety of epidemiologic studies to explore risk factors, spectrum of disease, and prevention strategies.

CDC uses the ELC and EIP platforms in its efforts to prevent and control infectious diseases, including zoonotic and vector-borne diseases, high consequence pathogens, respiratory pathogens, drug-resistant pathogens, and those associated with healthcare infections and refugee and immigrant health. CDC's efforts address many factors, which include the emergence and change of microbes and their relationship to the environment and their host; development of new technologies to address emerging infections; and working with federal and state public health agencies to investigate outbreaks not only to stop the spread, but also to gain information on what needs to be tracked and to identify research gaps and educational needs.

Budget Proposal: CDC's FY 2013 request of $182,232,000 for core infectious diseases is a decrease of $2,425,000 below the FY 2012 level. The request includes funds to focus on necessary activities for prion disease and reflects a reduction due to a decrease in global public health risk of variant Creutzfeldt-Jakob disease. Due to completion of population-based studies to address Chronic Fatigue Syndrome, the proposal also includes reduced funding that will shift focus of CDC's activities to patient and provider education and clinic-based studies. Funding for core infectious diseases includes the activities below.

Vector-borne Diseases: Pathogens Transmitted by Mosquitoes, Ticks, Fleas, and Other Vectors

Recent accomplishments:

- Developed one of the first candidate vaccines effective against all four species of dengue virus. This vaccine is now in Phase 1 human trials, with Phase 2 trials planned. Dengue infects approximately 100 million people worldwide annually, resulting in high costs due to hospitalization, lost wages, lowered productivity, and vector control.
- Developed and successfully tested innovative pesticides derived from natural products (citrus and Alaska Yellow Cedar) that are effective against mosquitoes, ticks, and other vectors. CDC established commercial licensing agreements with two private companies for development of insect repellents and environmental pesticides that have the potential for overcoming vector resistance to existing pesticides and being widely accepted by consumers.
- Responded promptly to emergencies in states, including the first dengue outbreaks in Florida (2009–2010) and Hawaii (2011) in years and large outbreaks in former Pacific territories (2011), imported dengue cases in Georgia and Nebraska (2010), and epidemics of West Nile Virus (WNV) and Rocky Mountain spotted fever in Arizona (2004–present). CDC worked in Puerto Rico to respond to the largest epidemic of dengue ever recorded in the territory (2010), managing the disease surveillance system and training over 8,000 physicians in the diagnosis and management of cases. CDC responded to epidemics of yellow fever, plague, and other vector-borne pathogens in Africa, Asia, and the Americas.

In FY 2013, CDC will:

- Detect, prevent, and control diseases spread by mosquitoes, ticks, fleas, and other vectors in the United States and abroad via intramural and extramural programs.
- Assist county, state, tribal, and territorial health authorities, as well as international partners, to diagnose vector-borne disease cases, identify risks, and respond to disease using tailored strategies, including integrated pest management. CDC will work with these partners to rapidly detect and implement timely, effective responses to both known pathogens; such as Lyme disease, WNV, and plague; and novel and emerging pathogens such as dengue and chikungunya viruses.
- Continue to operate and fund ArboNet, CDC's national surveillance system for arthropod-borne viruses. This integrated network funds staff in 49 states, Puerto Rico, and six large municipalities to conduct human case investigations, collect and analyze mosquitoes and other specimens, perform laboratory analysis, and submit information to CDC for analysis and wide dissemination. CDC will analyze and post weekly county-level data on WNV, dengue, eastern equine encephalitis, and other arboviruses, enabling health departments to evaluate and respond quickly to emerging outbreaks.
- Operate and fund a more focal program, TickNet, to work with state health departments to conduct surveillance and prevention activities for Lyme and other tick-borne diseases. TickNet will conduct and coordinate surveillance, research, education, and prevention of tick-borne diseases through working with health departments in areas of high tick-borne disease incidence.
- Conduct critical intramural activities at its vector-borne disease laboratories, such as developing cutting-edge technology for the rapid identification of emerging pathogens and research to understand pathogen transmission and means of control. CDC staff will continue to carry out fieldwork and evaluation in places such as Arizona, Florida, New York, and Puerto Rico to explain what places citizens at risk for vector-borne diseases and to evaluate the efficacy of prevention efforts. CDC will continue to partner with industry and universities to bring novel products to market, such as plant-based pesticides and an award-winning dengue vaccine.
- Develop, test, and deploy improved diagnostics for dangerous pathogens such as plague, dengue, and chikungunya. These diagnostics include both highly sensitive and specific tests for identification and discovery to inexpensive, rapid, and robust point-of-care "dipstick" diagnosis for developing countries.
- Maintain support for states and territories to collect and use integrated surveillance data in making effective decisions for the control of vector-borne diseases. This includes enhancing surveillance and prevention for Lyme and other tick-borne diseases by extramural funding of the TickNet program in more than 16 states and providing support for the nationwide mosquito-borne disease surveillance (ArboNet). ArboNet facilitates timely response to endemic threats, such as WNV and eastern equine encephalitis, and early warning of emerging vector-borne diseases like dengue and chikungunya.
- Conduct research to optimize the use of pesticides to control vector-borne disease. CDC will continue to evaluate the impact of home-based pesticide application on Lyme disease incidence via a randomized, placebo-controlled household trial in Connecticut and possibly other states with high Lyme disease incidence. CDC will also continue work to bring to market novel and highly efficacious botanical pesticides that have been developed and tested by CDC and university collaborators, in partnership with the pesticide and repellent industry.

- Develop and distribute a toolkit to communities and clinicians promoting the most effective strategies to prevent, diagnose, and treat Lyme and other tick-borne diseases.
- Evaluate and incorporate more effective antibiotics into the treatment of plague in Uganda, and continue to evaluate and implement an innovative system involving village healers in the timely referral of plague cases. These interventions will reduce mortality from plague in northwest Uganda, ultimately by 50 percent. CDC will also test new, effective methods of rat and flea control to prevent new plague cases.
- Expand training for the identification and management of severe dengue cases to clinicians throughout the United States and U.S. territories and elsewhere in the Americas, Asia, and the Pacific. This will reduce complications and mortality from dengue hemorrhagic fever.
- Continue development and testing of effective vaccines against vector-borne disease, including monitoring the safety and evaluating the real-world efficacy of existing vaccines against yellow fever and Japanese encephalitis, and the development of a novel and effective vaccine against dengue with commercial partners.
- Conduct a pilot prevention project to combat the deadly epidemic of Rocky Mountain spotted fever in the southwest United States in partnership with tribes and communities.

High-Consequence Pathogens: Diseases Caused by Dangerous or Unknown Infectious Agents

Recent accomplishments:

- Completed successful vaccine trials of a live-attenuated Rift Valley fever recombinant virus for use in livestock. This will reduce disease in domestic animals, preventing the economic cost due to the loss of livestock, and eliminate one of the most significant sources of human infection that occurs throughout Africa and the Arabian Peninsula.
- Began implementation of a viral hemorrhagic fever (VHF) surveillance program in Uganda—an emerging disease "hot spot" for some of the world's most dangerous pathogens—by providing training to 28 health professionals from 14 different surveillance sites on VHF identification, specimen and information collection, and infection control. In May 2011, the CDC-supported Viral Research Institute in Uganda, part of the VHF surveillance program, provided a rapid diagnosis of Ebola and there was no spread of disease beyond the initial confirmed case. This case was diagnosed in approximately eight days, compared to previous cases that have taken several weeks to confirm.
- Completed a multi-drug resistant inhalation anthrax post-exposure prophylaxis (PEP) study in a mouse model to verify that alternative PEP drugs are of equal efficacy as current first-line drugs. The development of animal models is a key element in the successful development of anthrax medical countermeasures, which cannot be evaluated in human clinical studies.
- Responded to 145 requests from public health departments and international partners for investigation of bacterial special pathogens, tested 3,780 reference and confirmatory specimens for hantaviruses and viral special pathogens, and provided 23 state public health and partner laboratories with reagents and training for diagnostic assays for hantaviruses and viral special pathogens in FY 2011.

In FY 2013, CDC will:

- Maximize public health and safety nationally and internationally through the detection, prevention, and control of disease, disability, and death caused by suspected and known high-consequence viral, bacterial, prion, and related infections that include hantavirus pulmonary syndrome, Ebola and Marburg hemorrhagic fevers, rabies, monkeypox, anthrax, smallpox, and Creutzfeldt-Jakob Disease. CDC will maintain BSL-3 and BSL-4 laboratories to support epidemiology, research, and prevention efforts to reduce the public health threat of these highly hazardous and infectious pathogens, many of which are Select Agents and bioterrorism threat agents.
- Provide laboratory reference and diagnostic support for state and local health departments and federal agencies (such as the Food and Drug Administration (FDA), National Institutes of Health, and Department of Defense) and investigate all suspect domestic cases of known high-consequence pathogens and infectious diseases of unknown causes reported to CDC by state and local health departments.
- Provide specialty expertise and support to domestic and international partner laboratories to assist in detecting and responding to outbreaks in order to prevent the spread of diseases caused by dangerous or unknown infectious agents. CDC's technical assistance is often requested by ministries of health and other international health organizations. CDC will continue to make investments in training selected laboratories, particularly those in Africa and Asia where many outbreaks occur, to handle initial response processes and detection efforts and to share protocols and reagents to allow for sustainable program development.
- Support surveillance and pathogen discovery efforts that are critical to rapidly identifying newly emerging pathogens associated with high-fatality disease outbreaks. CDC will enhance surveillance and ecology studies for multiple bat pathogens by increased sampling of animals and humans globally and through analysis of Marburg virus replication and shedding in experimentally infected fruit bats.
- Develop integrated ecologic and epidemiologic studies for monkeypox and other orthopoxvirus diseases in the United States and globally, and improve diagnostic capabilities for orthopoxvirus disease worldwide. These studies will focus on human disease, monkeypox disease ecology, and disease transmission dynamics and will provide evidence for disease control efforts, including vaccine use.
- Develop improved, simpler, and more rapid tests to detect more than 70 high-consequence pathogens.

Respiratory Pathogens: Pathogens Transmitted by the Respiratory Route

Recent accomplishments:

- Completed a project of the Active Bacterial Core (ABC) surveillance system that demonstrated sustained impact of pneumococcal conjugate vaccine (PCV7) in reducing the risk of invasive bacterial diseases caused by vaccine serotypes by 99 percent in children targeted by vaccine, and by over 90 percent among older age groups (over 18 years) who are protected by herd immunity.
- Demonstrated the leading causes of respiratory disease among infants and young children through a 10-year study. Among the project's accomplishments was a very definitive assessment of the burden of disease attributable to important respiratory pathogens, including respiratory syncytial virus (RSV). This information is useful both in formulating policy about currently available RSV preventive measures and for providing a foundation for policies for future RSV vaccines, several of which are in early-phase clinical and animal trials.

In FY 2013, CDC will:

- Support state public health and academic partners to conduct key surveillance, epidemiologic, and laboratory activities to detect emerging respiratory and related disease threats, including detection of changes in vaccine-preventable respiratory diseases. This information informs key policy decisions and prevention strategies.
- Enhance epidemiologic and laboratory surveillance for respiratory bacterial pathogens, through activities such as population-based Active Bacterial Core (ABCs) surveillance in 10 states (including Group A and Group B *Streptococcus*) and detection and monitoring for antibiotic resistance.
- Develop, enhance, and implement programs to prevent or reduce burden of respiratory diseases, including perinatal screening to prevent Group B streptococcal disease, implementing the Get Smart campaign to reduce antibiotic use in uncomplicated upper respiratory infections, and the environmental detection and remediation of Legionellosis.
- Optimize opportunities to prevent *cytomegalovirus* and RSV through the development of new diagnostic tools, better understanding of the disease burden, and prevention opportunities.

Antimicrobial Resistance: Diseases that Result from Drug Resistance

Recent accomplishments:

- Revised and updated the 2001 HHS Interagency Task Force Public Health Action Plan to Combat Antimicrobial Resistance (AR). CDC provided a blueprint for specific, coordinated federal action to address emerging health threats in AR.
- Identified and characterized three new strains of carbapenemase-producing bacteria, which are resistant to nearly all antimicrobial agents and are associated with significantly increased mortality, morbidity, and healthcare costs among infected patients.
- Developed a new component of the National Healthcare Safety Network (NHSN) that measures and evaluates antimicrobial drug use in healthcare settings. This component allows healthcare facilities the ability to report to the NHSN using data from each facility's existing electronic records. These data are used by healthcare institutions to benchmark antimicrobial use and describe regional differences in patterns of use.
- Collaborated with FDA and U.S. Department of Agriculture (USDA) to monitor the emergence of AR in bacterial pathogens transmitted from animals to humans. A summary report of results from over 4,700 isolates collected in 2008 show resistance in these foodborne pathogens is increasing among selected bacteria with specific resistance patterns, including the first identification of azithromycin resistance and the detection of emerging fluoroquinolone resistance in these microorganisms. The results are helping federal and state agencies identify gaps in the current food safety system and identify target areas in which to develop and evaluate food safety practices as food moves from the farm to the table.

In FY 2013, CDC will:

- Lead the fight to combat the rapidly growing problem of AR and reduce the spread of AR infections. CDC will continue funding state and local health departments to enhance activities related to surveillance, prevention and control interventions, and applied research for AR. In addition, CDC will continue to perform research and maintain laboratory and epidemiology infrastructure support, training, and programs to address the most critical and immediate AR problems.

- Further enhance national, regional, state-based, and local surveillance capacity to better characterize both the incidence of specific infections (e.g., multidrug-resistant Gram negative bacilli, *C. difficile*, and MRSA) and antimicrobial use. Progress will be made through the use of electronic medical records and health information exchanges to reduce the burden of data collection, including those currently developed and those coming online as a result of American Recovery and Reinvestment Act of 2009 (ARRA) funding.

- Conduct effectiveness research on interventions to prevent AR infections in healthcare settings and in the community to help prioritize public health action, as was recently done for hospital-based screening for MRSA.

- Enhance capacity in both clinical and public health laboratories to accurately detect priority, high-consequence antimicrobial resistant pathogens, such as carbapenem-resistant *Enterobacteriaceae* (CRE), in collaboration with state public health departments. CDC will conduct research to more precisely define the relationships between the emergence and the spread of antimicrobial resistant microorganisms and antimicrobial drug use in humans and animals. CDC will fund one to three state-based projects to strengthen public health laboratory capacity for detection and rapid reporting of new and spreading AR bacteria. By linking electronic laboratory information systems with public health reporting systems, this will provide real-time situational awareness of specific AR threats.

- Expand programs to eradicate newly emerging AR pathogens in specific localities or regions, using enhanced sentinel surveillance and aggressive infection control measures in all healthcare facilities sharing patients within that geographical area. CDC will integrate regional prevention collaboratives to search for locally relevant emerging and existing AR threats and destroy pathways of pathogen transmission. CDC will fund one to three state-based projects to implement strategies to interrupt the spread of AR pathogens between healthcare facilities (hospitals, nursing homes, dialysis centers, etc.), between facilities and the community, and between geographic regions.

- Enhance surveillance for antimicrobial resistant *Neisseria gonorrhoeae* by expanding laboratory capacity to perform accurate antimicrobial susceptibility testing to state public health laboratories and expand surveillance to identify clinical treatment failures with the current recommended therapeutic regimens.

Healthcare-Associated Infections: Diseases Associated With or Acquired In Healthcare Settings

Recent accomplishments:

- Demonstrated a 58 percent decline in central line-associated bloodstream infections (CLABSI) in U.S. hospital intensive care unit patients from 2001 to 2009 that resulted in 27,000 lives saved and $1.8 billion in excess medical costs averted. In addition, there was an 8 percent decline in surgical site infections, a 13 percent annual decrease in national estimates of invasive healthcare-associated MRSA between 2005 and 2008, and significant decreases (20–65 percent) in catheter-associated urinary tract infections (CAUTI) in hospitals since the 1990s. These decreases are due to an increase in adherence to CDC HAI prevention recommendations.

- Demonstrated a 60 percent reduction of MRSA in Veteran's Administration (VA) facilities through a prevention initiative. Initially implemented as a pilot project at the local level, the initiative has now been adopted by regional and national programs.

- Published *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, the *Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings*, and the *Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care* in collaboration with the Healthcare Infection Control Practices Advisory Committee (HICPAC) in 2011 that form the basis of checklists and tools for HAI prevention initiatives.

- Performed 15 onsite field investigations in 13 states in 2010 to control outbreaks of emerging HAI pathogens (Arizona, Colorado, Florida, Maine, Michigan, Missouri, Nevada, North Carolina, Pennsylvania, Puerto Rico, Texas, Virginia, and Washington). In addition to these onsite investigations, CDC responded to over 70 requests for technical assistance in 29 states and three countries (Canada, Georgia, and Guatemala).

In FY 2013, CDC will:

- Work to eliminate HAIs with state and local health departments, other federal agencies, and partners. CDC's HAI prevention investments form the basis for healthcare facility, state, local, and national prevention programs that include: outbreak control; guideline development; gold-standard laboratory testing; blood, organ, and tissue safety; and injection safety. CDC's HAI elimination work is integral to achieving prevention goals of the HHS Action Plan to Prevent HAIs, the HHS Priority Goals (www.performance.gov/), as well as the recently announced HHS Partnership for Patients initiative.

- Develop evidence-based infection prevention guidelines with the HICPAC that will provide the scientific foundation for HAI prevention interventions. These guidelines will be translated into practice through 'checklists' used by groups in hospital settings and incorporated into Centers for Medicare and Medicaid Services (CMS) survey tools that state inspectors can use to better ensure the quality of care and support the broader HHS Partnership for Patients initiative. Guidelines to be revised include: *Management of Multidrug-Resistant Organisms in Healthcare Settings, Guideline for Preventing Healthcare-Associated Pneumonia* and *Guidelines for Environmental Infection Control in Healthcare Facilities.*

- Extend development and implementation of tools for HAI prevention beyond hospitals to non-hospital settings such as dialysis and nursing home facilities. Despite success in hospitals, similar progress has not been seen in non-hospital settings. Additionally, an increasing number of HAIs are caused by bacteria resistant to currently available antibiotics (multi-drug resistant organisms). These issues are further complicated by the fact that patients are frequently transferred between facilities (e.g., nursing homes to hospitals), which can facilitate rapid spread of HAI pathogens.

- Reduce or prevent emerging HAI pathogens, such as carbapenem-resistant Enterobacteriaceae, through work with all state health departments and continue to support three state health departments to prevent HAI transmission caused by lapses in basic safety practices, such as re-using disposable syringes (i.e., injection safety) or inappropriate reprocessing of equipment.

- Continue to coordinate investigations, surveillance (e.g., hemovigilance), and outbreak responses related to blood, organ, and other tissue safety. Earlier detection and control of these outbreaks will save lives by helping to prevent the spread of HAIs within and between healthcare settings, as well as inform strategies to prevent the spread of emerging pathogens across the United States.

- Maintain critical core laboratory capacities, including acting as a national and international reference laboratory, performing antimicrobial susceptibility tests, and responding to environmental and diagnostic needs for new and emerging healthcare-associated pathogens. Identifying and evaluating these pathogens is critical to assessing appropriate patient treatment and to developing strategies to avoid the spread of emerging pathogens across the United States.

FOOD SAFETY BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$25.323**	**$27.113**	**$43.848**	**+$16.735**

Program Overview: CDC's foodborne illness prevention program has been a cornerstone of infectious disease prevention efforts since the 1940s. Recent estimates indicate that one in six Americans becomes ill with foodborne diseases each year, leading to 128,000 hospitalizations and 3,000 deaths. Since 1996, the frequency of *E. coli* O157 infections has decreased by 44 percent, though the frequency of *Salmonella* infections has not changed. Preventing a single fatal case of *E. coli* O157 infection saves an estimated $7 million. CDC works with its food safety partners to improve the health of all Americans, reduce healthcare costs, and achieve national food safety goals.

To provide the vital link between illness in people and food safety systems, CDC: 1) monitors emerging trends and measures progress of foodborne illnesses; 2) identifies and investigates outbreaks to stop illnesses and identify gaps in the food safety system; 3) defines and prioritizes interventions for food safety prevention; and 4) is a national source for advice, guidance, training, and education for state and local governments, other partners, and consumers. CDC utilizes its unique and strong partnerships with state and local public health agencies, as well as with FDA and USDA, to coordinate, fund, and lead critical networks in food safety, such as Foodborne Diseases Active Surveillance Network (FoodNet) and CDC's National Molecular Subtyping Network for Foodborne Disease Surveillance (PulseNet) that provides DNA 'fingerprinting" of pathogens, such as *E. coli*, *Salmonella*, and *Listeria*

Vital national surveillance, outbreak detection and response, and food safety prevention efforts, supported by CDC, depend on state and local public health agencies. CDC helps to maintain and reinforce capacity in state and local areas by providing cooperative agreement funding, through the ELC and EIP, and technical support for surveillance networks, including CDC's PulseNet and FoodNet systems. CDC drives improvements in foodborne outbreak response through a new network, Foodborne Diseases Centers for Outbreak Response Enhancement (FoodCORE), formerly OutbreakNet Sentinel Sites, which was created to identify and develop faster detection and investigation methods.

Recent accomplishments:

- Developed new and more accurate estimates of the health burden of foodborne infections in the United States, using data from CDC's FoodNet and other data systems that inform many food safety policy-making and prevention efforts.
- Coordinated and led 23 multi-state foodborne outbreak investigations with states, FDA, and USDA in 2011, detected primarily by PulseNet. Investigations led to prompt implementation of control measures to prevent illnesses, such as food recalls; identification of an emerging foodborne pathogen, *E. coli* O145; and identification of new types of contaminated foods, such as pine nuts and papaya (both contaminated with *Salmonella*).
- Deployed new laboratory and patient interviewing tools and trained 30 states in their use to make surveillance and outbreak response faster and more comprehensive, due in part to FoodCORE sites' efforts. These tools include a new laboratory method for rapidly characterizing *Salmonella* and a toolkit to support state and local implementation of the Guidelines for Foodborne Outbreak Response.

- Disseminated timely and appropriate public health and prevention messages on foodborne outbreaks and pathogens. 2011 internet web postings drew over 5 million page views from audiences ranging from federal, state, and local governments to households of American consumers. CDC posted information on priority pathogens, such as Listeria-related information that was released during this year's deadly outbreak. CDC also released a Vital Signs report for Food Safety with a total potential reach of more than 1 billion people in a one month period.

Budget Proposal: CDC's FY 2013 request of $43,848,000 for foodborne disease activities is an increase of $16,735,000 above the FY 2012 level. This increase will enable CDC to move toward implementation of CDC's provisions of the Food Safety Modernization Act (FSMA), including enhancing and integrating surveillance systems, upgrading the PulseNet system, improving timeliness of outbreak detection and response in state and local partners through the FoodCORE program, attributing illnesses to specific food commodity groups to aid in prevention efforts, monitoring the effectiveness of food safety prevention measures, and supporting FSMA's Integrated Food Safety Centers of Excellence. These investments will help restore and improve state and local capacity to monitor foodborne illness and respond to outbreaks.

In FY 2013, CDC will:

- Continue to provide national reference laboratory services to identify and characterize ever-evolving, antibiotic-resistant, and new foodborne pathogens; conduct epidemiologic research to identify targets for food safety prevention efforts; lead and coordinate investigations of large, multi-jurisdictional or unusual foodborne outbreaks; and assist states in their investigations. CDC's activities will continue to coordinate closely with FDA and USDA. This supports the President's Food Safety Working Group and FSMA principles by: 1) prioritizing prevention, 2) strengthening surveillance, and 3) improving outbreak response and recovery. Additionally, CDC will partner with FDA in an HHS Priority Goal to reduce the incidence of illness due to a subtype of *Salmonella* associated with shell eggs (www.performance.gov). Overall, it is estimated that the additional requested funding will help to hire as many as 110 full and part-time positions at the state and local levels.

- Enhance foodborne diseases surveillance systems.
    - Upgrade PulseNet laboratory and IT systems that serve all 50 states to improve the rapid identification and investigation of foodborne outbreaks.
    - Begin implementing next generation methods; such as molecular serotyping, Multiple Locus Variable number tandem repeat Analysis (MLVA), and standard questions for food consumption questionnaires to be used in multistate outbreak investigations; for rapidly identifying pathogens and increasing the quality and quantity of data submitted from all states so that tainted food products can be identified more quickly.
    - Expand coverage and increase data quality for other existing foodborne disease surveillance networks, including 10 FoodNet sites and the reporting system that tracks norovirus outbreaks, which provide critical information about the frequency, severity, trends, and sources of diagnosed foodborne infections.
    - Improve core CDC foodborne disease reference laboratory functions needed to support public health laboratories and surveillance systems by verifying the proper identification of known pathogens and characterizing novel pathogens.

- Improve the integration, analysis, sharing, and use of data with food safety partners.
    - Augment analytic capacity, data systems, and methods to more accurately attribute illness to specific foods and guide new prevention policies and interventions.

- Coordinate, integrate, and enhance foodborne disease surveillance systems to reduce data gaps and improve linkage across surveillance systems.
- Share data more widely and rapidly with public health partners, regulatory agencies, industry, academia, and the public to inform independent analyses to guide food safety and prevention policies to address food safety problems.
- Translate findings from outbreak investigations to identify and implement effective prevention practices to meet national food safety goals.

- Support food-related outbreak investigations and develop improved laboratory and epidemiological tools for rapid identification and investigation of outbreaks.
  - Perform outbreak investigations to assist state and local health departments in the detection and control of outbreaks of foodborne illness.
  - Develop new laboratory tools and diagnostic platforms, including a DNA sequence-based genotype test for Shiga toxin-producing *E. coli* (STEC), and seek Clinical Laboratory Improvement Amendments (CLIA) approval for a new *Salmonella* molecular serotyping test.
  - Lead the development of technologies that will address the emerging challenge of diagnostic tests being developed for use by clinical laboratories, which are incompatible with current CDC foodborne pathogen surveillance systems, including PulseNet. Current PulseNet technology is nearly 20 years old and will likely become obsolete in the near future if its underlying technology is not updated soon. Delaying investment in this effort would likely result in undercutting federal, state, and local agencies' abilities to detect foodborne disease outbreaks and result in increased numbers of foodborne-related illnesses, hospitalizations, and deaths.
  - Support the development of new IT tools, methods, and analytics in epidemiology, laboratory science, and environmental health to allow better, faster, and more complete identification of foodborne outbreaks and their causes.
  - Increase the network of FoodCORE sites from seven to approximately 10 sites to strengthen best practices in outbreak investigation. Increased funding from the FoodCORE program to state and local agencies is estimated to increase the number of worker positions from approximately 30 to as many as 45 positions. These sites will identify, develop, implement, assess, and standardize best methods and new technologies in epidemiology, laboratory science, and environmental health for efficient outbreak detection and response among investigators at the local, state, and federal levels.
  - Support ongoing and new Council to Improve Foodborne Outbreak Response (CIFOR) projects to improve the standardization, speed, and accuracy of foodborne disease outbreak detection and investigation.
  - Restore state and local capacity to respond to outbreaks by increasing funding to support food safety programs through the ELC cooperative agreement program.

- Continue and expand training and education efforts.
  - Train epidemiologists, microbiologists, environmental health specialists, and others in the methods used for foodborne disease diagnosis, surveillance, pathogen identification, outbreak investigation, and control.

- Designate five Integrated Food Safety Centers of Excellence, as required by FSMA. Centers will serve a critical role in transferring best practices and tools in food safety surveillance and outbreak response to state and local public health program staff and the food industry through training and regional capacity support.

Food Safety Grant Table[1,2]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	57	57	57
Average Award	$0.129	$0.129	$0.129
Range of Awards	$0.015–$0.666	$0.015–$0.666	$0.029–$1.327
Number of New Awards	0	0	57
Number of Continuing Awards	57	57	0

[1]Reflects awards funded by CDC's Food Safety budget authority.
[2]Excludes PPHF funding.

NATIONAL HEALTHCARE SAFETY NETWORK BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$14.872**	**$14.840**	**$27.468**	**+$12.628**

Program Overview: Tracking and monitoring HAIs is a crucial component of HAI elimination programs. CDC provides HAI data to identify patients at risk for infection, as well as identify types of infections and the impact of prevention strategies in hospitals and other healthcare settings. The National Healthcare Safety Network (NHSN) is a surveillance system used by over 5,000 facilities for HAI tracking and prevention across healthcare settings, including hospitals in all 50 states and non-hospital settings (e.g., dialysis facilities). Because patients are frequently transferred between facilities for their care, NHSN data are used to track infections across healthcare settings and prevent the rapid spread of HAIs. NHSN also provides data to measure progress and gaps in prevention, and is being extended to support state health department prevention activities, national CMS Value Based Purchasing programs, and federal and state reporting requirements. NHSN complements other HHS systems and tracks progress towards meeting the objectives of the HHS Partnership for Patients initiative.

To further support national HAI elimination efforts, CDC accelerates prevention research through the Prevention Epicenters to address important scientific gaps in HAI prevention and works with health departments and academic institutions to conduct population-based surveillance on emerging infections and conditions not covered by routine health department surveillance.

Recent accomplishments:

- Increased participation in NHSN. By December 2010, 3,400 healthcare facilities were participating in NHSN, and as of December 2011, more than 5,100 healthcare facilities were using NHSN for HAI reporting, including 420 hemodialysis facilities and 240 long-term acute care facilities.

- Transmitted data from CDC to CMS for hospital value-based purchasing. NHSN is a demonstrated prevention and tracking tool used by healthcare facilities in all 50 states for reporting and prevention initiatives and supports the CMS hospital Value-Based Purchasing (VPB) program.

- Worked with the National Quality Forum to standardize HAI measures for additional healthcare settings (e.g., non-ICU settings, dialysis, long-term acute care facilities, and rehabilitation facilities) and infection types (e.g., *C. difficile* and MRSA). This will facilitate accurate and consistent data reported to NHSN that will be used for state and federal reporting mandates and prevention initiatives.
- Began the final phase of a large-scale HAI prevalence survey to provide an updated HAI prevalence estimate in a large sample of U.S. acute care hospitals, which will be completed in early 2012.
- Worked with state health departments to identify and disseminate best practices for validation of NHSN data.

Budget Proposal: CDC's FY 2013 request of $27,468,000 for the NHSN is an increase of $12,628,000 above the FY 2012 level. This increase will allow CDC to modernize the NHSN information technology platform to accommodate the CMS Value-Based Purchasing program requirements for NHSN reporting of additional types of HAIs (e.g., *C. difficile* and MRSA infections) and from additional healthcare settings (e.g., long-term acute care, ambulatory surgical centers, and rehabilitation centers). CDC will also continue to support CLABSI, CAUTI, and surgical site infections (SSI) reporting in 5,000 hospitals and blood stream infection (BSI) reporting in 5,000 dialysis facilities as part of VBP and continue to work with CMS to expand infection-related quality measures in areas such as additional SSI. To ensure data accuracy, CDC will support 11 states for data validation and data quality activities, electronic reporting of HAI data from hospital commercial infection surveillance systems, implement national standards for reporting laboratory data for HAIs and communicable diseases, and develop methods for automatic (e.g., electronic algorithms) HAI detection.

CDC will accelerate prevention research through five multi-center, collaborative, academic Prevention Epicenters to address scientific gaps in HAI prevention and develop innovative ways to detect and prevent HAIs. CDC will also continue to support 10 sites comprised of health departments and academic institutions to conduct population-based surveillance on emerging infections and conditions not covered by routine health department surveillance, such as multi-drug resistant, Gram-negative bacteria. This surveillance documents national disease burden, improves understanding of transmission, and assesses the impact of prevention measures.

In FY 2013, CDC will:

- Modernize the NHSN information technology platform to accommodate the expansion of CMS quality reporting initiatives. Given an expected increase in NHSN participation, CDC must invest in a new sustainable NHSN architecture (e.g., additional servers, enhanced software and user interface) to better serve the various NHSN users and to improve NHSN functionality.
- Expand HAI reporting in NHSN to additional healthcare settings. This expansion will increase reporting from 170 ambulatory surgery centers participating in 2012 to approximately 5,300 in 2013, from 250 long-term acute care facilities in 2012 to approximately 430 in 2013, and from 50 rehabilitation centers in 2012 to 1,200 in 2013 to meet CMS VPB requirements and maintain support to 5,000 hospitals and to 5,000 dialysis facilities reporting for CMS' quality programs.

- Expand national surveillance of HAIs by the types of infections reported to NHSN to meet CMS VBP requirements by increasing the number of hospitals reporting SSI from 2,800 in 2012 to approximately 4,000 in 2013; *C. difficile* from 1,450 to approximately 4,500; MRSA from 1,650 to approximately 4,500; and CAUTI from 2,200 to approximately 4,500; and maintain support for 5,000 hospitals reporting CLABSI and CAUTI. CDC will provide CMS with NHSN facility-level data to be posted on the Hospital Compare website. NHSN will provide data for monitoring national progress towards the HHS HAI Action Plan and the HHS Partnership for Patients initiative.
- Enhance electronic data collection and analysis for local use and assess regional and national trends, work with health data system vendors to support electronic reporting of HAI data from electronic health records systems to NHSN, and develop and implement methods for automatic detection of select HAIs.
- Develop innovative surveillance methods, such as definitions and metrics, validation methods, and best practices to ensure that accurate, timely, complete, and consistent HAI data are reported to NHSN and that these data are used for healthcare quality improvement, surveillance, public reporting, and/or payment purposes, such as VBP. CDC will continue to promote ongoing state health department efforts to validate data.
- Through Prevention Epicenters, collaborate with leading academic centers to identify novel candidate prevention strategies in healthcare settings and patient populations. Research will include identifying HAI prevention strategies, developing future checklists used in healthcare settings, improving HAI surveillance strategies, and developing novel strategies for detection and prevention of emerging problems, such as infections caused by antimicrobial-resistant organisms and inappropriate antimicrobial use.

National Health Care Safety Network Grant Table[1,2]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	16	16	21
Average Award	$0.172	$0.172	$0.576
Range of Awards	$0.005–$0.430	$0.005–$0.430	$0.016–$1.100
Number of New Awards	0	0	5
Number of Continuing Awards	16	16	16

[1]Reflects awards supported with CDC's NHSN budget authority.
[2]Excludes ACA/PPHF funding.

QUARANTINE AND MIGRATION BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$26.032	$25.866	$25.929	+$0.063
Federal Isolation and Quarantine (non-add)	N/A	N/A	$1.000	N/A
Total	**$26.032**	**$25.866**	**$25.929**	**+$0.063**

Program Overview: CDC improves and protects the health of vulnerable international populations, such as international refugees, immigrants, and non-immigrant admissions (tourists and students). CDC's global migration health and quarantine activities reduce infectious diseases among immigrants, refugees, and international travelers and prevent disease importation and spread within the United States. CDC has a unique regulatory function in preventing disease spread in mobile populations.

To address infectious disease health risks associated with international travel and migrating populations, CDC carries out regulatory responsibilities and implements cost-effective public health programs for populations traveling internationally or migrating to the United States. CDC has specialized knowledge of the complex issues surrounding border and migration health, including legal and regulatory issues, and a strong relationship with nontraditional partners (e.g., Department of Homeland Security, International Air Transport Association, Department of State, Department of Transportation, International Organization for Migration, foreign governments). CDC's global migration and quarantine staff are able to have a greater impact by training and leveraging these partnerships (e.g., with 50,000 Customs and Border Protection agents, 600 panel physicians, and 3,000 civil surgeons) to execute frontline public health activities.

Recent accomplishments:

- Implemented improved tuberculosis (TB) screening and treatment with 2007 Culture and Directly Observed Therapy Technical Instructions (TI) in immigrants and refugees. This has resulted in the diagnosis and treatment of over 1,000 TB cases annually—a 300 percent increase, which leads to cost savings to states of $15 million to $25 million each year. Since 2008, these TB TIs identified more than 30,000 cases of latent TB infections—a 600 percent increase—that were referred to state and local health departments for follow-up after arrival into the United States to prevent new cases of TB infection.
- Documented gold-standard travel medical guidance and advice for healthcare providers and travelers via the 2012 edition of the *CDC Health Information for International Travel*, commonly referred to as the "Yellow Book," which is a renowned reference throughout the world.
- Responded to major epidemics, such as the 2010–2011 cholera outbreak in Haiti, as well as routine public health needs, such as the response to 2,186 reports of illness at U.S. ports of entry and distribution of 631 vials of lifesaving biologic medicines.

Budget Proposal: CDC's FY 2013 request of $25,929,000 for quarantine and migration is an increase of $63,000 above the FY 2012 level. Within this amount, $1,000,000 is to remain available until expended for quarantine-related medical and transportation costs. As a result of this shift from annual to no-year funds, CDC will reduce activities that support critical surveillance to detect, identify, and map infectious diseases of public health significance in U.S.-bound refugees and immigrants, international travelers, and migrants crossing the U.S.-Mexico border.

Activities are also supported with resources from CDC's influenza planning and response appropriation and CDC's core infectious diseases appropriation.

In FY 2013, CDC will:

- Provide technical and regulatory oversight of overseas health screening and post-arrival health monitoring of 1,000,000 immigrants and 80,000 refugee populations that are undergoing U.S. resettlement.
- Increase the proportion of applicants for U.S. immigration screened for TB and treated under the 2007 TB TI from 70 percent to 72 percent.
- Increase the percentage of immigrants and refugees with a TB Class A or B medical notification who undergo medical follow-up after arrival in the United States from 74 percent to 76 percent.
- Implement overseas interventions (e.g., vaccination) in U.S.-bound immigrants and refugees that improve the health of these vulnerable populations and realize considerable cost savings to states.

- Further develop the Bio-Mosaic Project into a comprehensive migration map of immigrant populations residing in the United States by country of birth, along with other social determinants of health disparities, in order to reduce major infectious disease disparities in immigrant populations.
- Characterize risks associated with international travel of more than two million people traveling to or through the United States daily and the 60 million Americans who are frequent international travelers. CDC staff analyzes data from GeoSentinel, an international surveillance network of travel/tropical medicine clinics, to develop evidence-based recommendations that are shared with healthcare providers, the public, and a wide array of travel industry and governmental partners.
- Manage CDC's Travelers' Health website, the fifth-most frequently visited CDC website with 28 million hits annually. On this site, travelers can access travel health advice, including country-specific vaccine recommendations and requirements, outbreak updates, travel notices, travel-related disease information, and destination-specific recommendations for travelers and their healthcare providers.
- Operate up to 20 quarantine stations across the United States that limit the introduction and spread of infectious diseases by working with federal, state, and local partners to respond to public health events and develop comprehensive operational plans to manage ill or exposed travelers.
- Improve situational awareness of infectious diseases of mutual public health importance to the United States and Mexico by conducting enhanced sentinel and population-based surveillance.
- Modernize regulations to ensure swift and appropriate response to events of public health significance. Through delegated authority, CDC has statutory responsibility for preventing the introduction, transmission, and spread of communicable diseases into the United States.
- Fund transportation, medical care, treatment, and other related costs of persons subject to federal or state quarantine laws under Title III of the Public Health Service Act.

Quarantine and Migration Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	22	23	23
Average Award	$0.131	$0.133	$0.133
Range of Awards	$0.005–$0.760	$0.011–$0.760	$0.011–$0.760
Number of New Awards	7	9	2
Number of Continuing Awards	15	14	21

[1]Reflects awards supported with CDC's Quarantine budget authority.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$51.750**	**$51.750**	**$51.750**	**$0.000**

The following activities are included:

- ELC/EIP – $40,000,000
- HAI/NHSN – $11,750,000

Epidemiology and Laboratory Capacity/Emerging Infections Program

CDC is enhancing the ability of state, local, and territorial ELC and EIP grantees to strengthen and integrate capacity for detecting and responding to infectious diseases and other public health threats. EIP grantees are making long-needed improvements to their infrastructure with coordination, training, and information technology necessary for managing the numerous and varied EIP program activities and studies. More specifically, the ELC/EIP platform aim is to increase:

- Epidemiology Capacity: Increase numbers of better trained and properly equipped epidemiology staff to provide rapid, effective, and flexible response to infectious disease threats.
- Laboratory Capacity: Modernize, equip, and staff public health laboratories and employ high-quality laboratory processes and systems that foster communication and integration between laboratory and epidemiology functions.
- Health Information Systems Capacity: Develop and enhance current health information infrastructure for public health agencies. This includes modern, standards-based, and interoperable systems that support electronic exchange of information within and between epidemiology and laboratory functions within public health agencies (e.g., systems that support public health surveillance and investigation, laboratory information management systems) among federal, state, and local public health agencies, and between public health agencies and clinical care systems. Overall, enhancing the electronic exchange of information between public health agencies and clinical care entities will make a critical contribution to health reform in the United States and allow health departments to effectively engage in an era of health information exchange evolving electronic health records.
- EIP Network Infrastructure: Strengthening EIP infrastructure in the states and their partners to ensure successful implementation of surveillance and studies through support of personnel (e.g., supervisory scientists, program managers), education/training of staff, and information technology and exchange efforts.

Healthcare-Associated Infections/National Healthcare Safety Network

CDC's goal is to eliminate HAIs in all healthcare settings and maintain state public health activities related to monitoring, response, and prevention; and continue regional prevention initiatives across all healthcare settings (e.g., nursing homes, long-term acute care facilities, dialysis facilities, rehabilitation facilities, etc.). In select states, CDC will support the critical public health role of state health departments through collaborations to implement and ensure adherence to evidence-based HAI prevention practices. CDC will establish systems that work with the NHSN for electronic capture of HAI data for prevention to achieve goals included in the HHS HAI Action Plan. These systems will support the urgent need for states to develop capacity in their health systems (hospitals, clinical laboratories, etc.) to capture and transmit HAI data to NHSN to fulfill state and federal reporting requirements.

CDC will build on the success of American Recovery and Reinvestment Act (ARRA) investments in preventing HAIs through the leadership and coordination of state health departments. Using the Epidemiology and Laboratory Capacity Grant Program and Prevention Epicenters as platforms to support state activities, CDC will continue to support model states that have effectively implemented HAI prevention initiatives through the development of programs and implementation of policies. Funding will help model states maintain sustainable programs that will work across the healthcare system to maximize HAI prevention efforts through collaboration with public health partners and healthcare partners, such as CMS quality improvement organizations, hospital associations, and consumer groups.

These funds will also help to support work with CMS to implement HAI VBP requirements under health reform and complement and support the HHS Partnership for Patients initiative. The ACA's VBP program requires hospitals to use HAI prevention metrics established in the HHS HAI Action Plan. In select states, CDC will continue to enhance automated data collection.

ACA/PPHF Healthcare-Associated Infections/National Healthcare Safety Network

Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	51	51	51
Average Award	$0.175	$0.175	$0.175
Range of Awards	$0.023–$0.782	$0.023–$0.782	$0.023–$0.782
Number of New Awards	51	0	0
Number of Continuing Awards	0	51	51

[1]Exclusively ACA/PPHF funding.

PERFORMANCE

Program: Core Infectious Diseases

Performance measures for Long Term Objective: Build and Strengthen health information systems capacity in state and local health departments

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.5.1: Increase the proportion of laboratories (large commercial/independent and hospital) using Electronic Laboratory Reporting (ELR) in Grantee Jurisdictions[1] (Intermediate Outcome)	FY 2010: 17% (Baseline)	37%	47%	+10%

[1]Targets reflect ACA/PPHF funding

Performance measures for Long Term Objective: Protect Americans from Infectious Diseases—Vector-borne.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.E: Establish state TickNet sites to collect and submit data Lyme and other tick-borne diseases (Output)	FY 2011: 16 (Target Met)	16	16	Maintain

Performance measures for Long Term Objective: Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.3.2: Reduce the estimated number of cases of healthcare associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections.[1,2] (Outcome)	FY 2010: 64,158 cases (Historical Actual)	46,000 cases	40,000 cases	-6,000
3.3.3: Reduce the central-line associated bloodstream infections (CLABSI) standardized infection ratio (SIR)[2] (Outcome)	FY 2010: 0.68 (Historical Actual)	0.6	0.5	-0.1

[1]This measure was revised in FY 2011from an estimated total number of invasive MRSA cases to reflect the number of healthcare-associated invasive MRSA cases. Targets were changed to match the revised measure.

[2] Targets do not reflect ACA/PPHF funding

Performance measures for Long Term Objective: Reduce the spread of antimicrobial resistance.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.2.1: Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (Outcome)	FY 2009: 59.2 (Target Not Met)	48	49	+1

Core Infectious Diseases Performance Trends: The Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) and Emerging Infections Program (EIP) platforms partly reflect CDC's health reform efforts and Patient Protection and Affordable Care Act (ACA) funding. One component is to advance national implementation of Electronic Laboratory Reporting (ELR). Prior to the FY 2011 ACA ELC funding for ELR, 17 percent of labs in grantee areas reported using ELR. Sustained ACA support for ELR will increase that number substantially, up to 47 percent by the end of FY 2013 (Measure 3.5.1). Specifically, grantees will be able to upgrade technical infrastructure and surveillance systems, engage with clinical, commercial, and other labs in their jurisdictions, and upgrade their Laboratory Information Management Systems (LIMS). CDC's technical support group will assist grantees and the Association of Public Health Laboratories in monitoring ELR implementation and track progress toward the targets.

Vector-borne Performance Trends: Estimates suggest that the costs of managing a vector-borne disease outbreak can be up to 300 times greater if response is delayed. CDC's met its target of establishing 16 TickNet sites (Measure 3.E), which improved reporting and analysis of state and regional trends in tick-borne diseases (e.g., Lyme disease (30,169 cases reported in 2010) and Rocky Mountain spotted fever (1,815 cases reported in 2009)), and facilitated multi-state field evaluations of interventions aimed at reducing disease burden. The results from these evaluations efforts, which are presently underway, will be used to inform programs strategies--ending the programs that do not produce results and intensifying the programs reduce disease and disease risk.

Antimicrobial Resistance Performance Trends: Ear infections among children less than five years of age result in more antibiotic prescriptions than any other clinical diagnosis. The American Academy of Pediatrics (AAP) guidelines for treatment of acute otitis media in children recommend watchful waiting instead of antibiotic therapy for children meeting certain criteria.[6] Annual antibiotic prescribing for ear infections remains high with a rate of 59.2 prescriptions per 100 children less than five years of age (Measure 3.2.1). CDC did not meet its 2009 target, with 4.2 more courses of antibiotics prescribed than the target of 59 courses per 100 children. Therefore, CDC slightly revised the FY 2013 target. While slight annual variations in reported data are not uncommon, CDC will determine whether this is an anomaly specific to the reporting period or an ongoing trend. Antibiotic prescribing rates for children aged less than 15 years seen in physician offices , declined 24 percent, from 300 antibiotic courses per 1,000 physician office visits in 1993–1994 to 229 antibiotic courses per 1,000 physician office visits in 2007–2008. CDC's Get Smart: Know When Antibiotics Work program focuses heavily on reducing antibiotic prescribing rates for children.

Healthcare-Associated Infections (HAIs) Performance Trends: CDC aggressively combats HAIs across a spectrum of healthcare facilities. Building upon the successes from CDC's work with states through the American Recovery and Reinvestment Act, CDC reduced the incidence of HAIs nationally, including the reduction of central line-associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), surgical site infections (SSIs), and methicillin-resistant *Staphylococcus aureus* (MRSA) infections. Adherence to CDC's HAI prevention recommendations reduced CLABSIs 58 percent in hospital intensive care units from 2001 to 2009, saving up to 27,000 lives and $1.8 billion in excess medical costs. Adherence to CDC HAI prevention recommendations significantly decreased (20–65 percent) CAUTIs in hospitals since the 1990s. In 2010, national CLABSI and SSI incidence in hospitals decreased 15 percent and eight percent, respectively. CLABSI SIR decreased from 0.8 to 0.68 in FY 2010 (Measure 3.3.3). Additionally, national estimates of healthcare-associated invasive MRSA (hospital onset and healthcare-associated invasive MRSA in other healthcare settings (e.g., dialysis)) decreased six percent. Estimated healthcare-associated invasive MRSA infections decreased from 71,828 in FY 2009 to 64,158 in FY 2010 (Measure 3.3.2). CDC monitors annual progress of HAI prevention with CDC's National Healthcare Safety Network (NHSN). Reduced HAIs in healthcare settings support progress toward the HHS HAI Action Plan five-year targets as well as HAI targets in the HHS 2010–2015 strategic plan. Additionally, NHSN CLABSI and CAUTI metrics are the key measures for an HHS Priority Goal to reduce HAIs (www.performance.gov/) for 2012-2013, further enhancing ongoing collaborations in this area and accelerating progress. CDC's HAI measures allow CDC, healthcare facilities and partners to target prevention practices for specific infections and healthcare settings and to better respond to new and emerging threats from HAIs.

[6] American Academy of Pediatrics Subcommittee on Management of Acute Otitis Media. Diagnosis and management of acute otitis media. Pediatrics 2004; 113:1451

Program: Food Safety

Efficiency measure for Food Safety

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.E.1: Enhance detection and control of foodborne outbreaks by increasing the number of foodborne isolates identified, fingerprinted, and electronically submitted to CDC's computerized national database networks with annual level funding. (Efficiency)	FY 2011: 44,658 (Target Exceeded)	40,000	45,000	+5,000

Performance measures for Long Term Objective: Protect Americans from infectious diseases – foodborne illnesses.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.1.1b: Reduce the incidence of infection with three key foodborne pathogens: Escherichia coli O157:H7 (Outcome)	FY 2010: 0.9 (Target Exceeded)	1	0.9	-0.1
3.1.1c: Reduce the incidence of infection with three key foodborne pathogens: Listeria monocytogenes. (Outcome)	FY 2010: 0.3 (Target Not Met but Improved)	0.26	0.25	-0.01
3.1.1d: Reduce the incidence of infection with three key foodborne pathogens: Salmonella species. (Outcome)	FY 2010: 17.6 (Target Not Met)	13.93	13.62	-0.31
3.A: Number of countries receiving training in PulseNet protocols (Output)	FY 2011: 37 (Target Exceeded)	18	35	+17
3.B: Cumulative number of Public Health Laboratories capable of accessing CaliciNet to detect viral diseases (Output)	FY 2011: 25 (Target Exceeded)	27	30	+3

Performance Trends: Since 2006, CDC exceeded its targets for identifying and analyzing foodborne isolates, specifically salmonella isolates, submitted to CDC for characterization (Measure 3.E.1). In 2010, FoodNet surveillance documented that *E. coli* O157:H7 reached the Healthy People 2010 target of less than one case per 100,000 population in 2009 (0.99), and the infection rate decreased to 0.9 cases per 100,000 population in 2010(Measure 3.1.1b).

CDC's food safety program demonstrated a significant return on investment. As evidenced by an analysis which found that the cost of running the PulseNet system in the state of Colorado for one year was offset if it averted as few as five cases of *E. coli* O157:H7 annually, because of costs associated with this infection. Additionally, the analysis estimated that preventing a single fatal case of *E. coli* O157 infection saves an estimated $7 million in societal costs. In 2011, 37 countries received training in PulseNet protocols, exceeding the target of 25 countries (Measure 3.A).

These FoodNet data also show that *Salmonella* infection rates have increased since 2009 (Measures 3.1.1d). In the past year, new national targets for disease reduction were set as part of the Healthy People

2020 goals, which call for important reductions in disease incidence below 2006-2008 rates. As a result, CDC's targets from 2012 on have been set based on updated performance targets for HP2020.

Listeria infection rates decreased from the baseline period 1996–1998, though to a lesser extent than *E.coli*. CDC met or exceeded targets from FY 2005 through FY 2008. Although CDC didn't meet targets in FY 2009 or FY 2010, *Listeria* infection rates improved in FY 2010 (Measure 3.1.1c). Current progress results from major efforts in the processed meat/hot dog industry to reduce contamination. The large *Listeria* outbreak in 2011 linked to cantaloupes, as well as other recent outbreaks related to produce and soft cheeses, show the need for more targeted control efforts. Swift investigation and control kept the cantaloupe outbreak from being even larger because one state interviewed cases and tested bacteria swiftly, per the National Listeria Action Plan. In collaboration with the Food and Drug Administration and the U.S. Department of Agriculture's Food Safety and Inspection Service, CDC broadly implements the National Listeria Action Plan to further reduce cases through efficient risk management, empowering consumers, and improving consumer safety to achieve future targets.

Program: National Healthcare Safety Network

Performance measures for National Healthcare Safety Network

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.3.4: Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN)[1] (Output)	FY 2011: 5,000 (Target Met)	6,500	10,000	+3,500

[1]Targets do not reflect ACA/PPHF funding.

Performance Trends: CDC met its NHSN target by expanding monitoring capacity from 3,400 facilities in October 2010 to 5,000 facilities in December 2011 (Measure 3.3.4). CDC accomplished its goal to increase the number of facilities using electronic data sources, such as clinical document architecture (CDA), to detect and report CLABSI, and increased automated data collection by expanding the number of vendors transmitting electronic data to CDC. Information technology systems to support this transmission are being used at more than 450 hospitals. To increase efficiency and simplify HAI case detection and data collection, CDC examined methods to simplify NHSN HAI surveillance using a CLABSI detection algorithm that exclusively uses electronic data sources. CDC assists health information technology vendors to incorporate these methods in systems used by healthcare facilities. NHSN performance data informs progress toward the HHS 2010-2015 strategic plan, inform CDC's strategic efforts to assess local, state, and national HAI trends, and target HAI prevention across the healthcare spectrum.

Program: Quarantine and Migration

Performance measures for Long Term Objective: Prevent the importation of infectious diseases to the U.S. in mobile human, animal and cargo populations

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.4.2: Increase the proportion of applicants for U.S. immigration screened for tuberculosis by implementing revised tuberculosis technical instruction (TB TI). (Outcome)	FY 2011: 68% (Target Exceeded)	70%	72%	+2%

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
3.4.3: Increase the likelihood of travelers seeking pre-travel medical advice for travel to Africa and Asia. (Outcome)	FY 2009: 4.4 (Target Not Met)	10	10.5	+0.5
3.4.4: Increase of the percentage of immigrants and refugees with a "Class A or B medical notification for tuberculosis" who undergo medical follow-up after arrival in U.S (Outcome)	FY 2010: 81% (Target Exceeded)	74%	76%	+2%

Performance Trends: CDC rolled out implementation of the 2007 revised TB TI to all immigration applicants in the Dominican Republic, Uganda, Ethiopia, Taiwan, Jordan, Kenya, Japan, China, and Haiti. Based on FY 2011 immigration data, CDC exceeded its target with 68 percent of U.S.-bound immigrants being screened according to the 2007 TB TI (Measure 3.4.2).

Although CDC didn't meet its 2009 target, travelers to Asia and Africa were 4.4 times more likely to seek travel advice than travelers to Europe, Australia, and New Zealand, (Measure 3.4.3). CDC will review historical data to determine appropriate future targets and to focus public health efforts to achieve the greatest impact. Because the highest disease risk is for travel to Africa and Asia, CDC currently focuses its outreach and educational activities on travelers to those two continents.

In FY 2010, CDC exceeded its target of 70 percent of immigrants and refugees with a "Class A or B medical notification for TB" who underwent medical follow-up after arrival in United States; 81 percent of these immigrants and refugees underwent TB follow-up (Measure 3.4.4). To achieve this increase in follow-up, CDC improved reliability of the Electronic Disease Notification (EDN) system by establishing a web-based TB follow-up reporting system; allocated resources to establish a stable workforce in the EDN Data Entry Center; provided timely notifications to health departments; improved functionality of the system; and conducted one-on-one correspondence with state TB coordinators to complete follow-up.

IT INVESTMENTS

CDC's work to prevent and control infectious diseases through a range of activities, including: surveillance, outbreak investigation and response, research, epidemiology and laboratory capacity, and the protection of populations through the use of quality systems, standards, and practices is largely supported by information technology (IT) investments. PulseNet is a national network for DNA "fingerprinting" of bacterial foodborne pathogens and works in collaboration with public health laboratories in all 50 states, Canada, and the federal regulatory agencies (FDA and USDA) to facilitate early recognition and investigation of outbreaks. CaliciNet is the national network for caliciviruses, including norovirus, and works in collaboration with public health laboratories in 25 states, while additional states are covered by CaliciNet outbreak support centers. The National Outbreak Reporting System (NORS) is a web-based application for states to report foodborne, waterborne, and other outbreaks electronically; the Foodborne Outbreak Online Database (FOOD) provides public access to this surveillance data.

New IT tools have been developed to enhance data collection and sharing during foodborne outbreak investigations to more rapidly identify contaminated foods. NHSN is currently being used for monitoring and detection of HAIs and blood safety, as well as several other activities that will increase the capacity for using electronic health records to collect data and detect infections. GeoSentinel is an electronic system that tracks patients who are U.S. residents and have sought pre/post travel advice, providing meaningful data on travel-related health risks, and is used for extensive analysis, reporting and

publications. The Electronic Disease Notification (EDN) system allows a timely, secure, and reliable notification to the health departments and provides a streamlined web-based mechanism for reporting the results of the domestic health evaluations (e.g. to promptly notify health departments when immigrants and refugees arrive with a TB classification). Quarantine Activity Reporting System (QARS) allows quarantine station personnel to record information on ill and diseased passengers that may be of public health significance and also to perform contact investigations when needed. In addition, QARS records information of non-human primates that may be of public health significance. QARS is used in 20 quarantine stations and also provides an electronic data feed from the vessel sanitation program that provides illness and death reports from cruise ships. ArboNet is an internet-based surveillance platform for state, territorial and large city health departments to enter and view near real-time data on arbovirus infection trends for humans, birds, animals and mosquitoes. This was the first surveillance database at CDC to integrate human and non-human information. The provisional data on WNV, dengue, eastern equine encephalitis, and other arboviruses analyzed and posted weekly at county-level resolution gives health departments the ability to evaluate and respond quickly to emerging outbreaks, and informs the public, media, and policymakers.

STATE TABLES[1,2]

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283, 93.521 (ACA) EPIDEMIOLOGY AND LABORATORY CAPACITY FOR INFECTIOUS DISEASES (ELC)	
State/Territory/Grantee	**FY 2011 Actual**
Alabama	$1,820,537
Alaska	$1,726,731
Arizona	$1,921,897
Arkansas	$1,466,258
California	$4,223,877
Colorado	$2,268,906
Connecticut	$1,339,701
Delaware	$1,147,731
Florida	$2,488,713
Georgia	$1,497,477
Hawaii	$1,250,236
Idaho	$861,499
Illinois	$2,905,445
Indiana	$1,813,150
Iowa	$2,772,032
Kansas	$1,391,026
Kentucky	$1,387,091
Louisiana	$1,642,072
Maine	$1,330,501
Maryland	$1,578,954
Massachusetts	$2,585,255
Michigan	$3,886,355
Minnesota	$1,992,996
Mississippi	$1,400,519

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2013 DISCRETIONARY STATE GRANTS
CFDA NUMBER: 93.283, 93.521 (ACA)
EPIDEMIOLOGY AND LABORATORY CAPACITY FOR INFECTIOUS DISEASES (ELC)

State/Territory/Grantee	FY 2011 Actual
Missouri	$1,400,402
Montana	$1,037,953
Nebraska	$1,637,260
Nevada	$1,503,533
New Hampshire	$1,677,427
New Jersey	$1,536,068
New Mexico	$1,670,079
New York	$2,795,944
North Carolina	$2,128,159
North Dakota	$1,009,163
Ohio	$2,688,153
Oklahoma	$1,114,019
Oregon	$1,705,149
Pennsylvania	$1,847,488
Rhode Island	$1,552,550
South Carolina	$2,058,562
South Dakota	$1,047,735
Tennessee	$2,537,827
Texas	$2,303,217
Utah	$2,567,435
Vermont	$1,534,427
Virginia	$1,892,267
Washington	$1,972,142
West Virginia	$1,722,714
Wisconsin	$2,828,712
Wyoming	$1,115,182
Subtotal States	$92,997,026
Chicago	$691,751
Houston	$1,777,401
Los Angeles County	$1,742,264
New York City	$3,372,052
Philadelphia	$970,189
Washington, D.C.	$817,911
Subtotal Cities	$9,371,568
Palau	$169,192
Puerto Rico	$659,883
Subtotal Territories	**$829,075**
Total States/Cities/Territories	**$103,783,168**

[1]This state table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://www.cdc.gov/Funding profiles/FundingProfilesRIA/.

[2]FY 2011 includes $45,345,367 from the Affordable Care Act Prevention and Public Health Fund.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$773.987	$756.377	$608.019	-$148.358
PHS Evaluation Transfers	$0.000	$0.000	$25.000	+$25.000
ACA/PPHF	$300.950	$427.050	$511.711	+$84.661
Total	**$1,074.937**	**$1,183.427**	**$1,144.730**	**-$38.697**
FTEs	1,012	1,007	1,006	-1

Authorizing Legislation: PHSA §§ 301, 307, 310, 311, 317, 317D, 317H, 317K, 317L, 317M, 330E, 399B–399D, 399E, 399W–399Z, 1501–1508, 1702, 1703, 1704, 1706; Fertility Clinic Success Rate And Certification Act of 1992 (P.L. 102-493); Comprehensive Smoking Education Act of 1984, P.L. 98-474 (15 U.S.C. 1335(a) and 15 U.S.C. 1341); Comprehensive Smokeless Tobacco Health Education Act of 1986 (P.L. 99-252); The Patient Protection and Affordable Care Act of 2010, § 4201 (P.L. 111-148)

FY 2013 Authorization..... Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $1,144,730,000 for chronic disease prevention and health promotion, including $511,711,000 from the Affordable Care Act Prevention and Public Health Fund and $25,000,000 in PHS Evaluation transfers, is an overall decrease of $38,697,000 below the FY 2012 level. The FY 2013 request includes an increase of $6,040,000 for Tobacco Prevention and Control, an increase of $128,699,000 for the Coordinated Chronic Disease Prevention and Health Promotion Program. The request also includes a decrease of $79,660,000 for Community Transformation Grants and of $2,900,000 for the Prevention Research Centers. The FY 2013 request also includes $5,000,000 in Affordable Care Act Prevention and Public Health Fund investments for the Million Hearts™ program, $4,000,000 for Workplace Wellness, $2,500,000 for Hospitals Promoting Breastfeeding activities, and $4,000,000 for Let's Move/Healthy Weight Task Force.

The FY 2013 request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program (-$53,940,000) and Johanna's Law (-$4,972,000).

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Tobacco Prevention and Control	$158.685	$191.077	$197.117	+$6.040
ACA/PPHF (non-add)	$50.000	$83.000	$89.000	+$6.000
Oral Health	$14.726	$14.644	$14.653	+$0.009
Safe Motherhood and Infant Health	$44.049	$43.803	$43.848	+$0.045
Cancer Prevention and Control[1]	$325.019	$328.105	$323.665	-$4.440
ACA/PPHF (non-add)	$0.000	$0.000	$260.871	+$260.871
Prevention Research Centers	$28.001	$27.900	$25.000	-$2.900
PHS Evaluation (non-add)	$0.000	$0.000	$25.000	+$25.000
ACA/PPHF (non-add)	$10.000	$10.000	$0.000	-$10.000
Coordinated Chronic Disease Prevention and Health Promotion Program[2]	$279.492	$249.908	$378.607	+$128.699
Competitive Grants to States and Local (ACA/PPHF)	$42.200	$0.000	N/A	N/A

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Nutrition, Physical Activity and Obesity	$44.189	$43.998	N/A	N/A
ACA/PPHF (non-add)	$10.000	$10.000	N/A	N/A
School Health[3]	$13.600	$13.522	N/A	N/A
Health Promotion	$16.348	$17.584	N/A	N/A
Heart Disease and Stroke	$55.284	$54.975	N/A	N/A
Diabetes	$64.796	$74.434	N/A	N/A
ACA/PPHF (non-add)	$0.000	$10.000	N/A	N/A
Arthritis and Other Chronic Diseases	$22.762	$25.196	N/A	N/A
Comprehensive Cancer Control[1]	$20.313	$20.199	N/A	N/A
Community Transformation Grants (ACA/PPHF)	$145.000	$226.000	$146.340	-$79.660
Healthy Communities	$22.197	$0.000	$0.000	$0.000
Racial and Ethnic Approaches to Community Health (REACH)	39.018	$53.940	$0.000	-$53.940
ACA/PPHF (non-add)	$25.000	$40.000	$0.000	-$40.000
All Other Chronic Disease Activities (ACA/PPHF)	$18.750	$48.050	$15.500	-$32.550
Million Hearts (non-add)	$0.000	$0.000	$5.000	+$5.000
Workplace Wellness (non-add)	$10.000	$10.000	$4.000	-$6.000
Healthy Weight Task Force Obesity Activities (non-add)	$0.000	$5.000	$4.000	-$1.000
Hospitals Promoting Breastfeeding (non-add)	$0.000	$7.050	$2.500	-$4.550
Total	**$1,074.937**	**$1,183.427**	**$1,144.730**	**-$38.697**

[1]The FY 2013 budget request proposes moving the National Comprehensive Cancer Control Program activities from Cancer Prevention and Control to the Coordinated Chronic Disease Prevention and Health Promotion Grant Program to coordinate with other efforts to address chronic diseases. FY 2011 and FY 2012 amounts for Cancer Prevention and Control have been comparably adjusted to reflect this proposal.

[2]The FY 2013 budget request proposes creating the Coordinated Chronic Disease Prevention and Health Promotion Program, which consolidates the following FY 2012 enacted budget lines: Nutrition, Physical Activity, and Obesity; School Health; Health Promotion; Heart Disease and Stroke; Diabetes; Comprehensive Cancer Control; and Arthritis and Other Chronic Diseases. FY 2011 and FY 2012 amounts for the Coordinated Chronic Disease Prevention and Health Promotion Grant Program have been comparably adjusted to reflect this proposal.

[3]In FY 2012, HIV school health activities were transferred from the National Center for Chronic Disease Prevention and Health Promotion to the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The FY 2011 amount for school health has been comparably adjusted to reflect this transfer.

Chronic diseases are among the most prevalent, costly, and preventable of all health problems. With a focus on the most common preventable chronic diseases and their risk factors, CDC leads and coordinates the nation's efforts to prevent and control these interrelated health problems. Chronic disease prevention and health promotion activities include preventing and controlling tobacco use, obesity, heart disease and stroke, diabetes, and cancer; promoting community health, oral health, safe motherhood and infant health, and healthy personal behaviors; and maintaining surveillance systems to track and monitor behavioral risk factors. Since many of these conditions share interrelated risk factors, such as tobacco use and physical inactivity, CDC's work to improve health outcomes will be greatly enhanced by the coordinated approaches proposed in this budget request.

To combat these deadly diseases, CDC:

- Monitors the national burden of chronic disease and prevention efforts' progress through national surveillance, which is essential to accelerate prevention efforts and rapidly identify best practices.
- Translates research into innovative community prevention strategies, bridging the gap between scientific findings and public health practice.

- Develops and disseminates tools and resources for national, state, and community stakeholders to support community-initiated strategies focused on reducing the leading causes of death and their associated risk factors. CDC's tools and resources also provide policymakers with the best available scientific evidence to make decisions that truly improve health outcomes.
- Supports programs in states, tribes, territories, and local communities, covering one in three Americans and 68 communities across the country. These programs build on over a decade of CDC's experience in identifying the best practices for community chronic disease prevention and health promotion.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$931.097
2009	$983.686
2010	$865.445
2010 (ACA/PPHF)	$58.933
2011	$773.987
2011 (ACA/PPHF)	$300.950
2012	$756.377
2012 (ACA/PPHF)	$427.050

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

TOBACCO PREVENTION AND CONTROL BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$108.685	$108.077	$108.117	+$0.040
ACA/PPHF	$50.000	$83.000	$89.000	+$6.000
Total	**$158.685**	**$191.077**	**$197.117**	**+$6.040**

Program Overview: Tobacco use is the single most preventable cause of disease, disability, and death in the United States, and CDC is the lead federal agency for comprehensive tobacco control. Comprehensive tobacco control programs are proven, coordinated efforts to reduce tobacco use by establishing smoke-free policies, reducing the social acceptability of tobacco use, promoting cessation, helping users quit, and preventing tobacco use initiation. This public health approach can end the tobacco epidemic, saving hundreds of thousands of lives and over $96 billion in tobacco-associated medical costs each year.

Through a cooperative agreement, CDC supports comprehensive programs to prevent and control tobacco use in all 50 states, Washington, D.C., eight U.S. territories/jurisdictions, and seven tribal-serving organizations. In addition, CDC funds six national networks to reduce tobacco use among specific at-risk populations. CDC also conducts ground-breaking research and surveillance on tobacco use, translating science into best practices that help states plan, implement, evaluate, and sustain their own tobacco control programs.

Recent accomplishments:

- Conducted essential research and evaluation to continue to build the scientific evidence of secondhand smoke exposure risks, the health effects of secondhand smoke exposure, and the impact of smoke-free policies on eliminating this exposure. This research included, for instance, surveillance on the current status of state smoke-free policies in worksites, restaurants, and bars, and a study on secondhand smoke exposure in airports.
- Provided state and local tobacco control programs, at their request, the evidence base and technical assistance needed to inform decisions on a record number of comprehensive smoke-free laws. As of September 30, 2011, 26 states (including Washington, D.C.) had comprehensive smoke-free laws in effect that prohibit smoking inside of workplaces, restaurants, and bars.
- Provided state programs, at their request, with the evidence needed to inform policymakers in two states about effective tobacco prevention interventions, including excise taxes and the value of comprehensive tobacco control programs.
- Conducted critical research on toxic and addictive substances present in tobacco products, tobacco smoke, and in people who use tobacco products or who are exposed to secondhand smoke through CDC's Tobacco Laboratory—the only federal laboratory with the capacity for this type of research. These activities are conducted by CDC's National Center for Environmental Health.
- Released scientific reports and studies and used earned media to increase the general public's awareness of the prevalence and dangers of tobacco use. CDC's earned media around scientific reports and studies was valued at $13.3 million, which includes $8.6 million from coverage of tobacco-related *Morbidity and Mortality Weekly Reports* and $4.7 million from the release of the Surgeon General's Report, *How Tobacco Smoke Causes Disease*.

Budget Proposal: CDC's FY 2013 request of $197,117,000 for tobacco prevention and control, including $89,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an increase of $6,040,000 above the FY 2012 level. CDC will use this increase in resources to expand the reach of a national tobacco education campaign and its tobacco cessation quitline capacity support.

In FY 2013, CDC will:

- Support 59 programs through the National Tobacco Prevention and Control program (50 states, eight territories/jurisdictions, and Washington, D.C.) to prevent tobacco use initiation among youth and young adults, promote tobacco use cessation, eliminate secondhand smoke exposure, and identify and eliminate tobacco-related disparities.
- Implement a national tobacco education campaign on the health effects of tobacco use to further prevent youth tobacco use initiation and motivate adult and young adult tobacco users to quit. This campaign will raise awareness of the dangers of tobacco use and of tobacco cessation quitline services.
- Expand smoking cessation services in 50 states, Washington, D.C., and two territories by funding states to maintain, enhance, or augment the national network of tobacco cessation quitlines. This investment will translate into a significant increase in quit attempts and successful quitters by promoting quitline services and increasing access to effective cessation services. State quitline call volumes are expected to rise substantially in FY 2012 and 2013 in response to the national tobacco education campaign and the inclusion of quitline number on new tobacco product labeling, when implemented.

- Provide technical assistance, program guidance, and training to state tobacco control program staff on best practices in policy development and evaluation, earned media development, and program funding sustainability.
- Fund six national networks to reduce tobacco use and disparities among priority populations, including African Americans, American Indians/Alaska Natives (AI/ANs), Asian Americans/Pacific Islanders, Hispanics/Latinos, lesbian/gay individuals, and persons with low socioeconomic status.
- Fund eight tribal support centers among tribes or tribal organizations to prevent and reduce the use of tobacco and exposure to secondhand smoke, and to evaluate and implement competent, culturally relevant tobacco control and prevention strategies for use with broader AI/AN populations.
- Conduct and disseminate state-of-the-art research, including research through CDC's Tobacco Laboratory.
- Provide technical assistance and laboratory support to the Food and Drug Administration's (FDA) Center for Tobacco Products to further enable FDA to regulate tobacco product manufacturing, distribution, and marketing to protect public health. CDC will continue to provide scientific expertise on graphic health warnings, reducing access to and appeal of tobacco products, and modified-risk tobacco products.

Tobacco Prevention and Control Grant Table[1,2,3]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	51	51	51
Average Award	$1.181	$1.181	$1.181
Range of Awards	$0.532–$1.872	$0.532–$1.872	$0.532–$1.872
Number of New Awards	0	0	0
Number of Continuing Awards	51	51	51

[1]Grants include all 50 states and Washington, D.C.

[2]Funding for these awards is from CDC's discretionary budget authority and does not include any funds from the Affordable Care Act (i.e., Prevention and Public Health Fund).

[3]FY 2013 is the last year of this cooperative agreement.

ORAL HEALTH BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$14.726**	**$14.644**	**$14.653**	**+$0.009**

Program Overview: In 2008, Americans' out-of-pocket expenditures for dental care costs totaled over $30 billion, second in health care expenses only to out-of-pocket costs for medication. Many oral health problems—and costly treatments—are preventable. CDC leads national oral health prevention efforts through research, surveillance, and technical assistance to put research into practice.

CDC's core oral health work includes informing and disseminating the best available science. CDC monitors community water fluoridation and works to enhance fluoridation quality by providing training and technical assistance to state and local fluoridation engineers. CDC's surveillance work includes the National Oral Health Surveillance System (NOHSS), which collects standardized data on the oral disease burden, dental care service use, and community water fluoridation. Furthermore, CDC provides

recommendations for policymakers and dental practitioners, guides infection control practices, and informs advances in dental technology.

Built on this evidence base, CDC's oral health programmatic infrastructure provides 20 states with the fiscal resources and technical assistance to build strong oral health programs. This technical assistance includes building web-based systems that bring together oral health data from multiple sources to inform public health programs and consumers.

Recent accomplishments:

- Promoted and expanded the science base to enhance preventive interventions and further document the link between poor oral health and other chronic diseases. For example, CDC documented the link between human papillomavirus (HPV) and oropharyngeal cancers (located at the base of the tongue and tonsils). Findings indicate that a majority (about two-thirds) of such cancers are associated with HPV and that the incidence of HPV-positive cancers increased by 225 percent between 1988 and 2004, while HPV-negative cancer incidence decreased by 50 percent during the same period. Researchers speculate that should these trends continue, HPV-positive oropharyngeal cancers among U.S. males will exceed female cervical cancers by 2020.

- Updated recommendations for dental sealant use in school-based sealant programs, published in the *Journal of the American Dental Association*. The report identified school-based sealant programs as an effective public health approach for improving schoolchildren's oral health and identified major barriers to sealant program implementation for low-income children.

- Developed newly proposed HHS recommendations for fluoride levels in drinking water in the United States. The new guidance will replace the 1962 U.S. Public Health Service recommendations for fluoride concentrations in drinking water and will optimize fluoridation effectiveness in preventing dental caries while maintaining safe fluoride levels for health.

- Provided key data and tools to help states expand access to fluoridated water. For instance, CDC provided technical assistance to Arkansas on expanding community water fluoridation. CDC also developed "Go with the Flow," a video that highlighted Arkansas' oral health problems and made the case for increasing water fluoridation. In 2011, Arkansas required that water systems serving 5,000 or more people guarantee customer access to fluoridated water. As a result, an anticipated 32 additional Arkansas systems will begin providing optimally fluoridated water.

- Expanded state surveillance of children's oral health indicators. In January 2011, CDC added new state-level data on children's oral health indicators to the NOHSS, which now includes children's oral health data for 43 states—up from 14 states in 2004.

- Released the Fluoride Legislative User Information Database (FLUID), a comprehensive online database of court decisions, laws, and policies related to community water fluoridation. FLUID is an easy-to-use tool for states and municipalities to compare their current or proposed policies with other communities to make informed decisions about their approach to water fluoridation.

Budget Proposal: CDC's FY 2013 request of $14,653,000 for oral health is an increase of $9,000 above the FY 2012 level.

In FY 2013, CDC will:

- Fund up to 20 states to support capacity-building oral health prevention programs. Prevention programs will work to increase the number of high-risk children receiving dental sealants. States target schools with a high percentage of students on free and reduced-cost meal programs to increase underserved, at-risk children's access to dental sealants.

- Provide technical assistance to all states for oral health issues, including surveillance, community water fluoridation, dental sealant programs, information to inform policy development, and program and policy evaluation. CDC will also continue to support partners, including the Association of State and Territorial Dental Directors and the Children's Dental Health Project, that offer technical assistance for data collection and analysis, program review and evaluation, and information to inform policy development.
- Conduct national surveillance to assess oral health including prevalence and severity of dental caries, periodontal disease, dental fluorosis, dental service use, and community water fluoridation through the National Health And Nutrition Examination Survey (NHANES) and NOHSS.
- Conduct research on effective interventions, ensure intervention cost effectiveness, facilitate efficient program delivery, and evaluate program impact. This work will also include further documenting linkages between poor oral health and other chronic diseases.
- Develop an online training system for state and community water fluoridation experts to increase state and community capacity to provide leadership and effective management of their water fluoridation programs.
- Evaluate the impact of HHS recommendations on fluoride levels in community water supplies on the prevalence of children's tooth decay.
- Collaborate with the Health Resources and Services Administration and the Centers for Medicare and Medicaid Services to increase access to preventive oral health services, including dental sealants among Medicaid and SCHIP beneficiaries.
- Continue to provide guidance on infection control practices in dental offices and investigate possible disease transmissions.

Oral Health Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	20	20	20
Average Award	$0.311	$0.311	$0.311
Range of Awards	$0.122–$0.402	$0.235–$0.355	$0.200–$0.350
Number of New Awards	1	0	20
Number of Continuing Awards	19	20	0

[1]FY 2013 was calculated predicting flat level funding based on FY 2011 for 20 states under a new cooperative agreement. FY 2012 is the final year for the current cooperative agreement with states.

SAFE MOTHERHOOD AND INFANT HEALTH BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$44.049**	**$43.803**	**$43.848**	**+$0.045**

Program Overview: CDC promotes safe motherhood before, during, and after pregnancy, including the aspects that ensure optimal reproductive, maternal, and infant health. In order to inform the nation about emerging maternal and infant health issues, CDC conducts critical surveillance and research activities. CDC also supports state and local communities and provides technical assistance for a range of reproductive health topics, from infertility to maternal and infant health, to preventing teen pregnancy and sudden unexplained infant death (SUID) syndrome.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is the cornerstone of CDC's safe motherhood and infant health surveillance work. The PRAMS provides state-specific data not available from other sources about preconception health, pregnancy, and the first few months after birth. These data are used to identify high-risk groups, to monitor changes in health status, and to measure progress towards improving maternal and infant health.

Protecting and supporting breastfeeding is another key strategy to improve maternal and infant health. CDC conducts research, surveillance, and translation activities that support breastfeeding initiation, duration, and exclusivity, and identifies barriers to breastfeeding, particularly among low-income populations. In addition, CDC provides technical assistance to states, communities, and tribal agencies and to hospitals and health care providers to implement policies and practices that increase breastfeeding rates among new mothers.

Recent accomplishments:

- Facilitated the use of surveillance data to inform state decision-making, including Medicaid family planning waivers, safe sleep campaigns, HIV testing and counseling, and obesity prevention campaigns. For example, Utah's PRAMS data indicated that two-thirds of pregnant women receiving late prenatal care were unaware of prenatal guidelines. As a result, Utah created a new media campaign to increase awareness of the importance of adequate health care before, during, and after pregnancy.

- Released evidence-based guidelines for the safe and effective contraception use, including recommendations for contraception use by adolescents for the first time. Since the release, over 1,500 health professionals have completed continuing education training on the guidelines. The American College of Obstetrics and Gynecology has endorsed the CDC guidance and major professional and service organizations have incorporated these recommendations into their protocol for contraceptive use, reaching over 35,000 obstetricians/gynecologists.

- Published the annual Assisted Reproductive Technologies (ART) Report, which showed that in 2009, there were 45,870 live births and 60,190 infants born, resulting from 146,244 ART cycles performed at 441 reporting clinics. Data provided by U.S. fertility clinics that use ART are a rich source of information about the factors that contribute to a successful ART treatment.

- Disseminated data to help states and health care providers identify strengths and areas for improvement to better support breastfeeding initiation and duration. CDC disseminated data from the 2010 Breastfeeding Report Card, which provides state-by-state data on breastfeeding practices. CDC also released the 2011 Surgeon General's Call to Action to Support Breastfeeding, which outlines 20 action steps individuals, organizations, employers, and communities can take to improve breastfeeding support.

- Provided scientific support to the Text4baby program, a public-private partnership offering underserved pregnant women and new mothers accurate health information and resources about caring for their health and the health of their babies. Women receive free weekly text messages timed to their due date or baby's birth through the baby's first year. Over 250,000 subscribers from all 50 states have received free text messages since its launch.

Budget Proposal: CDC's FY 2013 request of $43,848,000 for safe motherhood and infant health is an increase of $45,000 above the FY 2012 level.

In FY 2013, CDC will:

- Fund 40 state and New York City's PRAMS programs to collect data on women's behaviors and experiences before, during, and immediately after pregnancy to reduce infant mortality, as well as plan and allocate resources to maximize program effectiveness.

- Fund the National ART Surveillance System to evaluate the efficacy and safety of ART through surveillance and research, training, technical assistance, and collaboration with partners.
- Conduct research on preterm birth and infant mortality to identify women at-risk, as well as opportunities for prevention through a broad coalition of partners. For instance, CDC is conducting research on maternal vitamin D status and the risk of two pregnancy-related complications, preterm birth and preeclampsia. These partnerships will focus on social and biological factors causing preterm birth, along with racial disparities.
- Update and disseminate evidence-based guidelines for the safe and effective contraceptive use.
- Support CDC field staff assignees and graduate-level fellows in states through the Maternal and Child Health Epidemiology Program, which builds state, local, and tribal capacity to effectively use maternal and child epidemiologic research and scientific information to inform public health policy related to women, children, and families' health.
- Fund three state-wide Perinatal Quality Collaboratives among obstetrical and pediatric care providers in health care facilities to identify care processes that improve pregnancy outcomes for women and newborns, as well as reduce maternal and perinatal deaths.
- Conduct research, translate, and disseminate findings to identify and address barriers to breastfeeding among low-income and disproportionately impacted populations. This work also includes conducting the biennial national survey of maternity care practices and policies and surveying rates of breastfeeding initiation, duration, and exclusivity.
- Provide technical assistance to hospitals and health care providers to implement evidence-based maternity care practices that support parents to make informed infant feeding decisions consistent with Baby-Friendly hospital standards.

Pregnancy Risk Assessment Monitoring System Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	41	41	41
Average Award	$0.158	$0.143	$0.143
Range of Awards	$0.135–$0.213	$0.121–$0.190	$0.121–$0.190
Number of New Awards	3	0	0
Number of Continuing Awards	38	41	41

[1]A new five-year funding cycle for PRAMS began in FY 2011, funding three additional states.

Teen Pregnancy Prevention

Program Description: CDC's teen pregnancy prevention work is grounded in key research that identifies underserved populations at risk for early pregnancy, particularly among minority communities, as well as identifies risk and protective factors for teen pregnancy. CDC's community teen pregnancy prevention projects put the best prevention research into practice, as well as strengthen linkages between teens and the health care system.

In collaboration with other HHS operating divisions and other federal agencies, CDC leads the implementation of evidence-based, community-level teen pregnancy prevention programs that reduce risk factors that can lead to teen pregnancy. These programs increase linkages between teen pregnancy prevention programs and clinical services, as well as educate stakeholders, partners, and health care providers on effective prevention methods.

As part of the President's Teen Pregnancy Prevention Initiative, CDC is implementing a five-year project that will evaluate the impact of a multi-component, community-level effort to prevent teen pregnancy in

targeted communities through access to quality health services; increased use of evidence-based programs; and educating stakeholders, partners, and health care providers on effective prevention methods. Data suggest that this approach will result in a widespread, substantial, and sustained impact on teen birth rates in targeted communities.

Recent Accomplishments:

- Developed and disseminated a Teen Pregnancy Health Communicator's Social Media Toolkit. This quick reference guide explains how to create a social media strategy, highlighting a number of social media tools with credible, science-based teen pregnancy prevention messages. The toolkit describes common media channels that can be incorporated into social medial plans, such as blogs, video-sharing sites, mobile applications, and RSS feeds. These free, easy-to-use communication tools help expand the reach of health messages and increase public engagement.
- Released "A Message to Health Care Professionals: Teen Pregnancy," an online video that encourages health care professionals to talk to their teen patients about pregnancy and provides them with the information and tools they need to make health decisions. The video has been viewed from CDC-TV 10, 298 times and over YouTube 3,655 times. The video is one of the top five videos on CDC-TV.

Budget Proposal: CDC's FY 2013 request of $15,457,000 to support teen pregnancy prevention activities is level with FY 2012.

In FY 2013, CDC will:

- Implement teen pregnancy prevention projects in nine communities. Through these projects, CDC estimates that over 100 program implementation partners will reach over 13,000 youth. Enhanced referral networks will lead youth in target communities to the over 50 clinics with enhanced, teen-friendly clinical services. Programs will track teen birth rates in all nine intervention communities and comparison communities.
- Fund five national organizations to conduct trainings on evidence-based teen pregnancy prevention programs for community-based grantees, ensure linkages to clinical services, educate stakeholders on strategies to reduce teen pregnancy, and support sustainability of teen pregnancy prevention efforts in communities.
- Conduct surveillance to identify teens at high-risk and use the data to inform teen pregnancy prevention interventions. Surveillance data will identify trends and patterns of reproductive health service use among sexually active adolescents (National Survey of Family Growth (NSFG)); characteristics of teens who give birth (PRAMS); provider knowledge, attitudes, and practices related to teen pregnancy prevention activities; cost and cost-benefit analyses of teen pregnancy prevention programs; and new intervention strategies to reduce teen pregnancy.
- Conduct an in-depth evaluation to determine program impact and inform the best programmatic practices to prevent teen pregnancies in targeted, underserved communities.
- Conduct and disseminate research to evaluate the impact of state policies on teen birth rates and identify new interventions to provide family planning services.

CANCER PREVENTION AND CONTROL BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget[1]	FY 2013 +/- FY 2012
Budget Authority[1]	$325.019	$328.105	$62.794	-$265.311
ACA/PPHF	$0.000	$0.000	$260.871	+$260.871
Total[2]	**$325.019**	**$328.105**	**$323.665**	**-$4.440**

[1]The total includes $20,700,000 for the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), which is authorized through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Funding and activities for this program are administered through CDC's Heart Disease and Stroke Program. In FY 2013, the proposed Coordinated Chronic Disease Prevention and Health Promotion program will administer the WISEWOMAN program.

[2]The FY 2013 budget request proposes moving the National Comprehensive from Cancer Control Program activities Cancer Prevention and Control to the Coordinated Chronic Disease Prevention and Health Promotion Grant Program to coordinate with other efforts to address chronic diseases. FY 2011 and FY 2012 amounts for Cancer Prevention and Control have been comparably adjusted to reflect this proposal.

Program Overview: CDC's public health approach to cancer prevention and control is essential to reducing cancer morbidity and mortality, the second leading cause of death in the United States. CDC's population-based programs focus on risk reduction, early detection, primary prevention, increasing access to quality cancer care, quality of life for cancer survivors, and reducing disparities in cancer health outcomes. These programs continue to apply over 20 years of expertise in providing quality cancer screening services to the underserved through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), as well as more recent efforts to increase colorectal cancer screening rates through the Colorectal Cancer Control Program (CRCCP).

Critical cancer surveillance systems and applied research inform CDC's cancer prevention and control programs. The National Program of Cancer Registries (NPCR) provides U.S. population-level data for 96 percent of the population, as well as state- and county-level cancer incidence data not available from any other source. CDC also conducts applied research to enhance, for example, understanding of cancer incidence and risk factors, best practices for increasing screening in target populations, and education and awareness about various cancers among health care providers and the public.

Recent accomplishments:

- Increased the delivery and use of quality breast and cervical cancer screening and diagnostic follow-up through the NBCCEDP.
    - In FY 2010, the NBCCEDP screened 325,291 low-income women for breast cancer and detected 5,530 cancers, and screened 299,854 low-income women for cervical cancer and detected 4,813 cervical cancers and high-grade precancerous lesions.
    - For women diagnosed with breast cancer, 97 percent initiated treatment through NBCCEDP, and 93 percent of those initiated treatment within 60 days of diagnosis. Of those women with an abnormal Pap smear, 91 percent initiated treatment through NBCCEDP, and 89 percent were diagnosed with invasive cervical cancer initiated treatment within 60 days of diagnosis.
- Increased the delivery and use of quality colorectal cancer screening services through the CRCCP in 25 states and four tribes. In FY 2010, CRCCP provided screening for 8,494 individuals, identified 22 cancers, and prevented 1,187 cancers through removal of precancerous polyps.
    - Sixty-five percent of CRCCP grantees promoted the use of patient navigation, which guides clients through the screening and diagnostic process. Of these grantees, 46 percent funded patient navigation programs that also guide non-CDC funded clients through the screening process, helping to increase population-level screening rates.

- Supported states in using cancer surveillance data to target outreach and increase cancer screening. Texas used surveillance data from the CDC-funded Texas Cancer Registry, part of the NPCR, to document the higher invasive breast cancer incidence, inadequate mammography access, and low breast cancer screening rates in six Dallas-Fort Worth area counties. Using cancer registry data, the Moncrief Cancer Institute documented the need for breast cancer screening and diagnostic services in these counties and expanded its Breast Cancer Screening and Patient Navigation program to increase access to these critical services.

- Invested in the nation's cancer surveillance infrastructure by funding 15 states to enhance cancer registry data collection. These projects will produce new methods for sustainable data collection, expanded use of electronic reporting, and new innovative applications of cancer registry. These enhancements will improve cancer care quality by improving researchers' ability to determine whether cancer patients are receiving appropriate diagnosis and treatment.

Budget Proposal: CDC's FY 2013 request of $323,665,000 for cancer prevention and control, including $260,871,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall decrease of $4,440,000 below the FY 2012 level, reflecting the elimination of funding for gynecological cancer education activities authorized through Johanna's Law. CDC will continue to support education and awareness activities related to gynecologic cancers for the public and health care providers. CDC will work with and provide existing campaign materials through partner organizations, health care providers, CDC's NBCCEDP and NCCCP, and other agencies, such as the HHS Office of Women's Health, to ensure appropriate messages are disseminated.

The FY 2013 request redirects funding for the National Comprehensive Cancer Control Program (NCCCP) to the Coordinated Chronic Disease Prevention and Health Promotion Grant Program. The FY 2013 President's Budget promotes critical screening services and surveillance systems until relevant Affordable Care Act provisions take effect. However, the NCCCP will be integrated within the Coordinated Chronic Disease Prevention and Health Promotion Grant Program to address interrelated chronic disease risk factors, including obesity and tobacco use. This approach reflects CDC's comprehensive approach to cancer prevention and control through this program, from primary prevention through survivorship.

The FY 2013 request does not show amounts for specific categorical budget lines to promote flexibility and enhanced coordination between cancer prevention and control programs.

In FY 2013, CDC will:

- Enhance public health's role in increasing access to and use of lifesaving preventive services. This includes providing the evidence to inform policy decisions, applied research to identify best practices, better case management, improved care coordination, tailored outreach to underserved communities, improved cancer screening quality assurance, enhanced surveillance to monitor screening use and quality, and increased education for the public and health care providers on the use and benefits of screening.
    - For example, CDC plans to continue supporting a limited number of grantees to implement demonstration projects to enhance organized cancer screening efforts in states, tribes, and territories to increase population-level cancer screening rates.

- Support breast and cervical cancer screening and diagnostic services through the NBCCEDP for low-income uninsured and underinsured women in 50 states, Washington, D.C., five territories, and 12 tribes or tribal organizations. This funding also will support the essential public health activities—such as outreach, education, case management, quality assurance, and program evaluation—necessary to implement an effective screening program.

- Support NPCR cancer registries in 45 states, Washington, D.C., Puerto Rico, and the U.S. Pacific Island jurisdictions to collect, manage, and analyze data about cancer cases. Registries will also evaluate specific cancer registry data, such as race and ethnicity, stage-at-diagnosis, treatment, and follow-up data, for quality improvement.
- Support colorectal cancer screening programs in 25 states and four tribes or tribal organizations to implement population-based approaches to increase screening rates among people age 50 and older. CDC will also continue the *Screen for Life: National Colorectal Cancer Action Campaign's* work to inform adults about the importance of routine colorectal cancer screening.
- Conduct education, awareness, and applied research activities to reduce morbidity and mortality related to breast cancer in young women and prostate, ovarian, skin, and gynecologic cancers.

National Program of Cancer Registries (NPCR) Grant Table[1,2]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	48	48	48
Average Award	$0.774	$0.774	$0.774
Range of Awards	$0.187–$3.569	$0.187–$3.569	$0.187–$3.569
Number of New Awards	0	48	0
Number of Continuing Awards	48	0	48

[1]Amounts include funding to 45 states, Washington, D.C., Puerto Rico, and the U.S. Pacific Island jurisdictions.

[2]FY 2013 request assumes level funding with FY 2012. FY 2012 is the final year for the current cooperative agreement with grantees. FY 2013 was calculated predicting flat level funding based on FY 2011 for 48 states under a new cooperative agreement.

National Comprehensive Cancer Control Program (NCCCP) Grant Table[1,2,3]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget[4]
Number of Awards	65	65	65
Average Award	$0.303	$0.303	$0.303
Range of Awards	$0.147–$0.518	$0.147–$0.518	$0.147–$0.513
Number of New Awards	0	65	0
Number of Continuing Awards	65	0	65

[1]The NCCCP provides funding to 50 states, Washington, D.C., seven tribes or tribal organizations, and seven territories.

[2]Amounts include funding appropriated through the Comprehensive Cancer Control budget activity, along with funding provided through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), National Program of Cancer Registries (NPCR), Colorectal, Prostate, Ovarian, and Skin Cancer budget activities to support NCCCP activities.

[3]FY 2013 request assumes level funding with FY 2012. FY 2012 is the final year for the current cooperative agreement with grantees. FY 2013 was calculated predicting flat level funding based on FY 2012 for 20 states under a new cooperative agreement.

[4]The NCCCP is being integrated into Coordinated Chronic Disease Prevention and Health Promotion Program. Please see the Coordinated Chronic Disease Prevention and Health Promotion Program section below for further information.

PREVENTION RESEARCH CENTERS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$18.001	$17.900	$0.000	-$17.900
ACA/PPHF	$10.000	$10.000	$0.000	-$10.000
PHS Evaluation Transfers	$0.000	$0.000	$25.000	+$25.000
Total	**$28.001**	**$27.900**	**$25.000**	**-$2.900**

Program Overview: Prevention Research Centers (PRCs) are academic research institutions CDC selects to work with underserved communities on new ways to promote health and prevent disease. The PRC

program is a unique model of research that bridges the gap between scientific findings and translating these findings into public health practice.

The PRC program funds two types of centers: Developmental Centers focus on strengthening community partnerships and developing infrastructure; Comprehensive Centers, those that have developed infrastructure and built long-term partnerships, focus on core research. According to a national program evaluation, the PRC program reaches nearly 30 million people in communities throughout the nation.

This prevention research is critical to identify ways to reduce the nation's health care costs by comparing health promotion strategies and assessing cost-effectiveness and economically feasibility for low-income communities.

Recent accomplishments:

- Trained medical providers to monitor overweight children and counsel children and their families. Data indicate the training improved clinical practice, with significant improvements in physicians' documentation of body mass index (BMI) (from 38 percent to 94 percent documentation) and BMI percentile (from 25 percent to 89 percent documentation). Providers increased knowledge, changed attitudes, and gained confidence in addressing obese/overweight children. The National Initiative for Children's Healthcare Quality recognized the program for outstanding achievements in preventing and treating childhood obesity. Out of this training, the Harvard University PRC developed a set of simple, low-cost tools developed to help clinicians address overweight with their patients.

- Enhanced physical and psychosocial functioning among older adults, significantly lowering health care costs. The University of Washington's PRC developed EnhanceFitness, one of five physical activity programs CDC recommends to improve the quality of life for people with arthritis. In 2009, 5,900 seniors—at 315 sites and in 26 states—were enrolled in EnhanceFitness. A recent PRC analysis of Medicare enrollees indicated that EnhanceFitness participants had 7.9 percent fewer hospitalizations and lower health care costs (by $1,057) than nonparticipants.

- Examined sales and marketing practices of internet cigarette vendors and their impact on public health and policy issues, such as cigarette excise tax evasion and youth access to tobacco. Many state and federal policymakers noted the University of North Carolina at Chapel Hill PRC's research findings on the regulation of internet cigarette sales. Thirty-three states passed laws regulating internet and mail order cigarette sales. In 2010, the U.S. Senate cited this study in its unanimous decision to pass the Prevent All Cigarette Trafficking Act. The Act curtails the sale of untaxed cigarettes and other tobacco products over the internet and bans the delivery of tobacco products through the U.S. mail.

Budget Proposal: CDC's FY 2013 request of $25,000,000 for PRCs from PHS Evaluation transfers is an overall decrease of $2,900,000 below the FY 2012 level. CDC will implement this decrease by streamlining prevention research efforts through the Comprehensive Centers, which have the established capacity and partnerships necessary for optimally conducting and disseminating core research.

CDC will also focus on areas for cost savings and efficiencies to maximize public health impact.

In FY 2013, CDC will:

- Maintain support for 32 existing Comprehensive Centers, which would continue to develop infrastructure and established relationships, as well as conduct core research and special interest projects on public health priorities.

- Develop, test, and evaluate effective interventions identified by PRCs and partners that are targeted at costly chronic conditions like obesity, diabetes, and heart disease. These interventions will then be disseminated and used throughout the public health system at the federal, state, and local levels.

Prevention Research Centers Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	37	37	32
Average Award	$0.300 (developmental) $0.620 (comprehensive)	$0.300 (developmental) $0.620 (comprehensive)	$0.573 (comprehensive)
Range of Awards	$0.300 (developmental) $0.620 (comprehensive)	$0.300 (developmental) $0.620 (comprehensive)	$0.573 (comprehensive)
Number of New Awards	0	0	0
Number of Continuing Awards	37	37	32

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$14.018	$13.940	$0.000	-$13.940
ACA/PPHF	$25.000	$40.000	$0.000	-$40.000
Total	**$39.018**	**$53.940**	**$0.000**	**-$53.940**

Program Overview: The Racial and Ethnic Approaches to Community Health (REACH) program supports communities to design, implement, evaluate, and disseminate strategies to address health disparities in chronic disease. The REACH program aims to improve linkages between the health care system and minority communities, as well as reduce risk factors for chronic disease.

Budget Proposal: CDC's FY 2013 budget request eliminates funding for the REACH program, a decrease of $53,940,000 below the FY 2012 level. CDC will build on past program successes and integrate the best practices identified by the REACH program into the new Community Transformation Grants (CTG) program, described below, advancing science-based practices and approaches to community-based chronic disease prevention. CDC will continue to support science-based strategies that deliver innovative, culturally tailored interventions designed to reduce health disparities.

COMMUNITY TRANSFORMATION GRANTS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$145.000**	**$226.000**	**$146.340**	**-$79.660**

Program Overview: The Community Transformation Grants (CTG) program is an important opportunity for communities to develop and implement initiatives to reduce the risk factors responsible for the leading causes of death and disability and to prevent and control chronic diseases. The CTG program is the culmination of 13 years of CDC's community-based public health investments. CTGs will integrate the most valuable lessons learned to advance evidence-based practices in community-based approaches to chronic disease prevention from the Healthy Communities and REACH programs, as well as Communities Putting Prevention to Work (CPPW) program.

The CTG program's goal is to create healthier communities by making healthy living easier and more affordable where people live, work, play, and go to school. By promoting healthy lifestyles, especially

among population groups experiencing higher burdens of chronic disease, these grants help improve health, reduce health disparities, and control health care spending. Twenty percent of the funding is directed at programs and policies in rural or frontier areas—an approach intended to address disparities in access to preventive care. Ultimately, this approach will result in the improved health of the nation, demonstrating changes in weight, nutrition, physical activity, and tobacco use. During FY 2011, the CTG program reached approximately 120 million people, or one in three Americans.

CDC will build on major accomplishments, such as those described below, from CDC's community program portfolio, such as the CPPW and REACH, to maximize the CTG program's prevention impact.

Recent accomplishments:

- Supported a New York City-wide decision to improve nutrition for over one million children every school day. The Bronx Health REACH Coalition increased access to healthy foods and issued recommendations that led to healthier options in the food supply in targeted neighborhoods. Due to the Coalition's initiative, neighborhood grocers now carry low-fat milk and healthier snacks, and local restaurants now highlight their healthy menu options. The city also decided to switch from whole milk to low-fat milk in New York City schools.
- Increased community access to healthy food retailers, including farmers' markets, local corner stores, and other retail outlets in CPPW-funded communities.
    - The Seattle/King County, Washington Department of Public Health worked with local food retailers located in "food deserts" to introduce healthy food options. The first store to introduce healthy options had to increase its produce supply from one to three shipments a week due to high demand. The program also provides economic incentives to retailers to provide fresh fruit and vegetables. As a result of this initiative, approximately 650,000 residents have greater access to healthy foods.
    - Louisville, Kentucky is decreasing unemployment and making healthy meals possible through its Healthy in a Hurry Program. By implementing healthy options in corner stores and hiring managers from the neighborhood, this program provides 80,000 people with healthier food options.
- Improved vulnerable families' access to nutritious foods and fresh produce in CPPW-funded communities.
    - Olmsted County, Minnesota's rural areas opened new community farmers' markets, increasing access to fresh produce. Rochester markets—which accept Electronic Benefit Transfer (EBT) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits—increased access to healthy foods for the more than 17,500 EBT and WIC users. These customers receive an additional $10 in incentives to spend at the farmers' markets. Nearly 100 percent of customers redeemed these incentives, increasing EBT fresh produce sales by 58 percent in just one month.
- Supported the Rhode Island Farm-to-School Project to encourage all Rhode Island school districts to buy locally grown foods to serve in school meals. Currently, 35 of the state's 36 school districts purchase Rhode Island-grown foods. Documented local product sales to schools include over 40,000 pounds of fresh potatoes, 2,500 cases of apples, 157 bushels of corn, 2,000 pounds of butternut squash, and 1,500 pounds of zucchini annually.

- Enhanced diabetes management by raising awareness and increasing access to preventive services through the REACH La Vida program, a collaboration of community partners. The program increased the use of preventive medical center services in rural southwestern New Mexico and reduced hemoglobin A1c levels, an indicator of diabetes risk. Patients participating in the program after 9–12 months had an average blood A1c level of 7.6, which is substantially lower than the national average A1C level of 9 for Hispanic patients.

Budget Proposal: CDC's FY 2013 request of $146,340,000 from the Affordable Care Act Prevention and Public Health Fund for Community Transformation Grants is a decrease of $79,660,000 below the FY 2012 level. This decrease will have no impact on grants supported in FY 2011, which will be continued in FY 2013. New grants will be fully funded in FY 2012 for up to four years. In FY 2013, the CTG program will continue to amplify efforts to promote healthy behaviors that control health care costs. Within the total program funding level, at least 75 percent of resources allocated will be made available for extramural use.

In FY 2013, CDC will:

- Fund grantees to address five strategic priority areas:
  - Tobacco-free living,
  - Active living and healthy eating,
  - Increased use of high-impact, quality clinical preventive services to prevent and control high blood pressure and high cholesterol,
  - Social and emotional wellness, and
  - Healthy and safe physical environments.
- Fund national networks of community-based organizations to engage community members and to help extend CTG work across the nation, particularly in rural and frontier areas and communities that face significant barriers to better health. The National Networks support, disseminate, and amplify the evidence-based strategies of the CTG program nationally, and support CTG community efforts, which include sub-awards to local communities.

Community Transformation Grants Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	68	TBD	TBD
Average Award	$0.158	TBD	TBD
Range of Awards	$0.147–$10.000	TBD	TBD
Number of New Awards	68	TBD	TBD
Number of Continuing Awards	0	TBD	TBD

[1]Total number of awards includes 61 state and local government agencies, tribes, territories, and nonprofit organizations in 36 states, along with seven national networks of community-based organizations.

COORDINATED CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION PROGRAM BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority[1]	$237.292	$229.908	$378.607	+$148.699
ACA/PPHF	$42.200	$20.000	$0.000	-$20.000
Total[1]	**$279.492**	**$249.908**	**$378.607**	**+$128.699**

[1]The FY 2013 budget request consolidates the following activities into the Coordinated Chronic Disease Prevention and Health Promotion Program: Heart Disease and Stroke; Diabetes; Comprehensive Cancer Control; Arthritis and Other Conditions; Nutrition, Physical Activity, and Obesity Prevention; Health Promotion, and School Health activities. FY 2011 and FY 2012 amounts for the Coordinated Chronic Disease Prevention and Health Promotion program have been comparably adjusted to reflect this proposal.

Program Overview: A coordinated approach to chronic disease prevention will reduce the nation's significant, costly burden of chronic disease. This coordinated approach combines the following existing programs: heart disease and stroke, diabetes, comprehensive cancer control, arthritis and other conditions, obesity prevention, health promotion, and school health activities into a single, streamlined grant program, the Coordinated Chronic Disease Prevention and Health Promotion Program (CCDPHPP). The approach will enable CDC to create a coordinated, national response to chronic disease, maximizing program effectiveness, reducing interrelated risk factors, and accelerating health improvements. This will also provide states with additional flexibility to address the leading causes of chronic disease and disability, while increasing accountability and improving health outcomes through performance incentives.

These chronic diseases share many interrelated risk factors, as well as proven approaches to reduce these risk factors. A coordinated approach through one main program will allow public health practitioners to jointly invest in best practices to more effectively address interrelated risk factors to focus on the leading causes of chronic disease-related death and disability. The CCDPHPP will promote a more comprehensive approach to preventing chronic disease at the federal, state, and local levels, reducing compartmentalization and providing state public health officials with the flexibility they need to approach prevention in innovative, streamlined, and efficient ways. This comprehensive approach and added flexibility will translate into accelerated improvements in health outcomes—and with greater efficiency.

The CCDPHPP will complement the approaches to chronic disease prevention identified by CTG programs, described above. The centralized CCDPHPP will serve as a statewide dissemination vehicle for the proven strategies that have demonstrated impact through the CTG program. This collaboration will accelerate and enhance states' prevention work.

CDC will build upon previous program successes across chronic disease prevention to maximize program impact during this transition, including working with funded states, territories, and tribes to determine program priorities. This may involve continuing or expanding some existing programs as currently structured, altering the scope of existing activities based on demonstrated effectiveness and need, redirecting resources away from ineffective programs to those that are effective, or, if appropriate, using resources to start new activities.

CDC is proposing to include the National Comprehensive Cancer Control Program (NCCCP) as part of the CCDPHPP. This will allow CDC to programmatically align NCCCP investments with three CCDPHPP components: 1) evidence-based practice and environmental approaches to improve nutrition and physical activity in schools, worksites, and communities; 2) health system interventions to improve the delivery and use of selected clinical and other preventive services; and 3) strategies to improve community-clinical linkages to support chronic disease self-management.

Through this program, all grantees are expected to achieve population-level change in specified outcomes, such as increasing formal diabetes education, increasing control of high blood pressure, and increasing physical activity to reduce the leading causes of chronic disease-related death and disability and their associated risk factors. Grantees will also identify populations that are disproportionately affected by chronic diseases and implement strategies to reduce these health disparities. Grantees will include plans to deliver evidence-based interventions, evaluate these interventions, and evaluate their annual plan to CDC. CDC will also use program investments to support technical assistance, evaluation, oversight, and management activities to maximize program effectiveness.

Through a coordinated approach to chronic disease prevention and promotion of evidence-based interventions, the overarching efforts of the CCDPHPP will support the reduction of deaths related to chronic diseases, such as coronary heart disease, strokes, and diabetes. CDC will track overarching contextual indicators of chronic disease-related deaths (identified below) and has identified proximal performance measures that identify the short term and intermediate outcomes and the impact of programmatic efforts to reduce chronic diseases and contributing risk factors.

Contextual Indicator	Most Recent Result	2015 Interim Target
Reduce the age-adjusted annual rate of coronary heart disease deaths (per 100,000 population)	FY 2008: 122.7 (Historical Actual)	108.6
Reduce the age-adjusted annual rate of stroke deaths (per 100,000 population)	FY 2008: 40.7 (Historical Actual)	36.4
Reduce the age-adjusted annual rate of diabetes-related deaths (per 100,000 population)	FY 2007: 73.1 (Historical Actual)	68.5

Recent accomplishments from programs proposed to be integrated into the CCDPHPP:

- Enhanced coordination of chronic disease self-management, particularly among those with multiple chronic conditions. In the past, the Wisconsin Arthritis Program, the Arthritis Foundation Wisconsin Chapter (AFWC), and the Department of Health Services provided separate interventions for different diseases, such as arthritis, heart disease, and diabetes, but often targeted the same populations. The CDC-funded Wisconsin Arthritis Program proposed that all three organizations use the existing Information and Referral 1-800 number to develop a new communication campaign to reach more people and use resources more efficiently. The AFWC included brochures on the Chronic Disease Self-Management Program in every introductory packet sent to callers. After the initial rollout, the percentage of calls for information about the Chronic Disease Self-Management Program increased twentyfold to 20 percent.

- Increased the number of people in Montana with multiple chronic conditions (such as cardiovascular disease and diabetes) whose blood pressure is under control. With CDC investments and support, Montana's Cardiovascular Health program focused on improving heart health in disparate populations by working with nine community health centers and one satellite clinic to provide patient health education, promote home blood pressure monitoring, review blood pressure logs, and improve medical therapy. These efforts reached 1,676 patients, including patients with co-morbidities. A 2010 evaluation demonstrated that the program markedly increased patients' blood pressure control rates, from 33 percent to 42 percent for diabetic patients and from 56 to 62 percent for non-diabetic patients. By improving blood pressure control, these patients are much less likely to suffer from heart attacks, stroke, and kidney disease.

- Brought together cancer and tobacco organizations to leverage resources and strengthen information available for policymakers to consider when addressing cancer prevention and control strategies. Through the NCCCP, CDC supported the Arkansas Cancer Coalition to implement evidence-based strategies, including primary prevention interventions focused on tobacco. The Arkansas Cancer Coalition collaborated with the Step-Up Coalition (an anti-tobacco coalition) and other key partners to inform state legislators about the importance of decreasing tobacco use to prevent cancer and effective interventions to reduce tobacco consumption. In 2009, the Arkansas Senate decided to increase taxes on cigarettes and other tobacco products. Arkansas used this revenue to implement the state cancer plan, expand health programs, and make critical statewide trauma system improvements.

- Increased physical activity among New York state students in grades K–5. CDC supported the Education Department's Healthy Steps Program, which engaged students in a variety of exercise activities and measured their progress. Healthy Steps activities will also be integrated into art, math, health, geography, and language arts studies. By encouraging healthy habits, such as routine physical activity, these efforts reduce the likelihood these children will develop weight problems and associated chronic illnesses, such as diabetes and cardiovascular disease.

- As part of the First Lady's Let's Move! Child Care Initiative, created a self-assessment checklist and action plan development toolkit for early care and education providers to improve the quality of nutrition, physical activity, and screen time standards in child care facilities. In 2011, hundreds of child care providers—serving over 1.8 million children—committed to achieving 10 high-impact obesity prevention standards to improve children's health. Over 500 providers completed the checklist quiz and created action plans for making improvements. Eleven states have convened small teams for training on the state action guide for obesity prevention in early care and education settings and to incorporate efforts into state obesity action plans.

- Improved clinical indicators for diabetes patients. Utah's Diabetes Prevention and Control Program (DPCP) program, in partnership with nine major health care plans (six commercial and three Medicaid), committed to improving diabetes and other chronic diseases. This unique partnership allowed the DPCP to reach approximately 90 percent of state physicians and the majority of people seeking diabetes care, regardless of insurance status. Over a five-year period, the program demonstrated improvements in diabetes indicators. These indicators include average blood glucose control (measured as A1c greater than 7 percent), where the program saw an increase from 23.5 percent to 42.7 percent, and lipid control (measured as greater than 100), where the program saw an increase from 17.8 percent to 45.2 percent. The program also increased eye exam rates (from 41.9 percent to 64 percent) and kidney function screening (from 33.3 percent to 69.3 percent), which prevent complications such as blindness and kidney disease.

Budget Proposal: CDC's FY 2013 request of $378,607,000 for the CCDPHPP is an increase of $128,699,000 above the FY 2012 level. This increase demonstrates the consolidation of CDC's Heart Disease and Stroke; Nutrition, Physical Activity, and Obesity Prevention; School Health; Diabetes; Comprehensive Cancer Control; and Arthritis and Other Chronic Disease activities into a single grant program. The proposed FY 2013 CCDPHPP will increase the average awards to states from approximately $2.6 million to approximately $4.5 million. This increase in funding will permit states, tribes, and territories to support a broader range of programs targeting the leading causes of chronic disease-related death and disability and their associated risk factors. Within the total program level, no more than 20 percent of total funding will be allocated to program administrative costs, including CDC's technical assistance, evaluation, oversight, and management activities.

In FY 2013, CDC will:

- Support core, formula-based awards to state, tribal, and territorial health departments based on population size and chronic disease burden. Grantees will use these awards for cross-cutting chronic disease prevention expertise and capacity, as well as foundational epidemiology and surveillance activities. These activities will document and monitor chronic diseases and risk factors to generate information for action and improve program performance. In addition, the CCDPHPP provides a framework in which to efficiently and effectively deploy specific interventions to prevent and reduce targeted chronic diseases and associated risk factors. Strong capacity is a prerequisite for successful implementation, dissemination, and expansion of effective interventions.
- Support additional competitive awards to state, tribal, and territorial health departments for specific chronic disease interventions. These interventions include: 1) strategies that support and reinforce healthful behaviors and expand access to healthy choices; 2) health systems interventions to improve the delivery and use of clinical and other preventive services, such as blood pressure control, appropriate aspirin use, and cancer screenings; and 3) community-clinical linkage enhancement to better support chronic disease self-management. The interventions are designed to improve nutrition, physical activity, and quality of life for people with chronic disease and to prevent diabetes, heart disease, and cancer among those at high risk. Furthermore, high-performing grantees will receive incentives based on program efficiency and demonstrated health outcomes.
- Support, through competitive awards to national organizations, national networks, and other entities to disseminate best practices and effective interventions. Funded entities will provide technical assistance, training, and support to state, tribal, and territorial health departments. Entities will also support surveillance, research and evaluation, and extramural programs that complement and inform national- and state-based prevention and health promotion strategies.
- Support performance incentives for states, tribes, and territories that are able to meet targeted performance measures associated with the CCDPHPP competitive awards.
- Support CDC's national chronic disease subject matter expertise, technical assistance to grantees, state and national program surveillance, evaluation and research activities, and program leadership and administration.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$300.950**	**$427.050**	**$511.711**	**+$84.661**

The following activities are included:

- Tobacco Campaign and Quitlines – $89,000,000 (included in the Tobacco Prevention and Control narrative)
- Cancer Prevention and Control – $260,871,000 (included in the Cancer Prevention and Control narrative)
- Community Transformation Grants – $146,340,000 (included in the Community Transformation Grants narrative)
- Million Hearts™ – $5,000,000

- Let's Move/Healthy Weight Task Force Activities – $4,000,000
- Workplace Wellness – $4,000,000
- Hospitals Promoting Breastfeeding – $2,500,000

Million Hearts™

The Million Hearts™ initiative is a national public-private initiative intended to prevent one million heart attacks and strokes over five years, from January 2012 to January 2017. Million Hearts™ represents the first time there will be a system-wide—governmental and non-governmental—commitment to drastically improve cardiovascular disease prevention. A number of complementing public and private activities will be included under the umbrella of the initiative. Funding for public activities associated with Million Hearts™ will primarily come from existing investments and is not, with the exception of the FY 2013 Prevention and Public Health Fund request below, dependent on new resources. This specific FY 2013 budget initiative is intended to support a pilot program that could provide an important supplemental effort to the broader initiative, but Million Hearts™ as a whole is not dependent on this one proposed set of activities.

CDC will use Prevention and Public Health Fund investments to increase support of selected heart disease and stroke prevention activities within the Million Hearts™ initiative. The Prevention and Public Health Fund-supported components of the Million Hearts™ initiative will directly complement the CTG program's cardiovascular disease prevention activities. The Million Hearts™ initiative will provide $5,000,000 to promote medication management through counseling and pharmacy support in selected communities. CDC, potentially in collaboration with the Health Resources and Services Administration, can work with grantees to improve medication adherence among high-risk individuals using nurses as case managers with pharmacist support of medication management, as well as referrals to community services and lifestyle interventions. In addition, the Prevention and Public Health Fund investments will include $5,000,000 to support a network of model electronic health record-based registries and feedback systems to track blood pressure and cholesterol control. This network would also provide sentinel surveillance data on regional progress in these areas.

Let's Move/Healthy Weight Task Force Activities

Childhood obesity has more than tripled in the past 30 years, putting our nation's youth at immediate and long-term risk for developing costly, deadly chronic diseases. For instance, obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure; in a population-based sample of five to 17 year-olds, 70 percent of obese youth had at least one risk factor for cardiovascular disease. In the long term, obese youth are more likely than youth of normal weight to become overweight or obese adults with increased risk of heart disease, type 2 diabetes, stroke, certain types of cancer, and osteoarthritis.

CDC's public health expertise, including expertise in identifying what works to promote healthy behaviors such as healthy eating and active living, is essential to reduce these trends. CDC will support the First Lady's Let's Move Initiative and HHS Healthy Weight Task Force activities, which aims to improve dietary and physical activity behaviors through targeted sector initiatives (e.g., Let's Move Cities Child Care, partnerships with industry to improve availability of healthy foods). Together, these activities target obesity prevention and promoting healthy weight among children. These programs will focus on encouraging children to adopt healthy habits, especially in nutrition and physical activity.

Workplace Wellness

Chronic diseases account for over 75 percent of the $2.5 trillion spent in annual U.S. medical care costs. The indirect costs of poor health, including absenteeism, disability, and reduced work output, may be several times higher than direct medical costs. Productivity losses related to personal and family health

problems cost U.S. employers $1,685 per employee per year, or $225.8 billion annually. When employers pay more for health insurance and employee health care, they have fewer resources to invest in company growth, potentially lowering wages, slowing hiring, and shifting health care costs to employees. However, research indicates that evidence-based, comprehensive workplace health programs can reduce chronic diseases and their associated costs, yielding an average return on investment of $3 for every $1 spent over a two- to five-year period.

By focusing on improving health in the workplace, where American adults spend much of their time, CDC can improve the health of workers and their families. CDC will use these Prevention and Public Health Fund investments to continue its work in establishing and evaluating comprehensive workplace health programs. In FY 2013, these programs will help employers create and expand workplace wellness programs aimed at three goals: 1) reduce chronic disease risk among employees and their families through science-based workplace health interventions and promising practices; 2) promote sustainable and replicable workplace health activities, such as establishing a workplace health committee, garnering senior leadership support, and forming community partnerships; and 3) promote peer-to-peer business mentoring. By evaluating the results of these programs, CDC can also rapidly translate best practices to its other prevention work, identifying promising practices in chronic disease prevention.

Hospitals Promoting Breastfeeding

Protecting, promoting, and supporting breastfeeding is a key strategy toward improving the health of mothers and infants. CDC will provide funds to states to develop or enhance initiatives to build support for breastfeeding including promoting action steps in the 2011 Surgeon General's Call to Action to Promote Breastfeeding and the 2009 CDC Recommended Strategies and Measurements to Prevent Obesity and other Chronic Diseases in the U.S.; supporting non-governmental organizations that assist mothers that choose to breastfeed; and, collaborate with hospitals that want to promote and create a breastfeeding friendly environment. This effort will aim to improve breastfeeding duration particularly among low income mothers. These activities will complement CDC's additional work to support breastfeeding that is conducted as part of the Safe Motherhood and Infant Health program activities.

CDC's work complements the technical assistance it provides to states, tribes, and communities to conduct research to identify and address barriers to breastfeeding. Breastfeeding significantly reduces health risks for infants, which in turn reduces medical care needs and health care costs. The medical care needs for non-breastfed infants are greater than those of their breastfed counterparts, requiring an estimated 2.2 million excess medical visits, 228,760 more days of hospitalization and 657,146 more prescriptions. Despite this, according to 2007 data, more than a million newborns in the United States were never breastfed at all. Suboptimal breastfeeding rates cost the country at least $13 billion annually, including at least $3.4 billion in avoidable direct and indirect medical costs. In 2007, hospitals across the United States scored an average of 63 out of 100 in an assessment of their policy and environmental support for breastfeeding. In that same year, the mothers of more than 1.5 million infants were unable to exclusively breastfeed for even the first week of the infant's life. This illustrates the significant, preventable societal costs that result from a failing to ensure that the largest proportion of health care dollars are spent providing optimal, high quality maternity care.

BUDGETARY OUTPUTS

Measures	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
Tobacco Prevention and Control				
4.A: Number of state tobacco prevention and control programs (includes Washington, D.C. and eight territories) (Output)	FY 2011: 59	59	59	Maintain
4.B: Tobacco Cessation Quitlines– States/ Territories/Tribes funded to maintain and enhance existing quitlines (Output)	FY 2011: 56	53	53	Maintain
4.E: Number of cooperative agreements for tobacco prevention with key organizations with access to diverse population (Output)	FY 2011: 13	13	13	Maintain

PERFORMANCE

Program: Tobacco Prevention and Control

Performance Measures for Long Term Objective: Reduce death and disability among adults due to tobacco use.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.6.2: Reduce per capita cigarette consumption in the U.S. per adult age 18+. (Outcome)	FY 2010: 1,281 (Target Exceeded)	1,150	1,068	-82
4.6.3: Reduce prevalence of cigarette smoking among US adults (Intermediate Outcome)	FY 2010: 19.4% (Historical Actual)	20%	19%	-1
4.6.4: Increase proportion of the U.S. population that is covered by comprehensive state and/or local laws making workplaces, restaurants, and bars 100% smoke-free (no smoking allowed, no exceptions) (Intermediate Outcome)	FY 2010: 48% (Historical Actual)	56.9%	56.9%	Maintain
4.6.5: Reduce the proportion of adolescents (grade 9 through 12) who are current cigarette smokers. (Intermediate Outcome) [1]	FY 2009: 19.5% (Historical Actual)	18.6%	18.2%	-0.4
4.C: Increase the number of calls received by Tobacco Cessation Quitlines (Output)	FY 2010: 1,086,296 (Historical Actual)	1,704,000	1,753,500	+49,500
4.D: Increase the number of persons provided cessation counseling and/or medications by Tobacco Cessation Quitlines (Output)	FY 2010: 463,737 (Historical Actual)	704,800	725,300	+20,500

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.G: Increase the total state health departments and other organizations (e.g., local health departments) requesting advertising campaign materials through the Media Campaign Resource Center (Output)	FY 2011: 250 (Target Met)	250	275	+25

[1] The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and is conducted every other year (odd years). To obtain data on an annual basis, beginning in FY 2011 the National Youth Tobacco Survey (NYTS), which track closely with YRBSS, was added as an additional data source and will be conducted in the intervening years (even years).

Performance Trends: Reducing tobacco use is a CDC priority and an HHS Priority Goal (http://www.performance.gov/). Effective tobacco control programs, implemented through evidence-based tobacco control policies, significantly prevent and reduce tobacco use. Through the implementation of its National Tobacco Prevention and Control program, CDC made significant progress in decreasing the burden of tobacco-related death and disease. Although cigarette use remains largely static in recent years, the percentage of adults that are current smokers increased in 2009 to 20.6 percent, but declined to 19.4 percent in 2010, thus achieving the target (Measure 4.6.3). Additionally, the per capita cigarette consumption among adults in the United States declined from 1,507 to 1,281 between 2008 and 2010 (Measure 4.6.2). The proportion of youth cigarette use significantly declined from 1997 to 2003, however it has since stalled. In 2009, the percent of adolescents (grades 9 through 12) who reported current cigarette use was 19.5 percent (Measure 4.6.5).

The percentage of the U.S. population covered by comprehensive state and/or local laws which make workplaces, restaurants, and bars 100 percent smoke-free steadily increased from 13.5 percent in 2005 to 48 percent in 2010 (Measure 4.6.4). On average, communities that enact strong smoke-free policies realize a 17 percent reduction in heart attack hospitalizations among the general public.

In addition to providing evidence to inform policy, system, and environmental changes, CDC also provides direct assistance to tobacco users through National Tobacco Quitlines. In 2010, the tobacco quitlines received 1,086,296 calls and provided cessation counseling and/or medications to 463,737 persons (Measure 4.C and 4.D). In FY 2012, implementation of the National Tobacco Education Campaign will increase awareness of the dangers of tobacco use, and it is projected that calls to the quitline will significantly increase by 2013.

Program: Oral Health

Performance Measures for Long Term Objective: Prevent oral health diseases and promote effective interventions that support optimal oral health.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.7.1: Increase the proportion of the people served by community water systems who receive optimally fluoridated water. (Intermediate Outcome)	FY 2008: 72.4 % (Historical Actual)	75.5 %	76.5 %	+1
4.H: Increase the number of community water systems at optimal levels for 12 months in a row (Output)	FY 2010: 1,603 (Historical Actual)	1,701	1,753	+52

Performance Trends: By 2013, CDC will increase the percent of the U.S. population with access to optimally fluoridated water by four percent over the 2008 levels of 72.4 percent. As of 2010, more than

1,600 community water systems were at optimal levels of fluoridation for 12 consecutive months (Measure 4.H). In 2011, there were several state and community successes in adopting fluoridation, including Arkansas and two large communities in California—San Jose and Santa Clara Valley, which will result in about 1.2 million additional Americans who will receive the protective benefits of optimally fluoridated water within the next five to six years.

Although substantial progress is being achieved, several significantly sized cities still do not have community water fluoridation programs, leaving large pockets of the population uncovered. Performance data are being used in conjunction with CDC's Oral Health Strategic Plan to better prioritize and target the focus of oral health activities nationally. CDC is working to update its systems and interface with EPA's Safe Drinking Water Information System in order to provide more rapid updates on the percentage of the U.S. population receiving optimally fluoridated water.

Program: Safe Motherhood and Infant Health

Performance Measures for Long Term Objective: To improve the health of women and infants through public health surveillance, research, capacity building and science based practices.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.8.1**:** Reduce birth rates among adolescent females aged 15 to 19 years in targeted communities. (Intermediate Outcome)	FY 2011: 68.3[1]	64.8	61.6	-3.2
4.8.2: Increase the number reporting areas that provide optimal data for assessing preconception health practices, gaps, and barriers related to maternal and infant health using the Pregnancy Risk Assessment Monitoring System (Intermediate Outcome)[2]	FY 2011: 6 (Target Met)	41	41	Maintain
4.8.3: Increase the number of evidence-based findings available to inform the delivery of effective maternal/child health and reproductive health interventions (Output)	FY 2011: 119 (Target Exceeded)	105	110	+5
4.I: Number of youth reached with evidence-based teen pregnancy prevention services across CDC funded communities (Output)	FY 2011: 0 (Historical Actual)[3]	12,500	13,000	+500
4.J: Number of maternal and child health (MCH) assignees providing epidemiologic support to national, state, or local MCH agencies (Output)	FY 2011: 18 (Target Exceeded)	19	16	-3

[1] Preliminary data. Final data will be available in late 2013.

[2] In 2012 preconception health questions will become part of the core set of question asked in all states. The target of 41 reflects the number of states expected to be using PRAMS by 2013.

[3] FY 2011 was a planning year for grantees and no interventions or outreach took place.

Performance Trends: As a leader in population-based reproductive, maternal and child health, CDC strengthens the evidence base for effective interventions that improve both maternal and infant health. The United States had the highest teen birth rate among industrialized nations, with 34.3 births per 1,000 women ages 15 to 19 in 2010, and societal costs of approximately $10 billion annually in 2008.

Reduction in teen birth rates in the targeted communities will provide an evidence base for effective interventions and evaluation of the sustained impact of these programs (Measure 4.8.1 and 4.I). FY 2011 was a planning year for these programs. FY 2012 will be the first year for implementation and data collection in funded communities.

Optimal data allows CDC and states to monitor changes in maternal and child health indicators (e.g., unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, infant health), identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress towards goals in improving the health of mothers and infants. In 2011, 41 sites (40 states and New York City) collected data using PRAMS, which represents 78 percent of live births in the United States; six of the PRAMS sites collected additional data for assessing preconception health practices, gaps, and barriers related to maternal and infant health (Measure 4.8.2). In 2012, CDC will realign the core set of questions for all states to include preconception health questions, which optimizes the availability of data needed to improve national population-based estimates of preconception health. Translation and dissemination of epidemiologic research findings is a key to ensuring that evidence-based findings are integrated into health care practices. In 2011, CDC strengthened the evidence base and enhanced state and local capacity in maternal and child health through the dissemination of 119 evidenced-based findings and placing 18 maternal and child health epidemiologists and research professionals in national, state, and local health agencies (Measure 4.8.3 and 4.J).

Program: Cancer Prevention and Control

Performance Measures for Long Term Objective: Improve health outcomes related to cancer.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.9.1: Decrease the incidence rate of late-stage breast cancer diagnosis in women ages 50 to 74 (per 100,000) (Intermediate Outcome)	FY 2008: 106.7 (Historical Actual)	102.5	101.5	-1
4.9.2: Increase age appropriate screening for colorectal cancer among adults age 50 to 75 (Intermediate Outcome)[1]	FY 2010: 65.4% (Historical Actual)	66%	N/A	N/A
4.9.3: Increase the number of central cancer registries that provide quality data on incidence and late-stage diagnosis of screening-amenable cancers (Output)	FY 2010: 34 (Baseline)	38	42	+4
4.K: Number of breast cancer screenings provided by the National Breast and Cervical Cancer Early Detection Programs (NBCCEDP) (Output)	FY 2010: 325,291 (Historical Actual)	327,000	328,000	+1,000
4.L: Number of breast cancer cases detected by National Breast and Cervical Cancer Early Detection Programs (NBCCEDP) (Output)	FY 2010: 5,530 (Historical Actual)	5,556	5,576	Maintain
4.M: Number of Colorectal Cancer Control Program (CRCCP) grantees promoting the use of patient navigation and support (Output)	FY 2010: 17 (Baseline)	19	21	+2

[1] Data on CRCCP screening is collected in even years; therefore, targets are not set/ reported for FY2011 and FY2013.

Performance Trends: Although, recommended by the U.S. Preventive Services Task Force, screening rates for breast, cervical, and colorectal cancers remain low. Women over the age of 50 are at highest risk for breast cancer and benefit the most from screening. The incidence of late-stage diagnosis among women ages 50–73 was 106.7 per 100,000 women in 2008 (Measure 4.9.1). In this age group, when compared to those not screened, mammography screening reduces breast cancer deaths by 17 percent. Through the implementation of its National Breast and Cervical Cancer Early Detection Program (NBCCEDP), CDC provides access to breast and cervical cancer screening and diagnostic services to high-risk women that are low-income, uninsured, and underinsured. In 2010, 325,291 women received breast cancer screenings (mammograms) and 5,530 cases of breast cancer were detected (Measures 4.K and 4.L). NBCCEDP has an enormous impact on breast cancer mortality, and is estimated to have saved 100,800 life-years between 1991 and 2006 through screening and early detection among medically underserved low-income women.

Colorectal cancer (CRC) is the second most commonly diagnosed cancer and the second leading cause of cancer death for cancers that affect both men and women in the United States. In 2010, only 65.4 percent of adults aged 50–75 were up-to-date with recommended colorectal cancer screening (Measure 4.9.2). CDC's Colorectal Cancer Control Program (CRCCP) funds 25 states and four tribal organizations to increase population-level screening rates and promote the implementation of evidenced based strategies such as patient/provider reminder systems and promotion of patient navigation system to promote screening. In 2010, 17 grantees promoted the use of patient navigation to increase screening rates (Measure 4.M).

State and local cancer incidence data provided to cancer registries are important tools for guiding cancer prevention and early detection efforts, as the surveillance data enable health departments and other public health stakeholders identify and target screening interventions to areas/populations with high incidences of cancer and those with high occurrence of late-stage diagnosis. These data also allow CDC programs to manage performance by assessing programmatic efficacy in meeting performance benchmarks. In 2010, 34 grantees provided targeted reports on incidence and late-stage diagnosis of screening-amenable cancers, thereby providing quality data necessary for cancer control planning and targeted interventions (Measure 4.9.3).

Program: Coordinated Chronic Disease Prevention and Health Promotion Grant Program

Contextual Indicators for the Coordinated Chronic Disease Grant: Reduce the leading causes of chronic disease-related death and disability.

Contextual Indicator	Most Recent Result	FY 2015 Interim Target
Reduce the age-adjusted annual rate of coronary heart disease deaths (per 100,000 population)	FY 2008: 122.7 (Historical Actual)	108.6
Reduce the age-adjusted annual rate of stroke deaths (per 100,000 population)	FY 2008: 40.7 (Historical Actual)	36.4
Reduce the age-adjusted annual rate of diabetes-related deaths (per 100,000 population)	FY 2007: 73.1 (Historical Actual)	68.5

Performance Measures for Long Term Objective for Obesity: Promote evidence-based interventions to improve physical activity and nutrition and reduce obesity.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.11.10: Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese [1]	FY 2010: 35.7% (Historical Actual)	35.1%%	N/A	N/A
4.11.7: Increase the proportion of infants that are breastfed at 6 months (Intermediate Outcome)	FY 2008: 44.3% (Historical Actual)[2]	54.1%	55.7%	+1.6%
4.11.8: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older (cup equivalents per 1,000 calories) (Intermediate Outcome) [1]	FY 2010: 0.86 (Historical Actual)	N/A	0.95	N/A
4.11.9: Increase the proportion of adults who engage in leisure time physical activity (Intermediate Outcome)	FY 2010: 67.4% (Historical Actual)	68.0%	68.3%	+0.3%
4.12.1: Increase in the number of states with nutrition standards for foods and beverages provided in early care and education centers (Intermediate Outcome) [3]	FY 2010: 8 (Baseline)	12	14	+2
4.12.2: Increase the number of states with standards to improve the nutritional quality of competitive foods in schools. (Intermediate Outcome)	FY 2010: 39 (Historical Actual)	41	42	+1
4.12.3: Increase the percent of high school students who attend PE classes on 1 or more days in an average week when they were in school (Intermediate Outcome) [1]	FY 2009: 56.4% (Historical Actual)	N/A	59.8%	N/A
4.P: Number of states that require children to engage in vigorous- or moderate-intensity physical activity (Output) [3]	FY 2010: 6 (Baseline)	10	12	+2
4.Q: Number of states with policies that promote optimal physical education standards at all grade levels in schools (Output)	FY 2010: 22 (Historical Actual)	25	26	+1
4.R: Number of Urban Physical Education Leadership Summit school districts that do not allow waivers or exemptions for student participation in physical education (Output)	FY 2011: 13 (Baseline)	15	17	+2

[1] "N/A" reflects measures with data collected biennially, thus targets and data will not be provided for years in which the data is not available.

[2] Data is based on provisional rates for 2008. Final data is expected Aug. 2012.

[3] Baselines and targets for this measure have been revised to reflect the criteria and standards of the national assessment conducted by the National Resource Center for Health and Safety in Child Care and Early Education (NRC).

Performance Measures for Long Term Objective for Heart Disease: Reduce risk factors associated with heart disease and stroke.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.11.5: Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (<140/90). (Intermediate Outcome) [1]	FY 2010: 46% (Target Not Met)	50%	N/A	N/A
4.11.6: Reduce consumption of sodium in the population aged 2 years and older (milligrams per day) (Intermediate Outcome) [1]	FY 2008: 3,330 (Baseline)	3,050	N/A	N/A
4.N: Increase the number of blood pressure screenings provided by the WISEWOMAN program (Output)	FY 2010: 46,910 (Target Not Met but Improved)	50,000	52,000	+2,000
4.O: Increase the number of evidence-based tools disseminated to promote sodium and hypertension reduction and awareness (Output)	FY 2011: 58 (Target Exceeded)	65	83	+18

[1] "N/A" reflects measures with data collected biennially, thus targets and data will not be provided for years in which the data is not available.

Performance Measures for Long Term Objective: Improve prevention, detection, and management of chronic disease through education, self-management and the promotion of clinical preventative services for those diagnosed with or at risk for chronic diseases.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
4.10.1a: Increase the proportion of adults over age 65 who are up to date on core clinical preventive services (men) (Intermediate Outcome) [1]	FY 2010: 46.3% (Historical Actual)	47.2%	N/A	N/A
4.10.1b: Increase the proportion of adults over age 65 who are up to date on core clinical preventive services (women) (Intermediate Outcome) [1]	FY 2010: 47.9% (Historical Actual)	48.8%	N/A	N/A
4.11.1: Reduce the age-adjusted percentage of adults 18+ with doctor-diagnosed arthritis who engage in no leisure time physical activity (Intermediate Outcome) [1]	FY 2009: 30.1% (Historical Actual)	N/A	29.1%	N/A
4.11.2: Increase the percentage of CDC-funded states that increase arthritis appropriate self-management education or physical activity course (Output)	FY 2010: 58% (Baseline)	75 %	83%	+8
4.11.3: Increase the proportion of the diabetic population with an A1c value less than 9% (Intermediate Outcome) [1,2]	FY 2009: 53.5% (Historical Actual)	N/A	55%	N/A

[1] "N/A" reflects measures with data collected biennially, thus targets and data will not be provided for years in which the data is not available.

[2] A1c data for NHANES 2007-2008 and 2009-2010 are being re-evaluated to ensure that any trends in the prevalence of diabetes or pre-diabetes are accurate and not due to laboratory equipment or calibration changes that occurred during this timeframe.

Performance Trends: Chronic diseases are the leading causes of death and disability in the United States, and account for 70 percent (almost 1.7 million) of all deaths annually. These diseases also cause major limitations in daily living for almost one out of every 10 people. In 2008, 405,309 deaths were due to coronary heart disease, an annual death rate of 122.7 per 100,000 persons, and strokes accounted for 134,138 of deaths, with an annual death rate of 40.7 per 100,000 persons. Additionally, diabetes is a related cause of mortality in 73.1 deaths per 100,000 population.

Obesity increases the risk of many health conditions, including heart disease, stroke, high blood pressure and cancer. Obesity accounts for more than 300,000 deaths per year and is associated with more than $147 billion in annual medical care expenditures. In 2010, 35 percent of adults were obese (Measure 4.11.10). Environmental and behavioral risk factors that promote poor dietary quality and physical inactivity contribute greatly to the obesity epidemic. In 2008, only 63.8 percent of adults engaged in leisure-time physical activity, and only 56.7 percent of high school students attend physical education classes on one or more days a week (Measures 4.11.9, 4.12.3). In 2010, only six states (baseline) met the *Caring for Our Children: Health and Safety Guidelines for Early Care and Education (CFOC)* obesity prevention standards for requiring children to engage in vigorous- or moderate-intensity physical activity and eight states meet the nutrition standards for food and beverages provided to children (Measures 4.12.1, 4.P). Approximately 44.3 percent of infants are breastfed at six months and vegetables account for less than one cup (0.86) per 1,000 calorie diet of children over age two (Measures 4.11.7, 4.11.8). To combat these trends, CDC provides strategies and interventions to improve nutrition and physical activity and promote healthy lifestyles. These strategies include developing and disseminating guidelines/standards, advancing environmental strategies to support healthy eating and active living, and implementing a coordinated approach to community-based and statewide nutrition and physical activity programs.

In addition to reducing obesity, the coordinated grant program promotes strategies and interventions to detect chronic diseases among those at high risk and improve the quality of life for people with chronic disease through education, self-management and lifestyle changes. For high risk population such as adults over age 65, effective delivery of preventive services reduces health risks. In 2010, 46.3 percent of men, and 47.9 percent of women were up to date with recommended core clinical services which include influenza vaccination within the past year, ever having an pneumococcal vaccination, a colonoscopy or sigmoidoscopy in the past 10 years or a fecal occult blood test in the past year, and a mammogram in the past two years for women (Measures 4.10). CDC has increased support for chronic disease self-management to improve quality of life for people with chronic diseases. While 30 percent of adults with diagnosed arthritis did not engage in leisure time physical activity in 2009, the availability of arthritis appropriate self-management education or physical activity courses increased in CDC funded programs (Measure 4.11.1 and 4.11.2). Unmanaged, diabetes can lead to risk of other serious chronic disease complications such as heart disease, blindness, and kidney disease. Controlling diabetes, including maintaining preventive care practices are essential for the health of persons with diabetes. In 2009, 53.5 percent of the diabetic population reported having an A1c value less than nine percent (Measure 4.11.3)[7].

Hypertension affects one in three adults, and is a modifiable risk factor for heart disease, stroke, and other chronic diseases. It contributes to one out of every seven deaths in the U.S., including nearly half of all

[7] A1c data for NHANES 2007-2008 and 2009-2010 are being re-evaluated to ensure that any trends in the prevalence of diabetes or pre-diabetes are accurate and not due to laboratory equipment or calibration changes that occurred during this timeframe.

cardiovascular disease-related deaths. In 2010, CDC did not meet the targeted increase for the proportion of adults with high blood pressure who have it controlled, however between 2008 and 2010 the rate increased from 45 to 46 percent (Measure 4.11.5). Since 2008, CDC's WISEWOMAN program increased blood pressure screenings annually from 34,185 to 46,910 in 2010. However, 2010 screenings fell short of the target by roughly 790 (Measure 4.N). The number of evidence-based tools disseminated to promote sodium and hypertension reduction awareness increased to 58 in 2011, increasing by 27 and exceeding the 2010 target (Measure 4.O).

IT INVESTMENTS

CDC's IT investments in chronic disease prevention and health promotion include:

- Administrative Systems, which include multiple systems that support funding decisions, research and contracts tracking, and other administrative services.
- Data Dissemination Systems, which support the study of chronic diseases, conditions, and risk factors in populations, as well as research to understand and predict how demographic, behavioral, cultural, and environmental factors influence health. By applying scientific theory and methods and drawing from qualitative and quantitative research, the outcome of these activities includes increasing essential knowledge of behavioral and other causes of disease and the context in which it occurs.
- Public Health Monitoring Systems, which provide electronic capabilities for gathering, storing, manipulating, and disseminating valuable data for public health monitoring activities supporting Chronic Disease Prevention and Health Promotion.
- Public Health Program Support Systems involve the activities related to identifying, assessing, providing funding, or otherwise supporting programs that provide health and human services promotion, education, awareness, research, or other services.
- National Center for Chronic Disease Prevention and Health Promotion engages in surveillance activities in order to: 1) collect data to better understand the extent of health risk behaviors, preventive care practices and the burden of chronic diseases; 2) monitor the progress of prevention efforts; and 3) help public health professionals and policymakers make more timely and effective decisions.
- National Program of Cancer Registries provides information technology (IT) support for state-based cancer registries that collect, manage, and analyze data about cancer cases and cancer deaths. In addition, registry surveillance systems monitor the cancer burden at the state and local level, collecting data on 96 percent of the population, to assess changes in cancer types and rates over time, identify high-risk populations, guide planning and evaluation of cancer control programs (e.g., prevention, screening and treatment efforts), and help set priorities for allocating resources.
- Public Health Reproductive Health Systems provide electronic capabilities for gathering, storing, manipulating, and disseminating valuable data for reproductive health monitoring activities in support of chronic disease prevention and health promotion.
- Public Health Application Support supports the facilitation of data being received in a usable medium and data being provided, disseminated, or otherwise made available or accessible to the stakeholders.

- Public Health Information Dissemination for Chronic Disease Prevention and Health Promotion supports the communication and exchange of information between the federal government, citizens and stakeholders in direct support of chronic disease prevention and health promotion. CDC Public Health Tools and Training Systems support developing electronic tools to promote increased understanding of risk factors and policy interventions that effect personal and systems-level decision making.

STATE TABLE[1]

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919 (NBCCEDP, Tobacco), 93.283 (Comprehensive Cancer), 93.988 (Diabetes Prevention and Control) CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION				
State/Local/ Territory/Tribal Grantee	**FY 2011 Actual Breast and Cervical Cancer**	**FY 2011 Actual National Comprehensive Cancer Control Program**	**FY 2011 Actual Diabetes Prevention and Control Programs**	**FY 2011 Actual Tobacco**
Alabama	$3,314,203	$300,000	$291,564	$1,326,918
Alaska	$2,007,950	$285,000	$424,661	$1,155,593
Arizona	$2,382,234	$285,000	$250,017	$1,281,398
Arkansas	$2,730,098	$274,076	$464,177	$1,030,871
California	$7,183,517	$0	$1,043,922	$1,617,668
CA Public Health Institute	$0	$656,153	$0	$0
Colorado	$3,965,864	$430,000	$507,359	$1,326,312
Connecticut	$1,392,800	$227,000	$252,782	$1,079,240
Delaware	$1,126,313	$255,000	$386,912	$669,373
District of Columbia	$459,648	$202,542	$261,917	$531,753
Florida	$4,945,692	$445,000	$694,394	$1,873,958
Georgia	$4,237,328	$264,706	$369,150	$1,094,478
Hawaii	$875,443	$256,234	$328,887	$926,456
Idaho	$1,846,989	$255,000	$330,219	$1,141,439
Illinois	$6,608,935	$236,631	$850,153	$1,141,246
Indiana	$2,050,000	$450,000	$312,007	$1,037,551
Iowa	$2,763,748	$268,915	$229,862	$1,011,630
Kansas	$2,356,428	$267,704	$716,078	$1,285,389
Kentucky	$2,708,945	$0	$681,698	$1,139,397
University of Kentucky	$0	$480,000	$0	$0
Louisiana	0	0	$202,000	$1,101,612
Louisiana State University	$1,893,467	$457,142	$0	$0
Maine	$1,489,978	$254,999	$340,473	$944,248
Maryland	$4,965,122	$259,162	$301,588	$1,205,315
Massachusetts	$2,161,587	$475,000	$854,983	$1,558,516
Michigan	$9,031,859	$480,000	$947,905	$1,662,974
Minnesota	$4,581,042	$474,999	$913,246	$1,199,593
Mississippi	$2,123,664	$255,000	$292,533	$1,104,566
Missouri	$3,018,261	$260,387	$470,314	$1,156,691

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919 (NBCCEDP, Tobacco), 93.283 (Comprehensive Cancer), 93.988 (Diabetes Prevention and Control) CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION				
State/Local/ Territory/Tribal Grantee	**FY 2011 Actual Breast and Cervical Cancer**	**FY 2011 Actual National Comprehensive Cancer Control Program**	**FY 2011 Actual Diabetes Prevention and Control Programs**	**FY 2011 Actual Tobacco**
Montana	$2,252,092	$296,957	$599,533	$961,792
Nebraska	$2,956,376	$305,000	$271,399	$1,218,442
Nevada	$2,529,397	$250,000	$344,404	$857,535
New Hampshire	$1,587,002	$275,000	$294,478	$1,041,719
New Jersey	$3,023,727	$250,000	$478,533	$1,274,834
New Mexico	$3,439,578	$305,000	$433,792	$1,141,221
New York	$8,132,535	$480,000	$986,305	$1,873,958
North Carolina	$3,453,909	$300,000	$887,207	$1,672,280
North Dakota	$1,456,233	$303,739	$244,261	$1,144,568
Ohio	$4,219,076	$255,000	$734,631	$1,364,363
Oklahoma	$1,652,112	$250,000	$244,892	$1,326,840
Oregon	$2,311,302	$480,000	$797,756	$1,094,341
Pennsylvania	$2,310,737	$256,235	$522,169	$1,283558
Rhode Island	$1,606,275	$278,689	$758,986	$1,144,904
South Carolina	$3,110,924	$313,266	$666,163	$1,217,811
South Dakota	$1,061,951	$222,542	$257,525	$963,055
Tennessee	$1,210,409	$310,000	$268,653	$1,281,398
Texas	$7,004,006	$293,750	$976,813	$1,873,879
Utah	$2,734,731	$454,500	$888,327	$1,215,563
Vermont	$676,306	$255,000	$242,247	$1,140,226
Virginia	$2,808,366	$245,000	$372,906	$1,057,786
Washington	$4,932,039	$255,000	$974,690	$1,411,385
West Virginia	$4,205,253	$285,000	$916,152	$1,170,995
Wisconsin	$3,261,280	$277,526	$852,883	$1,191,137
Wyoming	$683,331	$269,565	$259,499	$1,037,398
Indian Tribes	$7,013,161	$1,860,472	$0	$0
Baltimore City	$0	$0	$0	$0
Broward County, FL	$0	$0	$0	$0
Chicago	$0	$0	$0	$0
Detroit	$0	$0	$0	$0
Houston	$0	$0	$0	$0
Los Angeles	$0	$0	$0	$0
Memphis City	$0	$0	$0	$0
Miami-Dade County, FL	$0	$0	$0	$0
New York City	$0	$0	$0	$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919 (NBCCEDP, Tobacco), 93.283 (Comprehensive Cancer), 93.988 (Diabetes Prevention and Control) CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION				
State/Local/ Territory/Tribal Grantee	**FY 2011 Actual Breast and Cervical Cancer**	**FY 2011 Actual National Comprehensive Cancer Control Program**	**FY 2011 Actual Diabetes Prevention and Control Programs**	**FY 2011 Actual Tobacco**
Newark, NJ	$0	$0	$0	$0
Orange County, FL	$0	$0	$0	$0
Palm Beach County, FL	$0	$0	$0	$0
Philadelphia	$0	$0	$0	$0
San Diego	$0	$0	$0	$0
San Francisco	$0	$0	$0	$0
Seattle Public Schools	$0	$0	$0	$0
American Samoa	$238,424	$225,000	$58,378	$139,305
Guam	$391,357	$250,000	$200,000	$206,570
Marshall Islands	$0	$180,000	$86,301	$100,000
Micronesia	$0	$475,000	$144,200	$211,403
Northern Mariana Islands	$242,796	$255,000	$72,478	$148,650
Palau	$506,347	$205,000	$73,754	$131,470
Puerto Rico	$0	$0	$238,953	$879,528
University of Puerto Rico	$341,618	$0	$0	$0
Virgin Islands	$0	$0	$202,000	$156,990
Total	**$163,573,765**	**$19,672,891**	**$28,069,069**	**$63,535,587**

[1]This state table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://wwwn.cdc.gov/Fundingprofiles/FundingProfilesRIA/.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$136.072	$137.287	$18.476	-$118.811
ACA/PPHF	$0.000	$0.000	$107.089	+$107.089
Total	**$136.072**	**$137.287**	**$125.565**	**-$11.722**
FTEs	232	231	231	0

Authorizing Legislation: PHSA §§ 301, 304, 307, 308D, 310, 311, 317, 317C, 317J, 317K, 317L, 317Q, 327, 352, 399G, 399M, 399Q, 399S, 399T, 399AA, 399BB, 399CC, 1102,1108–1115; The Prematurity Research Expansion And Education For Mothers Who Deliver Infants Early Act §§ 3,5 (42 U.S.C. 247b-4f and 42 U.S.C. 247b-4g).

FY 2013 Authorization……..…….……Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $125,565,000 for birth defects, developmental disabilities, disabilities and health, including $18,476,000 in budget authority and $107,089,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall decrease of $11,722,000 below the FY 2012 level. CDC is proposing to consolidate activities into three budget lines that will allow CDC to more aggressively track birth defects and developmental disabilities, expand its effort to improve the lives of people with disabilities by focusing on the most critical public health threats to these populations, and widen the scope of CDC's efforts to mitigate the unnecessary morbidity and mortality associated with non-malignant blood disorders in the United States.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget [1]	FY 2013 +/- FY 2012
Child Health and Development	$62.295	$61.966	$58.610	-$3.356
Autism (non-add)	$21.380	$21.265	$21.340	+$0.075
Health and Development for People with Disabilities	$54.920	$56.574	$51.201	-$5.373
Public Health Approach to Blood Disorders	$18.857	$18.747	$15.754	-$2.993
Total	**$136.072**	**$137.287**	**$125.565**	**-$11.722**

[1]FY 2013 amounts include budget authority and allocations from the ACA/PPHF.

CDC works to prevent birth defects and developmental disabilities and improve health outcomes for individuals who live with these and other disabling conditions, eliminate disparities associated with disabilities, and prevent death and disability associated with blood disorders. CDC is continuously improving its strategy to maximize public health impact.

CDC initially proposed consolidating budget lines related to this work for FY 2012. CDC communicated with partners throughout 2011 regarding the proposal for budget line consolidation, seeking to maximize opportunities to receive input from partners. Mechanisms for gathering and assessing partner input included: a series of approximately 25 partner and grantee briefings in February, five facilitated partner engagement meetings and two meetings with Congressional Appropriations Committee staff members in

April through June, and a capstone partner listening session in August. These events served as platforms for CDC to share its vision for the consolidation of the budget and for partners to present their ideas, questions, and concerns about the proposed consolidation and its execution.

In FY 2013, CDC proposes three budget lines, *Child Health and Development, Health and Development for People with Disabilities, and Public Health Approach to Blood Disorders*, designed to focus efforts on priority areas where the potential public health impact would be greatest. The priority focus areas will use resources to define the magnitude of burden from birth defects and developmental disabilities, disabilities across the lifespan, and blood disorders to identify and address public health needs. This will allow CDC to:

- Continue state-based public health surveillance of birth defects and disabilities in six states, including developmental, intellectual, physical, and mental disabilities surveillance in children and timely referral of children with birth defects and disabilities to appropriate services.
- Prevent birth defects by raising awareness of risk factors, such as alcohol use and smoking; providing improved data on the use of prescription and over-the-counter medication during pregnancy and ensuring these data are available to guide risk-benefit evaluations by pregnant women and their health care providers; promoting folic acid fortification and use; and promoting healthy nutritional behavior, in partnership with state, national, and global organizations.
- Continue to support short- and long-term follow-up for blood spot and hearing screening, with expansion to other conditions such as pulse oximetry screening for congenital heart disease.
- Continue to support increasing knowledge around child development and developmental disabilities such as autism spectrum disorders.
- Support early identification, intervention, and health promotion for children and adolescents with developmental and intellectual disorders and disabling conditions (including, but not limited to, muscular dystrophy, fragile x syndrome, and spina bifida) or at risk for poor developmental outcomes through public health surveillance, research, and health communications activities, in partnership with federal agencies and state, local, and national organizations.
- Strengthen CDC efforts to promote health and prevent secondary conditions among people with disabilities through a network of 16 state disability and health programs and five public health practice and resources centers addressing issues related to limb loss and paralysis, as well as important condition-specific issues, such as attention-deficit/hyperactivity disorder (ADHD) and Tourette Syndrome.
- Continue activities to identify coexisting conditions and poor health behaviors in people with intellectual disabilities and to increase their access to appropriate health services.
- Support the Administration's *Partnership for Patients: Better Care, Lower Costs*, a public-private initiative to reduce the incidence of preventable hospital-acquired conditions, such as deep vein thrombosis (DVT), and hospital re-admissions related to a preventable complication by developing and increasing health care providers' awareness of recommendations for improving DVT prophylaxis in hospitalized patients.
- Identify the burden of sickle cell disease (SCD) and hemophilia through the Hemophilia Treatment Centers and Universal Data Collection system and to increase awareness of clinical and public health policies via health communications activities in partnership with national organizations.

- Address prevention gaps by identifying the modifiable risk factors for birth defects, developmental disabilities, and various blood disorders through targeted research using contracts and academic agreements.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$127.366
2009	$138.022
2010	$143.626
2011	$136.072
2012	$137.287

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

CHILD HEALTH AND DEVELOPMENT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget [1]	FY 2013 +/- FY 2012
Child Health and Development	$62.295	$61.966	$58.610	-$3.356
Autism (non-add)	$21.380	$21.265	$21.340	+$0.075
Total	$62.295	$61.966	$58.610	-$3.356

[1]FY 2013 amounts include budget authority and allocations from the ACA/PPHF.

Program Overview: CDC conducts surveillance, research, and prevention activities with the ultimate goal of preventing or reducing birth defects and developmental disabilities. CDC has established monitoring and research programs to identify risk factors for birth defects and developmental disabilities, which is a critical step toward developing new and effective prevention efforts. CDC has enhanced surveillance for autism and developmental disabilities by assessing prevalence among young children. CDC works to promote health through early identification and intervention for children at risk for developmental problems. Other current priorities include preventing major birth defects attributable to maternal risk factors, such as diabetes, obesity, smoking, and alcohol and medication use during pregnancy. CDC funds activities through cooperative agreements for epidemiologic research, prevention, and surveillance. Grantees include state and local health departments, academic research centers, and multi-lateral organizations. CDC also provides technical assistance for birth defects and developmental disabilities surveillance.

Recent accomplishments:

- Identified specific medications as important risk factors for birth defects, including clomiphene citrate, a common fertility treatment; opioid analgesics, commonly used prescription pain medications; and antiepileptic medications through the National Birth Defects Prevention Study.
- Published updated national prevalence estimates for 21 major birth defects based on data from 14 population-based birth defects surveillance programs. Data are used to monitor trends, assess prevention efforts, determine service needs, and understand the burden of disease due to birth defects in the United States.

- Collaborated with researchers from the Health Resources Services Administration (HRSA) to publish trends in the prevalence of developmental disabilities in children in the United States. The study found that over a 12-year period (1997–2008), the prevalence of parent-reported developmental disabilities has increased 17.1 percent. Expanded surveillance for developmental disabilities to include monitoring prevalence among four year-olds and eight year-olds in several U.S. communities. Data are critical to monitoring the Healthy People 2020 objective to decrease the identification age for children with autism and other developmental disabilities.

- Developed and disseminated CHOICES (Changing High-Risk AlcOhol Use and Increasing Contraception Effectiveness Study), an evidence-based intervention to reduce alcohol-exposed pregnancies among women in primary care settings, including sexually transmitted infection (STI) clinics, family planning clinics, and community health centers. Eighty-five percent of women for which three months of follow-up data were available have reduced their risk of alcohol-exposed pregnancy after visiting STI clinics that have fully implemented CHOICES.

Budget Proposal: CDC's FY 2013 request of $58,610,000 for child health and development, including $8,653,000 in budget authority and $49,957,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall decrease of $3,356,000 below the FY 2012 level. This request includes $21,340,000 for autism from the Affordable Care Act Prevention and Public Health Fund. CDC is proposing to consolidate existing budget lines into the child health and development budget line to unify CDC's ongoing efforts to promote preconception health; support surveillance and research on risk factors for birth defects, developmental disabilities, and other atypical developmental outcomes; and promote early identification and intervention efforts for children with developmental delays and disabilities.

In FY 2013, CDC will:

- Prevent congenital heart defects (CHD) and other birth defects through the Treating for Two initiative, which will ensure that medication treatment for pregnant women with chronic or acute medical conditions minimizes any adverse effects on the mother and baby. CDC will work with private partners, other federal agencies, and the public to build a comprehensive approach to improve the quality of data on medication use in pregnancy. Information will be easily accessible to health care providers for the purpose of changing prescribing practices toward lower-risk medications.

- Work towards developing reliable clinical guidelines for people with CHD, assisting with planning for future health care needs in these individuals, and better understanding the costs of CHD among children, adolescents, and adults.

- Complete the first Early Autism and Developmental Disabilities Monitoring Network (ADDM) study to estimate the prevalence of autism spectrum disorders among four year-old children and develop a prevalence study to follow up with this initial cohort at age eight.

- Prevent fetal alcohol syndrome and other adverse effects of prenatal alcohol exposure by implementing evidence-based prevention approaches for women of reproductive age in primary care settings.

- Advance domestic initiatives to eliminate folic acid-preventable neural tube defects by providing technical support to The Corn Masa Flour Fortification Partner Group, which includes several national organizations that plan to submit a food additive petition to the Food and Drug Administration (FDA) to fortify corn masa flour with folic acid.

- Provide technical assistance for neural tube defect and blood folate surveillance activities in countries engaged in global folic acid fortification efforts to inform policies and strategies for prevention.

HEALTH AND DEVELOPMENT FOR PEOPLE WITH DISABILITIES

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget[1]	FY 2013 +/- FY 2012
Total	**$54.920**	**$56.574**	**$51.201**	**-$5.373**

[1]FY 2013 amounts include budget authority and allocations from the ACA/PPHF.

Program Overview: CDC provides surveillance to monitor health status and prevent secondary conditions in people with disabilities. Data from these surveillance activities support state and local programs and policies by providing information on disability-related health disparities. Programs also include newborn screening to identify and ensure intervention for children born with hearing loss and the promotion of health and development of people with disabilities across the lifespan. CDC also supports programs and policies that promote health care access and prevent diseases and secondary conditions among persons with disabilities, including an emphasis on state and local capacity to accommodate inclusion of persons with disabilities in public health planning and policies to reduce health disparities (e.g., obesity, smoking, health care access, and depression). CDC is engaged with monitoring and advancing select Healthy People 2020 disability-related objectives, as well as a public awareness campaign on disability inclusion for improved health and participation.

Recent accomplishments:

- Implemented a new, national, web-based data system to improve the utility of surveillance data for disabilities that helps quickly translate state-level, disability-specific data into actionable information for use by state health departments, national disability and health organizations, and policymakers.
- Exceeded prior year results with 97 percent of newborns in reporting jurisdictions screened for early hearing loss from the Early Hearing Detection and Intervention program (EDHI).
- Developed data analyses that illustrate health disparities for people with disabilities, which can support federal and state planning to address disability-related disparities. Through a network of 16 state Disability and Health programs, demonstrated the effective application of interventions to improve health care access and increase health promotion participation.
- Co-led the development of the *HHS Action Plan to Reduce Disability-Related Health Disparities* and guided the development of data standards for a HHS policy on inclusion of disability identifiers in HHS supported surveys.

Budget Proposal: CDC's FY 2013 request of $51,201,000 for health and development for people with disabilities, including $7,360,000 in budget authority and $43,841,000 from the Affordable Care Act Prevention and Public Health Fund, is $5,373,000 below the FY 2012 level. CDC is proposing the consolidation of existing budget lines into the health and development for people with disabilities budget line to allow CDC to focus funding on activities that build upon the successful collaboration with state and local health departments, national and community organizations, universities, and other partners. CDC plans to expand the scope of the program to reach a larger segment of people of all ages living with disabilities.

In FY 2013, CDC will:

- Support increasing the electronic system capacity of EHDI awardees to collect and exchange data accurately, effectively, securely, and consistently between the EHDI Information System and Electronic Health Record Systems (EHR-S).

- Develop and document system improvements to reduce loss-to-follow-up for infants who failed infant hearing screenings.
- Provide information, education, and consultation on disease prevention and health promotion for people with disabilities, health care providers, caregivers, media, researches, policymakers, and the public.
- Fund states' abilities to develop programs that improve health care access, health promotion, and emergency preparedness for people with disabilities through enhanced surveillance programs and policies.
- Co-lead the implementation of the *HHS Action Plan to Reduce Disability-Related Health Disparities* and use this plan to monitor and evaluate implementation of recommendations, providing information to HHS Operational Divisions on strategies that are effective and ineffective in successfully reducing targeted, disability-related health disparities.
- Invest in public health surveillance and education activities focused on social, emotional, and intellectual disorders in children and adolescents.
- Document the prevalence of medication use and non-pharmacological treatments for children with ADHD and use this information to determine ADHD prevalence, associated co-morbidities, diagnosis, treatment, and management.
- Expand efforts to describe the disability population, raise awareness of environmental barriers impeding the health of people with disabilities, and expand the knowledge base of proven, successful health promotion strategies to achieve health outcomes by collaborating with disability and health state grantees to ensure data collection occurs for people with limb loss or limb difference and those involved in their lives.

Early Hearing Detection and Intervention Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	52	52	52
Average Award	$0.150	$0.150	$0.150
Range of Awards	$0.083–$0.175	$0.100–$0.175	$0.125–$0.175
Number of New Awards	0	0	0
Number of Continuing Awards	52	52	52

Disability and Health Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted[1]	FY 2013 President's Budget
Number of Awards	16	16–20	16–20
Average Award	$0.275	$0.300	$0.300
Range of Awards	$0.200–$0.450	$0.200–$0.400	$0.200–$0.400
Number of New Awards	0	16	0
Number of Continuing Awards	16	0	16

[1] A new FOA will be re-competed in FY 2012.

PUBLIC HEALTH APPROACH TO BLOOD DISORDERS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget[1]	FY 2013 +/- FY 2012
Total	**$18.857**	**$18.747**	**$15.754**	**-$2.993**

[1]FY 2013 amounts include budget authority and allocations from the ACA/PPHF.

Program Overview: CDC's blood disorders activities determine the causes of and risk factors for blood disorders; minimize occurrences and complications of blood disorders; develop, evaluate, and facilitate widespread adoption of effective prevention strategies; and ensure people at-risk for blood disorders have access to credible health information. Key strategies for improving health outcomes and preventing complications for those at-risk for blood disorders include promoting the use of a comprehensive care model for people with blood disorders; evaluating and identifying effective prevention strategies; and increasing the public's and health care provider's awareness of bleeding (such as hemophilia) and clotting disorders (such as venous thromboembolism), and hemoglobinopathies (that are thalassemia and sickle cell disease). CDC also supports redesigning data collection systems from those that focus on a single disorder to a single system that collects data for several disorders and monitors emerging health threats to the blood disorders populations.

Recent accomplishments:

- Convened an expert panel of health care practitioners and representatives from federal agencies, professional associations, quality improvement organizations, health insurance programs, and advocacy groups on the "Prevention of Hospital-Acquired Venous Thromboembolism (VTE)" to begin the development of a set of recommendations to improve VTE prophylaxis in hospitalized patients.
- Collaborated with the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, FDA, HRSA, the National Institutes of Health, and HHS Office of Minority Health to operationalize the HHS initiative to increase access and improve the care of people with SCD through enhanced disease surveillance, reliable access to quality care and services, innovative new drug development, and biomedical and behavior research.
- Began field testing of a VTE event reporting module for the Patient Safety Component of the National Healthcare Safety Network. The reporting system will quantify the burden of VTE in hospitalized patients and evaluate and translate evidence of effective interventions. This intra-agency collaboration helps support the HHS Partnership for Patients Initiative and provides data for VTE Healthy People 2020 objectives.
- Compiled and made available a public-use database, CDC Hemophilia A Mutation Project (CHAMP), a database listing more than 2,000 mutations that have been reported worldwide in the factor VIII gene, *F8*, that causes hemophilia. The dataset may be used by researchers and others for the purpose of health statistical reporting and analysis.

Budget Proposal: CDC's FY 2013 request of $15,754,000 for a public health approach to blood disorders, including $2,463,000 in budget authority and $13,291,000 from the Affordable Care Act Prevention and Public Health Fund, is $2,993,000 below the FY 2012 level. CDC is proposing to consolidate the blood disorders budget lines into one line supporting a public health approach to blood disorders. This broader public health approach will extend CDC's scope beyond the approximate number of people who are seen at HTCs to reach more of the people with one of the targeted blood disorders.

In FY 2013, CDC will:

- Maintain data collection on blood disorders at 50 hemophilia treatment centers and expand to include other non-malignant blood disorders with an immediate focus on disorders with the greatest burden and unmet need: VTE and SCD. The data will better inform research and decision-making to improve the health and quality of life for Americans with blood disorders.
- Continue health promotion activities to develop and evaluate prevention strategies needed to improve the health of populations affected by blood disorders, bleeding and clotting disorders, and hemoglobinopathies.
- Increase focus on health services research, cost studies, and epidemiologic analysis of emerging public health issues for blood disorders populations.
- Develop a hospital-associated VTE event reporting module for the Patient Safety Component of the National Healthcare Safety Network.
- Implement a framework of surveillance, health promotion and awareness, and laboratory capacity-building that will address three new Healthy People 2020 objectives pertaining to preventing and controlling complications resulting from hemoglobinopathies.

BUDGETARY OUTPUTS

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Child Health and Development[1]				
5.E: Number of sites participating in research for the Study to Explore Early Development (Output)	FY 2011: 6	6	6	No change

[1]Recent trend data not available, as baselines are being established.

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Health and Development for People with Disabilities[1]				
5.F: State Tracking and Surveillance projects on Early Hearing Detection and Intervention (Output)	FY 2011: 52	52	52	No change

[1] Recent trend data not available, as baselines are being established.

PERFORMANCE

Program: Child Health and Development

Performance Measures for Long Term Objective: Prevent birth defects and developmental disabilities[1]

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
5.1.1: Increase the evidence base on effective interventions to decrease the prevalence of modifiable risk factors for major birth defects (Output)	FY 2011: Published study results demonstrating the role of healthy diets in the prevention of neural tube defects and orofacial clefts (Baseline)	Identify an intervention that can potentially decrease the prevalence of a modifiable risk factor for major birth defects OR understand the role of one effect modifier in reducing the impact of a modifiable risk factor for major birth defects	Identify an additional intervention that can potentially decrease the prevalence of a modifiable risk factor for major birth defects OR understand the role of one effect modifier in reducing the impact of a modifiable risk factor for major birth defects	Maintain
5.1.2: Reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of these conditions among Hispanics (Outcome)	FY 2008: 5.8 (Target Not Met)	4.4	N/A	N/A
5.1.4: Enhance the quality and utility of birth defects surveillance systems (Output)	FY 2011: Published national prevalence estimates for 21birth defects by pooling data from 24 surveillance programs	Demonstrate an increased use of birth defects surveillance programs and data	Demonstrate an increased use of birth defects surveillance programs and data	Maintain

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
5.1.5: Increase the proportion of children with autism spectrum disorders (ASDs) who receive a first evaluation by 36 months of age, with additional focus on children of low socioeconomic status (SES) and minority race/ethnicity (Outcome)	FY 2011: All children: 39% (Baseline) Children of low SES: 32.6% (Baseline) Children of Minority Race/ethnicity (non-white): 36.1% (Baseline) Children of Low SES and Minority Race/Ethnicity: 35.7% (Baseline)	All children: 39% Children of low SES: 32.6% Children of Minority Race/ethnicity (non-white): 36.1% Children of Low SES and Minority Race/Ethnicity: 35.7%	All children: 40.6% Children of Low SES: 33.9% Children of Minority Race/Ethnicity (non-white): 37.5% Children of Low SES and Minority Race/Ethnicity: 37.1%	All children: +1.6% Children of Low SES: +1.3% Children of Minority Race/Ethnicity (non-white): +1.4% Children of Low SES and Minority Race/Ethnicity: +1.4%
5.C: Number of model state-based fetal alcohol syndrome surveillance systems and regional training centers (Output)	FY 2011: 8 (Target Met)	4	4	Maintain
5.D: Number of states participating in monitoring for autism and other developmental disabilities (Output)	FY 2011: 12 (Target Met)	12	12	Maintain
5.K: Number of countries conducting surveillance of neural tube defects and/or monitoring blood folates among countries with a CDC presence (Output)	N/A[2]	Baseline	1-2 countries above baseline	N/A

[1]Measures and targets have not yet been adjusted for the new consolidated approach.
[2]Recent trend data are not available as baselines are being established.

Child Health and Development

Performance Trends: In FY 2012 CDC developed new measures that reflect efforts to enhance surveillance and increase the evidence base for effective interventions (Measures 5.1.1, 5.1.4). CDC will include a new measure in FY 2014—monitoring the percentage of primary care providers who screen women of reproductive age for risky alcohol use. The new measure will provide appropriate, evidence-based interventions to reduce alcohol-exposed pregnancy for those at risk, an improvement over the previous measure that focused only on healthcare providers in general.

To better understand the prevalence of autism spectrum disorders (ASDs) and other developmental disabilities and to inform early intervention efforts, CDC maintains a network of Autism and Developmental Disabilities Monitoring (ADDM) sites. Additionally, these sites help monitor the rates of

ASDs in various geographic regions and conduct surveillance of younger children. Prevalence estimates published in 2009 (surveillance year 2006) from the ADDM Network indicate that an average of one in 110 eight-year-old children met criteria for ASDs. Overall, CDC identified that ASD prevalence increased a significant 57 percent between surveillance years 2002 and 2006. Data from surveillance year 2006 also demonstrate that 39 percent of children with ASDs received a first evaluation by 36 months of age. Because early screening and diagnosis improve access to services during a child's most critical developmental period, CDC developed a new measure to increase the proportion of children with ASDs who receive a first evaluation by 36 months of age. Further, this measure targets reductions in disparities, by focusing on children of low socioeconomic status and minorities (Measures 5.1.5, 5.D).

CDC did not meet its target in FY 2008 to reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly among Hispanic women; CDC was unable to implement national level interventions, and birth prevalence data is only available at the state/national level (Measure 5.1.2). Program evaluations indicated that the small scale interventions supported by CDC increased awareness of folic acid, knowledge about how to prevent birth defects, and consumption of folic acid. The program, however, was unable to apply these positive results broadly to state and national level birth defect prevalence data.

Despite public health advisories and subsequent outreach efforts, recent data indicate that a significant number of women continue to drink alcohol during pregnancy. Implementing interventions to reduce alcohol-exposed pregnancy is an important strategy to reduce the occurrence of alcohol-related birth defects and developmental disabilities, including fetal alcohol syndrome (FAS) and other fetal alcohol spectrum disorders (FASD). CDC supports FASD prevention activities with focused efforts to increase the uptake of alcohol screening and appropriate evidence-based interventions in systems of care serving women of reproductive age. CDC also implements training programs through four FASD Regional Training Centers (RTCs) to enhance knowledge and skills among medical and allied health students and professionals in the prevention, identification, and treatment of FASDs. From 2008–2011, the RTCs conducted 724 trainings/events reaching 7,140 students/residents and 10,631 health care professionals. Final reports containing additional evaluation findings from the previous funding cycle of RTCs will be available in February 2012.

These performance measures align with strategic priorities that CDC established for its Child Health and Development programs. Performance data inform further strategic planning, target program activities, and track program performance.

Program: Health and Development for People with Disabilities

Performance Measure for Long Term Objective: Improve the health and quality of life of Americans with disabilities

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
5.2.5: Increase the percentage of jurisdictions that collect, report, and use individually identifiable data in order to reduce the number of infants not passing hearing screening that are lost to follow-up (Outcome)	FY 2009: 28% (Baseline)	30%	32%	+2.0%

Health and Development for People with Disabilities

Performance Trends: CDC's support for state- and territorial-based early hearing detection and intervention (EHDI) programs ensures that infants who do not pass hearing screenings receive timely follow-up for diagnostic tests. In CY 2009 (baseline year), 28 percent of CDC-funded jurisdictions

collected, reported and used EDHI data (Measure 5.2.5), and CDC documented screenings for hearing loss for more than 95 percent of babies born in the United States. CDC will increase the percentage of jurisdictions using data to 32 percent in FY 2013. Early diagnosis is important to ensure that infants with a hearing loss develop appropriate communication skills that are commensurate with their cognitive abilities, allowing them to do well both academically and socially. Furthermore, early identification and intervention programs can be cost effective for people with disabilities and their families. Estimates show that early hearing screening and intervention can save approximately $200 million in additional education costs each year.

Program: Public Health Approach to Blood Disorders

Performance Measures for Long Term Objective: Improve the health and quality of life for Americans with blood disorders.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
5.3.1: Increase the percentage of hemophilia patients enrolled in the Universal Data Collection (UDC) system who are routinely screened for inhibitors (Outcome)	FY 2006 – FY 2010: 46.1% (Baseline)	Assess the inhibitor screening practices of a nationally representative sample of hemophilia care providers.	Develop national guidelines for inhibitor screening. Develop and implement ongoing provider & patient education programs.	N/A

Public Health Approach to Blood Disorders

Performance Trends: Approximately 15–20 percent of people with hemophilia (PWH) develop an inhibitor where the individuals' immune system destroys the clotting factor replacement (CFR) proteins used to prevent bleeds making the treatments ineffective. Consequently, medical providers typically treat PWH with larger and more frequent doses of CFR, exacerbating the inhibitor. This can result in significant treatment costs reaching up to $1,000,000 per year and can cause increased hospitalizations and compromised physical functioning. Further, those affected are four times more likely to experience an intracranial hemorrhage.

Although it is widely accepted by hemophilia care providers that the development of an inhibitor is a serious complication of treatment, routine screening is not the standard of care. CDC's Universal Data Collection (UDC) system provides population-level information that informs the development of national inhibitor screening guidelines and education programs. CDC also uses the UDC to monitor screening trends and the impact of routine screening on health outcomes. Data will help advance research to identify risk factors and evidence-based prevention practices for effective treatments. CDC will measure the increase from the baseline FY 2014 to determine the immediate effectiveness of education and guidelines on screening practices (Measure 5.3.1).

STATE TABLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
Alabama	$147,030	-
Alaska	$156,933	-
Arizona	$157,372	-
Arkansas	$154,440	$399,372
California	$148,800	$250,000
Colorado	$157,298	-
Connecticut	$145,720	-
Delaware	$122,047	$200,000
District of Columbia	-	-
Florida	$140,275	$374,876
Georgia	$159.909	-
Hawaii	$77,663	-
Idaho	$137,801	-
Illinois	$169,060	$200,000
Indiana	$155,650	-
Iowa	$175,000	$425,000
Kansas	-	$375,000
Kentucky	$163,216	-
Louisiana	$166,461	-
Maine	$157,334	-
Maryland	$146,651	-
Massachusetts	$156,370	$275,000
Michigan	$175,000	$250,000
Minnesota	$126,376	-
Mississippi	$138,246	-
Missouri	$139,002	-
Montana	$154,998	$400,000
Nebraska	$136,100	-
Nevada	$132,985	-
New Hampshire	$132,001	-
New Jersey	$172,000	-
New Mexico	$130,144	-
New York	$156,338	$204,796
North Carolina	$163,962	$250,000
North Dakota	$155,703	$200,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
Ohio	$130,782	-
Oklahoma	$142,750	-
Oregon	$162,365	$450,000
Pennsylvania	-	-
Rhode Island	$143,474	-
South Carolina	$138,804	$300,000
South Dakota	$122,472	-
Tennessee	$156,873	-
Texas	$162,852	-
Utah	$154,950	-
Vermont	$150,000	-
Virginia	$156,274	$200,000
Washington	$170,257	-
West Virginia	-	-
Wisconsin	$165,205	-
Wyoming	$141,924	-
State Sub-Total	**$7,006,867**	**$2,004,796**
America Samoa	-	-
Guam	$139,735	-
Marshall Islands	-	-
Micronesia	$83,056	-
Northern Marianas	$122,350	-
Puerto Rico	-	-
Palau	$78,835	-
Virgin Islands	-	-
Territory Sub-Total	**$423,976**	-
Total	**$7,430,843**	**$2,004,796**

STATE TABLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
Alabama	$147,030	-
Alaska	$156,933	-
Arizona	$157,372	-

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
Arkansas	$154,440	$399,372
California	$148,800	$250,000
Colorado	$157,298	-
Connecticut	$145,720	-
Delaware	$122,047	$200,000
District of Columbia	-	-
Florida	$140,275	$374,876
Georgia	$159.909	-
Hawaii	$77,663	-
Idaho	$137,801	-
Illinois	$169,060	$200,000
Indiana	$155,650	-
Iowa	$175,000	$425,000
Kansas	-	$375,000
Kentucky	$163,216	-
Louisiana	$166,461	-
Maine	$157,334	-
Maryland	$146,651	-
Massachusetts	$156,370	$275,000
Michigan	$175,000	$250,000
Minnesota	$126,376	-
Mississippi	$138,246	-
Missouri	$139,002	-
Montana	$154,998	$400,000
Nebraska	$136,100	-
Nevada	$132,985	-
New Hampshire	$132,001	-
New Jersey	$172,000	-
New Mexico	$130,144	-
New York	$156,338	$204,796
North Carolina	$163,962	$250,000
North Dakota	$155,703	$200,000
Ohio	$130,782	-
Oklahoma	$142,750	-
Oregon	$162,365	$450,000
Pennsylvania	-	-
Rhode Island	$143,474	-

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
South Carolina	$138,804	$300,000
South Dakota	$122,472	-
Tennessee	$156,873	-
Texas	$162,852	-
Utah	$154,950	-
Vermont	$150,000	-
Virginia	$156,274	$200,000
Washington	$170,257	-
West Virginia	-	-
Wisconsin	$165,205	-
Wyoming	$141,924	-
State Sub-Total	**$7,006,867**	**$2,004,796**
America Samoa	-	-
Guam	$139,735	-
Marshall Islands	-	-
Micronesia	$83,056	-
Northern Marianas	$122,350	-
Puerto Rico	-	-
Palau	$78,835	-
Virgin Islands	-	-
Territory Sub-Total	**$423,976**	-
Total	**$7,430,843**	**$2,004,796**

STATE TABLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
Alabama	$147,030	$0
Alaska	$156,933	$0
Arizona	$157,372	$0
Arkansas	$154,440	$399,372
California	$148,800	$250,000
Colorado	$157,298	$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
Connecticut	$145,720	$0
Delaware	$122,047	$200,000
District of Columbia	$0	$0
Florida	$140,275	$374,876
Georgia	$159,909	$0
Hawaii	$77,663	$0
Idaho	$137,801	$0
Illinois	$169,060	$200,000
Indiana	$155,650	$0
Iowa	$175,000	$425,000
Kansas	$0	$375,000
Kentucky	$163,216	$0
Louisiana	$166,461	$0
Maine	$157,334	$0
Maryland	$146,651	$0
Massachusetts	$156,370	$275,000
Michigan	$175,000	$250,000
Minnesota	$126,376	$0
Mississippi	$138,246	$0
Missouri	$139,002	$0
Montana	$154,998	$400,000
Nebraska	$136,100	$0
Nevada	$132,985	$0
New Hampshire	$132,001	$0
New Jersey	$172,000	$0
New Mexico	$130,144	$0
New York	$156,338	$204,796
North Carolina	$163,962	$250,000
North Dakota	$155,703	$200,000
Ohio	$130,782	$0
Oklahoma	$142,750	$0
Oregon	$162,365	$450,000
Pennsylvania	$0	$0
Rhode Island	$143,474	$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH		
	Early Hearing and Detection and Intervention	**State Disability Grants**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**
South Carolina	$138,804	$300,000
South Dakota	$122,472	$0
Tennessee	$156,873	$0
Texas	$162,852	$0
Utah	$154,950	$0
Vermont	$150,000	$0
Virginia	$156,274	$200,000
Washington	$170,257	$0
West Virginia	$0	$0
Wisconsin	$165,205	$0
Wyoming	$141,924	$0
State Sub-Total	**$7,006,867**	**$2,004,796**
America Samoa	$0	$0
Guam	$139,735	$0
Marshall Islands	$0	$0
Micronesia	$83,056	$0
Northern Marianas	$122,350	$0
Puerto Rico	$0	$0
Palau	$78,835	$0
Virgin Islands	$0	$0
Territory Sub-Total	**$423,976**	**$0**
Total	**$7,430,843**	**$2,004,796**

PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$147.795	$143.972	$35.695	-$108.277
PHS Evaluation Transfer	$247.769	$247.769	$379.374	+$131.605
ACA/PPHF	$72.000	$70.000	$90.000	+$20.000
Total	**$467.564**	**$461.741**	**$505.069**	**+$43.328**
FTEs	1,114	1,109	1,107	-2

Authorizing Legislation: PHSA §§ 241, 301, 304, 306, 307, 308, 317, 317G, 318, 319, 319A, 353, 391, 399V, 778, 1102, 2315, 2341, 2521; P.L. 107-347, Title V (44 U.S.C. 3501 note); Intelligence Reform and Terrorism Prevention Act of 2004 § 7211 (P.L. 108-458); Food, Conservation, And Energy Act of 2008 § 4403 (7 U.S.C. 5311a); P.L. 101-445 § 5341 (7 U.S.C. 5341); The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

FY 2013 Authorization……...……..……...Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $505,069,000 for public health scientific services, including $90,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of $43,328,000 above the FY 2012 level. The FY 2013 request includes an increase of $23,150,000 for health statistics and $20,000,000 for a Laboratory Efficiencies initiative.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Health Statistics	$138.683	$138.683	$161.833	+$23.150
Surveillance, Epidemiology, and Public Health Informatics	$220.747	$217.129	$217.541	+$0.412
Public Health Workforce and Career Development	$36.134	$35.929	$35.695	-$0.234
ACA/PPHF	$72.000	$70.000	$90.000	+$20.000
Total	**$467.564**	**$461.741**	**$505.069**	**+$43.328**

Our public health system must continue to address health problems in this country. To achieve this goal, CDC:

- Compiles statistical information to inform policies that improve public health.
- Assures accuracy and reliability of laboratory tests.
- Applies digital information technology to help detect and manage diseases, injuries, and syndromes.
- Leads in the development, adoption, and integration of sound public health surveillance, laboratory protocols, and epidemiological practices.
- Uses public health science to improve the population's health.
- Prepares public health professionals to meet emerging and ongoing public health challenges.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	N/A
2009	N/A
2010	$408.351
2010 (ACA/PPHF)	$32.358
2011	$395.564
2011 (ACA/PPHF)	$72.000
2012	$391.741
2012 (ACA/PPHF)	$70.000

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

HEALTH STATISTICS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
PHS Evaluation Transfer	**$138.683**	**$138.683**	**$161.833**	**+$23.150**

Program Overview: The National Center for Health Statistics (NCHS) is a designated Federal Statistics Agency and the nation's principal health statistics agency. CDC collects data on births and deaths, health status, and health care. CDC's health statistics program compiles statistical information to guide actions and policies to improve the health of the nation. NCHS' data products provide a unique resource for health information and play a critical role in documenting public health challenges, supporting epidemiologic and biomedical research, and informing health policy development.

Recent accomplishments:

- Tracked the progress in adopting electronic medical and health records throughout the nation's health care system to improve the quality and efficiency of health care services.
    - The National Health Care Surveys provide estimates of the adoption of Electronic Health Records (EHR) and EHR Systems among office-based physicians. Preliminary 2011 estimates show the percentage of physicians with a basic system increased by 35.7 percent from 2010 (from 24.9 percent to 33.8 percent). The percentage of physicians with systems that met the criteria of a basic system by state ranged from 15.6 percent (New Jersey) to 60.7 percent (Minnesota).
- Documented trends in the teen birth rate using data from the National Vital Statistics System.
    - Teenage birth rates for each age group and for nearly all race and Hispanic origin groups in 2009 were at the lowest levels ever reported in the United States. The rate overall was 39.1 births per 1,000 women aged 15–19 years.
- Provided current and complete national and state specific data to track health insurance coverage.
    - Demonstrated among adults aged 19–25 years of age—a group targeted by provisions in the Affordable Care Act—that the percentage of uninsured decreased from 33.9 percent (10 million) in 2010 to 28.8 percent (8.7 million) in the first six months of 2011.

Budget Proposal: CDC's FY 2013 request of $161,833,000 for health statistics is an increase of $23,150,000 above the FY 2012 level. The budget maintains CDC's capacity to fully support its ongoing seminal health and health care surveys, in particular the National Health Interview Survey, National Health and Nutrition Examination Survey and the National Health Care Surveys (NCHS) and purchase

data needed for public health purposes currently collected from vital registration jurisdictions and collection of 12 months of these data within the calendar year. Of the $23,150,000 increase, $16,450,000 will enable CDC to begin to phase in full implementation of the electronic death records in as many jurisdictions as possible (initial target of 15 to 17 states). The $23,150,000 increase will also support full implementation of new questions on sexual orientation into the full National Health Interview Survey (NHIS) data collection pending the successful conduct of the pretest and the development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods.

In FY 2013, CDC will:

- Monitor the U.S. population's health, access to, and use of health care services by conducting the NHIS. Pending the completion of a successful field test, new questions will be incorporated on sexual orientation into the full NHIS to support initiatives to reduce disparities in health and health care by sexual orientation in January 2013. NHIS is the nation's largest household interview survey. It provides extensive data on a broad range of health topics and serves as the core of HHS' data collection.
- Conduct the NHCS, a family of nationally representative health care surveys providing objective, reliable information obtained from ambulatory and inpatient care providers, including physician offices, hospitals, and long-term facilities. The NHCS are the only source of comparable data on health care providers, services rendered, and the patients they serve.
- Collect the nation's official statistics for births and deaths through the National Vital Statistics System (NVSS). The NVSS provides the most complete and continuous data available to public health officials at the national, state, and local levels, as well as the private sector.
- Measure diagnosed and undiagnosed medical conditions across the United States. CDC will collect data using personal interviews, physical examinations, diagnostic procedures, and lab tests. The National Health and Nutrition Examination Survey (NHANES) is the only national source of objectively measured health data capable of providing accurate estimates of both diagnosed and undiagnosed medical conditions in the population.
- Support data access and dissemination by:
    - Making data more easily accessible.
    - Providing health, health care, and health insurance information through Health, United States, the Secretary's report to Congress on the health of the nation.
    - Providing access to confidential aggregate CDC data through the Research Data Center.
- Support data collection methodology research and dissemination to meet increasing data requests by:
    - Developing a range of methods to evaluate and improve question quality through the Questionnaire Design Research Laboratory.
    - Measuring the impact and implications of cell phone use on telephone surveys and identify differences between wireless-only households (or with no telephone service) and other households.

SURVEILLANCE, EPIDEMIOLOGY, INFORMATICS, AND LABORATORY SCIENCE BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$111.661	$108.043	$0.000	-$108.043
PHS Evaluation Transfer	$109.086	$109.086	$217.541	+$108.455
ACA/PPHF	$47.000	$45.000	$65.000	+$20.000
Total	**$267.747**	**$262.129**	**$282.541**	**+$20.412**

Program Overview: CDC's public health scientific support services provide a crosscutting, scientific perspective to public health sciences across the agency, including surveillance, epidemiology, informatics, and laboratory science. CDC works to advance the science and practice of surveillance by managing various surveillance systems with cross-CDC utility, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Notifiable Diseases Surveillance System (NNDSS). CDC supports information management projects across the agency through a shared informatics support model and ensures that CDC programs and state and local health departments prepare for and use electronic data in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act-related Meaningful Use objectives. CDC provides expertise in scientific publication and systematic reviews and puts epidemiology to work with products and services such as the *Morbidity and Mortality Weekly Report* (*MMWR*), the Guide to Community Preventive Services, and Epi Info™. CDC's laboratory science, policy, and practice program provides leadership, advocacy, and training services to strengthen the quality of laboratory science at CDC, in the United States, and globally by providing guidelines and recommendations for public health laboratories.

Budget Proposal: CDC's FY 2013 request of $282,541,000 for surveillance, epidemiology, informatics, and laboratory science, including $65,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of $20,412,000 above the FY 2012 level. Of the $20,412,000 increase, $20,000,000 will support state public health laboratories' adoption of proven, high-efficiency operating models to achieve cost efficiencies and improved quality of testing.

In addition, the budget maintains CDC's capacity to support the ongoing quality, timeliness, and accessibility of public health data for decision making; development of methods to improve quality and access to information from EHRs, such as communicable disease reports; collection and analysis of behavioral risk factor data to address health conditions; publication and dissemination of scientific products used for public health intervention, including the *Morbidity and Mortality Weekly Report*, Guide to Community Preventive Services, and Vital Signs; capacity to conduct research through the Public Health Library Information Center; and provision of new laboratory diagnostics, training of laboratory staff, and assurance of laboratory practice quality standards and guidelines.

Behavioral Risk Factor Surveillance System

Program Overview: CDC funds state health departments through cooperative agreements to administer the BRFSS. The BRFSS is the largest ongoing telephone survey system in the world and is the only nationwide health system that collects state-specific information on health status, health behaviors, preventive health practices, and access to health care. The structure of the BRFSS: 1) ensures standardized administration of core and optional survey questions across all 55 participating states and territories, 2) reserves space within the core component for questions on emerging issues that can be added to the survey rapidly, within an ongoing data collection cycle, and 3) provides states the flexibility to add questions. States may choose to administer optional BRFSS modules, which either expand on topics addressed in the core component or collect information on additional health topics. State-added questions target specific state needs and are not part of the official BRFSS questionnaire or dataset. BRFSS datasets are made available to the public within four months after annual data collection ends.

Recent accomplishments:

- Improved population coverage of the BRFSS by achieving at least 10 percent of completed interviews in all states from adults in a household with only a cell phone. Nationally, about 28 percent of adults live in a cell phone-only household.
- Completed over 35,000 interviews from December 2010 to November 2011 for the Gulf States Population Survey (GSPS). The GSPS is the first BRFSS-like stand-alone survey of its kind and might serve as a model for future BRFSS stand-alone surveys.

In FY 2013, CDC will:

- Fund grantees to increase the proportion of completed cell phone interviews relative to the proportion of completed landline telephone interviews to 20 percent (per-interview costs for cell-phone interviews are two to three times more expensive than landline interviews). This will address possible reductions in the representativeness of the BRFSS, specifically in the 18 to 44 year old population, caused by increases in the proportion of U.S. households that contain only cell phones.
- Develop estimates for all counties in the United States for 11 health indicators, including obesity, diabetes, smoking, and access to care, that state and local health departments can use to address health disparities within the state and target resources more efficiently.
- Complete data collection and initial analysis of data from the GSPS, a special BRFSS-like survey that collects data in Gulf Coast counties affected by the Deepwater Horizon oil spill. GSPS data collection will yield a dataset—amenable to analysis by CDC, the Substance Abuse and Mental Health Services Administration, and participating states—to determine mental and behavioral health status and assess the need for health services in the populations across the affected areas.
- Provide technical assistance to states in survey operations to ensure standardized, high-quality data.

Behavioral Risk Factor Surveillance System (BRFSS) Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	57	57	57
Average Award	$0.222	$0.222	$0.222
Range of Awards	$0.043–$0.390	$0.043–$0.415	$0.043–$.415
Number of New Awards	2	0	0
Number of Continuing Awards	55	57	57

[1]BRFSS is funded through both budget authority and PPHF dollars.

National Notifiable Diseases Surveillance System

Program Overview: The NNDSS is a cornerstone of the nation's ability to identify, monitor, and investigate diseases and conditions. At the federal level, NNDSS focuses on monitoring infectious disease morbidity for state and territorial reportable diseases designated as nationally notifiable. Data provided to NNDSS comes from health care providers and laboratories that are legally mandated to report conditions of public health importance to state and local health departments. These nationally notifiable diseases are specified by state and territorial disease reporting laws and regulations. States voluntarily report data through NNDSS, the only national source for these data. The NNDSS provides the standards for data collection, transmission, and management, which are updated periodically in accordance with developments in public health surveillance and health information technology.

NNDSS provides funding to states, territories, and local health departments using the Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement. The National Electronic Disease Surveillance System (NEDSS) serves as the transmission component of the NNDSS and is supported by funding for staff and technology in state, territorial, and local health departments. The NEDSS Base System (NBS), a software program developed by CDC, supports state surveillance systems in standardized reporting. The NNDSS program will continue to support states in the implementation of electronic laboratory reporting (ELR) in order to meet objectives in Meaningful Use.

Recent accomplishments:

- Provided funding to 56 (in FY 2011) and 63 (FY 2012) states/territories/local health departments to support electronic disease surveillance for personnel and technology.
- Aggregated data from 50 states each week and shared these data with CDC programs and the general public via the *MMWR*.
- Implemented, with states, national immediate case notification guidelines to enhance reporting to CDC. These guidelines enhance CDC's ability to collect data, rapidly address health problems, and support International Health Regulations.
- Provided training and technical assistance to 12 states to receive electronic laboratory reports consistent with Meaningful Use.

In FY 2013, CDC will:

- Improve quality of and access to data on nationally notifiable diseases. CDC will use new data warehousing structures, simplify methods to access data, and expand the availability of essential disease-specific data elements (beyond core data elements routinely part of all case reports).
- Expand the adoption of ELR in each state as part of notifiable disease surveillance in order to increase the capacity of eligible health care providers to meet Meaningful Use of Electronic Health Record (EHR) standards.
- Develop and adopt standards to exchange, aggregate, analyze, and disseminate data on nationally notifiable diseases by collaborating with CDC Programs, the Council on State and Territorial Epidemiologists (CSTE), and state and territorial health departments.

Epidemiology

Program Overview: CDC contributes to health through prevention by providing scientific expertise for the Guide to Community Preventive Services (Community Guide) and technical assistance to decision makers and public health practitioners who want help in selecting and implementing recommendations; disseminating timely, useful health information through the *MMWR*; and developing innovative methods to collect, analyze, and communicate public health surveillance information.

Recent accomplishments:

- Reached all state and local health departments and over 95 percent of local boards of health with evidence-based recommendations from the Community Guide.
- Developed and distributed weekly Public Health Library and Information Center (PHLIC) Science Clips, providing applied research and prevention science to over 5,400 state and local subscribers, including some who would not have access to emerging science due to local budget cuts, and responded to over 750,000 internal requests for library print and electronic resources in support of CDC research.

- Provided timely information and recommendations for solving public health problems to over 130,000 subscribers through electronic and print communications published in the *MMWR*. Through the *MMWR*, CDC promoted good public health practices among health care professionals and supported their career development by offering free *MMWR* Continuing Education (CE) credits for reading the weekly articles and Recommendations and Reports.
- CDC Vital Signs reached over one million people with a monthly *MMWR* Early Release, Fact Sheet, and Communications package describing new analyses of the latest available data to provide a call-to-action on 12 topics of great public health importance, including prescription narcotic overdose, health care-acquired infections, asthma, and food safety.
- Supported scientists in the United States and abroad with Epi Info™, software tools that help epidemiologists collect and manage data when investigating and controlling disease outbreaks and adverse health conditions.

In FY 2013, CDC will:

- Continue to build the scientific evidence base for Community Guide recommendations by conducting and updating reviews to address significant public health problems.
- Expand support of state and local public health decision making through the PHLIC by increasing the number of subscribers to Science Clips and using innovative strategies to link Science Clips to other critical sources of public health data, such as CDC Vital Signs.
- Reach more readers with critical information about disease prevention and control in the *MMWR* by partnering with constituents in state and local health departments, colleagues overseas, clinical medicine counterparts, and colleagues across CDC including the Center for Global Health (CGH) and the Office for State, Tribal, Local, and Territorial Support (OSTLTS).

Informatics

Program Overview: CDC's informatics program uses information science and technology to improve the effectiveness and efficiency of programs to prevent disease, disability, and death. This includes the use of information technology (IT) as an integral element of CDC surveillance systems. CDC develops policies and standards for information exchange between health care providers, public health agencies, and emergency response officials. The program supports information management projects for at least 30 programs across all CDC centers, institutes, and offices through a shared informatics support model that translates public health needs into information processes that are cost effective, strategic, and congruent with the larger health IT world. The program operates critical messaging, directory, storage, emergency countermeasure inventory management, and routing systems used across the nation's public health system. CDC also works with health care organizations around EHR systems to provide prevention-oriented decision support for clinical providers. In addition, the program advances the knowledge of public health informatics and provides information on best practices to the local, state, federal, and global public health workforce.

Recent accomplishments:

- Created a cooperative agreement to bring 500 hospital labs into ELR with their respective public health agencies, and helped the nation's health departments upgrade to a new HITECH ELR standard.

- Increased the number of state and city health departments testing HITECH Act Meaningful Use-compliant electronic lab reports, immunization reports, or surveillance reports from zero to over 38 in nine months. CDC rapidly stood-up implementation guides, mapping tables, message translation and validation tools, training, and technical assistance to help public health departments keep up with fast-paced changes related to HITECH's Meaningful Use Incentive Program.
- Established an EHR-alerting pilot project in collaboration with Chicago public and private partners to provide public health alerts and reminders to clinicians during patient care.
- Implemented the new Applied Public Health Informatics Laboratory and Research Cloud, which enables CDC scientists across 22 programs to build, evaluate, and train on new public health tools and technologies. This improved selection and use of technology, at significant cost-savings, speed, and convenience, when compared to prior methods.
- Disseminated millions of public health tools through the CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) website. Over 700,000 users visited the WONDER website in FY 2011 and WONDER provided over two million customized statistics tables, charts, and maps for health departments, health planners, academics, and the general public worldwide. In FY 2011, WONDER added nine new and three updated data sets, including mortality, sexually transmitted disease, infant mortality, cancer incidence, tuberculosis, vaccination-adverse events, and influenza/pneumonia mortality. Data.gov released 11 additional "tool" descriptions regarding CDC WONDER, and the WONDER Application Programming Interface makes its content available to private application developers. CDC WONDER serviced over 29 million web requests in FY 2011, greatly reducing work for data users and CDC (the data provider) alike.

In FY 2013, CDC will:

- Use health information technology and exchange (as enhanced by the HITECH Act) to improve health and disease surveillance, immunization rates, and the delivery of preventive services. Emphasis will be on improving local and state capacity to receive and manage information from EHRs for both Stage 1 and Stage 2 of Meaningful Use, particularly implementing new secure message transport protocols, electronic lab reporting, and surveillance of biothreats, health care-acquired infections, heart health, and cancer.
- Enhance public health efficiency and effectiveness through better information management, reduce costs, and enhance interoperability using shared practices and services across multiple health information systems.
- Advance and share knowledge about how information technology can improve health outcomes through research, development, and electronic communication with health care providers and the public.

Laboratory Science, Policy, and Practice

Program Overview: CDC's laboratory science, policy, and practice program works to strengthen the capacity of public health laboratories in every state to perform their critical role in protecting the public's health. The program helps public health laboratory leaders and professionals by developing and providing science-based recommendations for best practices; providing technical assistance on rapidly evolving testing protocols, technologies, and informatics applications; delivering training in cutting-edge testing methods both in laboratories and through using distance-based methods; and supporting commercialization of CDC inventions to ensure their wide availability.

CDC serves the nation's more than 230,000 clinical laboratories by working with the Centers for Medicare and Medicaid Services (CMS) to develop regulatory standards to assure the accuracy and

reliability of clinical laboratory testing. CDC also contributes to the development of voluntary practice standards and guidelines used domestically and globally to improve laboratory testing in support of quality health care. In addition, CDC develops and disseminates companion educational products to improve practitioners' understanding and use of standards and guidelines. Through its quality improvement research program, CDC conducts studies to establish a scientific basis for policy decisions, evaluate quality gaps, and develop tools and interventions to help address the need for safe, timely, effective, efficient, equitable, and patient-centered health care.

Recent accomplishments:

- Trained over 6,300 laboratory professionals in biosecurity and biosafety best practices and in testing for influenza, tuberculosis, vaccine-preventable diseases, newborn screening, parasitology, and other key subjects in FY 2010.
- Developed CDC's first agency-wide Select Agents and Toxins Compliance Policy to assist CDC laboratories that work with select agents and toxins in complying with the federal regulation in order to guard against malicious and unintentional use of dangerous pathogens.
- Provided 830,156 specimens in FY 2011 from CDC's repository of extensive and unique biological collections to researchers in the private sector, academic institutions, and CDC programs for research that supports development of new vaccines, diagnostic tests, and health interventions on diseases and conditions such as human immunodeficiency virus (HIV), severe acute respiratory syndrome (SARS), Hantavirus, Legionnaire's disease, and lead poisoning.
- Expanded the availability of CDC-invented technologies and tools to public health and clinical care providers issuing 17 technology licenses and providing unique materials for research purposes to private firms through 20 patent-based material transfer agreements in FY 2011.

In FY 2013, CDC will:

- Develop and deliver 60 training courses in advanced public health laboratory practice to state and local public health professionals.
- Provide laboratory practice quality standards, guidelines, and educational products that serve and support clinical and public health laboratories and, as technology evolves, evaluate and address gaps in quality practices.
- Manage collections of biological specimens (totaling 5,016,840 as of December 2011) that CDC and other scientists use to identify new threats, develop vaccines, and address conditions such as lead poisoning and nutritional deficiencies.
- Promote and accelerate transfer of 30 CDC-developed diagnostic devices and other inventions. For example, provide new diagnostic tools for use by state health labs and other public health practitioners, including tests for influenza, West Nile virus, HIV, and dengue fever.
- Coordinate with public health laboratories to adopt proven, high-efficiency operating models—such as multi-state regionalization of testing and standardized test technologies—to achieve both cost efficiencies and improved quality, enabling them to reestablish and sustain essential testing capacity.

PUBLIC HEALTH WORKFORCE AND CAREER DEVELOPMENT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$36.134	$35.929	$35.695	-$0.234
ACA/PPHF	$25.000	$25.000	$25.000	$0.000
Total	**$61.134**	**$60.929**	**$60.695**	**-$0.234**

Program Overview: CDC's workforce programs help to ensure a prepared, diverse, sustainable public health workforce through experiential fellowships and high-quality training programs, including e-learning. CDC's fellowship programs provide opportunities to develop public health skills while providing service to state and local health departments. These programs also fill critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventive medicine, program management, and policy analysis. Routine placement of fellows in the field also strengthens the ability of state and local health departments to respond to public health problems and emergencies. The fellowships include the Emerging Leaders Program, Epidemic Intelligence Service (EIS), Presidential Management Fellows Program, Prevention Effectiveness Fellowship Program, Preventive Medicine Residency and Fellowship, Public Health Associate Program (PHAP), Public Health Informatics Fellowship Program (PHIFP), and Public Health Prevention Service (PHPS). As physicians take care of the health of patients during their on-the-job learning during a medical residency, public health professionals take care of the health of a population during their on-the-job training as public health fellows.

Recent accomplishments:

- Local, state, and international health agencies also request public health informatics assistance (i.e., InfoAids) from CDC. In FY 2011, CDC responded to eight InfoAids requests. Of the eight InfoAids, two of these were joint InfoAids/Epi-Aids, which provided assistance to Guam (assessed the capacity of Guam's communicable disease surveillance system to monitor mobile populations) and Ohio (examined influenza-like illness mortality in a residential facility for children and young adults with developmental disabilities).

- Forty-six PHPS fellows were assigned to state and local public health organizations in FY 2011 for two-year field assignments to address critical public health needs. The work of these fellows included coordinating a response to the incidence of *Clostridium difficile* in hospitals that resulted in a significant reduction in the level of infection among staff and patients.

- One hundred twenty-four PHAP associates were assigned to state, tribal, local, and territorial health agencies in FY 2011 as part of their two-year assignments aimed at launching them into public health-related careers. The associates serve on the frontlines of public health, providing screening services, individual and community outreach and education, infectious disease investigation services such as partner notification, and support for emergency responses to outbreaks such as foodborne diseases, seasonal diseases like influenza, or natural disasters that put communities at high risk for diseases.

- Added a new learning management system, CDC TRAIN, to the CDC Learning Connection, that provides advanced search capabilities for a catalog of over 5,000 courses. Since the launch of CDC TRAIN in August 2011, over 16,000 learners have registered.

- In FY 2011, CDC's CE Program accredited 168 new educational activities and had over 80,000 course registrations. CDC is the only HHS agency accredited to award six types of CE credits for health professionals and others.

Budget Proposal: CDC's FY 2013 request of $60,695,000 for public health workforce and career development, including $25,000,000 from the Affordable Care Act Prevention and Public Health Fund, is $234,000 below the FY 2012 level. Funds will maintain CDC's capacity to support fellowship programs that fill critical gaps in the public health workforce, provide on-the-job training, and provide continuing education and training for the health professional workforce.

In FY 2013, CDC will:

- Train the next generation of public health leaders through fellowship programs that develop public health skills through service and experiential on-the-job learning.
- Expand access to high-quality public health e-learning products and training for the health professional workforce.
- Provide instructional design services for innovative e-learning products and accredit educational activities for CE credit for a range of health professions.
- Build linkages between public health and medical care through a one-year practicum for graduates of the EIS fellowship program that will focus on patient safety and quality improvement challenges.
- Enhance support to state and local public health agencies by extending PHPS fellows' two-year field assignments through a one-year, competency-based residency. This residency will allow for the fellow to focus more exclusively on an issue or program area that the state or local area identifies as a significant challenge to the health or condition of its population.
- Strengthen public health informatics assistance to state and local public health agencies through additional field placements of PHIFP fellows and graduates.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$72.000**	**$70.000**	**$90.000**	**+$20.000**

The following activities are included:

- Health Care Surveillance/Health Statistics – $35,000,000
- Public Health Workforce Capacity – $25,000,000 (included in the Public Health Workforce narrative)
- Community Guide – $10,000,000
- Laboratory Efficiencies Initiative (LEI) – $20,000,000

Health Care Surveillance/Health Statistics

The National Health Interview Survey (NHIS), National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS) are the core data systems used to monitor the effects of the ACA. The NHIS will track the ACA impact on care access and utilization. The increase in the NHIS sample will provide stable estimates for targeted populations. The NAMCS sample of physicians will expand to permit greater precision for estimates related to care that different population groups and groups with different conditions receive. These monitoring efforts will illustrate the impact of improved access to care on prevention of illness, control of acute episodes, management of chronic conditions, and ultimately, health outcomes.

Surveys of ambulatory care through NAMCS and to hospital outpatient departments through NHAMCS will expand the data collected on clinical management and on patient's risk factors for those with heart disease and stroke during the 12 months before the sampled visit. These data and resulting analysis will permit monitoring and evaluating goals to increase prevention through health care programs and expanded insurance coverage.

CDC will provide funding to the four states and territories that have not implemented the re-engineered, web-based electronic birth record systems and 2003 U.S. Standard Birth Certificate. This will build on $2,500,000 provided in FY 2012 to implement electronic birth record systems in four states.

CDC will utilize the BRFSS to collect more detailed state-specific data for state- and sub-state adult populations on health insurance coverage, access to health care, and use of clinical preventive services than is currently available in the BRFSS. State and local health departments can use this data to: 1) establish a timely baseline for monitoring the impacts of the ACA on state health care access and utilization and 2) evaluate the impacts of the ACA on state prevalence estimates for diseases, health conditions, and risk behaviors for the leading causes of death and disability.

Community Guide

The Community Preventive Services Task Force's role is to develop additional topic areas for new recommendations and related interventions; update all existing reviews every five years; improve integration with federal government health objectives and related target setting; enhance dissemination of recommendations; provide technical assistance to health care professionals, agencies, and organizations requesting help in implementing Community Guide recommendations; and provide annual reports to Congress and related agencies in identifying gaps in research and recommending priority areas that deserve further examination.

CDC will provide ongoing administrative, research, and technical support for the operations of the Task Force. CDC will: 1) increase production of Community Guide reviews and related Task Force recommendations that address high-priority public health needs; and 2) enhance dissemination and implementation support to assist policymakers, practitioners, and other decision makers in accessing and using Task Force recommendations. These recommendations identify programs, services, and policies proven effective in a variety of real-world settings, such as communities, worksites, schools, and health plans. Task Force recommendations empower community, local, state, federal, tribal, territorial, corporate, public health, and health care decision makers to optimize resources to 1) protect and improve health, 2) reduce demand for future health care spending that is driven by preventable disease and disability, and 3) increase productivity and economic competitiveness of the U.S. workforce.

Laboratory Efficiencies Initiative (LEI)

A new effort for FY 2013 will be the Laboratory Efficiencies Initiative (LEI). The nation's public health laboratories perform critically needed services to protect the public's health and support patient treatment. But many laboratories have had to reduce or eliminate critical services because of deep budget cuts and other serious challenges. The LEI will make competitive grants to: 1) consortia of state public health laboratories to support implementation of shared testing services in regions and 2) state public health laboratories to implement high-efficiency management practices that have been proven effective in the field. Laboratories will also pilot-test additional, novel management practices for national dissemination and appropriate adoption. The LEI's strategic goal is to help assure that public laboratories in all U.S. communities have the capacity to address infectious disease outbreaks, mitigate environmental and hazardous health threats, and communicate high-quality test results rapidly to public health and clinical care decision makers. To achieve critically important, long-term sustainability, public health laboratories will use LEI financial and technical assistance to adopt such high-efficiency management practices as:

- Regionalization of testing across states and consolidation of testing services within states;

- Contracted testing services;
- Generation of new revenue streams for states;
- Procurement savings through joint purchasing and other mechanisms; and
- Adoption of cost-saving technologies and standard testing platforms.

PERFORMANCE

Program: Health Statistics

Performance Measures for Long Term Objective: Monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.A.E.1: The number of months for release of data as measured by the time from end of data collection to data release on internet (Outcome and Efficiency)	FY 2009: 7.5 (Target Exceeded)	9.4	9.3	-0.1
8.A.1.1a: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: web survey (Outcome)	FY 2011: 77.9% (Target Exceeded)	75.2%	75.2%	Maintain
8.A.1.1b: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: federal power users (Outcome)	FY 2011: 100% Good or Excellent (Target Met)	100% Good or Excellent	100% Good or Excellent	Maintain
8.A.1.3: Number of web visits as a proxy for the use of NCHS data[2] (Output)	FY 2010: 8.7 Million (Target Exceeded)	8.5 Million	10.5 Million	+2
8.E: Number of key elements of the health care system for which data are collected (Output)	FY 2011: 3 (Target Met)	3	3	Maintain
8.F: Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey (Output)	FY 2011: 15 (Target Met)	15	15	Maintain
8.G: Number of households interviewed in the National Health Interview Survey[1,3] (Output)	FY 2011: 39,926[4] (Target Not Met but Improved)	46,500	55,000	+8,500
8.H.1: Number of physicians surveyed in the National Ambulatory Medical Care Survey[1,3] (Output)	FY 2011: 4,012 (Target Exceeded)	10,200	12,000	+1,800

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.H.2: Number of patient visit records surveyed in the National Ambulatory Medical Care Survey[1,3] (Output)	FY 2011: 40,000 (Target Exceeded)	90,000	100,200	+10,200
8.I: Number of states funded to provide electronic birth records (either completely or in part) [1,3] (Output)	FY 2011: 0 (Historical Actual)	4	4	Maintain

[1]Some targets reflect ACA/PPHF funding.

[2] Results for FY 2011 are not reported due to Omniture technical issues which prevented collection of site visits due to RSS traffic. Results will be available for FY 2012.

[3]The increase in NHIS, NAMCS and electronic birth records will vary depending on when funds are received.

[4]The target improved but was not met by 74 households (out of a 1,000 household increase).

Performance Trends: CDC collaborated with the National Association for Public Health Statistics and Information to improve the timeliness and quality of information derived from vital records and vital registration systems operated by cities, states, and territories. Thirty-eight states, the District of Columbia, and New York City re-engineered birth registration systems, corresponding to 87 percent of all births in the United States, by the end of FY 2011. By January 2014 CDC expects that all jurisdictions will submit birth records electronically (8.I). In addition, 38 states re-engineered death registration systems, but a substantial number of these systems were not fully implemented at the state and local level and among the key data providers, such as physicians.

Over the last few years, CDC increased the number of interviews for two surveys—National Health Interview Survey and National Ambulatory Medical Care Survey. In addition, in order to monitor and inform current national health reform efforts, CDC will increase the sample size of these two surveys in FY 2013 to demonstrate the impact of improved access to care on prevention of illness, management of chronic conditions, and ultimately, health outcomes (8.G, 8.H). The following indicators help the program measure its ability to provide useful, timely, and high-quality data:

- Assess the number of months for release of data. CDC exceeded the target of 9.7 months and released FY 2009 data within 7.5 months (8.A.E.1).
- Assessing user satisfaction drives program improvements. In 2011, CDC interviewed Federal Power Users (users in HHS sister agencies) to assess their satisfaction with CDC products and services including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. CDC met the target of 100 percent Good or Excellent (Measure 8.A.1.1b).

Program: Surveillance, Epidemiology, and Laboratory Services

Performance Measures for Long Term Objective: Lower barriers to data exchange across jurisdictions for public health surveillance and response

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.1.2: Increase the number of jurisdictions that can send at least one type of electronic message to CDC in compliance with published standards (Output)	FY 2011: 30 (Target Met)	42	43	+1

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.1.2: Increase the number of jurisdictions that can send at least one type of electronic message to CDC in compliance with published standards (Output)	FY 2011: 30 (Target Met)	42	43	+1
8.A: Increase the number of metropolitan/ micropolitan statistical areas (i.e. local) for which BRFSS[1] data is available[2] (Output)	FY 2010: 194 (Historical Actual)	150	150	Maintain
8.K: Sustain the number of states developing NEDSS-compatible systems, in deployment, or lie with the NEDSS[3] Base System (Output)	FY 2011: 50 (Target Met)	50	50	Maintain

[1]Behavioral Risk Factor Surveillance System

[2]Targets reflect ACA/PPHF funding

[3]National Electronic Disease Surveillance System

Performance Measures for Long Term Objective: Improve access to and reach CDC's scientific health information among key audiences to maximize health impact

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.2.1: Provide health information to health professionals and partner organizations (e.g. state and local health departments) in order to educate, inform and improve health outcomes (system approaches to health) a. Increase the number of subscribers to the Morbidity and Mortality Weekly Report (MMWR) (Outcome)	FY 2011: 139,210 (Target Exceeded)	145,648	152,085	+6,437
8.B.2.2: Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets (Output)	FY 2011: 1,113,531 (Target Exceeded)	1,169,208	1,215,976	+46,768
8.B.2.5: Increase awareness and use of the Guide to Community Preventive Services, and Task Force findings and recommendations, using page views as proxy[4] (Outcome)	FY 2011: 927,357 (Baseline)	973,724	1,032,147	+58,423

[4]Targets reflect ACA/PPHF funding

Performance Measures for Long Term Objective: Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies; and prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.3.1: Evaluate the impact of National Laboratory Training Network training programs on laboratory practices (Outcome)	FY 2011: 66.2% (Target Met)	More than 50% of public health and clinical laboratorians attending NLTN public health laboratory workshops either updated or improved laboratory policies or practices as a result of the training.	More than 50% of public health and clinical laboratorians attending NLTN public health laboratory workshops either updated or improved laboratory policies or practices as a result of the training.	No Change

Behavioral Risk Factor Surveillance System (BRFSS) Performance Trends: In FY 2011 CDC completed over 400,000 BRFSS interviews. As a result of BRFSS's uniquely large sample size, CDC began meeting the growing demand for localized information by increasingly providing sub-state level BRFSS data. The number of metropolitan and micropolitan statistical areas (MMSA) with available BRFSS data increased from 177 in 2008 to 194 in 2010, although the 2010 figure reflects a special, triennial survey conducted by Florida sampling every county in the state. CDC expects the number of MMSAs to decline to 150 in FY 2012 and FY 2013 (Measure 8.A). This decline reflects the anticipated reduction in the BRFSS total sample size as states decrease the landline sample in order to increase the cell-phone sample. Cell phone interviews are relatively more costly, but are necessary to capture health behaviors within the 18-44 year old age group, which constitutes nearly half of the U.S. adult population and more frequently relies on cellular telephones than landline telephones. Additionally, CDC will change the surveillance analysis methodology for MMSAs in FY 2012, requiring the completion of a greater number of county-level surveys (from 250 to 500 starting in FY 2012).

National Notifiable Disease Surveillance System (NNDSS) Performance Trends: CDC uses data from NNDSS to identify opportunities for immediate disease control and prevention, monitor trends and the effectiveness of prevention and control activities, conduct program planning and evaluation, develop public health policy, and conduct research. NNDSS provides funds from the ELC cooperative agreement to state, territory, and local health departments to build and maintain epidemiologic and surveillance capacity to support electronic disease reporting and information exchange using a compatible National Electronic Disease Surveillance System (NEDSS). Currently, 18 states and Washington, D.C. use the CDC-developed NEDSS-Base System, 28 states use a state- or vendor-developed NEDSS-compatible system, and the remaining four states are either in the process of adopting or changing their NEDSS-compatible system. As a result, jurisdictions are able to implement integrated surveillance systems to improve their ability to identify cases of illness, manage investigation and response activities, and allow data analyses for public health action. Further, jurisdictions improved their ability to exchange data electronically with partners for surveillance purposes (Measure 8.K).

Epidemiology Performance Trends: CDC disseminated recommendations for solving public health problems to over 130,000 clinicians, epidemiologists, laboratorians, and other public health professionals

through electronic and print communications published in the *MMWR*. The number of *MMWR* subscribers increased by approximately 30,000 since 2008. Electronic subscribers increased by over 10 percent in FY 2011 (Measure 8.B.2.1). Similarly, electronic media reach of CDC Vital Signs—a monthly *MMWR* feature that targets public, health care professionals, and policymakers—increased to over one million in the program's first year, exceeding the target (Measure 8.B.2.2). CDC measures Vital Signs media reach by page views (www.cdc.gov/vitalsigns) and followers on social media groups. The audience exposed to Vital Signs in all forms, which far exceeded expectations, expanded due to growing print, broadcast, and cable media interest. Due to media saturation, CDC does not expect continued growth in this manner, making this a unique occurrence. Therefore, CDC expects slower, sustainable growth in 2012 and beyond.

CDC established a performance measure to track awareness and use of Community Guide findings and recommendations (8.B.2.5). In the short term a proxy measure—page views of the Community Guide website (www.thecommunityguide.org)—will monitor awareness. In 2011 CDC experienced 927,357 page views on the Community Guide website. CDC is currently developing a baseline of state and local awareness and use to measure how decision makers use the Community Guide's evidence-based recommendations and findings. Additionally, CDC tracks the number of reviews completed by the Community Guide; the Community Guide completed nine reviews in FY 2011, including updates of earlier reviews.

Informatics Performance Trends: In FY 2011 Public Health Information Network (PHIN) standards enabled 21 states to demonstrate their capability to exchange public health alerts across state lines within one hour. In FY 2011 CDC met its target of 30 unique jurisdictions capable of electronically exchanging public health data for infectious disease cases with CDC using Public Health Information Network standards (Measure 8.B.1.2). By December 2011 CDC certified 30 jurisdictions for electronic tuberculosis (TB) notifications, 22 jurisdictions for *Varicella* notifications, and six jurisdictions for a generic notification for multiple diseases.

Laboratory Science Performance Trends: In FY 2011, 66.2 percent of the public health and clinical laboratorians who completed the CDC and National Laboratory Training Network (NLTN) training on biosecurity and biosafety reported the ability to upgrade key practices (Measure 8.B.3.1). CDC collected performance data through course reaction evaluations, pre- and post-tests, and impact surveys six months after the training. CDC then analyzed data to determine trainees' improvement in knowledge and practice and improve the training curriculum. For state public health laboratory trainers who complete a prerequisite train-the-trainers course, CDC annually updates and disseminates the biosafety and biosecurity course so they can deliver training to professionals in sentinel clinical laboratories throughout the country.

Program: Public Health Workforce and Career Development[5]

Performance Measures for Long Term Objective: CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management[6] (Output)	FY 2011: 218 (Target Exceeded)	200	200	Maintain

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management[6] (Output)	FY 2011: 218 (Target Exceeded)	200	200	Maintain
8.B.4.2: Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies[7] (Output)	FY 2011: 309 (Target Exceeded)	237	248	+11
8.B.4.3: Maintain the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies[8] (Output)	FY 2011: 197 (Target Exceeded)	176	176	Maintain

[5]Targets reflect ACA/PPHF funding.

[6]8.B.4.1 includes all (new and continuing) CDC-funded trainees in the Epidemic Intelligence Service (EIS), Public Health Prevention Service (PHPS), and Preventive Medicine Residency/Fellowship (PMR/F).

[7]8.B.4.2 includes all (new and continuing) CDC-funded trainees in EIS, PHPS, PMR/F, Public Health Informatics Fellowship Program (PHIFP), Public Health Associate Program (PHAP), Emergency Infectious Diseases (EID) Laboratory Fellowship, CDC/CSTE Applied Epidemiology Fellowship, Post-EIS Practicum (PEP), PHPS Residency, and Applied Public Health Informatics Fellowship (APHIF) assigned to state, tribal, local, and territorial public health agencies.

[8]8.B.4.3 includes new CDC-funded trainees in EIS, PHPS, PMR/F, PHIFP, Prevention Effectiveness Fellowship (PEF), Presidential Management Fellows (PMF) program , and PHAP.

Performance Trends: In 2011, 78 percent of CDC's unique fellowship programs' graduates pursued careers in public health, which contrasts with the less than 25 percent of graduates of schools of public health who pursue careers in public health practice. Measures 8.B.4.1 and 8.B.4.3 assess continued contributions to the public health workforce pipeline through CDC's experiential fellowship programs. Measure 8.B.4.1 assesses the number of new and continuing trainees in three long-standing CDC fellowship programs. Measure 8.B.4.3 assesses the annual change in the number of new trainees in a larger set of CDC's fellowship programs. In FY 2011, CDC exceeded its targets for these two measures. CDC sets the targets based on the typical, annual class size for each of the fellowship programs included in this measure.

CDC helps bolster the public health workforce capacity for state and local partners through several key initiatives and efforts. Measure 8.B.4.2 assesses CDC's increased support to state, tribal, local, and territorial (STLT) public health agencies through the placement of field trainees. By FY 2011 CDC increased the number of fellows in STLT public health agencies from 119 trainees in 2009 to 309 , exceeding the FY 2011 target. CDC also created the Post-Epidemic Intelligence Service Practicum, Public Health Prevention Service Residency, and Applied Public Health Informatics Fellowship in FY 2011 using Prevention and Public Health (PPHF) support. These programs will retain 22 fellowship graduates——for a one-year practicum at the state and local level. This will strengthen workforce capacity in several critical disciplines, such as applied epidemiology, public health management, and informatics. At the end of FY 2011, 309 field trainees (210 supported by PPHF) were on assignment in 43 states, Washington, D.C., Puerto Rico, and three tribal locations. This measure supports HHS Strategic Plan Goal Five, Objective C.

IT INVESTMENTS

Because of investments in health IT, CDC's public health scientific services program can more rapidly and efficiently collect, monitor, analyze, respond to, and disseminate public health information. These investments have developed and continue to support the detection and management of secure epidemiologic surveillance and laboratory science standard vocabularies, message formats, infrastructure, and systems. Investments in IT support multiple programs within CDC and state, local, and tribal health departments across the country. IT investments create the framework and systems necessary to monitor and track outbreaks, epidemics, and pandemics. These investments lay the groundwork for building interoperability between state, local, and tribal health jurisdictions and the CDC, as well as between and across the health jurisdictions themselves.

IT investments include:

- The Public Health Information Network (PHIN): Laboratory Response Network (LRN) Real Time Laboratory Information Exchange efforts equip LRN laboratories to share data securely with public health partners in real time to ensure the quality and availability of LRN data and decrease the time needed to detect and respond to public health threats.
- Epi Info™ is a suite of software tools for public health professionals for ad hoc data gathering, analytical needs, or as a rapid development environment for quickly programming public health focused outbreak and surveillance data applications.
- Public Health Laboratory Interoperability Solutions and Solution Architecture (PHLISSA) supports the Meaningful Use of EHRs through two-way communications between clinicians and national, state, and local public health entities.
- CDC WONDER, a web-based data dissemination system that provides statistical analysis, visualization, and reporting of CDC surveillance data available to public health professionals and the general public.
- The NVSS collects data from the vital records of states and then processes, tabulates, analyzes, and disseminates demographic and medical information related to all recorded births and deaths in the United States.
- National Health Interview Survey data are used to characterize the health level of the non-institutionalized U.S. population and a number of subgroups to address a wide range of health-related issues.

STATE TABLE[1,2]

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2011 Appropriation**	**FY 2012 Enacted**	**FY 2013 President's Budget**	**FY 2013 +/- FY 2012**
Alabama	$166,373	$166,373	$166,373	0
Alaska	$317,147	$317,147	$317,147	0
Arizona	$272,871	$272,871	$272,871	0
Arkansas	$289,386	$289,386	$289,386	0
California	$282,621	$282,621	$282,621	0

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2011 Appropriation**	**FY 2012 Enacted**	**FY 2013 President's Budget**	**FY 2013 +/- FY 2012**
Colorado	$316,320	$316,320	$316,320	0
Connecticut	$239,377	$239,377	$239,377	0
Delaware	$176,410	$176,410	$176,410	0
District of Columbia	$220,559	$220,559	$220,559	0
Florida	$261,678	$261,678	$261,678	0
Georgia	$148,789	$148,789	$148,789	0
Hawaii	$267,909	$267,909	$267,909	0
Idaho	$321,681	$321,681	$321,681	0
Illinois	$170,431	$170,431	$170,431	0
Indiana	$208,050	$208,050	$208,050	0
Iowa	$202,800	$202,800	$202,800	0
Kansas	$340,356	$340,356	$340,356	0
Kentucky	$220,069	$220,069	$220,069	0
Louisiana	$162,338	$162,338	$162,338	0
Maine	$230,858	$230,858	$230,858	0
Maryland	$263,672	$263,672	$263,672	0
Massachusetts	$269,236	$269,236	$269,236	0
Michigan	$240,043	$240,043	$240,043	0
Minnesota	$253,795	$253,795	$253,795	0
Mississippi	$197,821	$197,821	$197,821	0
Missouri	$196,157	$196,157	$196,157	0
Montana	$272,543	$272,543	$272,543	0
Nebraska	$214,900	$214,900	$214,900	0
Nevada	$297,268	$297,268	$297,268	0
New Hampshire	$236,390	$236,390	$236,390	0
New Jersey	$178,034	$178,034	$178,034	0
New Mexico	$309,716	$309,716	$309,716	0
New York	$248,698	$248,698	$248,698	0
North Carolina	$216,917	$216,917	$216,917	0
North Dakota	$223,679	$223,679	$223,679	0
Ohio	$244,882	$244,882	$244,882	0
Oklahoma	$210,691	$210,691	$210,691	0
Oregon	$306,498	$306,498	$306,498	0
Pennsylvania	$191,276	$191,276	$191,276	0
Rhode Island	$185,923	$185,923	$185,923	0
South Carolina	$255,074	$255,074	$255,074	0
South Dakota	$189,170	$189,170	$189,170	0
Tennessee	$198,151	$198,151	$198,151	0
Texas	$260,112	$260,112	$260,112	0
Utah	$288,769	$288,769	$288,769	0

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2011 Appropriation**	**FY 2012 Enacted**	**FY 2013 President's Budget**	**FY 2013 +/- FY 2012**
Vermont	$190,707	$190,707	$190,707	0
Virginia	$206,347	$206,347	$206,347	0
Washington	$292,434	$292,434	$292,434	0
West Virginia	$272,646	$272,646	$272,646	0
Wisconsin	$191,367	$191,367	$191,367	0
Wyoming	$306,063	$306,063	$306,063	0
State Sub-Total	$12,225,002	$12,225,002	$12,225,002	0
America Samoa	0	0	0	0
Guam	$192,862	$192,862	$192,862	0
Marshall Islands	0	0	0	0
Micronesia	0	0	0	0
Northern Marianas	0	0	0	0
Puerto Rico	$207,602	$207,602	$207,602	0
Palau	$29,530	$29,530	$29,530	0
Virgin Islands	$114,342	$114,342	$114,342	0
Territory Sub-Total	**$544,336**	**$544,336**	**$544,336**	**0**
Total States/Territories	**$12,769,338**	**$12,769,338**	**$12,769,338**	**0**

[1]Table does not include ACA/PPHF funding.

[2]This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/.

ENVIRONMENTAL HEALTH

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$134.855	$104.998	$103.672	-$1.326
ACA/PPHF	$35.000	$35.000	$29.000	-$6.000
Total	**$169.855**	**$139.998**	**$132.672**	**-$7.326**
FTEs	455	453	452	-1

Authorizing Legislation: PHSA §§ 301, 307, 310, 311, 317, 317A, 317B, 317I, 327, 352, 361, 366, 1102; Toxic Substances Control Act, § 405(c) (15 U.S.C. 2685)

FY 2013 Authorization..... Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $132,672,000 for environmental health, including $29,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall decrease of $7,326,000 below the FY 2012 level.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Environmental Health Laboratory	$42.628	$42.383	$42.394	+$0.011
Environmental Health Activities	$35.526	$35.322	$33.962	-$1.360
Healthy Home and Community Environments	$56.701	$27.293	$27.316	+$0.023
Asthma (non-add)	$27.444	$25.298	N/A	N/A
Healthy Homes/Childhood Lead Poisoning (non-add)	$29.257	$1.995	N/A	N/A
Environmental Health Tracking Network (ACA/PPHF)	$35.000	$35.000	$29.000	-$6.000
Total	**$169.855**	**$139.998**	**$132.672**	**-$7.326**

CDC's environmental health programs prevent illness, disabilities, and premature death caused by environmental exposures. In particular, CDC's environmental health programs protect the health of vulnerable populations, such as children, older adults, and people with disabilities, compromised immune systems, or chronic conditions. These programs also serve as the CDC leads for environmental emergencies like natural disasters and radiologic and/or chemical emergencies caused by natural or man-made events like terrorist attacks.

Recent data show that investments in CDC's environmental health programs are yielding results. Two examples are CDC's national programs to reduce childhood lead exposure and national programs to control asthma. Between 2008 and 2010, CDC-supported efforts to reduce childhood lead exposure saved $7.5 billion in increased lifetime productivity because 200,000 fewer children suffered these dangerous exposures. CDC's national asthma control program reduced medical costs and saved lives. CDC's national asthma control programs help people control their asthma, stay out of the hospital, and miss less school and work. Trends over the last 10 years show that more people with asthma are living with their disease under control, which means lower medical costs and saved lives. For example, in 2008, our nation

saved $4 billion in medical costs because 245,000 fewer people were hospitalized due to asthma. More importantly, 1,400 fewer Americans now die from the disease.

CDC's Environmental Health Laboratory provides unique laboratory science. Biomonitoring methods supported by the program measure more than 300 chemicals in blood and urine and provide data for more than 50 studies per year assessing exposure and health effects. The program provides accurate testing for congenital diseases in more than 98 percent of newborns in the United States to identify 5,000 to 6,000 babies with treatable diseases each year that may have otherwise died or been severely disabled. In the area of terrorism response, the laboratory has a mass spectrometry method for anthrax lethal factor that detects disease 24 hours before symptoms start and is critical to identifying anthrax exposures during a bioterrorism event. In the area of chronic diseases, the program has developed a first-time method to measure trans fats in people, successfully used to track extent of population exposure and demonstrate the effectiveness of interventions. These are but a few of the successful programs in this area.

CDC's Environmental Public Health Tracking program is connecting environmental exposure with health indicators yielding essential information helping to diagnose how the environment is influencing disease.

This program supports key public actions to protect people from possible threats posed by environmental exposures and, according to the Public Health Foundation, could save up to $1.44 for every $1 invested . In 2011, 24 states used data generated by the program in a myriad of ways to protect the public by determining disease impacts and trends, recognizing clusters and outbreaks, and identifying populations and geographic areas most affected. For example, the program has quickly identified clusters of pre-term births associated with traffic exposure in California, quantified indoor pollution levels associated with tobacco exposure in Oregon showing three times the acceptable pollution exposure levels identified by the Environmental Protection Agency (EPA), and evaluated community concerns about cancer clusters in Massachusetts showing an unexpected spike in oral cancers.

Access to clean water, clean air, healthy food, and healthy housing are critical components of health and disease prevention. For example, acute foodborne illnesses cost the United States an estimated $152 billion per year in health care, workplace, and other economic losses. CDC's state and community environmental health programs are helping people improve their lives and save money by protecting them from these environmental threats and exposures.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$154.486
2009	$185.415
2010	$181.004
2011	$134.855
2011 (ACA/PPHF)	$35.000
2012	$104.998
2012 (ACA/PPHF)	$35.000

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment

ENVIRONMENTAL HEALTH LABORATORY BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$42.628**	**$42.383**	**$42.394**	**+$0.011**

Program Overview: CDC's Environmental Health Laboratory is globally recognized as an advanced state-of-the-art laboratory providing unique laboratory science that improves the detection, diagnosis,

treatment, and prevention of diseases resulting from exposure to toxic chemicals in the environment and selected other diseases that need advanced laboratory measurement for accurate diagnosis. The Environmental Health Laboratory assesses population and individual exposure to environmental chemicals using unique and high-quality measurements in blood and urine (biomonitoring); assures the quality of selected diagnostic tests essential for early disease detection, such as nationwide newborn screening for treatable diseases that cause malformation, mental retardation, and death; provides standardization for cholesterol and selected other diagnostic tests for chronic diseases so that results are sufficiently accurate for correct clinical use; develops and applies innovative laboratory methods to respond to emergencies, including disease and death from unknown causes; develops and applies new methods to diagnose and assess risk for disease; and conducts and collaborates in studies of populations exposed to environmental chemicals to better determine safe and unsafe human exposure levels. CDC is the sole or primary source for high-quality laboratory tests for many priority environmental chemicals, such as biphenyl-A (BPA), speciated arsenic, uranium, speciated mercury, volatile organic compounds (VOCs), phthalates, triclosan, select radionuclides (including polonium-210, cesium-134, cesium-137, and iodine-131), and many others.

Recent accomplishments:

- Provided a portable blood lead instrument and laboratory assistance for a lead poisoning outbreak in Nigeria, where 118 children under the age of five in two remote mining villages died and 97 percent of children tested had blood-lead levels ≥45 μg/dL, the threshold for initiating chelation therapy. CDC staff used the Lead Care II instrument to rapidly identify exposed children on-site, enabling life-saving medical treatment.

- Provided laboratory studies and method improvements that substantially supported the addition of Severe Combined Immunodeficiency (SCID) to the Secretary of HHS's Recommended Uniform Newborn Screening Panel, including sponsoring pilot studies in Wisconsin and Massachusetts and ensuring testing quality. SCID is the first condition to be added to the original panel of 29 conditions after a scientific review process was established and is the first molecular test to be included; states are using the Secretary's Recommended Panel to begin discussions regarding adding SCID to state newborn screening panels.

- Demonstrated the impact of voluntary discontinuation of the use of perfluorooctane sulfonic acid (PFOS) by measuring a substantial reduction in human exposure to PFOS, following the end of production in 2002. CDC's Biomonitoring Program had previously documented widespread human exposure to PFOS in the United States.

- Developed an accurate and specific method to monitor vitamin D blood levels in populations. The method detects vitamin D from sunlight, diet, and supplement sources, and is essential to evidence-based investigations that relate disease risk and low vitamin D status and develop cost- and life-saving interventions for deficiency.

- Improved the accuracy and comparability of numerous laboratory measurements, including the Hormone Standardization (HoSt) Program's new testosterone test that more accurately diagnoses polycystic ovary syndrome, adrenal cancers, and other diseases of androgen excess and deficiency.

Budget Proposal: CDC's FY 2013 request of $42,394,000 for the environmental health laboratory is $11,000 above the FY 2012 level.

In FY 2013, CDC will:

- Conduct laboratory measurements for 50 studies that examine exposure of vulnerable population groups to environmental chemicals, or that investigate the relationship between exposure levels and adverse health effects. CDC's high-quality exposure measurements contribute substantively to identifying safe and unsafe levels of exposure, identifying potential health impacts of human exposure to chemicals in our environment, helping to avoid unnecessary regulation identifying true hazards, and protecting lives and reducing health care costs.
- Measure and report on the U.S. population's nutritional status and exposure to environmental chemicals. CDC will release the *2nd National Report on Biochemical Indicators of Diet and Nutrition in the US Population*, which is the most extensive assessment ever done of the nutritional status of the U.S. population. Measuring and tracking over time the presence and amount of environmental chemicals and nutritional indicators in humans identifies at-risk population groups and assesses the effectiveness of interventions to reduce harmful environmental exposures and improve nutritional status.
- Develop new and improved biomonitoring methods for priority environmental chemicals and develop new and improved methods to measure nutritional indicators and dietary bioactive compounds.
- Provide biomonitoring technical support, training, quality assurance, and technology transfer to state and local laboratories to support investigations of known and potentially unsafe exposures.
- Continue funding biomonitoring programs in California, New York, and Washington to increase national capacity and technical expertise in measuring human exposure to environmental chemicals and to assess specific exposures of concern in states.

Biomonitoring Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	16	16	16
Average Award	$0.358	$0.358	$0.358
Range of Awards	$0.005–$2.652	$0.005–$2.652	$0.005–$2.652
Number of New Awards	10	1	2
Number of Continuing Awards	6	15	14

ENVIRONMENTAL HEALTH ACTIVITIES BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Environmental Health Activities	$35.526	$35.322	$33.962	-$1.360
Environmental Health Tracking Network (ACA/PPHF)	$35.000	$35.000	$29.000	-$6.000
Total	**$70.526**	**$70.322**	**$62.962**	**-$7.360**

Program Overview: CDC supports environmental public health activities to save lives, protect people, and reduce medical costs. These activities build federal, state, and local capacity to address environmental health hazards and respond to public health needs. Within this framework, CDC's Environmental Health

activities include an expansive range of environmental health programs and services, from ensuring food and water free of environmental contaminants and ensuring appropriate sanitation to providing expert technical assistance during emergency responses like the recent nuclear events in Japan and the Deep Water Horizon oil spill in the Gulf of Mexico. These activities provide significant public health benefits to the American public.

Recent accomplishments:

- Provided radiation dose estimates and technical expertise for a Food and Drug Administration-(FDA) requested Epi-Aid investigation to help assess exposures to radioactive strontium among patients who received rubidium-82 infusions for position emission tomography (PET) cardiac imaging scans.
- Expanded the use of Health Impact Assessments (HIAs) to guide public health decisions by training over 600 health, planning, and community design professionals; completing five HIAs; and creating HIA tools for local jurisdictions. This pilot program in only four states has provided communities in those states with data to assess several policy changes, including a restriction on alcohol outlets, comprehensive plans that support walking and bicycling, and design modifications to reduce motor vehicle fatalities.
- Developed tailored training materials, survey instruments, and sustainable clean water and sanitation strategies in response to the Haiti cholera outbreak.
- Continued to provide technical assistance to CDC-Kenya and the Kenyan Ministry of Public Health and Sanitation in response to outbreaks of aflatoxicosis.
- Funded eight states to identify exposures, assess well-monitoring coverage, evaluate regional water issues, and identify and prioritize areas for intervention in order to ensure safe and plentiful drinking water for the nearly 39 million Americans using private wells or other small water systems.
- Launched the Climate Ready States and Cities Initiative to provide funding and technical support to eight states and two city health departments to investigate, prepare for, and respond to climate-related health impacts.
- Provided critical health expertise to the White House; State Department; and state, local, and tribal governments in response to radiation releases related to the March 2011 earthquake and resulting tsunami in Japan.
- Investigated with the American Red Cross tornado-related deaths in Alabama to identify risk and protective factors and prevent future tornado-related fatalities. On April 27, 2011, 67 tornadoes including several powerful (EF-4, EF-5) tornadoes tore through Alabama, killing 258 people.

Budget Proposal: CDC's FY 2013 request of $62,962,000 for environmental health activities, including $29,000,000 from the Affordable Care Act Public Health and Prevention Fund, is an overall decrease of $7,360,000 below the FY 2012 level. This level includes a reduction to climate change activities and the elimination of the Built Environment activities; CDC will aim to integrate aspects of the former Built Environment activities into the Community Transformation Grants, supported by the ACA Prevention and Public Health Fund in order to have a more integrated approach. The FY 2013 budget request also reduces funding for studying and addressing the impacts of climate on health. This will reduce surveillance and early warning system capacity. The budget also includes a redirection of $3.752 million to support core environmental health activities.

In FY 2013, CDC will:

- Protect the public's health in the event of a radiological emergency.

- Respond to harmful exposures and advance the identification of potentially harmful human exposures and/or contamination related to ionizing radiation.
- Study methods to communicate information about radiation exposures and/or contamination to the public, responders, and clinicians.
- Providing emergency response training for state and local workers to help protect the public during and after natural and man-made catastrophes. This training focuses on restoring clean drinking water, proper sewage disposal, ensuring food safety, preventing spread of diseases by mosquitoes and rodents, etc., and inspecting mass shelters to prevent the spread of infectious diseases. CDC also trains state and local workers to conduct disease, injury, and death surveillance following a disaster.
- Provide technical support for states to participate in the new surveillance system: National Voluntary Environmental Assessment Information System (NVEAIS). Each year, one out of six Americans get sick from and 3,000 die of foodborne diseases. Reducing foodborne illness by 10 percent would keep five million Americans from getting sick each year. NVEAIS is a data collection system critical to identify underlying environmental causes of foodborne and waterborne illness outbreaks and developing effective measures to prevent outbreaks.
- Protect American lives by overseeing the U.S. Army's chemical weapons destruction program to ensure that the workers who are destroying the chemical weapons and the people living near the destruction sites are not exposed to the chemical agents or other dangerous chemicals resulting from the destruction process.
- Provide training and technical assistance for on-the-ground local, state, and tribal environmental health practitioners involved in front-line pest control programs (e.g. mosquitoes, bedbugs, rodents) to prevent vector-borne diseases from taking hold in local communities.
- Support state participation in the Environmental Health Specialist Network (EHS-Net) to carry out research used by states, CDC, FDA, and others to inform policy decisions related to preventing foodborne and waterborne illness outbreaks.
- Fund seven health departments to address the impact of climate change on human health.
- Investigate and recommend strategies to reduce water related exposure and health risks for people using drinking water systems that are not protected by the Safe Drinking Water Act.
- Fund eight states through a cooperative agreement to identify exposures, assess well monitoring coverage, evaluate regional water issues, and identify and prioritize areas for intervention.

Safe Water (Previously Pfiesteria) Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	26	26	26
Average Award	$0.092	$0.092	$0.092
Range of Awards	$0.030–$0.140	$0.030–$0.140	$0.030–$0.140
Number of New Awards	8	25	21
Number of Continuing Awards	18	1	5

HEALTHY HOME AND COMMUNITY ENVIRONMENTS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Healthy Home and Community Environments	$56.701	$27.293	$27.316	+$0.023
Asthma (non-add)	$27.444	$25.298	N/A	N/A
Healthy Homes/Childhood Lead Poisoning (non-add)	$29.257	$1.995	N/A	N/A
Total	**$56.701**	**$27.293**	**$27.316**	**+$0.023**

Program Overview: In FY 2013, CDC proposes the creation of a Healthy Home and Community Environments program—a new, multi-faceted approach to address healthy homes and community environments through surveillance, partnerships, and implementation and evaluation of science-based interventions to address the health impact of environmental exposures in the home and to reduce the burden of disease through comprehensive asthma control. This integrated approach aims to control asthma and mitigate health hazards in homes and communities such as air pollution, lead poisoning hazards, second-hand smoke, asthma triggers, radon, mold, unsafe drinking water, and the absence of smoke and carbon monoxide detectors. The consolidated program will replace CDC's long-standing National Asthma Control Program and Healthy Homes and Lead Poisoning Prevention Program. CDC will take two years to transition to this new, coordinated approach.

Lead poisoning remains an important public health issue in the United States, and CDC remains committed to eliminating childhood lead poisoning. There is no safe level of exposure to lead; any exposure to lead can reduce brain development and children's Intelligence Quotients. For every one microgram per deciliter increase in blood lead levels, there is a $3,220 loss in productivity. Though the levels in children have dropped over time, in 2010, approximately 650,000 children had blood lead levels above five micrograms per deciliter.[9,10] Most people spend over 90 percent of their time indoors and about half of every day inside their homes. Under the new consolidated Healthy Home and Community Environments program, CDC will continue to collaborate with states and other federal agencies to reduce or eliminate multiple housing-related health hazards, including lead poisoning hazards, second-hand smoke, asthma triggers, radon, mold, unsafe drinking water, and the absence of smoke and carbon monoxide detectors. CDC will support state and local data collection via CDC's Healthy Homes and Lead Poisoning Prevention Surveillance System. This data will be used by the U.S. Department of Housing and Urban Development and other federal, state, and local agencies to target the most vulnerable populations living in homes with lead-based paint hazards.

Asthma remains a common disease with significant health disparities and associated health care costs. The number of people with asthma continues to grow, now reaching almost 25 million. CDC has been working with state health departments for over 10 years to conduct surveillance, build coalitions, and implement evidence-based interventions to address the burden of asthma and ensure that asthma control and management are available to those in need. Under the new consolidated Healthy Home and Community Environments program, CDC will continue to support evidence-based comprehensive asthma control programs in state health departments. CDC will provide limited surveillance of asthma prevalence and control and will support the training of health professionals and the education of patients, families, and the public on how to improve asthma self-management and control.

[9]National Surveillance Data 2008.
[10]Barnett SBL, Nurmagambetov TA. "Costs of Asthma in the United States: 2002–2007." J Allergy Clin Immunol 2011;127:145–52.

Recent accomplishments:

- Funded 34 states, Puerto Rico, and Washington, D.C. to implement evidence-based, comprehensive asthma programs to reduce the morbidity and mortality of people with asthma living in their states. Impacts include:
    - Improved primary care for asthma and other chronic health conditions in Rhode Island using a team approach, quality improvement methods, and electronic patient monitoring.
    - Funded Montana community-based programs in areas with a greater burden of asthma, particularly those low-income, rural, and tribal communities that are at increased risk for exposure to asthma triggers. These programs provide education on asthma triggers and assistance to schools and daycares to improve building air quality.
    - Developed a training curriculum to integrate environmental asthma management into pediatric health care practice through the Hawaii Community Rural Asthma Control Program.
- Analyzed and released data showing that while asthma prevalence increased, deaths due to uncontrolled asthma decreased in CDC's Vital Signs, "Asthma in the U.S.: Growing Every Year," in May 2011. The *MMWR*, fact sheet, and related materials provide new prevalence and cost data, as well as key recommendations for federal, state, and local policymakers; health care providers; schools; people with asthma; and parents of children with asthma.
- Trained more than 11,000 public health workers in the principles of Healthy Homes. This includes how to identify and implement low-cost, reliable methods to reduce lead and other health and safety risks in substandard housing.
- Deployed the new Healthy Homes and Lead Poisoning Surveillance System in 17 states and Washington, D.C. to gather information on housing-related health hazards.
- Partnered with stakeholders involved with immigrant and adopted children from other countries—who have a much higher rate of lead poisoning—to ensure they have appropriate blood lead screening and follow-up.
- Provided key scientific expertise and technical assistance to CDC-Nigeria and the Nigerian Federal Ministry of Health in response to a lethal lead poisoning outbreak in six villages in Zamfara, Nigeria associated with the artisanal processing of gold ores. The mortality rate of affected children under five was reduced from 44 percent to 1 percent within two weeks of CDC arriving on the ground there.

Budget Proposal: CDC requests $27,316,000 in FY 2013 for an integrated Healthy Homes/Childhood Lead Poisoning Prevention Program. Prior to FY 2013, CDC maintained separate programs for the National Asthma Control Program (NACP) and the Healthy Homes/Childhood Lead Poisoning Prevention Program (HHCLPPP). In FY 2013, CDC will develop a strategy to integrate these two programs into a Healthy Home and Community Environments program. The goal is to maintain a multi-faceted approach through surveillance, partnerships, and implementation and evaluation of science-based interventions to address the health impact of environmental exposures in the home and to reduce the burden of asthma through comprehensive control. CDC will take two years to complete the transition to this new, integrated approach. Findings indicate that multi-component, multi-trigger home based environmental interventions are effective in improving overall quality of life, reducing health care costs, and improving productivity. A healthy homes approach works to mitigate health hazards in homes such as lead poisoning hazards, secondhand smoke, asthma triggers, radon, safe drinking water, and the absence of smoke and carbon monoxide detectors. Evidence shows that comprehensive asthma control programs are most effective in improving asthma outcomes and reducing health care costs. One key intervention to

manage asthma is to increase use of inhaled corticosteroids, something that will be facilitated in 2014 and beyond through expanded coverage through the Affordable Care Act.

In FY 2013, CDC will:

- Work toward establishing a consolidated funding announcement in which states can apply for comprehensive asthma control and/or lead poisoning prevention funding to support surveillance, interventions, training, national expertise and leadership, and efforts to reduce disparities.
- Reduce funded states from 36 to 15 or fewer for comprehensive asthma control programs that implement effective interventions to reduce asthma-related morbidity and mortality and support state-based surveillance systems to monitor progress.
- Support funded states to continue implementation of asthma self-management education in non-clinical and clinical settings and to pursue comprehensive asthma management programs that address asthma in a variety of environments (schools/daycares, community and other health care settings, homes, and workplaces).
- Fund up to 15 states for primary prevention and case management of lead poisoned children.
- Continue to monitor national data on asthma prevalence, but narrow surveillance activities used to track progress in helping people control their asthma and reduce medical costs in the United States through the collection and analysis of asthma surveillance data.
- Provide software and technical assistance to support state and local health department data collection on lead and other health hazards in homes via the nation's only Healthy Homes and Lead Poisoning Surveillance System (HHLPSS). This system triggers actions by the U.S. Department of Housing and Urban Development and other federal, state, and local agencies to protect children from lead exposure and to serve children who have already been lead poisoned. It also targets the limited federal, state, and local government resources to the highest-risk children and to track incidence and risk factors from lead poisoning.
- Support training of health professionals and the education of patients, families, and the public on how to improve asthma self-management and control.
- Continue to be a Federal Partner with the National Healthy Homes Training Center and Network (HHTC). HHTC provides training to public health, environmental health and housing professionals to recognize and address housing related health hazards.
- Continue to participate and provide leadership for multiple federal workgroups on asthma.
- Continue to provide lead expertise and analysis at the national level and remain a resource to state and local public health agencies.
- Maintain the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP). The ACCLPP advises and guides the Secretary and Assistant Secretary of the U.S. Department of Health and Human Services and the Director of the Centers for Disease Control and Prevention regarding new scientific knowledge and technical developments and their practical implications for childhood lead poisoning prevention efforts.
- Provide expertise and epidemiological support in response to lead poisoning outbreaks.
- Work with Environmental Justice groups to address disproportionately high and adverse human health or environmental effects on minority and low-income (and tribal/indigenous) populations.
- Evaluate program impact.

Asthma Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	65	65	19
Average Award	$0.301	$0.301	$0.300
Range of Awards	$0.076–$0.594	$0.076–$0.594	$0.070–$0.500
Number of New Awards	0	0	0
Number of Continuing Awards	65	65	19

Healthy Homes-Lead Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	38	0	15
Average Award	$0.522	$0.000	$0.583
Range of Awards	$0.005–$0.594	$0.000–$0.000	$0.250–$1.000
Number of New Awards	37	0	15
Number of Continuing Awards	1	0	0

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$35.000**	**$35.000**	**$29.000**	**-$6.000**

National Environmental Public Health Tracking Network

Program Overview: The National Environmental Public Health Tracking Program strengthened state and local agencies' ability to prevent and control diseases and health conditions that may be linked to environmental hazards. Public health professionals and policymakers use data from the National Environmental Public Health Tracking Network (Tracking Network) to target preventive services. Tracking Network data is used at state and local levels for interventions, education, outbreak investigations, and program evaluation. The public can use information from the Tracking Network to better understand health trends and events in their communities, and protect their own health. The program provides over 75 percent of its budget to fund state and local health departments, university public health programs, information technology operations and enhancements, and nongovernmental organizations. Investment supports improving the ability of state, local, and tribal governments to evaluate linkages between disease and environmental exposures in their areas and to document improvements through interventions using the National Environmental Public Health Tracking Network.

Recent accomplishments:

- Prevented negative health effects from environmental exposures using state and local tracking programs. Examples include:
    - Monitored and provided information to residents and workers related to the Gulf Deepwater Horizon incident.
    - Helped New Mexico residents reduce their exposure to uranium from contaminated drinking water.

  - Demonstrated to San Jose, California city officials how heat related illnesses peaked during heat waves. City officials used this data to allocate resources to re-open cooling centers during heat waves.
  - Analyzed Oregon tracking data, which revealed that workers at locations with indoor smoking were exposed to pollution levels more than three times higher than the annual EPA exposure standard. Local officials took action to institute smoking bans in most work and public places to curb the public health threat detected by the tracking network.

- Expanded the scope and functionality of the National Environmental Public Health Tracking Network to include new and updated content areas to provide health professionals, elected officials, and the public with better disease burden estimates, such as:
  - Health impacts of fine particulates ($PM_{2.5}$) in air. These data combine health and environmental variables to provide estimates of the impact fine particle pollution has on health. Each county in the United States can estimate deaths prevented based on variables related to air pollution reduction.
  - Climate and health data that includes heat vulnerabilities, heat related mortality, and temperature distribution. Vulnerability measures include topics such as diabetes, disabilities, poverty, land use, and more.
  - A cutting-edge new data query system that allows greater flexibility for mapping, sorting, and graphing data. Expanded national maps, side-by-side mapping comparisons, and faster results are a few of the enhancements now available.
- Updated birth defects, carbon monoxide poisoning, cancer, childhood lead poisonings, air monitoring, and heart attack statistics.
- Increased state use of tracking networks for reporting asthma hospitalizations, carbon monoxide poisonings, community drinking water, and heart attack hospitalizations.
- Added two new tracking networks in Minnesota and South Carolina.
- Funded universities to study connections between air quality and cardiovascular effects, as well as drinking water and health outcomes, including cancers and low birth weight.

In FY 2013 CDC will:

- Identify opportunities for prevention of chronic diseases using environmental public health tracking data. For example, Massachusetts' analysis of cancer data in two neighborhoods detected an elevated rate of oral cancer due to high tobacco usage. They alerted the health department's tobacco control program to work with the city on cessation strategies.
- Identify opportunities for improving public health by using available environmental public health tracking data. For example, with data from the carbon monoxide (CO) poisoning surveillance system, the Maine Tracking Program found that almost every case of CO poisoning in the state was associated with not having a CO detector. These data led to a requirement that CO detectors be installed in all rental units and in single family homes when there is an addition or renovation and whenever a property is sold.
- Focus on sustaining local environmental public health tracking networks in at least 23 states, New York City, and the National Tracking Network for non-infectious health conditions and environmental hazards and seek other partners to continue important research.

- Maintain a repository of tools, methods, and other resources available to state and local health departments to examine data trends, assess the impact of the environment on health, identify susceptible populations, and respond to community concerns.
- Provide over 75 percent of the budget for the National Environmental Public Health Tracking Network to fund state and local health departments, universities, public health programs, information technology operations, and nongovernmental organizations.
- Focus on investments improving the ability of state, local, and tribal governments to evaluate linkages between disease and environmental exposures in their areas and to document improvements through interventions using the National Environmental Public Health Tracking Network

National Public Health Tracking Network Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	30	30	30
Average Award	$0.760	$0.760	$0.760
Range of Awards	$0.1–$1.100	$0.1–$1.100	$0.1–$1.100
Number of New Awards	17	0	4
Number of Continuing Awards	13	30	26

PERFORMANCE

Efficiency Measure for National Center for Environmental Health and Agency for Toxic Substances and Disease Registry

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
6.E.2: Increase the percentage of cost savings each year for NCEH/ATSDR as a result of the Public Health Integrated Business Services HPO.[1] (Efficiency)	FY 2010: 42 % (Target Exceeded)	N/A	N/A	N/A

[1]This efficiency measure will be retired but remains as a placeholder as CDC and ATSDR explore options for replacing.

Program: Environmental Health Laboratory

Performance Measures for Program: Environmental Health Laboratory

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
6.1.1: Increase the number of environmental chemicals, including nutritional indicators that are assessed for exposure of the U.S. population. (Output)	FY 2011: 323 (Target Met)	323	323	Maintain
6.1.3: Increase the number of laboratories participating in DLS[2] Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements[3] (Output)	FY 2011: 974 (Target Met)	974	974	Maintain

6.A: Increase the number of new or improved methods developed for measuring environmental chemicals in people (Output)	FY 2011: 9 (Target Met)	9	9	Maintain
6.B: Increase the number of laboratory studies conducted to measure levels of environmental chemicals in exposed populations (Output)	FY 2011: 52 (Target Met)	52	52	Maintain
6.F: Increase the number of states assisted with screening newborns for preventable diseases (Output)	FY 2011: 50 (Target Met)	50	50	Maintain

[2] CDC Division of Laboratory Sciences

[3] (i.e., newborn screening, chronic diseases [diabetes, cholesterol], environmental health [blood lead, cadmium and mercury], and nutritional indicators).

Performance Trends: CDC is the only agency that tests for chemical exposure and nutritional indicators in a nationally representative sample of the U.S. population. In FY 2011, CDC met its target of 323 chemicals measured, a continued trend since the inception of this measure (Measure 6.1.1). CDC released data from the 2005–2006 and 2007–2008 National Health And Nutrition Examination Survey for 54 of the chemicals previously reported along with data for nine more recently added chemicals in the *Updated Tables to the Fourth National Report on Human Exposure to Environmental Chemicals*. These tables provide critical exposure data to scientists, physicians, and health officials who use the data to determine which chemicals and indicators are in people's bodies and at what levels, and establish national reference ranges and trends against which physicians and health officials can determine which groups may have an unusually high exposure.

Additionally, in FY 2011, CDC met its target by developing nine new or improved methods to measure environmental chemicals in people (Measure 6.A). In FY 2011, CDC met the target to complete 52 laboratory studies that help identify populations with unsafe exposures to chemicals and demonstrate the effectiveness of public health actions (Measure 6.B).

CDC's Environmental Health Laboratory provides quality assurance and standardization programs for tests for chronic diseases, newborn screening disorders, nutritional status, and environmental exposures. While participation is voluntary, CDC met its target of 974 laboratories participating in these programs in FY 2011, continuing a trend since the inception of this measure (Measure 6.1.3). Participation in a rigorous quality assurance program helps ensure laboratory and medical tests are comparable and accurate. For example, CDC's Newborn Screening Quality Assurance Program (NSQAP) found that performance of the methods used to identify a biochemical marker for Cystic Fibrosis was variable and dependent upon recognizing and recovering the relevant antibodies. NSQAP collaborated with states and vendors to resolve assay concerns and provide information to reassess cutoff values for positive and negative results. Additionally, CDC provided assistance to 50 states in newborn screenings for preventable diseases and additional funding to Delaware, Texas, and Utah to improve testing for disorders such as congenital adrenal hyperplasia and cystic fibrosis (Measure 6.F).

CDC continuously reviews and revises activities to ensure laboratory measurements are relevant, consistent, and high-quality, undertaken studies provide substantive public health impact, and state and local laboratory needs are prioritized.

Program: Environmental Health Activities

Performance Measures for Program: Environmental Health Activities

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
6.1.2: Complete studies to determine the harmful health effects from environmental hazards. (Output)	FY 2011: 27 (Target Exceeded)	24	24	Maintain
6.C: Increase the number of public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures[4] (Output)	FY 2011: 20 (Target Exceeded)	15	15	Maintain
6.H: Increase the number of emergency radiation preparedness toolkits provided to clinicians/public health workers (Output)	FY 2011: 1,350 (Target Exceeded)	750	750	Maintain

[4]Targets reflect ACA/PPHF funding.

Performance Trends: Acute foodborne illnesses cost the United States an estimated $152 billion per year in healthcare, workplace, and other economic losses. In addition to supporting multi-state studies resulting in seven publications on a variety of food safety issues, 93 percent of CDC-funded states participating in the Environmental Health Specialist Network (EHS-Net) successfully changed policies to improve their food and water safety programs. The EHS-Net states were successful in changing the 2009 Food and Drug Administration (FDA) model food code to prohibit the sale of undercooked ground meat in restaurants that offer "kid's meal" menus. Changes to the FDA Food Code to address the reporting, exclusion, and restriction of foodworkers diagnosed with *Nontyphodial Salmonella* will be sought in a joint effort between CDC EHS-Net and FDA in 2012.

In FY 2011, public health officials undertook 20 public health actions using environmental public health tracking data, exceeding the target (Measure 6.C). Since FY 2002, state and local public health officials used the Tracking Network to implement more than 120 data-driven public health actions to prevent adverse health effects from environmental exposures. Specific public health actions include monitoring and providing information to residents and workers related to the Deepwater Horizon incident, helping residents reduce their exposure to uranium from drinking water, and providing information to the public on bed bug infestations and prevention strategies. In FY 2011, CDC exceeded its target and completed 27 studies examining the health effects from environmental health hazards such as water and air pollutants, radiation, and hazards related to natural and other disasters (Measure 6.1.2). These study results help CDC develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their health consequences. Since 2005, CDC met or exceeded targets for this measure and is on track to meet the targets for FY 2012. In FY 2011, CDC distributed 1,350 emergency radiation preparedness toolkits to clinicians and public health workers to improve their ability to identify and respond to radiological events (Measure 6.H). Since 2005, CDC met or exceeded targets and is on track to meet targets for FY 2012.

Program: Asthma, Healthy Home and Community Environments

Performance Measures for Program: Healthy Home and Community Environments

Measure[5]	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
6.2.4: Increase the proportion of those with current asthma who report they have received self –management training for asthma in populations served by CDC funded state asthma control programs. (Output)	FY 2009: 45% (Target Not Met but Improved)	50%	Unable to report	N/A
6.2.5a: Reduce health disparities associated with blood lead levels in children aged 1-5 in the U.S. such that: a. The gap in blood lead levels between black children and children of other races is reduced (Outcome)	FY 2010: 0.52 (Baseline)	0.52	0.50	-0.02
6.2.5b: The gap in blood lead levels between children living above the federal poverty level and those living below the poverty level is reduced (Outcome)	FY 2010: 0.54 (Baseline)	0.54	0.52	-0.02

[5] Due to programmatic changes, these measures may be revised in FY 2014 to better reflect CDC activities.

Performance Trends: CDC estimates the total direct cost of asthma at $3,259 per person per year for the period 2002–2007 (calculated in 2009 dollars).[1] In 2007, the estimated total cost of asthma (incremental direct cost and productivity costs) was $56 billion (2009 dollars).[2] These costs would exceed $58 billion in 2011 dollars. Implementing asthma action plans and effective asthma self-management (per the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma) are vital to helping people stay out of the hospital and manage their asthma. One study shows asthma self-management education, delivered to high-risk adult asthma patients in the clinic, by phone, and at home, as needed, results in 54 percent fewer hospital readmissions and 34 percent fewer emergency department visits, saving $35 in health care costs and lost work days for every $1 spent.[3] Four billion dollars were saved in medical costs in 2008 because 245,000 fewer people were hospitalized due to asthma. Measure 6.2.4 reports increases in the number of individuals with current asthma who report they have received self–management training for asthma. The most recent result of 45 percent in 2009 increased two percent over the 2008 result of 43 percent, but did not meet the target. However, CDC is on track to continue positive increases in this measure (Measures 6.2.4) in FY 2012, including strengthening patient self-management education efforts by physicians and other health care providers. In FY 2013, under the new consolidated Healthy Home and Community Environments program, CDC will continue to monitor national data on asthma prevalence but narrow surveillance activities of asthma control, and unable to report a target for FY 2013.

Because of the CDC partnership with the Department of Housing and Urban Development (HUD), $18.6 billion (2011 dollars) was saved by abating homes from lead, thus protecting all future residents.[4] In addition, between 2008 and 2010, the number of children with a blood lead level over five µg/dL decreased by 200,000. This reduction translates to $7.5 billion in savings in lifetime productivity. The focus of Measures 6.2.5 a, b is on closing the health disparity gaps that exists between children on the basis of race and household income. African American children are three times more likely than white children to have blood lead levels greater than five micrograms per deciliter, a significant disparity that needs continued attention. While focusing specifically on health disparities, the new two-part measure is a

key component of targeting a continued overall decrease in mean blood lead levels among all children ages one through five in the United States (2010 baseline: 1.53 micrograms per deciliter; target for 2013 NHANES data release:1.38 micrograms per deciliter).

[1] Barnett SBL, Nurmagambetov TA. Costs of asthma in the United States: 2002–2007. J Allergy Clin Immunol 2011;127:145–52

[2] Barnett SBL, Nurmagambetov TA. Costs of asthma in the United States: 2002–2007. J Allergy Clin Immunol 2011;127:145–52

[3] Castro M, et al. "Asthma Intervention Program Prevents Readmissions in High Health Care Users". American Journal of Respiratory Critical Care. 2003; 168:1095-1099

IT INVESTMENTS

CDC invests in numerous Information Technology (IT) systems that support strategic and performance outcomes. Systems track non-infectious diseases and other health effects that may be associated with environmental exposures. The systems also maintain and collect standardized data from surveillance systems at the state and national level. IT investments allow federal, state, and local agencies and others to monitor and distribute information about environmental hazards and disease trends; advance research on possible linkages between environmental hazards and disease; and develop, implement, and evaluate public health actions to prevent or control environment-related diseases.

INJURY PREVENTION AND CONTROL

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$143.714	$137.693	$137.754	+$0.061
Total	**$143.714**	**$137.693**	**$137.754**	**+$0.061**
FTEs	218	217	217	0

Authorizing Legislation: PHSA §§ 214, 215, 301, 304, 307, 308D, 310, 311, 317, 319, 319D, 327, 352, 391, 392, 393, 393A, 393B, 393C, 393D, 394, 394A, 399G, 399P, 1102; Bayh-Dole Act of 1980 (P.L. 96-517); Safety of Seniors Act of 2007 (P.L. 110-202); Traumatic Brain Injury Act of 2008 (P.L. 110-206); Family Violence Prevention and Services Act § 413 (42 U.S.C. 10418)

FY 2013 Authorization……Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $137,754,000 for injury prevention and control is $61,000 above the FY 2012 level.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Intentional Injury	$101.877	$96.753	$96.789	+$0.036
Unintentional Injury	$31.315	$30.966	$30.988	+$0.022
Injury Control Research Centers	$10.522	$9.974	$9.977	+$0.003
Total	**$143.714**	**$137,693**	**$137.754**	**+$0.061**

In the United States, one person dies every three minutes from an injury. CDC is the lead federal agency that focuses on preventing all forms of unintentional and intentional injuries that occur outside of the workplace, including:

- Identifying and promoting prevention strategies to reduce intentional injuries and their consequences, including injuries due to intimate partner violence, sexual violence, teen dating violence, youth violence, suicidal behavior, and child maltreatment.
- Developing and disseminating effective evidence-based interventions to address unintentional injuries, including injuries from motor vehicle crashes, older adult falls, prescription drug overdoses, and childhood injuries (including drowning and youth sports injuries). CDC also addresses injuries from traumatic events, such as traumatic brain injuries (TBIs) and blast injuries.
- Documenting the burden, conducting research to identify ways to prevent injuries and their consequences, and supporting the Injury Control Research Centers (ICRCs), research centers located nationally that specialize in identifying injury prevention and control best practices.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$134.837
2009	$145.242
2010	$148.790
2011	$143.714
2012	$137.693

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

INTENTIONAL INJURY PREVENTION BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$101.877**	**$96.753**	**$96.789**	**+$0.036**

Program Overview: Violence-related injuries and deaths—including those from intimate partner violence, sexual violence, teen dating violence, youth violence, suicide, and child maltreatment—cost our nation approximately $69 billion a year in medical costs and work loss costs. Over two million violence-related injuries are treated in emergency departments each year. Preventing violence before it starts also reduces the long-term consequences of violence, including involvement in other high-risk behaviors such as smoking, risky sexual behaviors, alcohol abuse, and drug use.

CDC collects data on factors that lead to and protect from violence. These data help CDC identify proven interventions and support implementation of these interventions, including building state and local violence prevention capacity. CDC's surveillance activities include the National Violent Death Reporting System (NVDRS) and the National Intimate Partner and Sexual Violence Survey (NISVS). Additionally, CDC compiles national level data and makes data available through the Web-based Injury Statistics Query and Reporting System (WISQARS™).

CDC identifies risk and protective factors for violence and evaluates prevention strategies through investigator-initiated and collaborative research, such as CDC's Academic Centers of Excellence in Youth Violence Prevention. CDC investments build state and local prevention capacity by translating science into capacity building programs, including the Rape Prevention and Education (RPE) Program and Core Violence and Injury Prevention Program (Core VIPP) (described in the Unintentional Injury section). CDC also builds capacity by disseminating effective prevention strategies through programs such as Striving To Reduce Youth Violence Everywhere (STRYVE), which focuses on youth violence prevention, and Dating Matters™, which aims to prevent teen dating violence. Intentional injury prevention funding supports over 90 state, local, university, and community grantees, which link over 900 community organizations (including local health departments, rape crisis centers, domestic violence coalitions, and other organizations) across the country to prevention resources.

Recent accomplishments:

- Supported four public health departments as initial STRYVE communities to bring together a number of existing efforts to inform and advance communities' youth violence prevention efforts. The release of these awards marks a major accomplishment and critical next step for STRYVE and youth violence prevention, as CDC moves the field from a planning phase to the application of evidence-based programming and partnerships in communities. The funded communities include Salinas, California; Boston, Massachusetts; Portland, Oregon; and Houston, Texas.

- Provided funding and technical assistance to all states and territories through the RPE program. These resources supported statewide implementation of the new "Green Dot" program in Kentucky, which encourages bystanders to intervene to prevent sexual violence. Green Dot empowers students to actively question peer acceptance of sexual violence so they can intervene to change social norms. All 13 regional rape crisis centers are implementing this program in community high schools statewide. CDC is now funding Kentucky to conduct an effectiveness trial to document Green Dot's impact.

- Disseminated new data to help understand intimate partner and sexual violence in the United States. CDC developed the NISVS to fill gaps in the scientific understanding of sexual violence, stalking, and intimate partner violence victimization. The survey found that these types of violence are widespread in the United States, affecting millions of adults' health. In the year preceding the survey, more than 12 million women and men reported being a victim of rape, physical violence, or stalking by an intimate partner; more than one million women reported being raped and many more were victims of other forms of sexual violence; and over six million women and men were a victim of stalking. CDC also collaborated with the Department of Defense and Department of Justice to collect additional data on people in the military and American Indian/Alaskan Natives (AI/ANs).

- Increased availability of comprehensive violent death surveillance data and public health applications of this data in 18 states via NVDRS. For example, the New Jersey Governor's Council on Mental Health Stigma was concerned about anecdotal reports of a recent statewide rise in suicide, but lacked information to confirm these reports or identify persons most at-risk. The New Jersey Department of Health and Senior Services used NVDRS data to provide the Council with timely, in-depth information on suicides. The data showed that men were four times more likely to commit suicide. Data also showed that suicide rates had increased among both sexes between 2007 and 2008, and suicide rates in 10 of New Jersey's 21 counties accounted for the majority of this increase. The Governor's Council used the data to tailor prevention messages to the most at-risk populations.

- Implemented a new, multi-year teen dating violence prevention initiative called Dating Matters™: Strategies to Promote Healthy Teen Relationships. The funding will aid local health departments in developing, implementing, and evaluating a comprehensive approach to prevent teen dating violence before it starts. The funded communities include Oakland/Hayward, California; Ft. Lauderdale, Florida; Chicago, Illinois; and Baltimore, Maryland.

- Supported statewide implementation in Delaware of a new curriculum, Developing Healthy Relationships, to reduce domestic violence. This curriculum was developed by the Delaware Coalition Against Domestic Violence through CDC's Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program. The Delaware Department of Education approved this curriculum as a "model instructional unit" for teachers to use in the classroom. Delaware regulations now require interpersonal violence prevention instruction for grades K–12, and the Developing Healthy Relationships curriculum is the only model instructional unit approved to fulfill this requirement.

Budget Proposal: CDC's FY 2013 request of $96,789,000 for intentional injury prevention is $36,000 above the FY 2012 level. The FY 2013 request reflects level funding for the RPE program of $39,399,000, which will support efforts to strengthen the evidence base of sexual violence prevention and maximize program impact.

In FY 2013, CDC will:

- Strengthen the RPE sexual violence prevention program at the state level. Activities will focus on maintaining state prevention (including education and outreach) capacity and increasing program evaluation activities with the goal of generating practice-based findings to inform the implementation of interventions that can reduce sexual violence nationwide. Fifty-nine states and territories will receive base funding to conduct program implementation and evaluation activities, and funds will continue to support the National Sexual Violence Resource Center.

- Support level funding of $3,472,000 for 18 states participating in the NVDRS and provide on-going support for the NISVS. NVDRS is a state-based system that pools information about the "who, when, where, and how" surrounding violent incidents to better understand the "why." State and local decision makers will be able to use detailed data on selected factors from NVDRS, such as demographics, victim/suspect relationship, and method of injury. NISVS collects data on intimate partner violence, sexual violence, and stalking through a survey of U.S. English- and Spanish-speaking adults. Researchers and practitioners will be able to continue to use NISVS data to better understand the burden of intimate partner violence, sexual violence, and stalking victimization which will in turn help guide and evaluate progress toward reducing the substantial health, social and economic burdens associated with intimate partner violence.

- Continue to fund four cities to implement Dating Matters™: Strategies to Promote Healthy Teen Relationships, the first and only rigorously evaluated, comprehensive teen dating violence prevention initiative for 11–14 year-olds in high-risk, urban communities. The initiative will also build public health capacity. CDC estimates that up to 100,000 students, parents, and educators participate in Dating Matters™, and that up to one million individuals will benefit from the initiative's broader communications and policy strategies to keep youth safe and healthy.

- Continue to support four cities to implement the STRYVE program to prevent youth violence. STRYVE enables communities to foster multi-sectoral partnerships and implement evidence-based youth violence prevention strategies. The four cities will continue to conduct demonstration projects designed to increase the capacity of public health departments and their coalition partners to prevent youth violence in high-risk communities. These community coalitions will continue to work across governmental sectors (e.g., justice, law enforcement, education, health, social services) and with business and nongovernmental organizations. CDC will support the funded communities with technical assistance, training, and other resources.

- Help communities address intimate partner violence by supporting 14 domestic violence coalitions through the DELTA program. DELTA will build organizational capacity and state leadership for primary prevention of interpersonal violence, as well as provide prevention-focused training, technical assistance, and financial support for coordinated community responses.

Rape Prevention and Education Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted[1]	FY 2013 President's Budget[2]
Number of Awards	57	57	59
Average Award	$0.612	$0.612	$0.612
Range of Awards	$0.008–$4.122	$0.008–$4.122	$0.008–$4.122
Number of New Awards	0	0	59
Number of Continuing Awards	57	57	0

[1] Funding amounts are pending approval of the FY 2012 operating plan.

[2] New FOA will be recompeted in 2013. Average award amounts and range of awards are estimated on current structure and are subject to change.

National Violent Death Reporting System Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted[1]	FY 2013 President's Budget[1]
Number of Awards	18	18	18
Average Award	$0.212	$0.212	$0.212
Range of Awards	$0.123–$0.265	$0.123–$0.265	$0.123–$0.265
Number of New Awards	0	6	12
Number of Continuing Awards	18	12	6

[1] Funding amounts are pending approval of 2012 operating plan and results of the new FOAs in FY 2012 and FY 2013.

UNINTENTIONAL INJURY PREVENTION BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$31.315**	**$30.966**	**$30.988**	**+$0.022**

Program Overview: Unintentional injuries are the leading cause of death for people ages 1 to 44, cost our nation more than $70 billion in medical costs each year and account for over one-third of all emergency department visits annually. Scientific evidence demonstrates that these injuries are not random, they can be prevented, and, when they do occur, their consequences can be minimized.

CDC uses a science-based, public health approach to promote safety and develop recommendations for effective programs and policies in motor vehicle injury prevention (e.g., booster seat and seat belt use, Graduated Drivers Licensing (GDL) for teen drivers, alcohol-impaired driving prevention, cyclist and pedestrian injury prevention). CDC also promotes unintentional child injury prevention (e.g., drowning prevention), TBI prevention and care, prescription drug overdose prevention, and older adult falls prevention, as well as works to reduce injuries among AI/AN and other high-risk populations. CDC's Core VIPP[1] provides resources and technical assistance to state health departments to implement science-based strategies and evaluate health impacts. Core VIPP's Base Integration Component supports state capacity to implement injury and violence prevention activities. A subset of states receive additional funding to serve as Regional Network Leaders, which will provide structured assistance to all states in a designated region for collaboration. Additional states receive funding for other expanded components, such as working to improve surveillance data quality, and injury-specific efforts, including older adult falls prevention and child injury/motor vehicle injury prevention. Combined, CDC's unintentional injury prevention activities, including the Core VIPP, provide technical assistance and prevention tools to all 50 states and territories.

[1]In 2011, the Core VIPP reorganized to support states more effectively and build on injury and violence prevention infrastructure established in previous funding cycles. This infrastructure built the foundation necessary for disseminating, implementing, and evaluating science-based program and policy strategies. Efforts include: focusing on policy, communications, and evaluation; establishing Regional Network Leaders; strengthening collaboration between VIPP and early childhood home visitation programs (funded by the Health Resources and Services Administration and the Administration for Children and Families) by assisting with benchmark development and reporting; promoting implementation; establishing long-term priorities with documented health outcomes; and an increase in the average award. Funding from both the intentional and unintentional injury budget lines support this program.

Recent accomplishments:

- In spring 2011, initiated development of the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) tool, a comprehensive tool to integrate fall risk reduction into clinical care. STEADI instructs health care providers on how to incorporate falls assessments and proven prevention strategies into older adult clinical care, which is a key step in preventing falls before they happen. Providers following this model will be able to, identify a patient's risk for falls, assess the scope of a patient's risk, introduce tailored interventions and provide effective referrals.

- Tracked an emerging poisoning epidemic, prescription drug overdose. CDC's Vital Signs (November 2011) reported that opioid pain relievers killed nearly 15,000 people in the United States in 2008—more than tripling in the past decade. The Vital Signs noted that increased use of these powerful for nonmedical reasons, along with growing sales, has contributed to the growing number of overdoses and deaths. Furthermore, a CDC study found Florida's prescription drug overdose death rate increased by 84.2 percent between 2003 and 2009, while another study found that patients with higher opioid dosages, multiple providers, and multiple prescriptions were associated with a higher overdose risk.

- Continued a multifaceted approach to improving teen driver safety. First, CDC continued a multiyear pilot of a GDL Planning Guide in six states. In 2011, two participating states, Michigan and North Dakota, used the Planning Guide to inform policies to strengthen GDL policies in their state. CDC also launched the evidence-based teen driving multimedia campaign toolkit, "Parents Are the Key," which offers parents tools and proven steps for reducing teen driving injuries and deaths.

- In March 2011, disseminated a review of the evidence of ignition interlock programs' effectiveness in reducing alcohol-impaired driving. This review found that ignition interlocks can reduce re-arrest rates for alcohol-impaired driving by a median 67 percent, making them more effective than other prevention methods.

- Provided ongoing scientific evidence to inform state decisions about booster seat policies. Through CDC's Core VIPP, the Colorado Department of Public Health conducted surveillance and gathered evidence to inform decision makers about booster seat use. The Department of Public Health ensured that the state legislature relied on the best available science to develop a law that requires all children between ages four and seven to be properly restrained in a booster seat.

- Developed and disseminated educational materials on identifying and managing TBIs, including concussions, to schools, health care professionals, coaches, parents, and athletes. As of December 2011, over four million Heads Up educational materials have been downloaded or disseminated nationwide. Widespread dissemination of CDC's Heads Up materials contributed to increased awareness of TBI in youth sports and has been cited by multiple states as justification for adopting return to play legislation to protect injured athletes. In addition, CDC has educated over 300,000 coaches through online trainings and videos since 2010.

Budget Proposal: CDC's FY 2013 request of $30,988,000 for unintentional injury prevention activities is $22,000 above the FY 2012 level.

In FY 2013, CDC will:

- Support activities to prevent prescription drug overdoses, including enhancing surveillance and tracking of the problem and trends, identifying and evaluating promising prevention policies, and working to improve clinical practice. CDC leads a number of Action Items within the Administration's 2011 Prescription Drug Abuse Prevention Plan, including collaborating with the American College of Emergency Physicians to develop, publish, and disseminate clinical guidelines for the prescribing of opioids in emergency departments. CDC will disseminate these guidelines and encourage institutions to adopt these as prescribing policies.

- Fund 28 state health departments for the Core VIPP to build critical state injury prevention and control capacity. All funded states will receive Base Integration Component funding to continue injury surveillance, implement interventions, and evaluate prevention strategies. A subset of states will receive funding for the expanded components, including Regional Network Leaders (five states), Surveillance Quality Improvement (four states), older adult falls (three states), and motor vehicle safety (ten states). CDC will also support the Safe States Alliance to provide assistance to both Core VIPP-funded and unfunded states. CDC will provide technical assistance to all states and will monitor and evaluate the Core VIPP. As a result, Core VIPP state health department grantees are well-positioned to strategically plan for, implement, and evaluate injury prevention interventions.

- Support a multi-component effort to address older adult falls, including developing and disseminating the STEADI tool in three pilot states (all Core VIPP grantees) and connecting clinical services with community-based fall prevention programs. CDC will provide tools, technical assistance, and guidance; facilitate public-private collaborations to find ways to improve older adults' quality of life; and evaluate activities.

- Lead partners in disseminating and implementing the National Action Plan for Childhood Injury Prevention. This plan, currently in development with input from over 50 experts and organizations, will guide stakeholders involved in unintentional injury prevention among children, including federal, state, and local agencies; non-governmental organizations; and policymakers. The plan identifies specific goals and strategies that can catalyze a coordinated effort to reduce childhood injury.

- Evaluate ignition interlock programs throughout the United States in partnership with the National Highway Traffic Safety Administration and Governors Highway Safety Association. This project builds on the Community Guide's findings by evaluating specific aspects of state ignition interlock programs and how they are implemented. The project will answer remaining questions and is expected to provide important insights on program effectiveness.

- Assist states in improving seat belt policies to reduce the number and severity of motor vehicle crash-related injuries by providing them with the best available evidence on effective prevention measures. Seat belt use is higher in states that have primary enforcement laws (88 percent) than in those states that do not have them (79 percent). Seat belt use reduces serious injuries and deaths in crashes by 50 percent.

- Fund eight AI/AN tribal organizations to tailor, implement, and evaluate interventions to reduce motor vehicle injuries. This highly successful pilot program will continue to improve seat belt and child safety use, decrease alcohol-impaired driving, strengthen traffic safety laws and policies, and reduce motor vehicle-related death rates by implementing effective interventions that have been tailored for individual AI/AN communities.

- Support national and state efforts to prevent, recognize, and respond to youth sports concussions and TBIs through the Heads Up campaign. Campaign priorities include developing online training and disseminating care guidelines and educational materials. The campaign will increase parents, coaches, primary care providers, and school personnel's ability to help school-aged youth who have suffered a TBI. This investment should result in identifying more youth that experience a TBI, increasing the likelihood that they receive appropriate care.

Core Injury and Violence Prevention Program Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request[1]
Number of Awards	28	28	28
Average Award	$0.346	$0.346	$0.346
Range of Awards	$0.150–$0.803	$0.150–$0.803	$0.150–$0.803
Number of New Awards	0	0	0
Number of Continuing Awards	28	28	28

[1]All 28 Core VIPP grantees are funded for the Base Integration Component of Core VIPP. Select states are funded for additional components in addition to the Base Integration Component. See the state table for details.

INJURY CONTROL RESEARCH CENTERS

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$10.522**	**$9.974**	**$9.977**	**+$0.003**

Program Overview: The injury prevention field and injury prevention research are consistently evolving as new interventions are identified, new risk factors emerge, and the injury burden continues to grow. Because of this evolution, the injury prevention field needs consistent, continuous research to inform prevention interventions with the most current scientific and evaluation findings.

The purpose of CDC's ICRC program is to develop centers that conduct high-quality multidisciplinary research to build the scientific base for injury prevention and translate scientific discoveries into practice. ICRCs conduct various types of research, including intervention development and testing and research on methods to enhance the adoption and maintenance of effective intervention strategies. Centers use scientific resources to focus on local, regional, and national issues. As a result, public health practitioners have innovative injury prevention strategies to put into practice. Additionally, CDC and decision makers across the United States have used ICRC research to shape federal, state, and local programs and policies.

ICRC activities are intrinsically linked with CDC injury and violence prevention priorities. CDC guides ICRC research by setting an injury research agenda and linking research and practice (including linking the research community to state health departments). CDC also disseminates individual ICRC activities and key research findings across the country. CDC provides technical assistance to funded ICRCs to develop and disseminate their programmatic activities and findings.

Recent Accomplishments:

- Informed discussions about high school sports safety. The ICRC at Nationwide Children's Hospital in Columbus, Ohio used an internet-based high school sports-related injury surveillance system called High School RIO™ (Reporting Injuries Online) to track injuries in nine high school sports in 100 U.S. high schools. As this surveillance system is the only source of national data on high school sports-related concussion, concussion symptomology, and return-to-play decisions, the data informed discussions on state return-to-play laws for athletes following concussions.

- Enhanced intentional injury data collection tools to improve program effectiveness. The Iowa ICRC and the Iowa Department of Public Health developed a database of domestic abuse, homicide, and suicides cases in the state. Data previously gathered and analyzed by hand is now collected more efficiently, hastening data translation into informed programs and policies.

Budget Proposal: CDC's FY 2013 request of $9,977,000 for Injury Control Research Centers is $3,000 below the FY 2012 level.

In FY 2013, CDC will:

- Facilitate timely and cross-cutting injury and violence prevention research that will fill gaps in the science base in 11 ICRCs across the United States.
- Provide technical assistance and strategic direction for the ICRCs and the injury prevention research field.
- Disseminate key ICRC injury violence prevention research findings to the public health community, including partner organizations, state health departments, and policymakers.

Injury Control Research Center Program Grant Table[1]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	11	≤11	≤11
Average Award	$0.900	≤$0.905	≤$0.905
Range of Awards	$0.901–$0.901	$0.905–$0.905	$0.905–$0.905
Number of New Awards	0	≤7	≤11
Number of Continuing Awards	11	4	0

[1]Funding amounts are pending approval of 2012 operating plan and results of the new FOA in review.

BUDGETARY OUTPUTS

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
Intentional Injury Prevention				
7.A: Number of states collecting violent death data using the National Violent Death Reporting System (Output)	FY 2008: 17 FY 2009: 17 FY 2010: 18 FY 2011: 18	18[1]	18[1]	No Change
7.B: Number of grantees funded by the Rape Prevention and Education Grants (Output)	FY 2008: 57 FY 2009: 57 FY 2010: 57 FY 2011: 57	57	59	+2
Measure	**Most Recent Result**	**FY 2012 Enacted Target**	**FY 2013 Target**	**FY 2013 +/- FY 2012**
Unintentional Injury Prevention				

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
7.C: Number of Core VIPP-funded states implementing evidence-based injury and violence prevention policies and programmatic activities (Output)	FY 2008: 30 FY 2009: 30 FY 2010: 30 FY 2011: 28	28	28	No change
Measure	**Most Recent Result**	**FY 2012 Enacted Target**	**FY 2013 Target**	**FY 2013 +/- FY 2012**
Injury Control Research Centers				
7.D: Number of Injury Control Research Centers funded that conduct research to identify and translate scientific discoveries into practice (Output)	FY 2009: 11 FY 2010: 11 FY 2011: 11	≤11	≤11	No Change

[1] Cooperative agreement funding will be recompeted in FY 2012 and 2013.

PERFORMANCE

Program: Intentional Injury Prevention

Performance Measures for Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from intentional injuries for people at all life stages.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
7.1.2b: Reduce victimization of youth enrolled in grades 9-12 as measured by: the 12-month incidence of dating violence (Outcome)	FY 2009: 9.8% (Target Not Met)	N/A	9.2%	N/A

Performance Trends: Violence-related injuries and deaths cost approximately $69 billion a year in medical and work loss costs. In 2007, one out of every 50 deaths in the United States was due to a homicide or a suicide. In 2009, 650,843 youth between the ages of 10 and 24 years were treated in emergency departments for nonfatal injuries sustained from incidences of youth violence. Each year, one in four adolescents report being a victim of instances of verbal, emotional, physical or sexual abuse by a dating partner. In 2009, one in 10 high school students reported experiencing physical violence from a dating partner (Measure 7.1.2b). Although CDC did not meet its target and there has been little decline in the rate of dating violence, CDC is working to identify effective programmatic strategies and further implementation of scalable prevention programs that are based on the best available science.

The Dating Matters™ initiative, which promotes respectful, nonviolent dating relationships among youth ages 11–14 in high-risk urban communities, supports local communities in the implementation of evidence based prevention programs. The first phase of Dating Matters™ (2011-2015) is a five-year demonstration during which CDC examines the cost, feasibility, sustainability, and effectiveness of a comprehensive approach to teen dating violence in up to four high-risk urban communities. CDC grantees will use and adapt the following evidence-based programs: 1) Safe Dates, which demonstrates effectiveness at decreasing levels of dating violence among eighth graders; 2) Families for Safe Dates, which encourages families to talk about healthy dating relationships and dating abuse; and 3) Parents Matter, a community-level, family prevention program that enhances protective parenting practices.

Program: Unintentional Injury Prevention

Performance Measures for Long Term Objective: Achieve reductions in the burden of injuries, disability or death from unintentional injuries for people at all life stages.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
7.2.4**:** Reduce motor vehicle deaths per 100 million miles traveled (Outcome)	CY 2010: 1.09 (Target Met)[1]	1.03	1.00	-0.03
7.2.5**:** Increase the percent of Core VIPP funded states that assess outcomes and impact of injury and violence prevention strategies using surveillance data. (Intermediate Outcome)[2]	CY 2011: 17 (Baseline)	21	25	+4

[1]Most recent result for FY 2010 is based on preliminary data from the Fatality Analysis Reporting System (National Highway Traffic Safety Administration).
[2]Funding from both the intentional and unintentional injury budget lines support this program.

Performance Trends: Unintentional injuries are the leading cause of death for Americans ages 1–44. Each year unintentional injuries cost the United States more than $70 billion in medical costs and over $281 billion in total costs, including lost productivity. Motor vehicle injury is the leading cause of death for persons ages 5 to 34.

The rate of traffic fatalities per 100 million vehicle miles traveled has steadily declined between 2007 and 2010 (Measure 7.2.4). These declines are likely attributable to a number of factors, including prevention policies like seat belt laws, safer motor vehicles, and improved driving behaviors. Although these declines are a sign that motor vehicle safety efforts are effective, the dramatic rates of decline experienced between 2007 and 2010 are likely unsustainable. CDC continues to provide rigorous surveillance to identify problem areas and support for evaluation and implementation of evidence-based strategies. CDC promotes new strategies to support the implementation of effective motor vehicle injury prevention interventions. For example, the "Parents Are the Key" communications campaign toolkit provides strategies to support graduated driver licensing systems and parental involvement in teen driving. In addition, CDC implements effective interventions with four tribal communities through the Tribal Motor Vehicle Injury Prevention Program.

In 2011, CDC entered into a new five-year cooperative agreement period for the Core Violence and Injury Prevention Program (Core VIPP), which will provide support to state health departments to increase state capacity to effectively disseminate, implement, and evaluate best practices and science-based strategies for injury and violence prevention programs. The 28 new Core VIPP grantees will use surveillance data to inform injury prevention activities. In 2011, 17 of the 28 grantees reported using data to assess outcomes and impact of injury and violence prevention strategies (Measures 7.2.5).

IT INVESTMENTS

CDC's information technology investments improve tracking and monitoring of injury trends and funding expenditures. CDC's WISQARS™ is an interactive, online database that provides fatal and nonfatal injury, violent death, leading causes, and cost of injury data from a variety of trusted sources. Researchers, the media, public health professionals, and the general public can use WISQARS™ data to learn more about the public health and economic burden associated with unintentional and violence-related injury in the United States. Users can search, sort, and view the injury data and create reports, charts, and maps based on the following:

- Intent of injury (unintentional injury, violence-related, homicide/assault, legal intervention, suicide/intentional self-harm)
- Mechanism (cause) of injury (e.g., fall, fire, firearm, motor vehicle crash, poisoning, suffocation)
- Body region (e.g., TBI, spinal cord, torso, upper and lower extremities)
- Nature (type) of injury (e.g., fracture, dislocation, internal injury, open wound, amputation, burn)
- Geographic location (national, regional, state) where the injury occurred
- Year of death/nonfatal injury when hospitalized or treated in the emergency department
- Sex, race/ethnicity, and age of the injured person

STATE TABLE[1]

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 INJURY PREVENTION AND CONTROL			
	Core State Injury Program[2]	**Rape Prevention and Education**	**National Violent Death Reporting System**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**	**FY 2011 Actual**
Alabama	$0	$543,390	$0
Alaska	$0	$78,752	$155,761
Arizona	$180,621	$626,527	$0
Arkansas	$249,242	$327,659	$0
California	$250,000	$4,122,229	$0
Colorado	$803,029[b,c,d]	$523,152	$209,546
Connecticut	$0	$416,711	$0
Delaware	$250,000	$97,807	$0
District of Columbia	$0	$72,078	$0
Florida	$250,000	$1,946,399	$0
Georgia	$247,500	$998,199	$249,834
Hawaii	$150,000	$149,856	$0
Idaho	$0	$159,880	$0
Illinois	$0	$1,513,029	$0
Indiana	$0	$742,055	$0
Iowa	$0	$358,422	$0
Kansas	$278,623[a]	$329,486	$0
Kentucky	$397,745[d]	$494,091	$212,974
Louisiana	$0	$546,051	$0
Maine	$250,000	$157,566	$0
Maryland	$294,057[a]	$646,699	$244,439
Massachusetts	$577,227[a,b,d]	$774,726	$232,217

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 INJURY PREVENTION AND CONTROL			
	Core State Injury Program[2]	**Rape Prevention and Education**	**National Violent Death Reporting System**
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**	**FY 2011 Actual**
Michigan	$0	$1,211,289	$256,257
Minnesota	$392,820[d]	$600,845	$0
Mississippi	$0	$348,489	$0
Missouri	$0	$683,032	$0
Montana	$0	$112,232	$0
Nebraska	$299,693[d]	$210,637	$0
Nevada	$0	$243,043	$0
New Hampshire	$221,363	$152,806	$0
New Jersey	$0	$1,025,918	$194,939
New Mexico	$247,128	$223,746	$180,488
New York	$675,000[c,d]	$2,310,562	$0
North Carolina	$428,078[a,b]	$981,519	$249,865
North Dakota	$0	$80,609	$0
Ohio	$400,000[d]	$1,383,356	$265,516
Oklahoma	$250,000	$422,195	$201,488
Oregon	$524,975[c]	$418,637	$193,342
Pennsylvania	$400,000[d]	$1,496,216	$0
Rhode Island	$250,000	$130,005	$123,038
South Carolina	$250,000	$490,472	$209,452
South Dakota	$0	$94,310	$0
Tennessee	$247,686	$694,474	$0
Texas	$0	$2,538,658	$0
Utah	$482,417[b,d]	$274,115	$200,582
Vermont	$0	$76,550	$0
Virginia	$0	$863,443	$235,403
Washington	$449,114[a,d]	$719,388	$0
West Virginia	$0	$222,445	$0
Wisconsin	$0	$654,871	$212,125
Wyoming	$0	$62,558	$0
State Sub-Total	$9,696,318	$34,351,184	$3,827,266
America Samoa	$0	$0	$0
Guam	$0	$21,306	$0
Marshall Islands	$0	$8,284	$0
Micronesia	$0	$15,058	$0
Northern Marianas	$0	$8,746	$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
(CENTERS FOR DISEASE CONTROL AND PREVENTION)
FY 2013 DISCRETIONARY STATE GRANTS
CFDA NUMBER: 93.136
INJURY PREVENTION AND CONTROL

	Core State Injury Program[2]	Rape Prevention and Education	National Violent Death Reporting System
STATE/TERRITORY	**FY 2011 Actual**	**FY 2011 Actual**	**FY 2011 Actual**
Puerto Rico	$0	$463,232	$0
Palau	$0	$0	$0
Virgin Islands	$0	$17,207	$0
Territory Sub-Total	$0	$533,833	$0
Total	$9,696,318	$34,885,017	$3,827,266

[1]This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://wwwn.cdc.gov/Fundingprofiles/FundingProfilesRIA/

[2]Note all Core VIPP grantees receive funding for the Base Integration Component of the Core VIPP program. A select group of states participating in the Base Integration Component were awarded funding for additional components under the Core VIPP program. These included: a- Regional Network Leaders, b -Surveillance Quality Improvement, c -Older Adult Falls Prevention and d -Motor Vehicle Injury Prevention. For more information on these additional components please go to http://www.cdc.gov/injury/stateprograms/index.html

OCCUPATIONAL SAFETY AND HEALTH

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$224.355	$181.864	$0.000	-$181.864
PHS Evaluation Transfers	$91.724	$110.724	$249.364	+$138.640
EEOICPA – Mandatory	$55.358	$55.358	$55.358	$0.000
World Trade Center – Mandatory	$71.000	$174.354	$170.636	-$3.718
Total	**$442.437**	**$522.300**	**$475.358**	**-$46.942**
FTEs	1,206	1,200	1,199	-1

Authorizing Legislation: PHSA §§ 301, 304, 306, 307, 308d, 310, 311, 317A, 317B, 319, 327, 352, 399G, 399M, 1102, 2695; Bayh-Dole Act of 1980 (P.L. 96-517); Occupational Safety and Health Act of 1970 §§20–22, P.L. 91-596 as amended by PL 107-188 and 109-236 (29 U.S.C. 669–671); Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164 and P.L. 109-236 (30 U.S.C. 811–813, 842, 843–846, 861, 951–952, 957, 962, 963, 964); Black Lung Benefits Reform Act of 1977 § 19, P.L. 95-239 (30 U.S.C. 902); Bureau of Mine Act, as amended by P.L. 104-208 (30 U.S.C. 1 note, 3, 5); Radiation Exposure Compensation Act, §§ 6 and 12 (42 U.S.C. 2210 note); Energy Employees Occupational Illness Compensation Program Act as amended (42 U.S.C. 7384, et seq); Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 §§ 3611, 3612, 3623, 3624, 3625, 3626, 3633 of P.L. 106-398; National Defense Authorization Act for Fiscal Year 2006, P.L. 109-163; Toxic Substances Control Act, P.L. 94-469 as amended by 102-550, (15 U.S.C. 2682, 2685); Ryan White HIV/AIDS Treatment Extension Act of 2009 § 2695, P.L. 111-87 (42 U.S.C. 300ff-131), James Zadroga 9/11 Health and Compensation Act (2010), P.L.111-347

FY 2013 Authorization……..……...Expired/Indefinite

Allocation Methods: Direct Federal/Intramural; Competitive Grant/Cooperative Agreements; Contracts; Other

SUMMARY

CDC's FY 2013 request of $475,358,000 for occupational safety and health, including $55,358,000 in mandatory funding for the Energy Employees Occupational Illness Compensation Program and $170,636,000 in mandatory funding for the World Trade Center Program, is an overall decrease of $46,942,000 below the FY 2012 level for NIOSH.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
National Occupational Research Agenda	$111.367	$111.366	$91.724	-$19.642
Other Occupational Safety and Health Research	$182.756	$181.222	$157.640	-$23.582
Mining Research (non-add)	$52.687	$52.363	$52.687	+$0.324
Education and Research Centers (non-add)	$24.321	$24.268	$0.000	-$24.268
Personal Protective Technology (non-add)	$16.880	$16.791	$16.880	+$0.089
Nanotechnology (non-add)	$9.500	$9.500	$9.500	$0.000
World Trade Center – BA	$21.956	$0.000	$0.000	$0.000
EEOICPA – Mandatory	$55.358	$55.358	$55.358	$0.000
World Trade Center – Mandatory	$71.000	$174.354	$170.636	-$3.718

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Total	**$442.437**	**$522.300**	**$475.358**	**-$46.942**

On an average day, 14 workers in the United States die from injuries sustained at work and 134 die from work-related diseases, despite improvements in workplace safety and health. CDC's National Institute for Occupational Safety and Health (NIOSH), established by the Occupational Safety and Health Act of 1970, conducts research and makes recommendations to prevent work-related injury and illness, and provides training to occupational safety and health professionals.

- CDC works to prevent the burden of workplace injury and illness through research, information dissemination, education, and training in the field of occupational safety and health.
- Through partnerships, CDC focuses research on developing effective products and translating research findings, technologies, and information into highly effective prevention practices and products that can be adopted in the workplace.
- CDC targets dissemination efforts to maximize outreach, and evaluates and demonstrates the effectiveness of these efforts in improving worker safety and health.
- CDC funding supports research to prevent or reduce work-related injury and illness, and provides guidance to and builds capacity in the occupational safety and health community.
- CDC administers two mandatory federal programs: the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) and the World Trade Center (WTC) Health Program.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$381.954
2009	$360.059
2010	$429.965
2011	$442.437
2012	$522.300

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment and do not include mandatory funding.

NATIONAL OCCUPATIONAL RESEARCH AGENDA (NORA) BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$19.643	$0.642	$0.000	-$0.642
PHS Evaluation Transfer	$91.724	$110.724	$91.724	-$19.000
Total	**$111.367**	**$111.366**	**$91.724**	**-$19.642**

Program Overview: The National Occupational Research Agenda (NORA) provides guidance to the occupational safety and health community on research priorities within nine industry sectors: Construction; Health Care and Social Assistance; Manufacturing; Mining; Oil and Gas; Services; Public Safety; Wholesale and Retail Trade; and Transportation, Warehousing, and Utilities. NORA works to maximize the impact of occupational safety and health research through partnerships to promote widespread adoption of improved workplace safety and health practices based on research findings. Work in two of the nine NORA industry sectors is described below.

Budget Proposal: CDC's FY 2013 request of $91,724,000 for NORA is $19,642,000 below the FY 2012 level as a result of the elimination of the Agricultural, Forestry and Fishing (AgFF) sector. AgFF is one of ten sectors that CDC has been focused on over several years. There have been positive accomplishments from this program. However, given the relation to CDC's mission and the ability to have a national impact on improved health outcomes, the AgFF program has been designated as a low-priority program and proposed for elimination in a limited resource environment. Over 136.9 million Americans, the majority of working adults, are employed in the nine remaining research sectors and CDC will focus on the needs of this significant group.

Construction Safety and Health Research

Program Overview: NORA's Construction Research program aims to reduce injury and illness from traumatic injuries through improved understanding of factors related to work organization and culture, strengthening and expanding training and education, and improving design strategies.

Recent accomplishments:

- Worked with the Occupational Safety and Health Administration (OSHA) to develop practical guidance on nail gun safety for contractors. Nail guns are commonly used in construction and are responsible for as many as 40,000 injuries requiring emergency department visits each year.
- Initiated multiple efforts to integrate worker safety and health into green and sustainable construction, including partnering with the U.S. Green Building Council to address worker safety and health issues. With the U.S. Department of Labor, CDC provided a critical review of several documents prepared under the aegis of the Vice President's Task Force on Middle Class Working Families, including the Strategic Plan of the Federal Healthy Homes Work Group. The plan provides comprehensives guidance for practitioners involved with weatherization efforts, which are used to make homes healthier and more energy-efficient; creates a focal point where healthy homes and worker safety and health efforts meet; and provides training for tens of thousands of workers.
- Published on-line "Blind Area Diagrams" for construction vehicles to reduce injuries and deaths from back-overs. A leading cause of work-zone fatalities is a result of being struck by construction equipment. Diagrams can be used as visual aids for training drivers and ground workers to improve awareness, by equipment manufacturers to improve vehicle design, and by companies when evaluating equipment to ensure safe working conditions for their workers.

In FY 2013, CDC will:

- Conduct research and develop templates, in conjunction with partners, for a national, industry-wide fall injury-related fatalities prevention campaign.
- Work with partners to implement fall injury controls and intervention for aerial lifts, an important technical engineering solution that fills a critical gap in preventing falls in construction.
- Continue to target research on high-priority issues affecting construction workers, including engineering controls to reduce silica exposures, new approaches to reduce noise-induced hearing loss, and developing additional hazard and exposure information on welding fumes.
- Continue research and development of measuring safety and health performance indices (i.e., leading indicators) in the construction industry to improve performance and benchmarks, monitor trends over time, and demonstrate the value of health and safety programs in business terms. This activity will be particularly helpful for small business owners.

- Continue to provide domestic and global leadership to prevent work-related illness, injury, disability, and death by systematically gathering information, conducting targeted research, and translating knowledge gained into products tailored to meet sector needs.

Manufacturing Safety and Health Research

Program Overview: The NORA Manufacturing Research program focuses on strategic areas such as injuries, hearing loss, cancer, and emerging issues. One of the most critical emerging issues is exposure to nanoparticles and nanomaterials. CDC provides national and international leadership in investigating the implications of nanoparticles and nanomaterials for work-related injury and illness and explores their potential applications in occupational safety and health. Research results serve as the basis for risk assessments, development of recommended exposure limits, and risk management methods to prevent occupational lung disease in workers exposed to nanomaterials. CDC works with a variety of partners in academia, safety and health, and government to conduct research in order to answer questions that are critical for supporting the responsible development of nanotechnology and for advancing U.S. leadership in the competitive global market. Funding for nanotechnology research is both intramural and extramural.

Recent accomplishments:

- Published the first recommended exposure limit for the nanometer form of a widely used chemical, Titanium Dioxide, based on its distinct toxicology and an assessment of risk.
- Led the first ever international conference on research needs in medical screening, epidemiology, and exposure registries for nanomaterial workers.
- Initiated an industry-wide study to develop detailed exposure data and possible human health consequences from occupational exposure to carbon nanotubes and nanofibers.

In FY 2013, CDC will:

- Continue research to reduce uncertainty about the health effects of nanotechnology, with a focus on high-priority nanomaterials. This research includes laboratory-based toxicological studies to evaluate adverse pulmonary, cardiovascular, central nervous system, cell reproduction, and dermal effects of exposure to nanoparticles.
- Conduct field investigations that support the development of an evidence base of risks and controls for workers, including specific prevention recommendations for employers that will support sustainable economic growth and job creation through increased investments in nanotechnology.
- Develop, disseminate, and assess the use and impact of guidance materials for businesses and government agencies to develop effective risk-management programs.

OTHER OCCUPATIONAL SAFETY AND HEALTH BUDGET REQUESTS

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$182.756	$181.222	$0.000	-$181.222
PHS Evaluation Transfer	$0.000	$0.000	$157.640	+$157.640
Total	**$182.756**	**$181.222**	**$157.640**	**-$23.582**

Program Overview: CDC's other occupational safety and health activities include crucial areas such as training of occupational safety and health professionals and personal protective technology. In terms of training, CDC supports academic degree programs and research training opportunities in occupational safety and health disciplines, as well as a number of short-term training programs for professionals.

CDC's personal protective technology program focuses on research, standards, development, respirator certification, surveillance and outreach. Occupational safety and health surveillance and exposure assessment research are also included within the key components that comprise CDC's other occupational safety and health activities.

Budget Proposal: CDC's FY 2013 request of $157,640,000 for Other Occupational Safety and Health is $23,582,000 below the FY 2012 level as a result of the elimination of the Education and Research Centers (ERCs). Given the limited federal resources in a resource-constrained environment, this program is a lower priority program across CDC. When the ERC program was originally created almost 40 years ago, there were a limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. The ERCs' reach and impact have grown substantially across the nation since the program's inception. More than 30 years later, many schools of public health include coursework and many have specializations in these areas. Although the federal portion of these grants will be terminated in the FY 2013 Budget, CDC will continue to provide technical assistance to the ERCs as requested.

Mining Safety and Health Research

Program Overview: The goal of CDC's Mine Safety and Health Research program is to eliminate mining fatalities, injuries, and illnesses through research and prevention. Collaboration with stakeholders, which encompass industry, labor, and government, provides a knowledgeable and diverse foundation for formulating a relevant research portfolio that addresses the most pressing mine safety and health issues of our time. CDC has made significant improvements in the areas of disaster prevention and response, respiratory-dust hazards, communication and tracking, oxygen supply, and refuge alternatives.

Recent accomplishments:

- Published guidance documents and conducted workshops on the safe use of diesel equipment in underground mines, including recommendations on maintenance, fuels, filter technologies, engine types, and monitoring.
- Completed research and prepared reports, including one to Congress, describing safety issues and engineering guidelines for deep-cover pillar recovery, which continues to be a significant ground control hazard in underground coal mines. Pillar recovery is an underground mining technique that involves excavating a room or chamber while leaving behind pillars of material for support.
- Completed research in lighting that has led to the development of a new type of cap lamp to better illuminate mining hazards and a visual warning system to alert miners of impending machine movements.

Budget Proposal: CDC's FY 2013 request of $52,687,000 for mine research is $324,000 above the FY 2012 level.

In FY 2013, CDC will:

- Reduce the likelihood of mine disasters by developing improved design techniques and improving the ability of mineworkers to escape the mine under emergency conditions through enhanced system design, more effective training, and appropriate application of technology.
- Identify, evaluate, demonstrate, and diffuse technologies that can improve mine worker survivability during post-accident conditions, increase the safety and effectiveness of mine rescue teams, prevent disasters, and reduce exposure to hazardous conditions in the mining environment.

Personal Protective Technology

Program Overview: Personal Protective Technology (PPT) is a cross-cutting area that is critical to all nine NORA industry sectors. An estimated 20 million workers use personal protective equipment (PPE) on a

regular basis to protect them from job hazards. The PPT program focuses on preventing work-related injury, illness, and death by advancing the state of knowledge and application of PPT. The PPT program is the only federal program responsible for conducting occupational PPT research, certifying respiratory protection, and evaluating product performance. Program activities are developed and conducted in collaboration with its strong private and public stakeholder base. In addition, seven National Academy of Sciences reports have defined and supported the PPT program, which has used these reports to focus its activities on the most important PPT issues.

Recent accomplishments:

- Improved the inventory and quality of respiratory protection for workers in all industry sectors by making 588 respirator approval decisions (including 356 new approvals) and completing 119 respirator audit activities in FY 2010.
- Produced a Respirator Trusted Source page on the CDC website that is designed to enable the PPE-user community to make informed decisions about respirators most appropriate for workplace environments.
- Developed real-time, end-of-service time indicators for air-purifying respirators using electronic microchips capable of informing users of the need to replace used cartridges before "breakthrough" of hazardous vapors occur. Six manufacturers participated in the integration of sensors into air-purifying respirator cartridges and found that sensors could be located inside the cartridge without adversely affecting the cartridge's performance.
- Added 66 new compounds to enhance the CDC MultiVapor™ computer tool, which estimates breakthrough times and service lives of air-purifying respirator cartridges manufactured to remove toxic organic vapors from breathed air. Industrial hygienists and other qualified personnel use MultiVapor™ to set respirator gas and vapor cartridge change-out schedules to keep respirators working effectively to protect workers from multiple hazardous vapor exposures.

Budget Proposal: CDC's FY 2013 request of $16,880,000 for PPT is $89,000 above the FY 2012 level.

In FY 2013, CDC will:

- Conduct research on PPT, including research to advance state-of-the art technology to understand and improve protection, usability, comfort, fit, and user acceptance for all workers who rely on PPE. Emphasis will be placed on fire fighter PPE ensembles, PPE for health care workers, and escape technology for miners.
- Develop PPT standards and test methods, including a standard to improve combination of self-contained/air-purifying respirators, a standard to define remaining service life alarms for self-contained breathing apparatus, a new fee schedule for respirator certification, and a standard on inward leakage requirements for half-mask filtering facepiece respirators to provide increased assurance that these respirators can be expected to protect the user against inhalation exposures when properly donned and used.
- Pursue continuous improvement of the respirator certification program by increasing the responsiveness and effectiveness of evaluations to ensure timely approvals and expedited resolution of audit and product investigation findings, and rapid investigation and correction of occurrences of misuse with the NIOSH certification label.

- Enhance protection for wild land firefighters from the inhalation hazards of smoke and fire by-products. The implementation of CDC certification for a new class of air-purifying respirators will enable the certification of respirators to the National Fire Protection Association's (NFPA) 1984 standard. The resulting class of air-purifying respirators identified in the NFPA 1984 standard's specifications will meet the needs of this responder group.

- Develop respirator use policy statement for the fire service practice of "buddy breathing" with self-contained breathing apparatus (SCBA). "Buddy breathing" allows a firefighter to share his/her SCBA's remaining breathing air with a fellow firefighter who has a depleted source of breathing air to facilitate the escape of the fellow firefighter from the fire scene.

State-Based Surveillance

Program Overview: For over 30 years, CDC has promoted and supported state-based occupational safety and health surveillance and intervention programs. CDC provides the tools necessary for states to understand and prevent work-related risks; introduce activities that are vital to the prevention of occupational injuries, illnesses, and death; and that are relevant to all nine NORA industry sectors. A 2009 Council of State and Territorial Epidemiologists capacity assessment survey showed that 35 states had minimal-to-no capacity in occupational safety and health. Currently, CDC funds 14 states to build capacity in occupational safety and health surveillance, and nine states to expand programs that address state priorities, including occupational fatalities, work-related asthma, silicosis, teen injuries, truck driver health, hospital worker injuries, and temporary worker health. CDC is building this capacity given that states are uniquely positioned to identify priorities, target prevention efforts, and measure success.

Recent accomplishments:

- Conducted investigations of several fires and worker deaths through the CDC-funded Massachusetts Fatality Assessment and Control Evaluation (FACE) program, which led to a new Massachusetts law in January 2011 that prohibits the sale of a highly flammable lacquer floor sealer.

- Conducted FACE investigations of youth less than 18 years of age and used the results to inform the Department of Labor's most ambitious revisions to the child labor regulations in the last 30 years, enacted in July 2010.

- Expanded funding from 15 to 23 states. These state-based surveillance programs are administered by a public health department, labor department, or state public health institute.

In FY 2013, CDC will:

- Fund 23 states to:
    - Build state health department capacity to conduct occupational safety and health surveillance and to develop intervention and prevention programs.
    - Conduct surveillance programs that track and target interventions in selected occupational conditions, hazards, or populations at high-risk.

State-Based Surveillance Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	23	23	23
Average Award	$0.271	$0.271	$0.236
Range of Awards	$0.094–$0.858	$0.094–$0.858	$0.094–$0.671
Number of New Awards	0	0	0
Number of Continuing Awards	23	23	23

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Mandatory Funding	**$55.358**	**$55.358**	**$55.358**	**$0.000**

Program Overview: The EEOICPA is a mandatory federal program that provides compensation to employees or survivors of employees of the Department of Energy (DOE) facilities and private contractors diagnosed with a radiation-related cancer, beryllium-related disease, or chronic silicosis because of their work in producing or testing nuclear weapons. CDC conducts dose reconstructions to estimate an employee's occupational radiation exposure for certain cancer cases, considers and issues determinations on petitions for adding classes of workers to the Special Exposure Cohort (SEC), and provides administrative support to the Advisory Board on Radiation and Worker Health (ABRWH). The Department of Labor (DOL) uses these estimates in making compensation determinations.

Recent accomplishments:

- Improved the timeliness of completing dose reconstructions through the establishment of a management objective to complete all draft dose reconstructions within one year. The number of cases in this category has been reduced from 4,311 at the time the objective was established to 95 cases in July 2011.
- Received 25 petitions for adding classes of workers to the SEC in FY 2010. During FY 2010, 21 classes of workers were added to the SEC; a total of 76 classes of workers have been added to the SEC as of July 2011.
- Completed the certification and accreditation process and were granted full authority to operate for all of the information systems used to support activities under EEOICPA. These information systems consist of 6.5 terabytes of files in 43 databases and much of this information is sensitive.

Budget Proposal: CDC's FY 2013 request of $55,358,000 in mandatory funding for EEOICPA is level with FY 2012.

In FY 2013, CDC will:

- Receive approximately 230 dose reconstruction cases per month from the DOL. The funds will be used to help CDC meet its established objectives for processing EEOICPA claims.
- Identify classes of workers whose radiation doses cannot be estimated and require inclusion in the SEC.
- Provide administrative assistance to ABRWH, which is responsible for evaluating the scientific validity of dose reconstructions and making recommendations to the HHS Secretary for adding additional classes to the SEC.

WORLD TRADE CENTER BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$21.956	$0.000	$0.000	$0.000
Mandatory Funding	$71.000	$174.354	$170.636	-$3.718
Total	**$92.956**	**$174.354**	**$170.636**	**-$3.718**

Program Overview: The James Zadroga 9/11 Health and Compensation Act of 2010 (the Act) was enacted on January 2, 2011. HHS, along with CDC, implemented the provisions of the statute on July 1, 2011, to provide monitoring and treatment benefits to eligible responders and survivors. The WTC Health Program provides quality care for WTC-related health conditions, conducts WTC research, and maintains a health registry to collect data on victims of the September 11, 2001, terrorist attacks.

Recent accomplishments:

- Enrolled approximately 58,000 eligible WTC responders and survivors in the WTC Health Program. Of these WTC responders and survivors, approximately 53,000 have received an initial health examination and in FY 2010 about 14,500 WTC responders received treatment for WTC-related health conditions.
- Awarded contracts to Clinical Centers of Excellence and Data Centers to provide the administrative and member services and uniform data collection, analysis, and reporting necessary for quality care to meet the provisions of the Act.
- Awarded a three-year cooperative agreement on April 29, 2009, to continue the WTC Health Registry of responders, residents, and other persons who were in the vicinity of the WTC site. The WTC Health Registry is the largest effort in the United States to track population health impacts due to a disaster. The WTC Health Registry enrolled over 71,000 residents, workers, students, and responders before it closed to new registrants in 2004.
- Awarded contracts to conduct scientifically rigorous research to help answer critical questions about physical and mental health conditions that may be related to the September 11, 2001, terrorist attacks, including 1) risk factors for disease, 2) patterns of illness, 3) exposure-response relationships, and 4) improvements in diagnosis and treatment.

Budget Proposal: CDC's FY 2013 request of $170,636,000 in mandatory funding for WTC is $3,718,000 below the FY 2012 level. The mandatory funding represents the federal share of the estimated obligations. The reduction represents one-time administrative costs associated with initial implementation of the Act, such as one-time enrollment efforts and other activities.

In FY 2013, CDC will:

- Conduct education and outreach for individuals potentially eligible for health monitoring and treatment benefits.
- Continue providing programs and services to help meet the on-going and long-term health needs associated with exposure to smoke, dust, debris, and psychological trauma following the September 11, 2001 attack on the WTC.
- Continue to provide for the uniform data collection, analysis, and reporting of WTC-related health condition data of all individuals provided monitoring or treatment benefits.

BUDGETARY OUTPUTS

Measures	Most Recent Result	FY 2012 Enacted	FY 2013 Target	FY 2013 +/-FY 2012
9.F: Number of agricultural centers (Output)	FY 2011: 10	10	0	-10
9.G: Number of research grants (Output)	FY 2011: 163	158	133	-25
9.H: Number of training grants (Output)	FY 2011: 50	50	20	-30
9.I: Number of states receiving public assistance (Output)	FY 2011: 37	35	35	No Change

PERFORMANCE

Efficiency Measure for Occupational Safety and Health

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
9.E.2: Reduce consumption of utilities (e.g., gas, electric, water) (Efficiency)	FY 2010: $2.66 / sq. ft. (Target Exceeded)	$3.16 / sq. ft.	$3.16 / sq. ft.	Maintain

Program: National Occupational Research Agenda (NORA)

CDC Contextual Indictors for Long Term Objective: Conduct research to reduce work-related illnesses and injuries

Measure	Most Recent Result	FY 2014 Target
9.2.3b: Reduce occupational illness and injury as measured by percent reduction in the number of construction workers killed in roadway construction work zones due to being struck by construction vehicles or equipment (Outcome)	Average of FY 1992-1998: 22	40% reduction

Performance Measures for Long Term Objective: Conduct research to reduce work-related illnesses and injuries

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
9.1.1: Improve progress in implementing activities in areas of occupational safety and health most relevant to future improvements in workplace protection[1] (Outcome)	FY 2010: Develop implementation plans in response to National Academies recommendations (Target Met)	50% of the [8] evaluated CDC NIOSH programs will receive a score of 2 out of 5 or better, and 50% of these will receive a score of 4 out of 5 or better based on an external review of their progress implementing recommendations from their National Academies reviews	N/A	N/A

[1]This is a biennial measure, and targets are established for FY 2012 and FY 2014.

Performance Trends: Since 2007, CDC met or exceeded nine of the 10 performance targets set around activities to reduce workplace injury, illness, and death. Ultimately, CDC monitors program performance through reductions in occupational illness and injury.

CDC entered into a contract with the National Academies (NA) to conduct a review of its occupational safety and health (OSH) research program portfolio. As part of the National Academies' comprehensive review of research activities and National Occupational Research Agenda (NORA), 100 percent of CDC programs developed comprehensive outcome-based measures and targets in conjunction with stakeholders and customers in 2011. As a result, each research project now links to these outcome-based measures and targets. Further, CDC will track intermediate outcomes and outputs for these projects to determine progress and identify gaps that need to be addressed (Measure 9.1.1).

Roadway construction workers risk fatal and serious non-fatal injuries in work zones; often, ground workers work in close proximity to construction equipment. Measure 9.2.3b reflects long-term results of a unique research project initially funded through NORA. Moreover, it is indicative of a larger population of workers at risk of being struck by operating equipment within the construction industry as well as in the mining, transportation, and warehousing industries. A CDC analysis of the Census of Fatal Occupational Injuries special research file (1992–1998) provided by the Bureau of Labor Statistics established the baseline in 2003. Over this seven year period, there were 154 fatal occupational injuries to workers in roadway work zones caused by workers hit by construction vehicles and equipment. CDC will reduce the baseline average of 22 deaths per year by 40 percent in 2014. Data since 2003 indicate that the number of fatalities peaked in 2005 at 32 and dropped annually thereafter to 14 deaths in 2010 (preliminary). If risk remains constant over time, the measure can be expected to rise and fall relative to changes in roadway construction activity.

Program: Other Occupational Safety and Health Research

Performance Measures for Long Term Objective: Promote safe and healthy workplaces through interventions, recommendations and capacity building

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
9.1.2a: Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; measure the success of implemented intervention strategies (Output)	FY 2010: 163 research and intervention projects were based on tracking information (Target Met)	Evaluate the role that tracking information had in designing research and intervention projects	Evaluate the role that tracking information had in designing research and intervention projects	No Change
9.1.2b: Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; measure the success of implemented intervention strategies (Output)	FY 2010: 52 intervention projects used tracking information to demonstrate the success of intervention strategy (Target Met)	Identify the role that follow-up tracking information can have in assessing the success of interventions	Identify the role that follow-up tracking information can have in assessing the success of interventions	No Change
9.1.2c: Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; measure the success of implemented intervention strategies (Output)	FY 2010: 7.0 adults per 100,000 with elevated blood lead levels (Target Not Met)	Reduce the prevalence rate of elevated blood lead levels in adults by 3% (from the previous year value)	Reduce the prevalence rate of elevated blood lead levels in adults by 3% (from the previous year value)	No Change
9.2.1: Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation (Output)	FY 2011: 81.3% (Target Exceeded)	80%	80%	Maintain
9.2.2a: Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors: Reduction of non-fatal injuries among youth ages 15–17 (Outcome)	FY 2011: 3.3 / 100 FTE (Target Exceeded)	4.2 / 100 FTE	4.2 / 100 FTE	Maintain
9.2.2c: Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors: Percentage of active underground coal mines in the U.S. that possesses NIOSH-approved plans to perform x-ray surveillance for pneumoconiosis (Outcome)	FY 2011: 97% (Target Exceeded)	90%	90%	Maintain
9.2.3a: Reduce occupational illness and injury as measured by: Percent reductions in respirable coal dust overexposure[1] (Outcome)	FY 2009: 30% (Historical Actual)	N/A	N/A	N/A
9.2.3c: Ensure the quality of NIOSH certified respirators by increasing the number of audit activities completed (Outcome)	FY 2011: 248 (Target Exceeded)	66	73	+7

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
9.A: Number of safety and health patent filings (Output)	FY 2011: 2 (Target Not Met)	5	5	Maintain
9.B: Certification decisions issued for personal protective equipment (Output)	FY 2011: 588 (Target Exceeded)	300	300	Maintain
9.C: Estimated academic graduates (Output)	FY 2011: 470 (Target Exceeded)	460	205	-255
9.D: Health Hazard Evaluations/Fatality Assessment and Control Evaluations (Output)	FY 2011: 281 (Target Not Met but Improved)	350	350	Maintain
9.E: Number of research articles published in peer-review publications (Output)	FY 2011: 366 (Target Exceeded)	250	250	Maintain

[1]This is a long term outcome measure, and final data will be collected in 2014.

Performance Trends: CDC continues to meet its performance targets by using surveillance information to develop and evaluate projects. In FY 2010, CDC based 163 research and intervention projects on tracking information, and 52 intervention programs used tracking information to demonstrate the effectiveness of the programs strategies. This data is useful in managing programs and setting strategic directions. In addition, CDC continues to make data available to researchers and the public (9.1.2a, 9.1.2b).

CDC targets resources to reduce occupational illnesses due to respirable coal dust overexposure by 50 percent in 2014. Recent trend data from 2009 indicates a 30 percent reduction in coal dust exposure, which is more than double the initial 13.7 percent reduction rate achieved in 2003 (9.2.3a).

An estimated 20 million workers use Personal Protective Equipment (PPE) to protect themselves from death and disabling injuries and illnesses, as well as from specific threats of exposure to certain airborne biological particles, chemical agents, splashes, noise exposures, fall hazards, head hazards, and fires. Further, improvements in personal protective technology (PPT) occur through new standards and regulations, revisions and alterations to existing standards, the subsequent availability of PPE that complies with the standards and regulations, and the successful use of PPE.

CDC's PPT program focuses expertise from many scientific disciplines to advance federal research on respirators and other personal protective technologies for workers. Audit activities ensure that CDC certified respirators achieve their approved level of performance and include respirator manufacturer site audits, product audits, product investigations, and product evaluations. CDC determines the number of audit activities completed through approval records. In 2011, CDC exceeded its target (9.2.3c). In 2011, data demonstrate improvements in the inventory and quality of respiratory protection for workers in all industry sectors through 588 certified respirator decisions and 248 completed respirator audit activities (9.2.3c, 9.B).

IT INVESTMENTS

CDC invests in several information technology systems that support Occupational Safety and Health (OSH) Research. These technologies include general support systems, such as tracking project-related activities, as well as targeted OSH systems to meet specific requirements, such as the radiation dose construction systems. CDC also invests in a searchable bibliographic database of occupational safety and

health publications, documents, grant reports, and other communication products supported in whole or in part by the agency. Additional OSH system investments include the Mine Rescue and Escape Training Lab System, the Underground Coal Mining System, World Trade Center Program Management and Administration, the Surveillance Image Management System (SIMS), Data-Mart (Division of Safety Research's Online Injury Surveillance Data Systems), National Occupational Respiratory Mortality System (NORMS), NIOSHTIC-2, Oak Ridge-Associated Universities (ORAU) Dose Reconstruction System, Division of Compensation Analysis Support (DCAS) Dose Reconstruction, Occupational Safety and Health Systems Rollup that pertains to similar surveillance-based OSH systems, OSH Industry and Occupation Computerized Coding System, Respiratory Disease Surveillance System, and the Underground Coal Mining System.

GLOBAL HEALTH

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$340.265	$347.594	$362.889	+$15.295
Total	**$340.265**	**$347.594**	**$362.889**	**+$15.295**
FTEs	722	719	718	-1

Authorizing Legislation: PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 361–369, 2315, 2341; Foreign Assistance Act of 1961 §§ 104, 627, 628; Federal Employee International Organization Service Act § 3; International Health Research Act of 1960 § 5; Agriculture Trade Development and Assistance Act of 1954 § 104; Economy Act 38 (38 U.S.C. 707); Foreign Employees Compensation Program (22 U.S.C. 3968); International Competition Requirement Exception (41 U.S.C. 253); The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L.108-25); Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act (P.L.110-293); Consolidated Appropriations Act, 2012 (P.L. 112-74)

FY 2013 Authorization……Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $362,889,000 for global health is an overall increase of $15,295,000 above the FY 2012 level. The FY 2013 request includes an increase of $15,079,000 for polio eradication activities.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Global HIV/AIDS	$118.741	$117.118	$117.156	+$0.038
Global Immunization	$150.854	$160.287	$175.417	+$15.130
Polio Eradication	$101.597	$111.286	$126.365	+$15.079
Global measles and other vaccine-preventable diseases	$49.257	$49.001	$49.052	+$0.051
Global Disease Detection and Emergency Response	$41.902	$41.601	$41.659	+$0.058
Parasitic Diseases and Malaria	$19.467	$19.367	$19.417	+$0.050
Global Public Health Capacity Development	$9.301	$9.221	$9.240	+$0.019
Total	**$340.265**	**$347.594**	**$362.889**	**+$15.295**

CDC is in the forefront of global health efforts and works in strong partnership with ministries of health (MOH), U.S. Government (USG) partners (i.e. Department of State (DOS) and U.S. Agency for International Development (USAID)), and non-government partners to:

- Implement and manage disease prevention, control, elimination, and eradication programs; strengthen the ability of governments and multilateral organizations to achieve international health goals; improve the effectiveness and efficiency of the world's health systems; develop new knowledge to better achieve global health goals; and expand programs that focus on the leading causes of mortality, morbidity, and disability, including both infectious and non-infectious diseases.
- Serve as a lead partner in the U.S. Global Health Initiative (GHI), which aims to improve global health through a coordinated and strategic whole-of-government approach, with a particular focus on women, newborn, and children's health. Building on the success of the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and other platforms, CDC brings technical expertise and established partnerships with MOH in support of GHI core principles, which include: a woman- and girl-centered approach; better interagency coordination; country ownership; strengthening and leveraging key multilateral organizations; improving metrics, monitoring, and evaluation; and promoting research and innovation.
- Build on CDC's long history of global health protection, including early successes in smallpox eradication, leadership in the response to Severe Acute Respiratory Syndrome (SARS), leadership in the response to the 2009 H1N1 influenza pandemic, and unique public health expertise. CDC is well-positioned to contribute to the success of GHI and to carry forward its core global health programs in FY 2013.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$302.371
2009	$308.824
2010	$346.614
2011	$340.265
2012	$347.594

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

GLOBAL HIV/AIDS BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$118.741**	**$117.118**	**$117.156**	**+$0.038**

Program Overview: As a principal USG agency implementing PEPFAR, CDC's primary role in global HIV/AIDS is to strengthen national responses to prevent the spread of HIV/AIDS, save the lives of persons living with HIV/AIDS, and enhance health systems to ensure local capacity for a comprehensive and self-sufficient response. CDC provides technical leadership and direct assistance to MOH and other partners in over 75 PEPFAR-supported countries through its headquarters office in Atlanta, four regional offices, and 41 field offices around the world. Regional offices are based in the Caribbean, Central America, Central Asia, and Southeast Asia. In addition to direct technical assistance, CDC provides financial assistance to MOH and other PEPFAR-implementing partners to perform activities in accordance with Country Operational Plans approved by the Department of State's Office of the Global AIDS Coordinator (OGAC).

CDC possesses unique scientific and technical expertise due to decades of experience addressing epidemics and emerging diseases in the United States and around the world. The 2008 PEPFAR reauthorization calls for CDC to lead program monitoring, impact evaluation research and analysis,

operational research, and implementation research to determine program effectiveness and to identify areas where further evaluation and research may be needed. Thus, CDC works to improve the quality and efficiency of PEPFAR programs, identify and implement cost-effective interventions, ensure transparency and accountability, assess population-based impact, and optimize delivery of services. In addition to its critical scientific and technical role, CDC maintains strong partnerships with other USG agencies and international organizations, such as the Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria; the Joint United Nations Programme on HIV/AIDS (UNAIDS); the World Health Organization (WHO); the World Bank; and many others.

Recent accomplishments, through PEPFAR, in FY 2011 CDC, in partnership with other USG agencies, directly supported:

- Life-saving antiretroviral drug treatment for more than 3.9 million people.
- HIV testing and counseling for more than 9.8 million pregnant women.
- Antiretroviral drug prophylaxis to prevent mother-to-child HIV transmission for more than 660,000 HIV-positive pregnant women, allowing approximately 200,000 infants to be born HIV-free.
- Care and support for nearly 13 million people, including more than 4.1 million orphans and vulnerable children.
- HIV counseling and testing for more than 40 million people, providing a critical entry point to prevention, treatment, and care.
- Accelerated transition of treatment program ownership in 13 countries from U.S.-based partners to indigenous organizations through programmatic, administrative, and fiscal oversight and leadership.
- Developed and launched the first-of-its-kind African Society of Laboratory Medicine, along with WHO and other partners. This initiative will help to ensure high quality laboratory capacity needed to support the entire public health system (beyond HIV/AIDS), including the rapid identification of emerging health threats, such as avian influenza.

Budget Proposal: CDC's FY 2013 request of $117,156,000 for global HIV/AIDS is an increase of $38,000 above the FY 2012 level. In addition to funding requested through the base appropriation, CDC receives interagency funding transfers to implement PEPFAR through the Department of State Global Health and Child Survival (GHCS) appropriations account.

In FY 2013, CDC will:

- Build epidemiologic, surveillance, and laboratory capacity, and support monitoring and evaluation systems that measure HIV prevalence and incidence, behavior change, and population health status in over 75 countries in which CDC provides technical assistance.
- Promote evidence-based, cost-effective HIV/AIDS services using established global platforms and domestic and international technical expertise.
- Conduct research to determine program impact, conduct economic analysis, and identify program efficiencies.
- Work to expand the following services and continue transitioning to country ownership:

- Develop comprehensive, evidence-based programs and training curricula to facilitate implementation of HIV prevention programs and conduct research, strengthen prevention strategies for most at-risk populations, and conduct research to determine the combined effectiveness of proven prevention interventions on rates of new HIV infection.
- Increase the number of HIV positive people on antiretroviral therapy to six million (cumulative) by providing supporting implementation of comprehensive HIV care and treatment programs and providing expertise to partners on management, standard operating procedures, human resources, physical infrastructure, lab services, monitoring and evaluation, linkages with other programs, and training on palliative care and antiretroviral therapy.
- Identify HIV-infected persons and offer risk-reduction counseling and linkage to care and treatment by developing and implementing counseling and testing policies, strategies, and programs, including scale up of these programs to national levels.
- Prevent mother-to-child HIV transmission, provide pediatric services, and link these programs with other health services while continuing efforts to reduce the number of new pediatric HIV infections by 90 percent by 2015.
- Increase TB/HIV prevention activities, including testing and counseling, referral, and care and treatment for TB patients.
- Support more than 4.7 million (cumulative) voluntary medical male circumcisions in eastern and southern Africa by leading male circumcision activities through facility and community assessments, clinical trainings, development of communication and counseling approaches, establishment of quality assurance and medical ethical standards, service provision, and contributions to development of normative guidelines.
- Develop, implement, and evaluate national strategies, policies, and practices for HIV/AIDS control including prevention, care, and treatment.

GLOBAL IMMUNIZATION BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$150.854**	**$160.287**	**$175.417**	**+$15.130**
Polio Eradication	$101.597	$111.286	$126.365	+$15.079
Measles and other vaccine-preventable diseases	$49.257	$49.001	$49.052	+$0.051

Program Overview: CDC's global immunization activities primarily focus on children under five years of age in developing countries who are at the highest risk for mortality and morbidity from polio, measles, and other vaccine-preventable diseases (VPDs). Activities also aim to protect children in the United States from VPDs acquired abroad and then transmitted into this country and to reduce domestic medical costs of morbidity and mortality associated with imported VPDs.

Recent accomplishments:

- Demonstrated a decline in global polio incidence by more than 99 percent, from more than 350,000 cases annually in 1988 to 1,349 cases in 2010. As of December 2011, there were 571 polio cases reported globally, with alarming increases in Chad, Democratic Republic of Congo (DRC), and Pakistan representing the bulk of the cases. Other countries, including India, are on track for wild poliovirus transmission interruption.

- Led the assessment of the risks of failing to detect and interrupt wild poliovirus transmission for the Global Polio Eradication Initiative (GPEI) and helped guide eradication efforts via publication of the first quarterly risk assessments at the end of 2010. Impressive progress toward controlling virus transmission was noted in all importation countries and in the endemic countries of India and Nigeria. Continuing areas of concern are: Angola, DRC, Pakistan, parts of the Russian Federation, and the Uganda/Kenya region.

- Activated the CDC Emergency Operations Center (EOC) on December 2, 2011 to support the Global Polio Eradication Initiative, in coordination with WHO, UNICEF, Rotary International, Bill and Melinda Gates Foundation, other USG agencies, and MOH. The EOC activation allows CDC to provide enhanced technical assistance for polio eradication through the deployment of teams to support field activities in immunization and surveillance, management training, and strengthening routine immunization.

- Responded to the African measles outbreaks by conducting measles outbreak investigations in Malawi, Namibia, Sierra Leone, and Zambia in 2010. CDC provided further support to the African region through measles vaccine purchase and technical assistance to improve measles surveillance systems.

- Spearheaded the production of a *Journal of Infectious Diseases* supplement titled, "Global Progress Toward Measles Eradication and Prevention of Rubella and Congenital Rubella Syndrome."

- Contributed to the vaccination of one billion children as a co-founder of the Measles Initiative and a reduction of 81 percent in global measles mortality in all ages from an estimated 733,000 deaths in 2000 to an estimated 139,000 deaths in 2010.[11,12]

- Contributed to sustaining 47 countries of the Americas free from non-importation of measles cases in the face of measles outbreaks in other regions of the world.

- Participated in planning and preparation for multi-antigen campaign in Haiti and rebuilding of national immunization program following the 2010 earthquake.

- Contributed to a year without polio transmission in India as of January 2012 by placing personnel on short- and long-term assignments through WHO or UNICEF country offices to support Indian polio eradication efforts, serving on national Expert Advisory Groups providing scientific and technical recommendation to national authorities to guide the eradication efforts, helping create policies and strategies to interrupt circulation of the wild poliovirus, and helping to implement those strategies in the field with local health officials and community leaders.

Budget Proposal: CDC's FY 2013 request of $175,417,000 for global immunization is an increase of $15,130,000 above the FY 2012 level. This increase will provide augmented support, through more frequent and intensive technical assistance, in the remaining four polio-endemic countries of Afghanistan, India, Nigeria, and Pakistan; the three reinfected countries of Angola, Chad, and DRC; and other countries at risk for polio infection or transmission in accordance to the USG-endorsed Global Polio Eradication Strategic Plan. These efforts will support the goals of removing India from the list of endemic

[11] http://www.measlesinitiative.org

[12] Measles outbreaks in Africa delayed the completion of WHO country consultations to validate global measles mortality data for 2009; WHO is expected to release these data in December 2011 or January 2012.

countries by end of 2012 and of achieving global polio eradication as outlined in the Global Polio Eradication Strategic Plan.

In FY 2013, CDC will:

- Provide greater support for new laboratory procedures that significantly decrease the time it takes to detect and confirm new polio infection from 42 to 21 days and correct operational challenges, such as maintaining proper storage and temperatures of samples transported to the laboratory. This support will enable more rapid detection of wild poliovirus and allow for faster response to importations and/or spread of virus.
- Continue to provide quarterly risk assessments reports to the Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative (GPEI).
- Enhance support for experienced Stop Transmission of Polio (STOP) Program vaccination teams in Angola, Chad, DRC, Nigeria, and South Sudan, and other countries at risk for polio infection or transmission, along with specialized National STOP (N-STOP) teams in Pakistan to reach local districts.
- Continue to ensure a sustainable supply and pricing of the most effective vaccines, in partnership with the United Nations Children's Fund (UNICEF) and industry partners, in order to achieve global polio eradication.
- Continue end-game discussions and research into timing and method(s) for switching from use of the Sabin to the Salk vaccine. The Strategic Advisory Group of Experts (SAGE) has a working group on inactivated polio vaccine policy that advises the SAGE on the role of inactivated polio vaccine in routine immunization following oral polio vaccine cessation, and on other polio immunization issues.
- Purchase at least 254 million doses of oral polio vaccine for use in mass vaccination campaigns in Southeast Asia, Africa, and Europe, as CDC works toward the target of certified global polio eradication by the end of 2015.
- Continue to provide enhanced technical assistance, via the CDC Emergency Operations Center, for polio eradication. Deployment of teams will support field activities in immunization and surveillance, management training, and strengthening routine immunization. This scale-up effort requires sustained commitment by the U.S. government to achieve success, for as long as polio transmission continues in any nation, it remains a threat to every nation.
- Provide leadership in the Global Polio Eradication Strategic Initiative as the lead partner responsible for monitoring the execution and verification of Initiative activities.
- Sustain epidemiologic, laboratory, and programmatic support to WHO and UNICEF to evaluate and strengthen surveillance capacity; collaborate with countries for outbreak investigations and rapid response activities; and support planning, monitoring, and evaluating supplementary immunization activities. CDC will also expand the provision of short-term technical assistance support through an estimated 75–150 additional CDC scientific experts, temporary assignments based on needs in the field.
- Expand measles vaccination campaigns into high-burden South Asian countries to help reduce the number of global measles-related deaths to 75,000 (down from an estimated 733,000 in FY 2000).
- Improve the quality of VPD surveillance through capacity building, training, and developing information systems.

- Strengthen routine immunization programs through multilateral partnerships to improve vaccination service delivery, improve vaccination coverage rates for WHO-recommended vaccines, and to provide access to new and underutilized vaccines for target populations.
- Provide epidemiologic, laboratory, and programmatic support to WHO and UNICEF and provide expertise in virology, diagnostics, and laboratory procedures.
- Serve as a global reference laboratory for polio, measles, and rubella in a global network of 690 laboratories responsible for confirming diagnostics from other countries and genomic sequences of samples obtained worldwide.
- Participate in planning and preparation of a multi-antigen campaign in Haiti (2012) to boost immunity levels for polio, measles, and rubella and to assist in rebuilding the Haitian national immunization program, including the introduction of new vaccines, following the 2010 earthquake.

GLOBAL DISEASE DETECTION AND EMERGENCY RESPONSE BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$41.902**	**$41.601**	**$41.659**	**+$0.058**

Program Overview: CDC's Global Disease Detection (GDD) and Emergency Response programs provide the technical assistance and support needed to detect and contain disease threats, build public health capacity, and provide support for humanitarian emergencies, protecting the health of the U.S. population and the global community. The GDD program is comprised of strategically positioned GDD Regional Centers in seven countries, the GDD Operations Center based at CDC headquarters, and international partner networks that support global health security activities. CDC's International Emergency Refugee Health activities reduce morbidity and mortality and improve the health of populations affected by humanitarian emergencies through humanitarian public health action, operational research, emergency public health policy development, and global capacity building activities. CDC's portfolio of global health security activities leverages agency-wide expertise to ensure adequate capacity in field epidemiology and surveillance; zoonotic disease investigation and control; public health information technology systems; and laboratory diagnostics, biosafety, systems development, and biosecurity practices for extremely dangerous pathogens in over 50 countries.

Recent accomplishments:

- Provided rapid response to 156 disease outbreaks and public health emergencies (704 total since 2006), including febrile encephalitis, human H5N1 influenza, viral hemorrhagic fever, and cholera.
- Increased capacity to detect dangerous pathogens through focused population-based surveillance for pneumonia and other locally important diseases and syndromes covering more than 108 million persons.
- Established 29 new laboratory diagnostic tests in-country through training and technology transfer, enabling host countries to detect emerging health threats locally.
- Discovered new disease threats, including two pathogens that are new to the world, three that are new within their regions, and one that has a new mode of transmission.

- Provided emergency technical assistance to over 70 humanitarian assistance missions in 26 countries in FY 2010, including stabilizing the public health system and responding to the ongoing cholera outbreak in post-earthquake Haiti.
- Provided emergency technical assistance to over 90 humanitarian assistance missions in 29 countries in FY 2011.

Budget Proposal: CDC's FY 2013 request of $41,659,000 for global disease detection and emergency response is an increase of $58,000 above the FY 2012 level.

In FY 2013, CDC will:

- Promote global health security and protect the health of U.S. citizens and the global community from urgent public health threats. CDC's GDD and Emergency Response programs will provide rapid response, similar to previous years, to approximately 100 disease outbreaks and public health emergencies, likely to include febrile encephalitis, human H5N1 influenza, viral hemorrhagic fever, and cholera.
- Expand and enhance core public health capacities in rapid outbreak response, strengthening surveillance and national laboratory systems, and training human resources in seven GDD Regional Centers currently located in China, Egypt, Guatemala, India, Kenya, South Africa, and Thailand.
- Continue to build scientific capacity and expertise to rapidly detect, identify, and contain outbreaks of emerging infectious disease, new pathogens, and bioterrorist threats. These GDD Regional Centers will detect dangerous pathogens through focused population-based surveillance covering approximately 108 million people.
- Strengthen interagency partnerships with existing USG partners (Department of Defense, DOS, USAID, and National Security staff) through the promotion of global health security.
- Expand CDC's involvement with new USG and non-governmental partners to promote coherent, coordinated policies and programs and effective use of global health security resources to partner governments.
- Provide technical expertise and experience, including rapid health and nutrition assessment, public health surveillance, epidemic investigation, disease prevention and control, program evaluation, and emergency preparedness to assist MOH, USG partners, and other non-governmental partners. Through these collaborations, CDC will establish dozens of new laboratory diagnostic tests in-country through training and technology transfer, enabling host countries to detect emerging health threats locally.
- Build a collaborative partner network with strategic international, bilateral, and non-governmental relief organizations to ensure data-driven, evidence-based public health interventions are used during humanitarian emergencies.
- Complete five operation research projects while simultaneously continuing to support an additional five projects that expand the USG's ability to effectively program and monitor U.S. humanitarian aid.

PARASITIC DISEASES AND MALARIA BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$19.467**	**$19.367**	**$19.417**	**+$0.050**

Program Overview: CDC works to reduce the death and illness caused by parasitic diseases, including malaria, both globally and in the United States. As a key implementing partner for the President's Malaria Initiative (PMI), CDC assists with enhancement of vector control, case management, surveillance, monitoring and evaluation, and capacity building. In addition to PMI activities, CDC works with MOH and other partners to conduct essential operations and laboratory research to develop new tools and strategies to prevent and control malaria and conducts activities to prevent, treat, and monitor malaria among U.S. travelers and visitors.

CDC also works, both domestically and internationally, with foodborne, waterborne, and bloodborne (non-malaria) parasitic diseases. CDC works to reduce death and illness associated with these diseases, through activities that improve knowledge and awareness, surveillance, diagnosis, treatment, and other interventions. Globally, CDC offers technical support and expertise in monitoring and evaluation to partners developing or operating Neglected Tropical Diseases (NTD) programs, and conducts critical implementation research that helps define best practices for NTD programs that aim to eliminate these diseases and the suffering they cause, particularly among the poorest populations of the world. CDC's programmatic support, monitoring, evaluation, laboratory support, and operational research activities have been vital to recent achievements through the presidential initiatives related to malaria and NTDs and through CDC's direct technical support and assistance for endemic countries.

Recent accomplishments:

- Procured, through PMI, more than 17 million long-lasting, insecticide-treated mosquito nets (ITNs), protected more than 27 million residents by spraying their houses with residual insecticides, and procured more than 41 million artemisinin-based combination therapies, in 2010. PMI teams in country, including CDC Resident Advisors, facilitated the distribution of these commodities.
- Led the implementation of monitoring and evaluation activities in support of the PMI in 17 countries. PMI data has shown a 23 to 36 percent reduction in all-cause mortality in children under five years old.
- Established international standards for Rapid Diagnostic Tests performance and reliability, leading to improved diagnosis of malaria, with WHO and the Foundation for Innovative New Diagnostics.
- Responded, through a 24/7 hotline to over 8,000 inquiries about malaria, including urgent requests for assistance with the diagnosis and treatment of malaria cases in the United States.
- Tested, using CDC's national reference laboratories, 15,000 specimens from U.S. residents and overseas government staff for parasitic diseases, enabling them to receive appropriate treatment for potential life-threatening infections.
- Released investigational drugs to hospitals and clinicians for the treatment of 100 U.S. residents infected with parasitic disease.
- Evaluated a new diagnostic test for schistosomiasis that could be used in the field for more rapid diagnosis and treatment.

- Implemented telediagnosis at the Haiti National Public Health Laboratory, enabling laboratory personnel in Haiti to seek consultation on parasitic diseases from CDC remotely.

Budget Proposal: CDC's FY 2013 request of $19,417,000 for parasitic diseases and malaria is an increase of $50,000 above the FY 2012 level. Within this total, $9,412,000 is provided for malaria.

In FY 2013, CDC will:

- Develop evidence-based guidance for USG-supported malaria programs to achieve >85 percent coverage of proven malaria prevention and treatment interventions (insecticide-treated mosquito nets, indoor residual spraying, intermittent preventive treatment for pregnant women, case management) and 50 percent reduction in malaria-related mortality.
- Co-implement PMI with USAID through joint planning and resource allocation across 19 African countries and the Greater Mekong Sub-region.
- Advise the USG Malaria Coordinator on and be a key implementer of monitoring and evaluation, surveillance, and operations research activities that measure malaria prevalence and incidence; insecticide-treated net use, durability, and effectiveness; adherence to clinical case management guidelines and antimalarial drug resistance through strategic collaborative research; and prevention programs with partner institutions in endemic countries.
- Strengthen strategic information, diagnostics, case management, and vector control in approximately 15 malaria-endemic, non-PMI countries where CDC provides technical assistance.
- Conduct laboratory-based research and development and epidemiological evaluations to inform new malaria control strategies and prevention approaches related to long-lasting, insecticide-treated nets; indoor residual spraying; durable wall linings; malaria in pregnancy; novel drugs, diagnostic tools, insecticides, vaccines and delivery systems; and case management including diagnosis, treatment, and antimalarial drug resistance.
- Conduct on-going surveillance of malaria in the United States, and develop prevention and treatment guidelines to protect U.S. travelers and to ensure the safety of the U.S. blood supply from transfusion-transmitted malaria by appropriate donor deferral.
- Accelerate control and elimination of the targeted NTDs (lymphatic filariasis, onchocerciasis, trachoma, schistosomiasis, and the soil-transmitted helminthes) and the eradication of Guinea worm, by providing technical support to approximately 36 countries, primarily in the Americas and Africa, and global partners in the areas of training, tool development (e.g. diagnostics, surveys), monitoring, evaluation, and integration of NTD programs.
- Maintain the global reference insectary that provides a unique resource for research related to mosquito vectors, insecticide resistance, and field implementation of vector-control interventions.
- Maintain national reference laboratories, conduct laboratory research, and build capacity of global, state, and local partners to improve parasitic disease diagnosis.
- Develop research protocols and treatment guidelines for investigational use of new drug therapies and supply 24/7 availability of expert advice and otherwise unavailable drugs to treat individuals with parasitic infections in the United States.

GLOBAL PUBLIC HEALTH CAPACITY DEVELOPMENT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$9.301**	**$9.221**	**$9.240**	**+$0.019**

Program Overview: Since 1980, CDC has worked in collaboration with local and international organizations to help MOHs develop Field Epidemiology Training Programs (FETPs) that build capacity in a range of areas, including epidemiology, outbreak investigation, health surveillance systems, laboratory management, applied research, program evaluation, communications, and program management. CDC supports an FETP generally for five years, with gradual transfer of responsibility and costs to ensure that the country can sustain the program once CDC staff is no longer present.

The Sustainable Management Development Program (SMDP) is a management capacity-building program that helps MOHs in developing countries strengthen public health management policies, practices, and systems through competency building, strategic partnerships that leverage technical expertise, and applied research and evaluation. Through these and other global health programs, CDC provides leadership, strategic direction, and technical support to MOHs to build sustainable public health capacity around the world.

Recent accomplishments:

- Improved prevention of mother-to-child transmission outcomes in select hospitals in Ethiopia's Oromia Region, increasing the percentage of HIV-infected mothers delivering in a medical setting from 23 percent to 56 percent and the percentage of infected partners being tested for HIV/AIDS from 13 percent to 51 percent.
- Prepared FETP graduates and residents who detected, investigated, and responded to cholera outbreaks that infected more than 30,000 people in Cameroon, Ghana, Kenya, Mozambique, Nigeria, and Tanzania.
- Improved TB control policy in China by supporting a Chinese FETP Officer who investigated a school-based TB outbreak, which revealed a significant problem in TB diagnosis, identification, reporting, treatment, and management. Data were used to increase awareness about TB in schools and educate the public and health care providers about the dire consequences of not diagnosing, reporting, and treating TB patients in a timely manner.
- Improved road traffic accident and injury surveillance by supporting an evaluation conducted by the South Caucasus Field Epidemiology and Laboratory Program (FELTP) based in Tbilisi, Georgia. FELTP residents determined a baseline mortality rate and made recommendations to the Georgian government for a standardized reporting and data sharing system.

Budget Proposal: CDC's FY 2013 request of $9,240,000 for global public health capacity development is an increase of $19,000 above the FY 2012 level.

In FY 2013, CDC will:

- Implement new training modules within FETPs to strengthen surveillance and epidemiology for the leading causes of illness and death and prevent and control those leading causes. Five additional countries will incorporate a module covering high burden risk factors for a total of 10 countries.

- Build epidemiologic and surveillance workforce capacity and support the systems essential for effective outbreak response in over 40 countries in which CDC provides technical assistance. CDC will train public health workers to gather and analyze public health data for evidence of outbreaks so diseases can be stopped before they spread to other nations, including the United States; conducts initial assessments to identify gaps, prepares comprehensive training plans, and supports resident technical advisors in country; and monitors and evaluates strategies for supported programs to ensure the most efficient and effective use of resources.
- Implement a model for extending FETP activities to provinces and other sub-national areas in up to 10 partner countries to increase the number of trained field epidemiologists available at all levels of the public health system.
- Maintain up to four regional FETP networks in areas of strategic importance, such as the Middle East, Africa, or Central Asia, to provide shared training and capacity building opportunities, staff multi-country outbreak response teams, and expand the partnership and collaboration capacity of individual country programs.
- CDC will continue to leverage partnerships with other USG agencies, private foundations, universities, and others to improve health impact among workforce capacity and systems strengthening programs.
- Enhance capacity of partner countries' health information systems, particularly for surveillance, and translate the data/information obtained into country policies that improve people's health.
- Leverage existing FETP programs in up to five partner countries by training residents from neighboring countries where an FETP does not exist.

PERFORMANCE

Program: Global HIV/AIDS

Performance measures for Long Term Objective: The Division of Global HIV/AIDS (DGHA) will help implement PEPFAR in 33[1] countries and three Regional Programs by partnering with other United States Government (USG) agencies to achieve the PEPFAR goals of treating 4 million HIV-infected people, caring for 12 million people infected with or affected by HIV/AIDS, and preventing 12 million new HIV infections by 2014.[2]

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.A.1.1: Number of individuals receiving antiretroviral (ARV) therapy (Output)	FY 2011: 3,903,300 (Target Exceeded)	5,000,000	6,000,000	+1,000,000
10.A.1.2: Number of individuals infected and affected by HIV/AIDS, including Orphans and Vulnerable Children (OVC), receiving care and support services (Output)	FY 2011: 12,983,306 (Target Not Met)	15,115,600	16,480,000	+1,364,400
10.A.1.3: Number of pregnant women receiving HIV counseling and testing (Output)	FY 2011: 9,817,400 (Target Not Met)	10,911,700	11,734,800	+823,100
10.A.1.4: Number of HIV+ pregnant women receiving ARV prophylaxis (Output)	FY 2011: 660,900 (Target Not Met)	819,800	923,400	+103,600

[1]Due to an increase in the number of countries under the purview of the program, FY 2012 Enacted Targets have been increased to reflect the shift from 31 to 33 countries. While the FY 2011 targets are based on 31 countries, the FY 2011 results will reflect data from 33 countries.

[2]Achievements of targets reflect a combination of CDC budget authority and funding transferred from the Department of State in support of PEPFAR. Office of Global AIDS Coordinator drives the target setting for these measures

Performance Trends: As an implementing agency for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), CDC leads groundbreaking efforts to assess service delivery costs and identify operational efficiencies for replication across all HIV/AIDS program areas. These efforts resulted in cost savings and efficiencies, enabling USG to reach more of those in need with the available financial resources. In addition, CDC's unique contributions to evidence-based interventions, innovative public health technologies, and promotion of data-driven decision-making help assure cost-effective programming with maximum public health impact.

While the total number of individuals receiving antiretroviral therapy (10.A.1.1) exceeded the FY 2011 target, CDC did not meet performance targets for measures 10.A.1.2, 10.A.1.3, and 10.A.1.4. The results, however, reflect aggregate efforts under PEPFAR for all USG partners, who are currently assessing the parameters and location for additional technical assistance needed to assure these targets are met in the future. The December 2011 announcements by the Administration supporting PEPFAR will help fortify this effort. In addition, the call to accelerate scale-up for prevention of mother to child transmission will positively impact performance trends for measures 10.A.1.3 and 10.A.1.4. Performance results in care and support services (Measure 10.A.1.2) are also expected to improve as program economies of scale and health systems continue to mature.

Program: Global Immunization

Efficiency measure for Global Immunization

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.B.E.1**:** The portion of the annual budget that directly supports the program purpose in the field (Efficiency)	FY 2010: 87.1% (Target Not Met)	>90%	>90%	Maintain

Performance measures for Long Term Objective: Help domestic and international partners achieve World Health Organization's goal of global polio eradication.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.B.1.2**:** Number of children reached with Oral Polio Vaccine (OPV) as a result of non-vaccine operational support funding provided to implement OPV mass immunization campaigns in Asia, Africa, and Europe (Output)	FY 2010: 29,473,857 (Target Not Met)	51,400,000	55,000,000	+3,600,000
10.B.1.3: Number of countries in the world with endemic wild polio virus (Outcome)	FY 2010: 4 (Target Not Met)	0	0	Maintain

Performance measures for Long Term Objective: Work with global partners to reduce the cumulative global measles-related mortality by 95 percent compared with 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.B.2.1**:** Number of global measles-related deaths[1] (Outcome)	FY 2010: 139,300 (Target Not Met but Improved)	100,000	75,000	-25,000
10.B.2.2**:** Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission (Outcome)	FY 2010: 0 (Target Met)	0	0	Maintain

[1]The Global Measles Partnership decided to formulate a better method for calculating global measles mortality in late 2010 following measles outbreaks in Africa in 2009 and 2010. The actual results from 2009 onward reflect the improved measurement. However, targets before 2012 are not based upon the revised formula.

Performance Trends: Global immunization funding supports global polio eradication and global measles mortality-reduction efforts. CDC is the lead technical monitoring agency for the Independent Monitoring Board of the Global Polio Eradication Initiative. Sustained commitment of the United States government is necessary to achieve success as the goal of polio eradication is challenging and gains are fragile. Endemic and reinfected polio countries continue to struggle with weak surveillance and poor quality immunization campaigns. The challenge of interrupting the residual wild polio virus (WPV) transmission (Measure 10.B.1.3) is compounded by the recurrent circulation of endemic WPV from northern Nigeria and northern India into previously polio-free areas within and outside their borders, preventing achievement of the FY 2011 target. Many of these re-infected countries, particularly in Sub-Saharan Africa, suffered substantial and recurrent polio outbreaks due to low routine immunization coverage rates (less than 80 percent), suboptimal outbreak response, and weak health systems—together constituting a "WPV importation belt" that stretched from West Africa to Central Africa to the Horn of Africa. In response to the 2009 outbreaks across Africa, the World Health Assembly in May 2010 adopted the 2010–2012 Global Polio Eradication Initiative Strategy, which sets a goal of WPV interruption by December 2013. By mid-2010, all 15 countries suffering new importations in 2009 interrupted WPV transmission. With CDC assistance, the 11 countries that experienced WPV importation in 2010 either achieved, or were on track to achieve, interrupted transmission within six months of the first importation case appearing.

Although CDC did not meet the FY 2010 target for the number of children reached with oral polio vaccine (OPV) (Measure 10.B.1.2), the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and CDC consult weekly on polio activities to review priorities for the program and redistribute UNICEF cooperative agreement funds to address any outbreaks or other developing needs. For FY 2010, CDC procured 296.7 million doses of OPV and provided operational funding to support vaccinating 29.5 million children in mass vaccination campaigns but did not meet its target of vaccinating 45 million children (Measure 10.B.1.2). In-country circumstances reviewed during weekly telephone conferences warranted that UNICEF use cooperative agreement funds to procure additional OPV doses, which resulted in a reduction of available funds for supplemental immunization activity operations.

The goal of 95 percent reduction in cumulative global measles-related mortality compared with 2000 estimates also presents unique challenges. The global measles mortality data released in late 2011 showed outbreaks of measles from 2009 through 2011 in Africa reversed some of the consistent gains in measles mortality-reduction. Therefore, CDC did not meet the target for the number of measles related deaths

(10.B.2.1). Additionally, measles outbreaks in Europe in 2011 threaten the Western Hemisphere. In 2011, there were 983 confirmed measles cases in the Americas.[13] CDC collaborates with the Pan American Health Organization (PAHO) to ensure that these measles cases do not become endemic (Measure 10.B.2.2)

CDC did not meet the FY 2010 target for the percentage of the annual budget supporting the program's purpose in the field for the first time since the establishment of the measure in 2005 (Measures 10.B.E.1). The difference between the target (greater than 90 percent) and the most recent result (87.1 percent) is the result of rising administrative costs and increasing travel costs that reduced the number of technical assistance days CDC staff provided in the field. CDC continues to review costs on a monthly basis to minimize administrative overhead costs while maximizing spending directly in the field. Plans to achieve the 90 percent threshold in FY 2013 include having a higher percentage of staff detailed to the field and increasing technical assistance.

Program: Global Disease Detection (GDD) and Emergency Response

Performance measures for Long Term Objective: The Division of Global Disease Detection (GDD) and Emergency response will work with Ministries of Health, other USG Agencies, and international partners to build outbreak detection and response public health capacity in support of the International Health Regulations (2005).

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.E.1: Percentage of outbreak and possible Public Health Emergencies of International Concern assistance requests that are handled in a timely manner (Outcome)	CY 2011: 86 % (Preliminary)	79%	76%	-3%

Performance Trends: The GDD Monitoring and Evaluation (M&E) framework captures quarterly data on GDD Regional Center activities on to monitor progress and assess program impact. The data informs opportunities to improve Global Disease Detection Regional Centers, including potential gaps in scientific discovery (e.g., pathogens detected and diagnostic tools developed), prioritization of program resources, and potential improvements with in-country partners. CDC also uses data to uncover, and later share, best practices from the Global Disease Detection Regional Centers that are most successful in specific technical areas. CDC began collecting data systematically in 2006 and continues to enhance monitoring and evaluation for Global Disease Detection Regional Centers on an ongoing basis.

Between January 1, 2011 and September 30, 2011 CDC assisted in over191 outbreak investigations and other public health emergencies around the world. Preliminary results indicate that CDC exceeded the 2011 calendar year target with 86 percent of outbreak and public health emergencies handled in a timely manner. CDC emergency responses include: cutaneous anthrax and viral encephalitis in China, H5N1 influenza in Egypt, dengue in Guatemala, cholera in Haiti, Panama, and the Dominican Republic, Congo-Crimean hemorrhagic fever in Kazakhstan, typhoid fever in Kyrgyzstan, Rift Valley fever in Kenya, viral hemorrhagic fever in Ethiopia, Dengue in Somalia and South Sudan, typhoid fever in Tanzania, and clusters of deaths from an unidentified cause in Thailand. Final data for the 2011 calendar year will be available in early 2012. CDC will continue to help ensure that countries have ready access to the support and technical assistance needed to detect and contain global disease threats and develop the expertise and

[13] Data as of Epidemiologic Week 35/2011 from country report to PAHO/WHO

capacity to fulfill their obligations to identify, report, and contain public health threats as outlined in the International Health Regulations.

Program: Parasitic Diseases and Malaria

Performance measures for Long Term Objective: Decrease the rate of all-cause mortality in children under five in the President's Malaria Initiative (PMI) target countries.[1, 2]

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.C.1: Increase the proportion of children under five years old who slept under an insecticide treated net the previous night PMI target countries[3] (Outcome)	FY 2011: 44.8% (Target Not Met)	85% (median) in 2007 countries	85% (median) in 2008 countries	N/A
10.C.2: Increase the proportion of children under five with fever in the previous two weeks that received treatment with antimalarials within 24 hours of onset of their symptoms in PMI target countries[4] (Outcome)	FY 2011: 18.9% (Target Not Met)	85% (median) in 2007 countries	85% (median) in 2008 countries	N/A
10.C.3: Increase the proportion of women who have received two or more doses of intermittent preventive treatment during pregnancy (IPTp) among women that have completed a pregnancy in the last two years[5] (Outcome)	FY 2011: 21.9% (Target Not Met)	85% (median) in 2007 countries	85% (median) in 2008 countries	N/A

[1] These measures reflect contributions from CDC funds leveraged with transfer funding from the United States Agency for International Development in support of the President's Malaria Initiative.

[2] FY 2011 results reflect reporting from two of the three countries reflected in the measure. Results from the third country will be available in April 2012

[3, 4, 5] Due to data reporting timeframes, there is a two year gap between the baseline for the third set of countries and the actual data for the first set of countries in 2011.

Performance Trends: Malaria prevention and treatment tools are among the most cost-effective interventions available to improve maternal and child survival and health. These include indoor residual spraying, insecticide-treated mosquito nets, artemisinin-based combination therapies, and intermittent preventive treatment of malaria during pregnancy. While countries more effectively apply malaria prevention and treatment tools as compared to baseline (2006), CDC did not meet FY 2011 PMI performance targets (Measures 10.C.1, 10.C.2, and 10.C.3). The shortfalls reflect delays in improvements of national distribution systems and delays in procurement. CDC is mitigating procurement delays so that programmatic scale-up is not delayed in the future. To date, scale-up of these interventions through PMI and other program efforts reduced all case mortality in children less than five years of age by 23–36 percent in PMI countries surveyed and contributed to saving more than 200,000 lives over the past nine years.[14]

[14] 2010 World Malaria Report

Program: Global Public Health Capacity Development

Performance measures for Long Term Objective: To increase the number of skilled Epidemiologists providing sustained public health capacity in low and middle income countries.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
10.F.1a: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FETP)— New Trainees (Outcome)	FY 2010: 192 (Target Exceeded)	179	255	+76
10.F.1b: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FETP) —Total Graduates (Outcome)	FY 2010: 2,351 (Target Exceeded)	2,660	2,846	+186

Performance Trends: Since 1980, CDC developed 41 international Field Epidemiology Training Programs (FETP) serving 57 countries and graduated 2,351 epidemiologists. In FY 2010, CDC exceeded targets for new residents and total graduates (Measures 10.F.1a and 10.F.1b). Data indicate that FETP and Sustainable Management Development Program graduates go on to serve in key public health positions within ministries of health (MOH) in their own country. Approximately 80 percent of FETP graduates work with the MOH after graduation. Moreover, many graduates are assigned to key leadership positions, such as the Deputy Director of the National Malaria Control Program in Ghana. Their presence enhances sustainable public health capacity in these countries, which is critical to support the transition of U.S. government global health investments to long-term host-country ownership. In addition, FETP graduates and residents conducted more than 132 outbreak investigations in their respective nations during 2010, implementing the concepts and techniques learned from FETP classroom sessions. CDC uses the performance data from these measures and other sources to inform program management within the country specific programs and also programs under development. Efficiencies from one program can improve the performance of all programs as lessons learned are shared through regional networks. This measure is also part of an HHS performance plan.

IT INVESTMENTS

CDC's information technology (IT) plan is designed to maximize local technical, financial, and managerial support to sustain the local response to HIV/AIDS and other global health challenges, such as emerging threats, malaria, and NTD. CDC provides basic office automation and IT infrastructure for field offices in over 25 program offices throughout Africa, Asia, and the Caribbean, supporting over 1,485 staff in the field, of which 1,200 are locally employed. IT resources help set up and maintain offices in-country and develop in-country resources. CDC manages Global Business Systems and CDC Mission Support services, which provide international business services applications and scientific regulatory services support for field staff. CDC also provides its field offices with a password-protected portal for them to access and share information and conduct web-based meetings. In addition, CDC is a WHO Collaborating Center for Public Health Informatics and works with the global community to standardize, strengthen, integrate, exchange, share, and inter-operate disparate data, tools, and services. CDC helps countries improve informatics and disease surveillance systems by integrating platforms for capturing, analyzing, and reporting health care-associated infections and notifiable conditions.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$1,336.901	$1,299.479	$1,228.360	-$71.119
ACA/PPHF	$10.000	$0.000	$0.000	$0.000
Pandemic Flu balances from PL 111-32	$68.515	$30.000	$46.776	+$16.776
Total	$1,415.416	$1,329.479	$1,275.136	-$54.343
FTEs	**523**	**521**	**520**	**-1**

Authorizing Legislation: PHSA §§ 301, 307, 311, 317, 319, 319C-1, 319D, 319F, 319F-2, 319G, 351A, 352, 369

FY 2013 Authorization……Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $1,275,136,000 for public health preparedness and response, including $46,776,000 from the PL 111-32 balances, is an overall decrease of $54,343,000 below the FY 2012 level. The FY 2013 request includes a decrease of $15,501,000 for State and Local Preparedness and Response Capability, an increase of $8,730,000 for CDC Preparedness and Response Capability, and a decrease of $47,572,000 for the Strategic National Stockpile.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
State and Local Preparedness and Response Capability	$664.294	$657.418	$641.917	-$15.501
CDC Preparedness and Response Capability	$160.121	$138.269	$146.999	+$8.730
Strategic National Stockpile	$591.001	$533.792	$486.220	-$47.572
Pandemic Flu balances from PL 111-32	$68.515	$30.000	$46.776	+$16.776
Total	**$1,415.416**	**$1,329.479**	**$1,275.136**	**-$54.343**

CDC works around-the-clock to ensure the security, safety, and health of Americans from threats, foreign and domestic, man-made or natural. One of few federal agencies providing surveillance, detection, and response seven days a week, 24 hours a day, 365 days a year, CDC provides life-saving response to chemical, biological, radiological, and nuclear threats, as well as other crises, outbreaks, and epidemics. The critical responsibility of protecting the health and safety of America is achieved through supporting state and local health departments, safeguarding deadly toxins, managing the Strategic National Stockpile, creating national tracking and surveillance systems, and overseeing a national laboratory network, a national asset for disease detection.

Since the attacks on September 11, 2001, CDC has increased the nation's overall "all-hazards" preparedness and response capability through training, support, and evaluation of preparedness practice and activity at the federal, state, and local levels. This capability extends through prevention, detection, response to, and recovery from the consequences of health security threats.

Public Health Preparedness and Response funding supports staff within public health departments and at CDC to coordinate strategic planning and response direction, provide preparedness and response resources, maintain disease detection and laboratory systems for public health preparedness and response,

engage key stakeholders, and evaluate and report on progress and challenges regarding CDC-wide preparedness and response efforts.

Public Health Preparedness and Response activities ensure CDC complies with and achieves national requirements and targets of the National Health Security Strategy, Presidential Policy Directive 8 (PPD-8), other national frameworks, and Executive Orders, which promote consistency across stakeholder coordination and best practices for health security activities.

FUNDING HISTORY[1]

Public Health Preparedness and Response Fiscal Year	Dollars (in millions)
2008	$1,479.455
2009	$1,514.657
2010	$1,549.358
2011	$1,405.416
2011(ACA/PPHF)	$10.000
2012	$1,329.479

Strategic National Stockpile Fiscal Year	Dollars (in millions)
2003	$298.050
2004	$397.640
2005	$466.700
2006	$524.339
2007	$496.348
2008	$551.509
2009	$570.307
2010	$595.749
2011	$591.001
2012	$533.792

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

STATE AND LOCAL PREPAREDNESS AND RESPONSE CAPABILITY BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$654.294	$657.418	$641.917	-$15.501
ACA/PPHF	$10.000	$0.000	$0.000	$0.000
Total	**$664.294**	**$657.418**	**$641.917**	**-$15.501**

Program Overview: CDC safeguards America's health security and supports preparedness activities nationwide by providing technical expertise and funding to state, local, and territorial public health agencies through the Public Health Emergency Preparedness cooperative agreement (PHEP). In addition, CDC programs provide significant daily support at the state, local, and territorial level for the core public health capabilities of laboratory testing, epidemiology, and surveillance. A critical component of protecting and securing our nation's public health is having state, local, and territorial public health agencies and allied front-line responders prepared to prevent, detect, respond to, and rapidly recover from a variety of public health threats. These threats include influenza pandemics; natural disasters; and

biological, chemical, radiological, and nuclear incidents. Response to public health threats begins at the local level and CDC's investment in state, local, and territorial health departments saves lives and protects the nation's health security by ensuring that tools are in place to quickly detect, monitor, and respond to health threats.

Recent accomplishments:

- Defined national standards for Public Health Emergency Preparedness and Response released in the Public Health Preparedness Capabilities: National Standards for State and Local Planning. This document contains a national set of public health preparedness capabilities that align with PPD-8 and guide state, local, and territorial public health emergency preparedness planning, preparedness, and response. To develop the standards, CDC obtained input from over 200 CDC subject matter experts, public health partner organizations, and other federal interagency programs.
- Reengineered the PHEP into a capabilities-based model. This approach will enable state and local public health agencies to identify what aspects of their emergency preparations are sufficient and what aspects need additional work. Once such preparedness gaps are determined, jurisdictions will have the knowledge needed to set priorities to build and sustain capabilities.
- Enhanced the PHEP grants management to improve program review and awardee accountability and to include enhanced tracking of deliverables, costs, performance measures, and progress towards achieving capabilities.
- Reduced the amount of time the Laboratory Response Network's (LRN) most advanced chemical laboratories (Level 1 chemical laboratories funded by the PHEP cooperative agreement) need to process and report on samples during the yearly LRN Surge Capacity Exercise. This exercise demonstrates the ability of our nation to respond to a large-scale chemical incident like the Tokyo Sarin subway attack of 1995. Between 2009 and 2010, the average hours to process and report on 500 samples by Level 1 laboratories decreased from 98 hours to 56 hours.

Budget Proposal: CDC's FY 2013 request of $641,917,000 for state and local preparedness and response capability is a decrease of $15,501,000 below the FY 2012 level. This reduction includes the elimination of the Academic Centers for Public Health Preparedness and funds designated for CDC's programmatic operating costs to provide oversight, guidance, and management of the PHEP. In FY 2013, the funds for the programmatic operating costs will come from the State and Local Preparedness and Response Capability budget. CDC will offer technical assistance to PHEP awardees to prioritize their funding to address core public health preparedness capabilities identified through each project area's needs assessment. These core capabilities include public health laboratory testing, surveillance and epidemiology investigations, and community preparedness. The Academic Centers for Public Health Preparedness, which are housed at universities across the country with a common focus on public health, have not resulted in the return on investment or significant impact on public health hoped at the program's outset. CDC will continue to provide technical guidance to the Academic Centers to ensure that the efforts in developing strategies for public health preparedness continue.

In FY 2013, CDC will:

- Continue to enhance the capabilities of state and local health departments to protect the health security of the United States by adhering to national standards described within *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. With technical assistance from CDC, public health departments will continue to prioritize capability development based upon their current capacities to respond to public health threats and emergencies.

- Identify specific investments of public funds by categorizing funding applied to each capability in order to better quantify the impact of investments in state, local, and territorial public health preparedness and response programs.
- Enhance coordination between CDC's PHEP Program and the HHS Assistant Secretary for Preparedness and Response Hospital Preparedness Program (HPP). Aligning these two programs will increase program efficiency and reduce application and reporting burdens for state, local, and territorial public health programs.

Public Health Emergency Preparedness Grant Table[1,2]

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	62	62	62
Average Award	$9.865	$10.005	$9.899
Range of Awards	$0.323–$41.154	$0.328–$41.739	$0.325–$41.299
Number of New Awards	0	0	0
Number of Continuing Awards	62	62	62

[1]Funding includes direct assistance to grantees provided through the Career Epidemiology Field Officer Program (CEFO). CEFO personnel are assigned to states by request and are funded by the PHEP. As of January 2012, there were 32 CEFOs in four states. States must agree to an initial two-year placement, with the option to renew the request annually. Funding will vary from published amounts, as this table removes funding for the Early Warning Infectious Disease Surveillance Program (EWIDS). While that program is awarded through the PHEP, it is a program run by the Assistant Secretary for Preparedness and Response.

[2]For FYs 2012–2013, this table makes the same funding assumptions as FY 2011 based on percentage of change due to the complexity of calculating actual award levels. Individual grantee funding levels may change depending on programmatic decisions made when calculating funding for the Cities Readiness Initiative, LRN-C Level 1 funding, and other programs funded through the PHEP cooperative agreement.

CDC PREPAREDNESS AND RESPONSE CAPABILITY BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$160.121**	**$138.269**	**$146.999**	**+$8.730**

Program Overview: CDC Preparedness and Response Capability supports activities across the agency designed to protect Americans by systematically preparing for, responding to, investigating, intervening in, and recovering from public health threats.

CDC's Emergency Operations Center (EOC) serves as the focal point of incident management for public health emergency responses. The EOC operates around-the-clock and conducts strategy development, information collection, analysis, distribution, and communication with stakeholders during a response.

Subject matter experts at CDC provide extensive guidance; support advanced public health systems; and broker technology transfer to state, local, and territorial public health departments. To ensure front-line health departments have the capability to detect public health threats when they occur, CDC supports the LRN. The LRN is a network of 160 state, local, federal, and international laboratories that provide rapid testing capability to respond to biological, chemical, some radiological and nuclear terrorism, and other public health emergencies. CDC's Real Time Laboratory Information Exchange equips LRN laboratories to share data according to common data standards via two solutions: the LRN Results Messenger software, which provides LRN labs the immediate ability to share data, and the Laboratory Information Management System Integration (LIMSi) effort. LIMSi is the "next generation," long-term solution and uses a lab's own systems to share LRN data. LIMSi benefits LRN labs by eliminating double data entry, enabling LRN data management within a lab's familiar workflow, and increasing the availability of LRN data for local disease surveillance.

HHS has delegated authority to CDC to regulate biological laboratories and operate the Select Agent program. CDC's Select Agent program has greatly increased the federal government's oversight of the safety and security of dangerous biological agents and toxins after the 2001 anthrax attacks. As a result, many entities registered to possess select agents and toxins have improved and strengthened their biosafety practices and procedures. The Select Agent program ensures compliance with safety and security standards by developing and enforcing select agent regulations; conducting unannounced and announced inspections of entities that possess, use, or transfer select agents; and providing guidance to the regulated community. The Select Agent program currently maintains active registrations and inspects more than 300 entities that possess select agents and toxins in the United States.

Recent accomplishments:

- Equipped and deployed 278 CDC staff in support of CDC's response to more than 29 public health emergency situations involving hazardous environmental conditions and diseases in FY 2011. CDC also strengthened alliances with federal and non-federal partners, which led to increased visualization technology production and emergency information sharing; and distributed 921 Epidemic Exchange (Epi-X) reports.
- Achieved a 94 percent cumulative passing rate by participating LRN member laboratories to detect biological threat agents through five proficiency test challenges. The LRN proficiency testing program is designed to simulate real-world scenarios. Laboratories are provided blinded samples in one or more matrix(ces) (e.g., clinical specimens, food samples, environmental samples, or a mixture of these) as proficiency test challenges. These samples are tested for one or more of the agents for which LRN methods are available. Proficiency testing ensures quality of lab results by challenging the laboratory staff, equipment, and reagents.
- Validated nine labs in 2011 as capable of submitting LRN results using their own systems in alignment with LRN LIMSi objectives, bringing the total number of implemented LIMSi labs to 11.
- Responded to 84 requests for CDC's epidemiologic assistance from state and local public health agencies and international partners during FY 2011 (64 domestic and 20 international). These Epi-Aids occurred in 39 states, three U.S. territories, and 14 foreign countries. Epidemic Intelligence Service (EIS) field officers conducted 293 investigations in their assignment locations in FY 2011. EIS officers played key roles in CDC's response to the 2009 H1N1 influenza pandemic, the Haiti earthquake and subsequent Haiti cholera outbreak, health care-associated infections, and the first confirmed case of HIV transmission from a living organ donor since 1985.
- Conducted 280 laboratory inspections, which included an increase in the number of non-routine/unannounced inspections from previous years to ensure that appropriate security and safety measures were in place.

Budget Proposal: CDC's FY 2013 request of $146,999,000 for preparedness and response capabilities is an increase of $8,730,000 above the FY 2012 level. CDC will use this increase to rebuild internal capacity to protect the nation's health security with a particular focus on the nation's ability to detect and respond to public health emergencies, specifically, the nation's ability to detect and respond to chemical, biological, and nuclear terrorism. This includes developing laboratory methods to detect chemical, biologic, and radiologic agents.

In FY 2013, CDC will:

- Continue to serve as the federal government lead for public health incident management, participate in interagency planning efforts across the full spectrum of response operations, and provide effective public health situational awareness by integrating analytical and visualization tools.
- Partner with other federal agencies, including the Assistant Secretary for Preparedness and Response (ASPR) and the Department of Defense (DOD), to consider expanding the LRN international community for detection of emerging infectious diseases to detect cross-border disease or event impacts earlier.
- Strengthen LRN Real Time Laboratory Information Exchange through the expansion of LIMSi to approximately five additional LRN laboratories. LIMSi enables laboratories to accomplish LRN data exchange using their own systems, which allows labs to submit their own data. In addition, labs will no longer be required to enter their LRN data into LRN Results Messenger, eliminating duplicate data entry for LIMSi labs. Laboratories will generate an HL7 message of the data, meaning those messages can be re-purposed for local biosurveillance. LRN Results Messenger will remain available to LRN sites that are not able to implement LIMSi.
- Maintain CDC laboratory capacity to respond to chemical emergencies and identify exposure to chemical agents. CDC will also provide state and local LRN-chemical public health laboratories with training and proficiency testing, which involves systematic and rigorous evaluation of the accuracy of the laboratories' test results by CDC laboratory experts. To further enhance preparedness capacity, CDC will also conduct a minimum of 27 proficiency challenges and coordinate a national surge capacity exercise for a chemical threat event to increase our nation's preparedness for chemical threats.
- Improve selected laboratory assays for identifying biological threat agents through signature refinement studies in collaboration with the Department of Homeland Security (DHS), DOD, and the Association of Public Health Laboratories (APHL).
- Increase security awareness at entities registered with the Federal Select Agent Program as directed by Executive Order 13546: "Optimizing the Security of Biological Select Agents and Toxins (BSAT) in the United States," develop a risk-based triage protocol for import permit applications to identify those that may require on-site inspections for updating Etiological Agent Import Permit regulations and database, and continue to improve and implement a new IT infrastructure for improved communication and sharing of select agent information.

BioSense

Program Overview: Beginning in FY 2010 and continuing in FY 2011, BioSense made advancements in its mission to provide early detection, characterization, and tracking of possible bioterrorism-related outbreaks with the deployment of BioSense 2.0, and worked closely with state and local public health communities to identify their biosurveillance capacities and needs. BioSense 2.0 has employed cloud technology to meet these needs, with the intended result of integrating local and state-level electronic health data into a cohesive regional and national "picture." This new direction allows for a larger and stronger network of local and state health departments, and promotes a broader community of users in BioSense 2.0. This network is crucial for the achievement of national situational awareness as required by the Pandemic and All-Hazards Preparedness Act, and identified in the December 2010 GAO report on "situational awareness." These efforts will continue as feasible to advance the national health and security of the nation.

Recent accomplishments:

- Launched BioSense 2.0 on November 15, 2011. BioSense 2.0 is the first HHS system to use a cloud-based IT infrastructure, and as more health departments join, the increased geographic coverage will result in more valid syndromic surveillance information for targeting preparedness and response activities. The cloud-based infrastructure will reduce program costs that could be distributed to states and local health departments to build capacity, and join the BioSense network. This new technology will allow greater sharing of information between partners.
- Provided 30 percent of core program fiscal resources to state health departments' syndromic surveillance efforts and partner organizations.
- Enhanced public health capacity at the state and local levels to participate in and contribute to a national public health surveillance network. In FY 2011, the BioSense program monitored 454 outpatient and emergency department patient visits per 1,000 populations in the United States, exceeding its target.
- Monitored and reported to CDC EOC data on health care activity in 20 DOD facilities located in Japan following the March 11, 2011, earthquake and tsunami for evidence of increased radiation exposure or resultant illness in the U.S. military population stationed in the region.
- Dengue surveillance continues to be conducted in DOD and VA facilities in Florida and Hawaii using data reported to BioSense.

In FY 2013, CDC will:

- Provide syndromic surveillance data and analyses as feasible to enhance shared situation awareness via BioSense 2.0's cloud technology, promote connection of existing systems and networks by reducing incompatible surveillance systems, sharing data across participating jurisdictions and at the federal level that can support planning and decision-making during an outbreak or other public health crisis, and promote communication across participating jurisdictions. These efforts will contribute to the improvement of surveillance and health indicator data quality, timeliness, and representativeness.
- Provide technical assistance to BioSense 2.0 end users (to include state and local health departments) to improve their capacity to conduct syndromic surveillance in their jurisdictions using this cloud-based technology. Technical assistance and internet-based tools will allow the enhancement of syndromic surveillance systems as state and local jurisdictions increase data sharing via electronic health records and prepare to meet the Meaningful Use requirements mandated by the Health Information Technology for Economic and Clinical Health (HITECH) portion of the American Recovery and Reinvestment Act.
- Explore innovative ways to develop comprehensive nationwide and regional situation awareness for all-hazard health threats (beyond bioterrorism), which leverage existing state, local, tribal, and territorial public health surveillance systems to signal alerts for potential health problems, facilitate exchange of health-related information to coordinate responses, monitor events, and assess health care capacity.

BioSense Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	21	11	11
Average Award	$0.143	$0.143	$0.143
Range of Awards	$0.060–$0.360	$0.060–$0.360	$0.060–$0.360
Number of New Awards	0	11	0
Number of Continuing Awards	21	0	11

Biosurveillance Coordination Activity

Program Overview: CDC's Biosurveillance Coordination (BC) activities, mandated by Homeland Security Presidential Directive 21 (HSPD 21), work to achieve an integrated biosurveillance capability, essential for the early detection, rapid response, management, and mitigation of the effects of potentially catastrophic infectious disease outbreaks and other public health emergencies originating either domestically or abroad. To meet this mandate, CDC coordinates working partnerships with a diverse set of federal, state, local, tribal, and private sector stakeholders (such as the White House National Security Staff, DOD, DHS, the Council of State and Territorial Epidemiologists, state and local health departments, etc.).

Recent accomplishments:

- Completed the National Public Health Surveillance and Biosurveillance Registry for Human Health (NPHSB Registry). This first-ever comprehensive registry of surveillance activities within CDC will streamline coordination and foster collaboration within the surveillance community.
- Advanced the strategic objectives of the National Biosurveillance Strategy for Human Health (NBSHH) by using the NPHSB Registry as a model to initiate development of a federal biosurveillance registry framework to facilitate communication among federal, state, local, tribal, and territorial officials.
- Led the White House Domestic Resilience Group Sub-Interagency Policy Committee and Biosurveillance Governance Work Group in drafting language for the national biosurveillance strategy that defined the roles and responsibilities that federal departments and agencies would undertake in establishing an enhanced biosurveillance network.
- Collaborated with the HHS and the National Security Staff's Sub-Interagency Policy Committee on Biosurveillance to ensure the strategic objectives of the NBSHH were incorporated in national policy, outlining steps needed to achieve situational awareness and enhanced biosurveillance capabilities, respectively.

In FY 2013, CDC will:

- Strengthen support of state and local partners and advance an enhanced national biosurveillance enterprise through the development of the necessary systems that will allow CDC to begin to provide electronic access to key information on the 280 surveillance activities cataloged in the NPHSB Registry.
- Begin the process to establish an advisory body of non-federal experts in the field of biosurveillance to identify and develop sound recommendations to strengthen and further enhance a national biosurveillance enterprise.

STRATEGIC NATIONAL STOCKPILE BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$522.486	$503.792	$439.444	-$64.348
PHSSEF Transfer	$68.515	$30.000	$46.776	+$16.776
Total	**$591.001**	**$533.792**	**$486.220**	**-$47.572**

Program Overview: The Strategic National Stockpile (SNS) is the nation's repository of life-saving pharmaceuticals, critical medical supplies, Federal Medical Station (FMS) units, and equipment that is available and managed for rapid delivery in the event of a catastrophic health threat in order to help reduce morbidity and mortality due to natural disaster; infectious disease; bioterrorism; or a chemical, radiological, or nuclear event. CDC manages the science, acquisition, storage, and logistical operations of the SNS for use during a public health emergency. CDC also provides training and technical assistance to support state, local, and territorial capabilities to receive, stage, store, distribute, and dispense federal medical supplies.

Recent accomplishments:

- Conducted lifesaving missions during FY 2011 including: vaccine-immune globulin (VIG) to Florida and Pennsylvania to treat patients with adverse reactions to smallpox vaccinations; anthrax-immune globulin (AIG) to a Minnesota hospital treating a patient with a confirmed case of anthrax, as well as a vial of Anthrax Vaccine Adsorbed (AVA) sent as a precaution for the patient's spouse; AVA to a Florida hospital treating a patient exposed to anthrax; and one FMS and FMS strike team to Hartford, Connecticut in support of federal response preparedness in advance of Hurricane Irene landfall.

- Deployed health/medical staff to provide technical assistance and expert consultation in relation to the distribution and dispensing of emergency medical countermeasures (MCM) as a result of the March 2011 earthquake and tsunami events in Japan that impacted the Fukushima nuclear power plant. The primary responsibility of the health and medical team was to assist the embassy in protecting U.S. citizens. The range of expertise included radiation oncology; health physics; potassium iodide (KI) distribution and dispensing; and health, crisis, and risk communication.

- Achieved the capability to receive, distribute, and dispense SNS assets in 94 percent of CRI local planning jurisdictions.

Budget Proposal: CDC's FY 2013 request of $486,220,000 for the SNS is a decrease of $47,572,000 below the FY 2012 level. This request includes $46,776,000 from the PL 111-32 balances. The SNS is a key resource in maintaining public health preparedness and response; however, the current fiscal climate necessitates scaling back. Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) will re-prioritize those threats for which SNS holds emergency medical countermeasures (MCM) to ensure the maximum possible protection against some threats that would create a public health emergency. PHEMCE will accomplish this by examining the SNS formulary to determine a reduced or re-balanced level of current MCM as well as purchases of new and replacement of expiring MCM, given available funds.

In FY 2013, CDC will:

- Continue to participate as one of the principal participants in the PHEMCE to define and prioritize requirements for public health emergency MCM that are stockpiled in the SNS.
- Conduct an annual review process that determines MCM life cycle costs, including costs associated with storage and replacement and also allows for a thorough evaluation of MCM in the SNS against current requirements, which is used to identify gaps and determine future MCM priorities through the PHEMCE process.
- Continue to work with its federal partners, including the Department of Veterans Affairs, Food and Drug Administration, and DOD to find cost efficiencies in the procurement, replacement, and maintenance of MCM.
- Ensure the ability to use MCM by improving the necessary regulatory mechanisms that allow for deployment, dispensing, and utilization of SNS MCM assets. Additionally, CDC will address the clinical guidance for public health and medical professionals, develop systems to better track MCM supply during a public health emergency response, and manage the timely evaluation of drugs and interventions in a response.
- Continue to explore non-traditional methods of distribution and dispensing of countermeasures to the population within 48 hours, including public-private collaborations and the implementation of the closed Point of Dispensing concept. The closed Point of Dispensing concept involves partnering with private businesses and other organizations to conduct their own dispensing in order to ease the burden on local public health departments.
- Implement national policy to prepare for anthrax-related events through collaboration with the DHS and strategic placement of stockpiled materiel through additional warehouse locations.
- Support the replacement of expiring MCM in high-priority public health preparedness categories in accordance with recommendations by the PHEMCE in order to build and ensure the capacity to limit morbidity and mortality from public health threats.
- Continue to purchase, warehouse, and manage MCM throughout their life cycle in order to provide a robust response during a catastrophic public health event to treat affected populations, prevent additional illness, and provide medical supplies and equipment.
- Strengthen state, local, and territorial health departments' capacity to receive, distribute, and dispense medical countermeasures through the provision of technical assistance tools, expert assessments, training, and consulting services.

BUDGETARY OUTPUTS

Measures	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
State and Local Preparedness and Response Capability				
13.B: Number of grantees funded for Public Health Emergency Preparedness	FY 2010: 62	62	62	No Change

PERFORMANCE

Program: State and Local Preparedness and Response Capability

Performance measures for Long Term Objective: Enhance and sustain preparedness and response capability across state, local and territorial health departments.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
13.5.E.1a: Decrease the amount of (A) time required for the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR System (Efficiency)	FY 2010: 19 days (Target Exceeded)	20 days	20 days	Maintain
13.5.E.1b: Decrease the (B) dollars required for the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR System (Efficiency)	FY 2010: 60% reduction (Target Exceeded)	0% reduction	20% reduction	+20%
13.5.2: Percentage of state public health laboratories that directly receive CDC PHEP funding that can correctly subtype E.coli O157:H7 and submit the results into a national reporting system within four working days for 90% of the samples received. (Output)	FY 2010: 76% (Target Exceeded)	65%	74%	+9%
13.5.3: Percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners. (Outcome)	FY 2010: 92% (Target Exceeded)	91%	94%	+3%
13.5.4: Percentage of public health agencies that directly receive CDC PHEP funding that can complete an After Action Report and Improvement Plan within 40 days of a real or simulated response. (Output)	FY 2010: 69% (Target Exceeded)	68%	84%	+16%

Performance Trends: CDC continues to increase accountability through required performance measure reporting. Among the required measures, Public Health Emergency Preparedness (PHEP) awardees report the time it takes for state and local public health emergency staff in activated incident management roles to assemble a trained team that can make decisions about appropriate response and interaction with

partners within 60 minutes of notification. OMB officially designated this measure as an Agency Priority Goal through 2011 to exclusively focus on the 50 states. CDC's performance improved from 70 percent in 2009 to 84 percent in 2010. For all PHEP awardees, performance exceeded CDC's target of 75 percent--92 percent of all awardees assembled a trained team within 60 minutes of notification (Measure 13.5.3). In FY 2010, PHEP-funded public health laboratories exceeded the target by 12 percent to correctly identify *E. coli* and submit the results within the allotted time (13.5.2). Sixty-nine percent of PHEP awardees successfully completed an After Action Report (AAR) in FY 2010, exceeding CDC's target of 66 percent (Measure 13.5.4). CDC strategically focuses technical assistance to awardees to continue improving awardee performance across these operational capabilities. By improving the ability of state and local public health emergency staff to rapidly convene a response team of trained key management staff as well as successful completion of AARs by PHEP awardees in FY 2010-2011, CDC ensured more timely and effective coordination within the public health system and with key partners during an emergency response.

Program: CDC Preparedness and Response Capability

Performance measures for Long Term Objective: Integrate and enhance existing surveillance systems at the local, state, national, and international levels to detect, monitor, report, and evaluate public health threats.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
13.1.3: Number of Laboratory Response Network member laboratories able to use their current Laboratory Information Management System (LIMS) for LRN-specific electronic data exchange (Output)	FY 2011: 11 (Target Exceeded)	15	20	+5
13.1.1: Increase the number of outpatient and emergency department (ED) patient visits under surveillance in BioSense program per 1,000 population in United States (Output)	FY 2011: 454 (Target Exceeded)	499	499	Maintain

Performance measures for Long Term Objective: Enhance and sustain nationwide and international laboratory capacity to gather, ship, screen, and test samples for public health threats and to conduct research and development that lead to interventions for such threats.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
13.3.1: Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents. (Output)	FY 2011: 94% (Target Exceeded)	92%	92%	Maintain

Performance Trends: Since 2007, BioSense tremendously enhanced public health capacity at the state and local level to participate in and contribute to a national public health surveillance network. The number of outpatient and emergency department (ED) patient visits under surveillance in the BioSense program increased from 424 ED visits per 1,000 in FY 2010 to 454 ED visits per 1,000 in FY 2011, an increase of three percent over FY 2010 and furthering the substantial improvement over the 2007 baseline of 339 per 1,000 population. Increasing emergency department patient visit coverage will improve the geographic picture of situation awareness to improve state and local ability to respond to all-hazard events (Measure 13.1.1). CDC reduced the target for FY 2013 as the anticipated reduction in public health workforce with key skillsets (informaticians, epidemiologists) will affect state health departments' capacity to conduct

syndromic surveillance or take advantage of healthcare reform (Meaningful Use stage two requirements). Specific examples of BioSense data utility to public health include appearance of dengue in Florida, injuries from a tornado in Joplin, Missouri, the earthquake and tsunami in Japan, and Hurricane Irene.

CDC investments in preparedness contributed toward improved performance across the spectrum of preparedness and response, from identification of public health threats to response. Laboratory Response Network (LRN) laboratories readily identified biological and chemical threat agents, as CDC's proficiency testing program provided laboratories with familiarity in working with agents, performing LRN assays using agent-specific testing algorithms, and using available electronic resources to submit test results. CDC exceeded its proficiency testing target of 92 percent-- consistent with proficiency testing performance results since 2006 (Measure 13.3.1). LRN Real Time Laboratory Information Exchange provides LRN laboratories with a common platform for data exchange using consistent data elements and terminology across the LRN. While 100 percent of LRN labs are capable of LRN data exchange through LRN Results Messenger, CDC is also working to accomplish Laboratory Information Management System Integration (LIMSi), which enables laboratories to share LRN data using their own systems. As of December 2011, a total of 11 labs successfully implemented LIMSi and now use their own systems to share LRN data (Measure 13.1.3). This is a significant improvement over 2010, when only three labs met the goal. In light of past performance, CDC undertook a concerted management effort to ensure it reached the 2011 target. CDC utilized constructive feedback from the 2010 labs to improve and streamline the implementation process which led to a realignment of resources that could be used to enhance ongoing lab activities. The program also engaged vendors to create standard bioterrorism modules to help make implementations faster and less expensive.

Increased numbers of investigations by Epidemic Intelligence Service (EIS) officers and training activities for EIS officers improved front-line capability to collect and analyze epidemiological data during an emergency response. Preparedness funding allowed CDC to support additional state and local level field officers. After events were detected, CDC used the incident command system to deploy responders to events upon request from state or local health departments and other governments, and intervened to reduce morbidity and mortality. EIS field officers are often involved in large, multi-state investigations to identify causes of outbreaks (e.g. the identification of Salmonella Enteriditis associated with eggs and Salmonella Montevideo associated with red and black pepper). As a result of these investigations, nationwide recalls of eggs, red and black pepper, and salami products occurred.

Program: Strategic National Stockpile

Performance measures for Long Term Objective: Assure an integrated, sustainable, nationwide response and recover capacity to limit morbidity and mortality from public health threats.

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
13.4.2: Percentage of state public health agencies that are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC. (Outcome)	FY 2011: 100% (Target Met)	100%	100%	Maintain
13.4.5**:** Number of trained and ready preparedness and response personnel available for response to multiple events. (Output)	FY 2011: 19 (Target Met)	19	19	Maintain
13.4.6: Percentage of inventory discrepancies that are reduced by using quality inventory management systems. (Outcome)	FY 2011: .02% (Target Exceeded)	<5%	<5%	Maintain

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
13.4.E.2: Dollars saved per $1 invested in the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) for available projects. (Efficiency)	FY 2011: $19 (Target Not Met but Improved)	$18	$18	Maintain

Performance Trends: Through FY 2011, CDC successfully delivered material within 12 to 48 hours, depending on the threat in a public health emergency, to mitigate loss of life. CDC increased the level of state and local preparedness for dispensing countermeasures at the local level, meeting the FY 2011 target of 100 percent (Measure 13.4.2). As of December 2011, 100 percent of states and directly funded cities received acceptable SNS preparedness ratings. The number of Cities Readiness Initiative (CRI) jurisdictions achieving at least the minimum required score on their technical assistance rating increased from 57 percent in October 2008 to 96 percent in December 2011.

CDC demonstrated improvement in management and distribution through systems derived from proven practices and innovative solutions for acquisition, flexible storage, configuration, and emergency response support. During the 2009 H1N1 Pandemic Influenza event, CDC determined insufficient visibility existed on SNS material deployed to state and local health departments. Therefore, CDC developed an inventory management and tracking system to track state and local medical counter measures usage and help inform deployment response decisions during a public health emergency. This system should be available in FY 2012. In FY 2011, CDC provided technical assistance and conducted 14 exercises with state and local public health representatives and emergency response personnel to enhance their ability to receive, stage, store, distribute, and dispense SNS assets. These efforts helped state and local health departments, in conjunction with federal teams, learn and improve from each exercise, leading to rapid and effective responses and enhancing preparedness levels. Inventory discrepancies have been consistently below the FY 2011 target, thus continuing a trend of meeting this target (Measure 13.4.6). CDC deferred $19 of product costs for every dollar spent on the Shelf Life Extension Program (SLEP) in 2011. While CDC did not meet the SLEP target of $20, CDC deferred significant costs. The value of product going through the SLEP program changes each year, causing significant variations in cost deferral. This measure is also highly dependent on external entities, such as the Food and Drug Administration, to test and validate product efficacy , thereby allowing for extended shelf life (Measure 13.4.E.2). Finally, for FY 2011, CDC met its target with 19 trained and ready SNS preparedness and response personnel available for rapid response to multiple events in multiple locations (Measure 13.4.5).

IT INVESTMENTS

CDC's investments in information technology (IT) under Public Health Preparedness and Response enhance the ability of state responders, governmental partners, and CDC partners to communicate, share information, and collaboratively respond to public health emergencies. BioSense automates ongoing syndromic surveillance to achieve shared situational awareness for the public health community and enhances system and data integration to maximize data sharing. The LRN Real Time Laboratory Information Exchange implements standard and secure data exchange solutions for the LRN, which provides rapid laboratory testing capacity to respond to public health emergencies. The Epidemic Information Exchange (Epi-X) system is CDC's secure, web-based communications network that enables communications exchange between CDC, state and local health departments, poison control centers, and other public health professionals.

The PHEP cooperative agreement supports state, local, and territorial public health agencies to further develop the capability to conduct multi-jurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of

government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance. A complement to the cooperative agreement is the Preparedness Emergency Response System For Oversight, Reporting, and Management Services (PERFORMS) database system, which houses information about performance of individual awardees to enable monitoring of progress. Intergovernmental partnerships also benefit from IT investment, as in the case of the National Select Agents Registry (NSAR) program. CDC, in collaboration with U.S.Department of Agriculture's Animal and Plant Inspection Service (APHIS), manages the eNSAR online resource, which registers entities that possess, use, or transfer biological agents and toxins in order to track and monitor the use of the agents and toxins.

Internally, CDC's investment in IT enhances the EOC and the operations of the agency's public health preparedness and response divisions. The Emergency Operations Management System (EOMS) is a central web portal, servicing all emergency preparedness tracking and reporting needs for CDC and the EOC. In support of the strategic national stockpile, IT investments include the Stockpile Resource Planning (SRP) system, which ensures the emergency response inventory is managed, tracked, and maintained at readiness levels.

STATE TABLES[1]

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93-069 PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM				
State/Territory/Grantee	**FY 2011 Appropriation**	**FY 2012 Enacted[2]**	**FY 2013 President's Budget [2,3]**	**FY 2013 +/- FY 2012**
Alabama	$8,633,983	$8,756,673	$8,664,325	-$92,348
Alaska	$5,169,600	$5,243,060	$5,187,767	-$55,293
Arizona	$11,689,091	$11,855,194	$11,730,169	-$125,025
Arkansas	$6,469,981	$6,561,920	$6,492,718	-$69,202
California	$41,154,467	$41,739,275	$41,299,092	-$440,183
Colorado	$9,397,930	$9,531,475	$9,430,956	-$100,519
Connecticut	$7,553,479	$7,660,814	$7,580,023	-$80,791
Delaware	$5,422,932	$5,499,992	$5,441,989	-$58,003
Florida	$27,687,829	$28,081,275	$27,785,130	-$296,145
Georgia	$15,653,814	$15,876,256	$15,708,825	-$167,431
Hawaii	$5,260,290	$5,335,039	$5,278,776	-$56,263
Idaho	$5,173,907	$5,247,429	$5,192,089	-$55,340
Illinois	$16,837,953	$17,077,222	$16,897,125	-$180,097
Indiana	$11,138,909	$11,297,194	$11,178,053	-$119,141
Iowa	$6,595,869	$6,689,597	$6,619,048	-$70,549
Kansas	$6,595,020	$6,688,736	$6,618,196	-$70,540

DEPARTMENT OF HEALTH AND HUMAN SERVICES
(CENTERS FOR DISEASE CONTROL AND PREVENTION)
FY 2013 DISCRETIONARY STATE GRANTS
CFDA NUMBER: 93-069
PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM

State/Territory/Grantee	FY 2011 Appropriation	FY 2012 Enacted[2]	FY 2013 President's Budget [2,3]	FY 2013 +/- FY 2012
Kentucky	$8,275,695	$8,393,293	$8,304,777	-$88,516
Louisiana	$8,632,297	$8,754,963	$8,662,633	-$92,330
Maine	$5,169,600	$5,243,060	$5,187,767	-$55,293
Maryland	$11,057,196	$11,214,320	$11,096,053	-$118,267
Massachusetts	$13,459,602	$13,650,864	$13,506,902	-$143,962
Michigan	$16,444,316	$16,677,991	$16,502,105	-$175,886
Minnesota	$10,825,630	$10,979,463	$10,863,673	-$115,790
Mississippi	$6,565,242	$6,658,535	$6,588,314	-$70,221
Missouri	$10,717,722	$10,870,022	$10,755,386	-$114,636
Montana	$5,169,600	$5,243,060	$5,187,767	-$55,293
Nebraska	$5,234,954	$5,309,343	$5,253,351	-$55,992
Nevada	$6,585,802	$6,679,387	$6,608,946	-$70,441
New Hampshire	$5,398,877	$5,467,482	$5,409,822	-$57,660
New Jersey	$16,184,853	$16,414,841	$16,241,730	-$173,111
New Mexico	$6,484,400	$6,576,544	$6,507,187	-$69,357
New York	$19,128,596	$19,400,415	$19,195,818	-$204,597
North Carolina	$14,020,450	$14,219,682	$14,069,721	-$149,961
North Dakota	$5,169,600	$5,243,060	$5,187,767	-$55,293
Ohio	$17,610,925	$17,861,178	$17,672,813	-$188,365
Oklahoma	$7,509,542	$7,616,253	$7,535,932	-$80,321
Oregon	$7,829,790	$7,941,052	$7,857,305	-$83,747
Pennsylvania	$19,766,638	$20,047,523	$19,836,102	-$211,421
Rhode Island	$5,302,058	$5,377,401	$5,320,690	-$56,711
South Carolina	$9,308,851	$9,441,130	$9,341,564	-$99,566
South Dakota	$5,169,600	$5,243,060	$5,187,767	-$55,293
Tennessee	$10,845,628	$10,999,745	$10,883,742	-$116,003
Texas	$36,807,732	$37,330,773	$36,937,082	-$393,691
Utah	$6,464,082	$6,555,937	$6,486,798	-$69,139
Vermont	$5,169,600	$5,243,060	$5,187,767	-$55,293
Virginia	$14,483,987	$14,689,805	$14,534,887	-$154,918
Washington	$11,619,010	$11,784,117	$11,659,842	-$124,275

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93-069 PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM				
State/Territory/Grantee	**FY 2011 Appropriation**	**FY 2012 Enacted[2]**	**FY 2013 President's Budget [2,3]**	**FY 2013 +/- FY 2012**
West Virginia	$5,336,731	$5,412,566	$5,355,485	-$57,081
Wisconsin	$11,227,615	$11,387,160	$11,267,071	-$120,089
Wyoming	$5,169,600	$5,243,060	$5,187,767	-$55,293
Chicago	$10,409,823	$10,557,747	$10,446,405	-$111,342
Los Angeles County	$20,404,916	$6,826,550	$6,754,557	-$71,993
New York City	$19,243,835	$20,694,871	$20,476,623	-$218,248
Washington, D.C.	$6,730,903	$19,517,291	$19,311,462	-$205,829
American Samoa	$374,003	$379,318	$375,317	-$4,001
Guam	$501,200	$508,322	$502,961	-$5,361
Marshall Islands	$372,756	$378,053	$374,066	-$3,987
Micronesia	$421,144	$427,128	$422,624	-$4,504
Northern Mariana Islands	$358,054	$363,142	$359,312	-$3,830
Palau	$323,450	$328,046	$324,587	-$3,459
Puerto Rico	$7,473,561	$7,579,761	$7,499,825	-$79,936
Virgin Islands	$423,822	$429,845	$425,311	-$4,534
Total States/Cities/Territories	**$611,618,342**	**$620,301,370**	**$613,759,663**	**-$6,541,707**

[1]This state table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA.

[2]Actual awards may vary depending on various factors.

[3]FY 2013 estimates reflect the proposed reduction to the State and Local Preparedness and Response Capability budget.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	$563.539	$617.913	$487.648	-$130.265
ACA/PPHF	$41.200	$41.200	$41.200	$0.000
Total	**$604.739**	**$659.113**	**$528.848**	**-$130.265**
FTEs	1,905	1,894	1,892	-2

Authorizing Legislation: PHSA §§ 301, 304, 306, 307, 308, 308D, 310, 311, 317, 317F, 319, 319A, 319D, 321 322, 325, 327, 352, 361–369, 391, 399G, 1102, 2821

FY 2013 Authorization ..... Expired/Indefinite

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

SUMMARY

CDC's FY 2013 request of $528,848,000 for CDC-Wide Activities and Program Support is an overall decrease of $130,265,000 below the FY 2012 level. This includes eliminating the Preventive Health and Health Services Block grant and no new funding for buildings and facilities.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Buildings and Facilities	$0.000	$24.946	$0.000	-$24.946
Business Services Support	$362.026	$394.682	$368.529	-$26.153
Public Health Leadership and Support	$121.419	$118.740	$119.119	+$0.379
Preventive Health Block Grant Program	$80.094	$79.545	$0.000	-$79.545
ACA/PPHF	$41.200	$41.200	$41.200	$0.000
Total	**$604.739**	**$659.113**	**$528.848**	**-$130.265**

CDC-wide activities and program support includes fundamental infrastructure and services needed for mission-critical activities and programs to function. Such activities include management of CDC's portfolio of assets through necessary repairs and improvements and capital investments, operation and maintenance contracts, capital leases, IT infrastructure and security. Other customer support services include procurement and grant support, security, and emergency preparedness. The office of the Director prioritizes resources and provides leadership for programs to achieve greater efficiency and effectiveness. CDC also provided support to increase the capacity and performance at state, tribal, and local public health agencies.

FUNDING HISTORY[1]

Fiscal Year	Dollars (in millions)
2008	$749.038
2009	$822.513
2010	$680.324
2010 (ACA/PPHF)	$50.142
2011	$563.539
2011 (ACA/PPHF)	$41.200
2012	$617.913
2012 (ACA/PPHF)	$41.200

[1]Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

BUILDINGS AND FACILITIES BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$0.000**	**$24.946**	**$0.000**	**-$24.946**

Program Overview: The buildings and facilities (B&F) program was established over 20 years ago to provide CDC with funding to replace, sustain, improve, and repair existing facilities and to construct new facilities to meet CDC's mission. The principal B&F activity is mission support, serving approximately 15,000 CDC staff, FTE and non-FTE, who occupy CDC-controlled space.

B&F indirectly supports all program activities that take place in CDC-controlled space, such as laboratory research (infectious diseases, environmental health, occupational safety and health, and mine safety), data and information system centers, and non-laboratory based public health research.

Primary activities include:

- Repair and improvements (R&I): Projects to restore or improve a failed or failing primary building system or real property component to effective use, including roofs, chillers, boilers, water and air conditioning systems, elevators, foundations, windows, and built-in laboratory equipment.
- Capital Projects: New construction projects including additions or major improvements (renovations or alterations) to existing buildings in the owned inventory.
- Real Property Acquisition: Acquisition of land and the improvement thereon.

Certain buildings and facilities activities are funded from the Business Services Support line, including operating and capital leases, utilities, operations and maintenance contracts, and administration costs for the Buildings and Facilities Office. For more information, refer to the Business Services Support section of this narrative.

Recent accomplishments:

- CDC completed Building 24 at its Roybal Campus and took ownership of the building in July 2011. Approximately 700 persons relocated from leased buildings at an estimated annual rent savings of $3.9 million in FY 2012, and $5.5 million thereafter.
- Completed the Alaska Arctic Investigations Program (AIP) Laboratory Expansion Project (in Anchorage), in partnership with the Indian Health Service in FY 2011.
- Incorporated sustainable design principles and effective operations and maintenance to reduce resource consumption (energy, water, and capital) and maintain the facilities in good condition.
- In November 2011, CDC held a ground breaking ceremony for Building 107 and Parking Deck 161A at its Chamblee campus. Building 107 will have eight floors above a full basement with 268,594 gross square feet. The building will feature office space for 1,032 personnel. The parking deck will be a seven-tier parking structure that will accommodate 867 vehicles.

Budget Proposal: CDC's FY 2013 request of no new funding for B&F in FY 2013 is $24,946,000 below the FY 2012 level. In FY 2013, CDC will support critical repairs and improvements (R&I) with carryover funds to maintain the condition of CDC's portfolio of assets.

In FY 2013, CDC will use carryover funds to:

- Complete R&I projects to maintain the condition of CDC's portfolio of assets and improve the energy efficiency of mechanical, electrical, and water systems.
- Support CDC's nationwide R&I program to remain in compliance with the Federal Real Property Council (FRPC) metrics.

National Repair and Improvements

In accordance with Office of Management and Budget (OMB) and FRPC guidelines, CDC's R&I program includes sustaining, improving, and repairing projects to maintain or improve the condition of the CDC portfolio of assets; improving the efficiency of mechanical, electrical, and water systems, moving CDC towards meeting or exceeding energy reduction and sustainability goals; supporting program mission needs; and ensuring secure, healthy, and safe facilities. R&I expenditures are expected to increase because many non-Atlanta campuses are approaching a half century or more in age and are beyond the intended life expectancy for such facilities, specifically the National Institute for Occupational Safety and Health (NIOSH) Cincinnati and Pittsburgh research campuses.

Fiscal Year	Dollars (in millions)
2007	$21.060
2008	$22.428
2009	$23.066
2010	$25.022
2011	$28.068

FRPC PERFORMANCE METRICS

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	**Impact**	**Explanation**
Mission Dependency		
Mission Dependency	Positive	R&I funds will be used for mission-critical and mission-dependent facilities in accordance with CDC's Condition Index (CI) Sustainment strategy. Repair funds are used to sustain buildings in an operational status. Improvement funds are used to modify space to bring it into compliance with current codes and reduce over-utilized space.
Facility Utilization		
Utilization Status	Positive	R&I funds will be used for laboratories and other critical facilities in accordance with CDC's asset business plans.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition allowing their continued effective designated use, and to improve an asset's functionality or efficiency, thus maintaining or improving the utilization of the asset.
Facility Condition	Neutral	R&I funding will support CDC's sustainment and improvement strategy to maintain a portfolio CI) of 90 or better.
Sustainment and Improvement Strategy	Neutral	A strategy of capital replacement of non-performing assets with R&I funding at appropriate levels and prioritization of critical assets and projects will allow CDC to achieve a portfolio-wide CI of 90 over the 2010–2020 planning horizon.
Facility Cost		
Operations and Management (O&M) Cost	Neutral	CDC anticipates a positive, but unquantified impact on O&M costs resulting from appropriate R&I funding. Appropriate R&I and Business Services Support (BSS) funding will ensure plants and equipment are operated and maintained in accordance with manufacturers' warranties and will maximize energy and operating efficiencies.

Sustainability

CDC continues to maintain a high performance sustainable buildings and facilities program for new construction, renovations, and alterations, as well as operations and maintenance. CDC's Sustainable Design and High Performance Building Guidelines are updated regularly to reflect changes in Federal, State, and local requirements and statutes; changes in technology or industry standards; and adjustments to CDC goals and priorities. CDC conducts on-going building assessments and commissioning of its existing buildings, with emphasis on energy and water conservation, to meet the challenges required by the Energy Independence and Security Act (EISA), the Guiding Principles for High Performance and Sustainable Federal Buildings, Executive Order 13514, and Executive Order 13423. Potential projects generated by the building assessments are incorporated into the annual facilities business plans. An analysis of potential on-site renewable energy systems and incorporation of innovative building strategies are also included as part of the existing building assessments. CDC continues to meet or exceed the energy conservation, water conservation, and sustainable practices performance targets. CDC's building inventory currently includes four U.S. Green Building Council (USGBC) "Leadership in Energy and Environmental Design" (LEED) certified projects. Two additional projects are registered with USGBC with the goal of achieving LEED certification.

CDC continues to maintain a transportation management program through the Buildings and Facilities Office. CDC maintains a transportation choices website and hosts alternative commute educational programs. CDC's Fare Share program provides ridership opportunities through planned commuter programs at all Atlanta area campuses. As an active member of the Clifton Corridor Transportation Management Association (CCTMA), CDC works with transportation management associations such as the Clean Air Campaign, Atlanta Regional Commission's Ride Smart Program, and other related organizations to address common transportation concerns, improve accessibility and mobility, share services, improve air quality, and mitigate traffic congestion by promoting alternative forms of transportation.

CDC BUILDINGS AND FACILITIES CARRYOVER TABLE

Carryover by Fiscal Year Project	From FY2008	From FY2009	From FY2010	From FY2011	Carryover FY2012	Carryover FY2013
Roybal, Emerging Infectious Disease Lab, Bldg #18	0	0	0	0	**0**	**0**
Roybal, Scientific Communications Center, Bldg #19	0	0	37,729	37,729	**0**	**0**
Roybal, Transshipment/Infrastructure Project, Bldg #20	2,389,908	1,030,045	1,721,404	1,721,404	**0**	**0**
Roybal, Headquarters & Emergency Operations Center, Bldg #21	0	63,665	63,665	67,616	**0**	**0**
Roybal, Blast-Resistant Glazing, Bldgs 1E, 2, and 16	0	25,805	25,805	25,805	**0**	**0**
Roybal, Entrance Security Modifications	0	20,817	54,685	54,685	**0**	**0**
Chamblee, Secure Entrance/Site work	0	0	0	0	**0**	**0**
Bldgs. #107	0	24,350,000	26,423,396	15,500,000	**0**	**0**
Bldgs. #108	0	26,350,000	0	0	**0**	**0**
Chamblee, Parasitic Disease Lab, Bldg #109	0	17,295	17,295	17,295	**0**	**0**
Roybal, East Campus Consolidated Lab Project, Bldg # 23	37,330,929	10,849,877	6,456,901	0	**0**	**0**
Chamblee, Environmental Health Facility, Bldg # 106	524,822	518,662	522,077	0	**0**	**0**
Adv Planning for Atlanta Projects in the Five Year Plan/Master plan	0	0	0	0	**0**	**0**
Chamblee, Environmental Toxicology Lab, Bldg # 110	1,201,844	1,219,744	1,219,744	0	**0**	**0**
All Campuses, Emergency Fire & Life Safety Initiative	270,563	270,563	270,563	0	**0**	**0**
Repairs and Improvement 1/	27,195,778	34,130,141	39,103,481	12,165,569	**18,082,785**	**0**
CCID Roybal, B24 Epi Tower 2/	56,507,000	39,777,808	28,777,847	11,000,000	**0**	**0**
Data Center/Recovery Site	580,927	976,936	1,398,474	0	**0**	**0**
Cincinnati Lab Consolidation Project	0	0	62,423	0	**0**	**0**
Ft. Collins Laboratory	0	572,328	572,328	0	**0**	**0**
Fort Collins, DVBID Replacement Lab	14,793	77,047	88,296	88,296	**0**	**0**
Ft. Collins, DVBID Shell Space Project	1,955,406	1,060,149	513,972	0	**0**	**0**
Roybal, Bldg #17	0	0	0	0	**0**	**0**
Lake Lynn Laboratory Property Acquisition 4/	4,750,000	4,750,000	4,407,129	14,086,459	14,086,459	14,086,459
Lake Lynn New Mine Entrance/Site Infrastructure 3/	0	0	0	0	10,000,000	10,000,000
Arctic Investigation Program (AIP) Laboratory Renovation Addition	3,524,000	519,737	221,596	221,596	0	0
Totals	**136,245,970**	**146,580,619**	**111,958,810**	**54,986,454**	**42,169,244**	**24,086,459**

[1] Projected Carryover FY2012 includes $12,165,569 carryover into FY2012 plus $15M 2012 Omnibus and $9,000,000 reapportionment from B24.
$18.1M R&I carryover shown in FY2012 is based on total planned obligation in FY2012 & FY2013 of $36.2M.

[2] $9M of the $11M Carryover from FY2011 will be reapportioned to R&I line item for FY2012. $2M will remain to be obligated in FY2012.

[3] Includes $10,000,000 of the FY2012 Omnibus appropriation of $25,000,000

[4] CDC would have to acquire the LLL before this project would be executed and therefore expect those funds to be carried over in both years. BFO concurs that all of the various subroutines for FPAA and OMB clearance would need to be in place prior to making a revised/increased offer.

BUSINESS SERVICES SUPPORT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$362.026**	**$394.682**	**$368.529**	**-$26.153**

Program Overview: CDC's business services support (BSS) budget line was established in FY 2005 to identify and fund costs related to business operations and processes, ensure greater transparency and accountability of programmatic dollars, and establish agency-wide shared services. CDC's business services offices (BSOs) report to the agency's Chief Operating Officer and are critical to the agency's program operations. The BSO directors also sit on the agency's Management Board, which governs CDC′s management practices in support of the strategic direction and ensures alignment with the agency's goals. There are six major BSOs:

- Buildings and Facilities Office (BFO): Conducts CDC's real property and space management activities and operates, maintains, repairs, and modifies CDC's facilities. BSS funds operating and capital leases, utilities, operation and maintenance contracts, and the administrative costs of the BFO office. Repairs and improvements (R&I), capital projects, and real property acquisition are funded in the Buildings and Facilities line. Additional information on these expenditures can be found in the Buildings and Facilities narrative.
- Financial Management Office (FMO): Administers CDC's budget and related financial and accounting functions to ensure compliance with regulatory and legislative requirements. FMO provides leadership, guidance, and advice on operational budget and financial matters. FMO coordinates with HHS, OMB, and Congress.
- Information Technology Services Office (ITSO): Maintains personal computing hardware and software; provides customer service support; serves as administrator for the mainframe, infrastructure software, application, and server hosting; and oversees networking and IT security.
- Management Analysis and Service Office (MASO): Coordinates policy development, management, and consultation activities; manages internal controls program; manages federal advisory committee activities; manages electronic forms design; and provides automation services and support.
- Office of Security and Emergency Preparedness (OSEP): Coordinates CDC's crisis management and security activities, provides intelligence information and support to the CDC Director and Emergency Operations Center (EOC), and manages and operates the agency's secure communications systems.
- Procurement and Grants Office (PGO): Provides leadership and direction for CDC acquisition, assistance, and management activities; and awards, administers, and terminates contracts, purchase orders, grants, and cooperative agreements.

Recent Accomplishments:

- Initiated plans to establish a working capital fund as directed by Congress in FY 2012. Plans include the creation of a governance board comprised of representatives from each center, institute, and office; the Chief Operating Officer; the Chief Information Officer; and the Chief Financial Officer to provide input and leadership, indirect cost methodologies, and a strong internal controls structure and tracking system.

- Supported and coordinated the expansion of CDC's telework and remote access infrastructure to support over 6,000 simultaneous users. This expansion was extremely successful during the mid-January 2011 snow storm in Atlanta, as 5,500 simultaneous users were able to telework reliably and successfully during the three snow closure days.
- Supported program implementation of CDC's Mobile Communications Management Consolidation Program (MCMCP) out-sourcing management of all CDC wireless phone and computer devices and services. Savings are achieved through service plan optimization, pooled minutes, and consolidated device acquisitions. In addition, CDC has worked with HHS, OMB and the General Services Administration on a contract vehicle to make this service available government-wide.
- Facilitated the transition of CDC's email system to the latest commercial software version and overhauled the hosting architecture resulting in annual cost avoidance.

Budget Proposal: CDC's FY 2013 request of $368,529,000 for BSS is $26,153,000 below the FY 2012 level. This decrease represents a return to funding levels prior to FY 2012. CDC is also requesting all BSS funds be appropriated to a two-year account to provide the initial capital for a working capital fund.

In FY 2013, CDC will:

- Expend funds from a two-year account to continue base funding for BSS for all of CDC's programs. Any funds not expended will be used in subsequent years to finance capital investments, excluding buildings and facilities capital investments, or provide the initial capital for a working capital fund. These functions include rent, utilities, maintenance, security, financial management, grants and acquisition support, and all IT hardware, software, security, and support for CDC's employees and contractors. These services are essential to CDC program operations.
- Promote cost control within programs by providing customers with visibility over the services and costs, achieve full cost recovery for services provided to the programs, plan and accumulate funding for capital investments (excluding buildings and facilities capital investments), and align the funding received with when it is expended. CDC proposes implementing a working capital fund in FY 2014 and will use FY 2013 to plan an orderly transition of current BSS financial activities to a working capital fund environment, including implementing the financial infrastructure and a robust governance process to provide transparency and accountability of all resources.
- Fund O&M contracts for CDC-owned buildings.

PUBLIC HEALTH LEADERSHIP AND SUPPORT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$121.419**	**$118.740**	**$119.119**	**+$0.379**

Program Overview: The public health leadership and support line funds portions of the CDC's Office of the Director; the Office for State, Tribal, Local, and Territorial Support; and urgent and emergent public health response activities. Public health leadership and support gives the CDC Director flexibility and capacity to respond to health emergencies not funded elsewhere in the agency before they become catastrophic. These funds are also needed to support the Director's priorities. In particular, these funds are used to strengthen core public health efforts such as surveillance, epidemiology and laboratory activities, as well as support public health at state and local levels.

Recent accomplishments:

- Expedited and expanded testing of a new dengue vaccine developed by CDC in 2011, necessitated by recent dengue outbreaks in Florida and Hawaii and a large outbreak in Puerto Rico.
- Continued to work toward developing better ways to identify and treat those at highest risk of heart attacks and strokes–the leading cause of death in the United States. CDC labs will develop new tests to better diagnose risk of heart attacks and strokes and improve treatment.
- Funded an initiative to work with the Department of Veterans Affairs (VA) system to better understand how to prevent blood clots in the hospital in 2011. These silent killers cause over 100,000 deaths per year and the evidence base to reduce blood clots is limited.
- Upgraded computer software to support public health investigations in the United States and abroad.

Budget Proposal: CDC's FY 2013 request of $119,119,000 for public health leadership and support is $379,000 above the FY 2012 level.

In FY 2013, CDC will:

- Continue to provide flexibility to carry out or improve initiatives associated with urgent and emergent public health events not typically supported elsewhere within CDC.
- Maximize health impact by streamlining and prioritizing resources during public health emergencies and coordinating a number of competing factors including: competition for scarce resources, emerging technologies, and threats to the nation's security. Examples of important initiatives that could be supported under this fund include:
    - Strengthen field epidemiology training programs to increase rapid detection of and response to health threats worldwide.
    - Develop new tests for CDC labs to better diagnose risk of heart attacks and strokes and improve treatment. Heart attacks and strokes are the first and third leading causes of death in the United States.
    - Work through laboratories included in CDC's FoodNet monitoring system to evaluate the use of non-culture and culture laboratory tests for foodborne diseases to detect infectious caused by contaminated food.
    - Continue development and testing of a new vaccine for dengue, which is spreading and has caused new outbreaks in Florida and Hawaii and a large outbreak in Puerto Rico.
- Develop and support minority health efforts; internal and external partnerships; management of intellectual property; communications and issues management; state and local support; and coordinate science-based, practice-oriented standards, policies, and laws.
- Improve the capacity and performance of state, tribal, and local public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public's health. This includes, but is not limited to:
    - Increase of the percentage of nationally accredited state and local public health agencies, similar to the accreditation programs of hospitals, schools, and law enforcement agencies.
    - Increase of the percentage of health departments that implement performance improvement initiatives to achieve greater efficiency and effectiveness of population-based programs and services.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT BUDGET REQUEST

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	**$80.094**	**$79.545**	**$0.000**	**-$79.545**

Budget Proposal: The FY 2013 budget request reflects the elimination of the Preventive Health and Health Services Block Grant (PHHSBG) program. Through CDC's existing and expanding activities, there is substantial funding to state health departments. When the PHHSBG was first authorized in 1981, there were minimal resources within CDC's budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity, and many states did not receive funding from CDC to support prevention of chronic disease. However, since 1981, categorical programs at CDC have grown to over $1 billion annually and the PHHSBG now represents a much smaller percentage of state budgets when compared to total available CDC funding. In addition, the FY 2013 budget request proposes a new Comprehensive Chronic Disease Prevention and Health Promotion Program that will provide funding for every state to reduce the prevalence of chronic disease, which will replace the PHHSBG.

These activities may be more effectively and efficiently implemented through the new Chronic Disease Prevention and Health Promotion Program and Affordable Care Act Prevention and Public Health Fund investments. Elimination of this program provides an opportunity to find savings, while expanding core public health infrastructure at the state level through the Affordable Care Act Prevention and Public Health Fund.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
ACA/PPHF	**$41.200**	**$41.200**	**$41.200**	**$0.000**

The following activities are included:

- National Prevention Strategy – $1,000,000
- National Public Health Improvement Initiative – $40,200,000

National Prevention Strategy

The National Prevention Strategy outlines a series of priority recommendations and effective prevention efforts that public, private, and non-profit sectors at the national, state, local, tribal, and territorial levels can implement. The National Prevention Strategy focuses on improving the health of communities, in addition to promoting access to and use of expanded preventive care practices. This community-centered approach to prevention and wellness will provide the foundation for many of the Strategy's actions. Specific recommendations contained within the Strategy will be based on the recommendations from CDC's Community Guide and include the most effective and sustainable prevention efforts.

Over the next five years, CDC will build health departments' capacity to more effectively manage and deliver their programs and services, meet national performance and accreditation standards, and share best practices to improve and protect the public's health. CDC and national partner organizations will provide training and targeted technical assistance to the 74 National Public Health Improvement Initiative (NPHII) awardees to ensure program goals are achieved. In addition, CDC will expand its National Performance Improvement Network linking state, tribal, local, and territorial health departments to share knowledge and experience with implementing performance management and improvement initiatives.

In FY 2013, CDC will continue to provide scientific and technical support to the National Prevention Council, including facilitation, implementation, coordination, and alignment to the evidence-based recommendations among the 17 federal departments that make up the Council; ensuring the ongoing engagement of the public and partners; and tracking the progress in implementing the National Prevention Strategy, such as collecting, analyzing, and refining data and measures to monitor and track the Strategy's implementation.

National Public Health Improvement Initiative

The goal of the NPHII is to increase the nation's health departments' performance management capacity and ability to meet national public health standards. CDC is funding directly, or through bona fide agents, a total of 48 states, four federally recognized tribes, four tribal organizations serving more than 280 federally recognized tribes, Washington, D.C., nine large local health departments, four U.S. territories, three U.S. Affiliated Pacific Islands (USAPI), and one USAPI bona fide agent that provides a regional voice for USAPIs.

In FY 2013, CDC will:

- Strengthen the public health infrastructure and establish the links necessary to support essential U.S. public health programs and continue the effective and efficient use of resources.
- Accelerate public health agency readiness to achieve national performance standards for the 12 domains of public health agency accreditation. These standards help officials ensure their agencies are:
    - More effective, well organized, and operating without waste;
    - Generating the objective information needed to make critical decisions about the future of programs and services in their communities;
    - Achieving/making progress toward targets for meeting national performance standards for public health practice;
    - Improving service, value, performance, management, leadership, and accountability; and
    - Delivering the three core public health functions and 10 essential services.
- Advance the quality of public health policies and decision making to preserve the programs and services critical to maintaining and improving quality of life, productivity, and life span.
- Increase the number of public health organizations focused on re-engineering programs, systems, and services (such as regionalization) and integration with the health care sector, the key to long-term cost savings and system transformation.

National Public Health Improvement Initiative Grant Table

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	81	81	81
Average Award	$0.460	$0.460	$0.460
Range of Awards	$0.100–$1.093	$0.100–$1.093	$0.100–$1.093
Number of New Awards	2	0	0
Number of Continuing Awards	79	81	81

PERFORMANCE

Program: Buildings and Facilities

Performance Measures for Program: Buildings and Facilities

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
12.E.1: Reduce energy and water consumption; implement high performance energy and water sustainability requirements (Efficiency)	CY 2011: 25.8% (E); 18.4% (W) (Target Exceeded)	21% (E); 10% (W)	24% (E); 12% (W)	+3 (E); +2 (W)
12.E.2: Incorporate sustainable practices in building construction, repair, renovation, and modernization projects, according to the Guiding Principles for High Performance and Sustainable Federal Buildings (Efficiency)	FY 2011: 24.4% (Target Exceeded)	9%	11%	+2%
12.1.1: Aggregate of scores for capital and repair/improvement projects rated on scope, schedule, and cost (Output)	FY 2011: 1.01 (Target Exceeded)	1.00±0.08	1.00±0.08	Maintain
12.2.1a: Improve CDC's Buildings and Facilities Office's processes and performance as reflected by two Key Performance Indicators - Work Order Closure Rates and Customer Satisfaction - and by three Federal Real Property Council (FRPC) metrics of Utilization, Mission Dependency, and Facility Condition Index for CDC buildings: Work Order Closure Rates (Output)	FY 2011: 94% (Target Exceeded)	91%	91%	Maintain
12.2.1c: Improve CDC's Buildings and Facilities Office's processes and performance as reflected by two Key Performance Indicators - Work Order Closure Rates and Customer Satisfaction - and by three Federal Real Property Council (FRPC) metrics of Utilization, Mission Dependency, and Facility Condition Index for CDC buildings: Condition Index (Output)	FY 2011: 94.6 CI (Target Exceeded)	90.0 CI	90.0 CI	Maintain
12.2.1d: Improve CDC's Buildings and Facilities Office's processes and performance as reflected by two Key Performance Indicators - Work Order Closure Rates and Customer Satisfaction - and by three Federal Real Property Council (FRPC) metrics of Utilization, Mission Dependency, and Facility Condition Index for CDC buildings: Mission Dependency (Output)	FY 2011: 5.5% (Target Not Met)	2%	2%	Maintain

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
12.2.1e: Improve CDC's Buildings and Facilities Office's processes and performance as reflected by two Key Performance Indicators - Work Order Closure Rates and Customer Satisfaction - and by three Federal Real Property Council (FRPC) metrics of Utilization, Mission Dependency, and Facility Condition Index for CDC buildings: Utilization (Output)	FY 2011: 3.88% (O); 3.88% (U[1]) (Target Exceeded)	6.7% (O); 5.00% (U)	6.7% (O); 5.00% (U)	N/A
12.2.1f: Improve CDC's Buildings and Facilities Office's processes and performance as reflected by two Key Performance Indicators - Work Order Closure Rates and Customer Satisfaction - and by three Federal Real Property Council (FRPC) metrics of Utilization, Mission Dependency, and Facility Condition Index for CDC buildings: Operating Costs (Output)	FY 2011: $13.15 /sq. ft. (Target Not Met)	$10.29 /sq. ft.	$10.29 /sq. ft.	Maintain

[1]Over-utilized (O); Under-utilized (U)

Performance Trends: Equipping CDC to carry out its mission in safe, sustainable, and efficiently operating facilities is core to the mission of the Buildings and Facilities Office (BFO). Overall, CDC consistently met or exceeded its performance targets since FY 2008 for seven of its nine measures. This includes reducing water and energy consumption (Measures 12.E.1, 12.E.2), increasing Condition Index (CI) (Measure 12.2.1c) by demolishing assets with very low CI, and improving project management through Earned Value Management Analysis/Management (EVA/M). Effective application of EVA/M gives CDC the ability to predict and adjust project schedules and budgets to meet shortfalls.

In FY 2011, CDC completed its newest office building through the Research Support Facility project. This project resulted in the demolition of existing laboratory and office buildings with low CI. CDC's overall CI for assets increased over the previous year's reporting period (Measure 12.2.1c) as these buildings were inactivated and demolished.

CDC continues to report on Utilization Rate (Utilization) in usable square feet per occupant (Measure 12.2.1e), but the Federal Real Property Council (FRPC) announced a replacement performance metric for Utilization for FY 2011: Percent of Space Utilization. CDC will revise this measure during FY 2012 to incorporate the FRPC replacement metric. CDC continues to maximize office space in both owned and leased assets with several ongoing initiatives. For example, CDC will vacate two entire buildings in FY 2012 due to increased utilization efforts in remaining buildings, providing a savings of over $4,000,000 in recurring, annual costs. Similar activities are ongoing with other leases for off-site office space, resulting in fewer leased spaces in future years.

Program: Business Services Support

Performance Measures for Business Services Support

Measures	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY2013 +/- FY 2012
15.2.2: Prompt payment, percent of invoices paid on time (Outcome)	FY 2011: 99.075% (Target Exceeded)	98%	98%	No change
15.4.2: Reduce the percentage of high-risk contract types awarded non-competitive, competitive one-bid, cost reimbursement, and time & material/labor hour (T&M/LH)	FY 2010: -13% (Historical Actual)	-10%	-10%	No change

Performance Trends: CDC's Financial Management Office (FMO) actively supports CDC's goals and customers through fiscal stewardship and financial strategy by providing financial services, budgetary and legislative guidance, and quality assurance to support CDC/ATSDR public health research and programs. CDC has an unqualified audit opinion on the agency's financial statements each year since FY 1999 that presents CDC's proprietary and budgetary resources fairly.

Moreover, CDC has a prompt payment percentage of 98 percent since at least FY 2008 (Measure 15.2.2), which is pursuant to the U.S. Treasury Department's Prompt Payment rule requiring federal agencies to pay vendors in a timely manner. Prompt Payment assesses late interest penalties against agencies that pay vendors after a payment due date, and CDC successfully limited interest payments to $25.39 per $1 million over the last fiscal year.

CDC's Procurement and Grants Office (PGO) is accountable to agency leadership, the administration, Congress, partners, and the public for effective and efficient procurement of CDC grants and contracts. This is accomplished in part by reducing and limiting high-risk awards and efficient closeout of contracts. Pursuant to the President's Memorandum on Government Spending issued by OMB in March 2009, CDC met its goal of reducing awards in high risk categories by achieving a 13 percent reduction for FY 2010 (Measure 15.4.2) over the 2009 baseline. While FY 2011 percentages are not available, CDC anticipates achieving the OMB target of 10 percent reduction in FY 2011 over the 2009 baseline. This includes establishing fixed price contracts with competed task orders as the preferred contract type for CDC.

Program: State, Tribal, Local and Territorial Support

Performance Measures for Long Term Objective: Improve the capacity and performance of State, Tribal, and local public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public's health

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
11.B.4.1: Increase the percentage of nationally PHAB[1] accredited state and local public health agencies (Intermediate Outcome)	FY 2011: 0% (Baseline)	15%	30%	+15%

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
11.B.4.2: Increase percentage of NPHII[2] awardees that have implemented performance improvement initiatives to achieve greater efficiency and effectiveness of population-based programs and services (Intermediate Outcome)	FY 2010: 0 % (Baseline)	30%	60%	+30%

[1]Public Health Accreditation Board

[2]National Public Health Improvement Initiative

Performance Trends:

In FY 2013, CDC proposes two new measures that reflect work to advance the performance and quality of public health departments resulting in improved health outcomes.

Measure 11.B.4.1 serves as an intermediate outcome to track progress in improving the capacity and performance of public health departments to more efficiently and effectively manage and deliver high-quality services to their communities. The measure tracks the proportion of state and local health departments that are accredited by the national accrediting body—the Public Health Accreditation Board (PHAB). This is a new initiative and no health departments were nationally accredited at baseline (2011). Now that the national voluntary program is operational, CDC is supporting the accreditation program as well as investing in accreditation readiness activities for state, tribal, local and territorial health agencies through training, technical assistance, and incentives for participation. Targets are set based on the expected time needed for a health department to become accredited (approximately one year) and to support the HHS Healthy People 2020 objective of increasing the proportion of nationally accredited health departments. Data from this measure will inform our understanding of the strengths and weaknesses in health department performance, identify priority investments needed by our nation's health departments, identify barriers to meeting national public health standards, and help determine potential use of non-financial and financial positive incentives to accelerate accreditation. This information will guide the development of tools and technical assistance to support health departments' accreditation efforts.

Measure 11.B.4.2 reflects the National Public Health Improvement Initiative's (NPHII) ultimate goal of increasing the adoption and implementation of performance improvement practices, thus leading to greater efficiencies and effectiveness that contribute to greater public health performance and health outcomes. CDC and national partner organizations will provide training on quality improvement methods and issues, and technical assistance will be tailored to meet grantee needs aligned with their specific quality improvement projects. The measure tracks the proportion of NPHII awardees implementing performance improvement initiatives that result in improved efficiency and effectiveness of the management and delivery of population-based programs and services. Targets are preliminary, based on current awardees that already have a performance improvement office or activities in their department. To date, 53 grantees have an established performance office. Seventeen of those pre-dated NPHII funding; 36 (69 percent) are new offices established using NPHII support. Data from this measure will be used to demonstrate return on investments; identify, select, and disseminate successful stories and practices for adoption, adaptation, and implementation; and identify grantees that may require additional support. This information will guide technical and capacity building assistance and the development of high priority peer-to-peer networks.

REIMBURSEMENTS AND TRUST FUNDS

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Reimbursements and Trust Funds	**$722.159**	**$748.882**	**$748.882**	**$0.000**

Authorizing Legislation: PHSA §§ 301, 306(b)(4), 353; Departments of Labor, HHS, Education & Related Agencies Appropriations Act of 2010 (P.L. 111-117, Division D, Title II)

SUMMARY

CDC's FY 2013 request of $748,882,000 for reimbursements and trust funds is level with the FY 2012 level.

CDC's reimbursable activities provide technical assistance and consultation to other agencies and organizations. CDC has a long history of working and partnering with other federal agencies in the shared interest of improving public health and prevention programs. Examples of these activities include:

- Public health data needs are addressed through agreements with the National Park Service to ensure safe drinking water and sanitation in the national parks. Other areas of CDC consultation include research on occupational carcinogens, laboratory tests, investigations, development of workers safety guidelines, and training programs.
- The Clinical Laboratory Improvement Amendments of 1967 (CLIA) transferred the responsibility for laboratory licensure programs from CDC to the Health Care Financing Administration (HCFA). Under the CLIA of 1988, the Secretary directed that the CLIA program be jointly implemented by HCFA and CDC. Under this agreement, CDC provides scientific/technical support, test categorization, and information materials, and works with HCFA to initiate a process for accrediting programs developed by nonprofit organizations and states to comply with the CLIA standards.
- CDC will continue its longstanding agreements with other agencies of the Public Health Service, HHS, and others associated with CDC's health statistics studies. CDC will continue to provide consultation and technical assistance in areas such as genetic diseases, laboratory tests, investigations, development of worker safety guidance, and training and model screening programs.
- CDC provides a wide range of support and assistance to other agencies. For instance, CDC is working with the U.S. Agency on International Development (USAID) on various projects to prevent infectious disease and increase family planning. CDC is also assisting the Department of Homeland Security (DHS) in evaluating and assessing fire prevention grants to firefighters. CDC collaborates with the Environmental Protection Agency (EPA) and the Federal Emergency Management Agency (FEMA) on several projects of public health concern.
- In addition to reimbursable agreements and user fees, CDC receives funds from Cooperative Research and Development Agreements (CRADAs) to enhance and facilitate collaboration between the agency's laboratories and various partners. CDC provides research personnel, laboratory facilities, materials, equipment, supplies, intellectual property, and other in-kind contributions, and uses the income from CRADAs to continue to improve programs.

SUMMARY TABLE

#	(dollars in thousands)	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate
18.A	Agency for International Development 15 agreements to assist developing counties with implementation of population-based surveys and Breast Cancer and Environments Research (BCERC).	$56,600	$56,600	$56,600
18.B	Department of Agriculture 5 agreements for National Health and Nutrition Examination Survey from 2007 through 2010; Pilot Demo Project; and support for the Forum on Aging-Related Statistics. 4 agreements to support Outbreak and Plant Health Inspection.	$10,380	$10,380	$10,380
18.C	Department of Commerce 6 agreements for coordinating a National Survey of Adoptive Parents (SLAITS), NHANES, and forum on aging-related statistics.	$380	$380	$380
18.D	Department of Defense 3 agreements to support the design and deployment of the Healthcare Safety Network & Electronic Disease Surveillance System for Saudi Arabia National Guard Various agreements with the Navy for Border Infectious Disease Surveillance Project (BIDS), survey and diagnose cases of febrile respiratory illnesses on the Mexican border. 4 agreements for assessing the presence and nature of health hazards at specific DOD sites.	$29,996	$35,932	$35,932
18.E	Department of Energy 6 agreements to assist with energy-related analytical epidemiologic research and school-associated violent death studies. 2 agreements for assessing the presence and nature of health hazards at specific DOE sites.	$5,416	$5,416	$5,416
18.F	Department of Health and Human Services 130 agreements to perform various projects, provide ongoing participation in the clinical laboratory improvement, develop questions for the National Health Interview Survey, and an estimated $352,357,000 derived from evaluation funding under section 241 of the Public Health Service Act. 83 agreements to perform various projects, provide ongoing participation in the clinical laboratory improvement, and to develop questions for the National Health Interview Survey.	$570,153	$590,500	$590,500

#	(dollars in thousands)	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate
18.G	Department of Homeland Security 14 agreements for design and development of rapid method for AMR susceptibility resting for potential bioterrorism agents.	$2,072	$2,072	$2,072
18.H	Department of Housing and Urban Development 5 public health assessments of air quality in temporary housing.	$1,488	$1,488	$1,488
18.I	Department of Interior 1 agreement for prevention and control of viral hepatitis infections.	$50	$50	$50
18.J	Department of Justice 4 agreements supporting the Federal Intra-Agency Forum on Child and Family Statistics. 1 agreement for Clinical Indicator of Sexual Violence surveillance system.	$920	$920	$920
18.K	Department of Labor 1 agreement for Q-Bank database development and support for the Federal Intra-Agency Forum on Child and Family Statistics. 1 agreement to provide NIOSH responsibilities under EEOICPA.	$67	$67	$67
18.L	Department of State 1 agreement for field assignee to assist with Delaware and Iowa and Laboratory Testing.	$200	$200	$200
18.M	Department of Transportation 1agreement for National Survey on youth traffic safety issues.	$7	$7	$7
18.N	Environmental Protection Agency 13 agreements to collaborate studies on occupational and environmental risk; waterborne contaminant and diseases. 4 agreements for the National Health and Nutrition Examination Survey, Dietary Consumption and Human Biomonitoring Data Components; augmenting the NCHS surveys for Cancer Care Surveillance. 5 agreements to assist with projects for Pilot Registry and public health assessment of air quality in temporary housing, the Love Canal, and Tar Creek & Indian Colony.	$18,270	$18,270	$18,270
18.O	Federal Emergency Management Agency 2 agreements for emergency responses and public health assessment of air quality in temporary housing. 1 agreement to assist with the bioelectrical impedance analysis (BIA).	$2,875	$2,875	$2,875

#	(dollars in thousands)	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate
18.P	Various Agencies/Organizations 31 agreements for surveillance and standardization of genetic testing; various agreements with WHO, UN, Peace Corps, and Executive Office of the President.	$523	$523	$523
18.Q	Department of Veterans Affairs 3 agreements for the development of electronic surveillance and control of infections and antibiotic resistance. 3 agreements to assist with the National Death Index Services.	$1,566	$1,566	$1,566
18.R	Other 7 agreements to assist with the mail supplement, and public health assessment of air quality in temporary housing.	$6,113	$6,553	$6,553
18.S	Department of Navy 3 agreements to provide assistance to Camp Lejune (6 projects), Disaster Preparedness and Emergency Response Association (DERA), and Veques.	$3,197	$3,197	$3,197
18.T	Social Security Administration	$186	$186	$186
18.U	CRADA 21 agreements with commercial and non-profit organizations and foundations.	$1,000	$1,000	$1,000
18.V	User Fees	$10,700	$10,700	$10,700
	TOTAL	**$722,159**	**$748,882**	**$748,882**

This page left intentionally blank

SUPPORTING INFORMATION

OBJECT CLASS TABLE - DIRECT

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
OBJECT CLASSIFICATION - DIRECT OBLIGATIONS
(DOLLARS IN THOUSANDS)

Object Class	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent(11.1)	$688,216	$791,679	$695,130	($96,549)
Other than Full-Time Permanent (11.3)	$85,702	$95,028	$83,439	($11,589)
Other Personnel Comp. (11.5)	$36,560	$42,053	$36,924	($5,129)
Military Personnel (11.7)	$60,800	$69,638	$62,163	($7,475)
Special Personal Service Comp. (11.8)	$922	$1,064	$935	($129)
Total Personnel Compensation	**$872,200**	**$999,463**	**$878,591**	**($120,871)**
Civilian personnel Benefits (12.1)	$234,833	$269,170	$236,343	($32,827)
Military Personnel Benefits (12.2)	$42,631	$46,673	$41,941	($4,732)
Benefits to Former Personnel (13.0)	$13	$31	$59	$28
SubTotal Pay Costs	**$1,149,677**	**$1,315,337**	**$1,156,934**	**($158,403)**
Travel (21.0)	$45,712	$47,235	$37,317	($9,918)
Transportation of Things (22.0)	$13,863	$16,027	$14,269	($1,758)
Rental Payments to GSA (23.1)	$8,815	$31,631	$32,193	$562
Rental Payments to Others (23.2)	$1,098	$1,270	$1,131	($139)
Communications, Utilities, and Misc. Charges	$30,615	$35,345	$31,468	($3,878)
NTWK Use Data TRANSM SVC (23.8)	$183	$211	$188	($23)
Printing and Reproduction (24.0)	$4,894	$5,658	$5,037	($621)
Other Contractual Services:				
Advisory and Assistance Services (25.1)	$439,737	$338,992	$286,539	($52,453)
Other Services (25.2)	$216,874	$197,699	$171,946	($25,753)
Purchases from Government Accounts (25.3)	$341,602	$314,659	$280,139	($34,520)
Operation and Maintenance of Facilities (25.4)	$42,892	$49,587	$44,147	($5,440)
Research and Development Contracts (25.5)	$58,012	$67,067	$59,710	($7,357)
Medical Services (25.6)	$24,968	$28,865	$25,699	($3,166)
Operation and Maintenance of Equipment (25.7)	$30,308	$35,039	$31,195	($3,844)
Subsistence and Support of Persons (25.8)	$403	$466	$415	($51)
Consultants, other and misc (25.9)	$27,971	$32,142	$28,616	($3,526)
Subtotal Other Contractual Services	**$1,182,767**	**$1,064,517**	**$928,405**	**($136,112)**
Supplies and Materials (26.0)	$475,784	$550,007	$500,669	($49,338)
Equipment (31.0)	$51,554	$53,704	$47,812	($5,892)
Land and Structures (32.0)	$7,701	$8,903	$7,784	($1,119)
Investments and Loans (33.0)	$0	$0	$0	$0
Grants, Subsidies, and Contributions (41.0)	$2,675,879	$2,525,332	$2,227,886	($297,446)
Insurance Claims and Indemnities (42.0)	$298	$344	$301	($43)
Interest and Dividends (43.0)	$129	$149	$130	($19)
Refunds (44.0)	$0	$0	$0	$0
Subtotal Non-Pay Costs	**$5,648,970**	**$4,340,333**	**$3,834,589**	**($505,744)**
Total Budget Authority	**$5,648,970**	**$5,655,670**	**$4,991,523**	**($664,147)**
Average Cost per FTE				
Civilian FTEs	**8,426**	**8,379**	**8,370**	(9)
Civilian Average Salary and Benefits	$124	$143	$126	($17)
Percent change	N/A	15%	-12%	-27%
Military FTEs	**768**	**771**	**771**	**0**
Military Average Salary and Benefits	$135	$151	$132	($19)
Percent change	N/A	12%	-12%	-24%
Total FTEs	**9,194**	**9,150**	**9,141**	**(9)**
Average Salary and Benefits	**$125**	**$144**	**$126**	**($18)**
Percent change	**N/A**	**15%**	**-12%**	**-27%**

OBJECT CLASS TABLE - REIMBURSABLE

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
OBJECT CLASSIFICATION - REIMBURSABLE OBLIGATIONS
(DOLLARS IN THOUSANDS)

Object Class	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's	FY 2013 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent(11.1)	$104,184	$105,092	$105,092	$0
Other than Full-Time Permanent (11.3)	$21,949	$22,140	$22,140	$0
Other Personnel Comp. (11.5)	$5,421	$5,468	$5,468	$0
Military Personnel (11.7)	$9,416	$9,498	$9,498	$0
Special Personal Service Comp. (11.8)	$251	$253	$253	$0
Total Personnel Compensation	**$141,221**	**$142,451**	**$142,451**	**$0**
Civilian Personnel Benefits (12.1)	$35,392	$35,701	$35,701	$0
Military Personnel Benefits (12.2)	$6,333	$6,388	$6,388	$0
Benefits to Former Personnel (13.0)	$0	$0	$0	$0
SubTotal Pay Costs	**$182,946**	**$184,539**	**$184,539**	**$0**
Travel (21.0)	$12,978	$13,091	$13,091	$0
Transportation of Things (22.0)	$648	$654	$654	$0
Rental Payments to GSA (23.1)	$883	$890	$890	$0
Rental Payments to Others (23.2)	$287	$289	$289	$0
Communications, Utilities, and Misc. Charges (23.3)	$1,536	$1,550	$1,550	$0
Printing and Reproduction (24.0)	$1,094	$1,103	$1,103	$0
Other Contractual Services:				
Advisory and Assistance Services (25.1)	$89,497	$90,277	$90,277	$0
Other Services (25.2)	$67,178	$88,196	$88,196	$0
Purchases from Government Accounts (25.3)	$68,212	$68,806	$68,806	$0
Operation and Maintenance of Facilities (25.4)	$3,050	$3,076	$3,076	$0
Research and Development Contracts (25.5)	$30,978	$31,248	$31,248	$0
Medical Services (25.6)	$29,213	$29,467	$29,467	$0
Operation and Maintenance of Equipment (25.7)	$2,612	$2,635	$2,635	$0
Subsistence and Support of Persons (25.8)	$3	$3	$3	$0
Consultants, other and misc (25.9)	$2,333	$2,354	$2,354	$0
Subtotal Other Contractual Services	**$293,076**	**$316,062**	**$316,062**	**$0**
Supplies and Materials (26.0)	$44,038	$44,421	$44,421	$0
Equipment (31.0)	$12,023	$12,128	$12,128	$0
Land and Structures (32.0)	$0	$0	$0	$0
Investments and Loans (33.0)	$0	$0	$0	$0
Grants, Subsidies, and Contributions (41.0)	$172,574	$174,077	$174,077	$0
Insurance Claims and Indemnities (42.0)	$77	$78	$78	$0
Interest and Dividends (43.0)	$0	$0	$0	$0
Refunds (44.0)	$0	$0	$0	$0
Subtotal Non-Pay Costs	**$539,213**	**$564,343**	**$564,343**	**$0**
Total Budget Authority	**$722,159**	**$748,882**	**$748,882**	**$0**
Average Cost per FTE				
Reimbursable FTEs	**1,101**	**1,095**	**1,094**	**(1)**
Average Salary	$151,632	$153,791	$153,931	**($140)**
Percent change	N/A	1.4%	0.9%	-0.5%
Military FTEs	**0**	**0**	**0**	**0**
Military Average Salary	NA	NA	NA	NA
Percent change	N/A	NA	NA	NA
Total FTEs	**1,101**	**1,095**	**1,094**	**(1)**
Total Average Salary	**$166,163**	**$168,529**	**$178,817**	**$10,288**
Percent change	**N/A**	**1%**	**1%**	**0%**

OBJECT CLASS TABLE – AFFORDABLE CARE ACT

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
OBJECT CLASSIFICATION - ACA
(DOLLARS IN THOUSANDS)

Object Class	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent(11.1)	$2,242	$3,015	$3,298	$282
Other than Full-Time Permanent (11.3)	$2,862	$3,849	$4,209	$361
Other Personnel Comp. (11.5)	$122	$164	$179	$15
Military Personnel (11.7)	$1,017	$1,368	$1,496	$128
Special Personal Service Comp. (11.8)	$0	$0	$0	$0
Total Personnel Compensation	**$6,243**	**$8,396**	**$9,183**	**$787**
Civilian personnel Benefits (12.1)	$1,466	$1,972	$2,157	$185
Military Personnel Benefits (12.2)	$2,259	$3,038	$3,323	$285
Benefits to Former Personnel (13.0)	$0	$0	$0	$0
SubTotal Pay Costs	**$9,968**	**$13,407**	**$14,663**	**$1,256**
Travel (21.0)	$637	$856	$936	$80
Transportation of Things (22.0)	$1	$1	$1	$0
Rental Payments to GSA (23.1)	$14,564	$19,587	$21,422	$1,835
Rental Payments to Others (23.2)	$0	$0	$0	$0
Communications, Utilities, and Misc.Charges (23.3)	$35	$48	$52	$4
NTWK Use Data TRANSM SVC (23.8)	$0	$0	$0	$0
Printing and Reproduction (24.0)	$9	$13	$14	$1
Other Contractual Services:			$0	$0
Advisory and Assistance Services (25.1)	$111,894	$150,486	$164,584	$14,098
Other Services (25.2)	$8,368	$11,254	$12,309	$1,054
Purchases from Government Accounts (25.3)	$58,272	$78,370	$85,712	$7,342
Operation and Maintenance of Facilities (25.4)	$0	$0	$0	$0
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical Services (25.6)	$0	$0	$0	$0
Operation and Maintenance of Equipment (25.7)	$0	$0	$0	$0
Subsistence and Support of Persons (25.8)	$0	$0	$0	$0
Consultants, other and misc (25.9)	$0	$191	$209	$18
Subtotal Other Contractual Services	**$178,676**	**$240,301**	**$262,813**	**$22,512**
Supplies and Materials (26.0)	$31	$41	$45	$4
Equipment (31.0)	$4,282	$5,758	$6,298	$539
Land and Structures (32.0)	$0	$0	$0	$0
Investments and Loans (33.0)	$0	$0	$0	$0
Grants, Subsidies, and Contributions (41.0)	$412,538	$554,823	$606,800	$51,978
Insurance Claims and Indemnities (42.0)	$0	$0	$0	$0
Interest and Dividends (43.0)	$0	$0	$0	$0
Refunds (44.0)	$0	$0	$0	$0
Subtotal Non-Pay Costs	**$610,773**	**$821,428**	**$898,382**	**$76,954**
Total Budget Authority[1]	**$620,741**	**$834,835**	**$913,045**	**$78,210**
Average Cost per FTE[2]				
Civilian FTEs	**51**	**63**	**73**	**22**
Civilian Average Salary and Benefits	$130.01	$143.48	$134.99	$5.0
Percent change	N/A	10%	-6%	N/A
Military FTEs	**25**	**30**	**35**	**10**
Military Average Salary	$131.99	$145.72	$137.01	$5.0
Percent change	N/A	10%	-6%	N/A
Total FTEs	**76**	**93**	**108**	**15**
Total Average Salary[2]	**$131**	**$144**	**$136**	**-$9**
Percent change	**N/A**	**10%**	**-6%**	**N/A**

[1]FY 2011, 2012 and 2013 amounts include direct funded ACA projects (Libby Montana and Childhood Obesity)

[2]ACA Civilian Avg. Salary only includes partial compensation

SALARIES AND EXPENSES

**FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SALARIES AND EXPENSES
(DOLLARS IN THOUSANDS)**

Object Class	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY2012
Personnel Compensation:				
Full-Time Permanent(11.1)	$688,216	$791,679	$695,130	($96,549)
Other than Full-Time Permanent (11.3)	$85,702	$95,028	$83,439	($11,589)
Other Personnel Comp. (11.5)	$36,560	$42,053	$36,924	($5,129)
Military Personnel (11.7)	$60,800	$69,638	$62,163	($7,475)
Special Personal Service Comp. (11.8)	$922	$1,064	$935	($129)
Total Personnel Compensation	**$872,200**	**$999,463**	**$878,591**	**($120,871)**
Civilian personnel Benefits (12.1)	$234,833	$269,170	$236,343	($32,827)
Military Personnel Benefits (12.2)	$42,631	$46,673	$41,941	($4,732)
Benefits to Former Personnel (13.0)	$13	$31	$59	$28
SubTotal Pay Costs	**$1,149,677**	**$1,315,337**	**$1,156,934**	**($158,403)**
Travel (21.0)	$45,712	$47,235	$37,317	($9,918)
Transportation of Things (22.0)	$13,863	$16,027	$14,269	($1,758)
Communications, Utilities, and Misc. Charges (23.3)	$30,615	$35,345	$31,468	($3,878)
Printing and Reproduction (24.0)	$4,894	$5,658	$5,037	($621)
Other Contractual Services:				
Advisory and Assistance Services (25.1)	$439,737	$338,992	$286,539	($52,453)
Other Services (25.2)	$216,874	$197,699	$171,946	($25,754)
Purchases from Government Accounts (25.3)	$341,602	$314,659	$280,139	($34,520)
Operation and Maintenance of Facilities (25.4)	$42,892	$49,587	$44,147	($5,440)
Research and Development Contracts (25.5)	$58,012	$67,067	$59,710	($7,358)
Medical Services (25.6)	$24,968	$28,865	$25,699	($3,167)
Operation and Maintenance of Equipment (25.7)	$30,308	$35,039	$31,195	($3,844)
Subsistence and Support of Persons (25.8)	$403	$466	$415	($51)
Subtotal Other Contractual Services	**$1,154,796**	**$1,032,375**	**$899,789**	**($132,585)**
Supplies and Materials (26.0)	$475,784	$550,007	$500,669	($49,338)
Subtotal Non-Pay Costs	**$1,725,665**	**$1,686,647**	**$1,488,549**	**($198,098)**
Rental Payments to Others (23.2)	$1,098	$1,270	$1,131	($139)
Total, Salaries & Expenses and Rent	**$2,876,441**	**$3,003,254**	**$2,646,614**	**($356,640)**
Direct FTE	**9,194**	**9,150**	**9,141**	**(9)**

DETAIL OF FULL TIME EQUIVALENT EMPLOYMENT (FTE)

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

	FY 2011		FY 2012		FY 2013	
Direct FTE	**Civilian**	**Comm Corp**	**Civilian**	**Comm Corp**	**Civilian**	**Comm Corp**
Immunization and Respiratory Diseases	568	101	565	101	564	101
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	969	100	964	100	963	100
Emerging and Zoonotic Infectious Diseases	1,049	133	1,043	133	1,042	133
Chronic Disease Prevention and Health Promotion	911	84	906	84	905	84
Birth Defects, Developmental Disabilities, Disability and Health	221	9	220	9	220	9
Environmental Health	386	37	384	37	383	37
Injury Prevention and Control	205	13	204	13	204	13
Public Health Scientific Services	471	58	468	58	468	58
Occupational Safety and Health	835	61	830	61	829	61
Global Health	581	88	578	88	577	88
CDC-wide Cross-cutting Activities	1,755	36	1,745	36	1,743	36
Public Health Leadership and Support	*397*	*9*	*395*	*9*	*394*	*9*
Business Services Support	*1,358*	*27*	*1,350*	*27*	*1,349*	*27*
Public Health Preparedness and Response	475	48	472	48	472	48
Agency for Toxic Substances and Disease Registry	255	42	258	39	258	39
Subtotal, Direct FTE	*8,681*	*810*	*8,637*	*810*	*8,628*	*810*
Reimbursable FTE						
Immunization and Respiratory Diseases	0	0	0	0	0	0
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	16	7	16	7	16	7
Emerging and Zoonotic Infectious Diseases	30	3	30	3	30	3
Chronic Disease Prevention and Health Promotion	15	2	15	2	15	2
Birth Defects, Developmental Disabilities, Disability and Health	2	0	2	0	2	0
Environmental Health	23	9	23	9	23	9
Injury Prevention and Control	0	0	0	0	0	0
Public Health Scientific Services	562	23	559	23	558	23
Occupational Safety and Health	286	24	284	24	284	24
Global Health	41	12	41	12	41	12
CDC-wide Cross-cutting Activities	113	1	112	1	112	1
Public Health Leadership and Support	*112*	*0*	*111*	*0*	*111*	*0*
Business Services Support	*1*	*1*	*1*	*1*	*1*	*1*
Public Health Preparedness and Response	0	0	0	0	0	0
Agency for Toxic Substances and Disease Registry	13	0	13	0	13	0
Subtotal, Reimbursable FTE	*1,101*	*81*	*1,095*	*81*	*1,094*	*81*
TOTAL, CDC/ATSDR FTE	**9,782**	**891**	**9,732**	**891**	**9,722**	**891**

DETAIL OF POSITIONS

FY 2013 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
PROGRAM ADMINISTRATION
DETAIL OF POSITIONS [1, 2]

	FY 2011 Actual	FY 2012 Estimate	FY 2013 Estimate
Executive Level	-	-	-
Executive level I	-	-	
Executive level II	-	-	
Executive level III	-	-	
Executive level IV	-	-	
Executive level V	-	-	
Subtotal	-	-	
Total-Executive Level Salary	-	-	
Total - SES	***33***	***33***	***33***
Total - SES Salary	**$5,565,087**	**$5,565,087**	**$5,565,087**
GS-15	601	601	601
GS-14	1,783	1,783	1,783
GS-13	2,558	2,558	2,558
GS-12	1,457	1,457	1,457
GS-11	879	879	879
GS-10	62	62	62
GS-9	498	498	498
GS-8	73	73	73
GS-7	359	359	359
GS-6	71	71	71
GS-5	77	77	77
GS-4	51	51	51
GS-3	19	19	19
GS-2	5	5	5
GS-1			
Subtotal	***8,493***	***8,493***	***8,493***
Total - GS Salary	**$791,338,386**	**$791,338,386**	**$791,338,386**
Average GS grade	12.0	12.0	12.0
Average GS salary	93,175	93,175	93,175
Average Special Pay Categories			
Average Comm. Corps Salary3	84,457	84,457	84,457
Average Wage Grade Salary	56,199	56,199	56,199
Recovery Act	0	0	0

1 Includes special pays and allowances

2 Totals do not include reimbursable FTEs

3 This table reflects "positions" not full-time equivalent(s) (FTEs)

PROGRAMS PROPOSED FOR ELIMINATION

The table below shows the programs proposed for elimination in the FY 2013 President's Budget Request. Following the table is the rationale for the elimination of each program.

PROGRAM	REDUCTION AMOUNT (dollars in millions)
Academic Centers for Public Health Preparedness	$7.980
Education and Research Centers	$24.268
National Occupational Research Agenda-AgFF	$19.642
Built Environment	$2.628
Preventive Health and Health Services Block Grant	$79.545
Racial and Ethnic Approaches to Community Health	$53.940
Johanna's Law	$4.972
Prevention Research Centers (Developmental Centers)	$2.900
Total	**$192.975**

Program (-$192.975 million)

Built Environment (-$2.628 million)

The FY 2013 budget request reflects the elimination of Built Environment Activities. CDC will integrate aspects of the Built Environment Activities into the Community Transformation Grants, supported by the ACA Prevention and Public Health Fund.

Education and Research Centers (-$24.268 million)

The FY 2013 budget request reflects the elimination of the Education and Research Centers (ERCs) ($24.268 million). As a result of limited Federal resources, in a resource constrained environment, the ERCs have been identified as a low priority program.

National Occupational Research Agenda (-$19.642 million)

The FY 2013 budget request reflects the elimination of the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupational Research Agenda (NORA) ($19.642 million). In a limited resource environment, the AgFF program has been identified as a low priority program.

Academic Centers for Public Health Preparedness (-$7.980 million)

The FY 2013 budget request reflects the elimination of the Academic Centers (-$7.980 million). CDC recognizes the important work conducted by the Academic Centers, but the Centers have not demonstrated the return on investment or public health impact anticipated at the program's outset.

Preventive Health and Health Services Block Grant (-$79.545 million)

The FY 2013 budget request reflects the elimination of the Preventive Health and Health Services Block Grant program ($79.545 million). CDC anticipates that these activities will be more effectively and efficiently implemented through the new Chronic Disease Prevention and Health Promotion Grant Program and ACA and Public Health Fund investments.

Racial and Ethnic Approaches to Community Health (-$53.940 million)

The FY 2013 budget request reflects the elimination of the Racial and Ethnic Approaches to Community Health (REACH) program ($53.940 million). The Community Transformation Grants (CTG) program, which builds on past program successes and lessons learned, marks the next stage of CDC's community-based programs. The CTG program will integrate best practices and lessons learned from the REACH program into its new approach, amplifying the dissemination of these best practices and lessons learned to communities across the nation.

Johanna's Law (-$4.972 million)

The FY 2013 budget request reflects the elimination of Johanna's Law activities ($4.972 million). CDC will continue to support gynecologic cancer education and awareness activities, targeting both the public and health care providers. Although the Inside Knowledge campaign will be discontinued, CDC will continue to work with and provide existing campaign materials through partner organizations and health care providers. CDC will also continue to disseminate gynecologic cancer educational materials through other programs, such as the National Breast and Cervical Cancer Early Detection Program and the National Comprehensive Cancer Control Program, as well as other agencies, such as the HHS Office of Women's Health.

Prevention Research Centers (Developmental Centers) (-$2.900 million)

The FY 2013 budget request reflects a reduction to the Prevention Research Centers program.

FY 2013 HHS ENTERPRISE IT AND GOVERNMENT-WIDE E-GOV INITIATIVES

The CDC will use $2,528,292 of its FY 2013 budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, $819,401 is allocated to developmental government-wide E-Government initiatives for FY 2013. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives[1]	
Line of Business - Human Resources	$19,246
Line of Business - Grants Management	$16,435
Line of Business - Financial	$18,064
Line of Business - Budget Formulation and Execution	$13,263
Disaster Assistance Improvement Plan	$9,495
Federal Health Architecture (FHA)	$535,100
Integrated Acquisition Environment- Grants and Loans	$174,019
Line of Business - Geospatial	$33,779
FY 2013 Developmental E-Gov Initiatives Total	**$819,401**

[1]Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally,

NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on

other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

Lines of Business-Geospatial: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

In addition, **$1,708,891** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives[1]	
E-Rule Making	$65,517
Integrated Acquisition Environment	$387,893
GovBenefits	$29,041
Grants.Gov	$1,226,440
FY 2013 Ongoing E-Gov Initiatives Total	**$1,708,891**

[1]Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Other IT Initiatives and Programs

Currently, the Enterprise IT Portfolio Office (EITPO) monitors the IT systems across CDC. CDC's IT spend for FY 2013 is $453,344,000. Our major investments are posted on the OMB Federal IT Dashboard website, http://it.usaspending.gov.

Enterprise Performance Life Cycle (EPLC) Framework

CDC is actively implementing the Enterprise Performance Life Cycle Framework (EPLC) which is a complex IT governance and project management framework. Implementation at the project level has been an extensive effort and has resulted in higher project success in meeting stated business objectives.

SUMMARY OF CDC CONTRIBUTIONS TO FY 2013 HHS PERFORMANCE PLAN

The HHS Performance Plan will include a total of 22 CDC-associated measures: three FY 2012–2013 federal High Priority Performance Goals, nine HHS Strategic Plan Measures, and 10 additional measures for key CDC program areas (below).

CDC CONTRIBUTIONS TO HIGH PRIORITY PERFORMANCE GOALS, FY 2012- 2013[1]

CDC Component	Program	Measure
National Center for Emerging and Zoonotic Infectious Diseases	Food Safety	By December 31, 2013, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 2.1 cases per 100,000.
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	By December 31, 2013, reduce annual adults' cigarette consumption in the United States from 1,281 cigarettes per capita to 1,062 cigarettes per capita, which represents a 17.1% decrease from the baseline.
National Center for Emerging and Zoonotic Infectious Diseases	Healthcare Associated Infections/National Healthcare Safety Network	By September 30, 2013, reduce the national rate of healthcare-associated infections (HAIs) by demonstrating significant, quantitative and measurable reductions in hospital-acquired central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

[1] CDC contributes to these shared goals but does not lead them

CDC CONTRIBUTIONS TO FY 2013 HHS STRATEGIC PLAN

CDC Component	Program	Measure
National Center for Emerging and Zoonotic Infectious Diseases	National Health Care Safety Network and Healthcare-Associated Infections	Reduce the estimated number of healthcare associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections. (3.3.2)
National Center for Emerging and Zoonotic Infectious Diseases	National Health Care Safety Network and Healthcare-Associated Infections	Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (3.3.4)
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	Reduce the proportion of adolescents (grades 9-12) who are current cigarette smokers (4.6.5)
Office of Surveillance, Epidemiology, and Laboratory Services	Epidemiology	Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets (8.B.2.2)
Office of Surveillance, Epidemiology, and Laboratory Services	Epidemiology	Increase monitoring of awareness and use of the Guide to Community Preventive Services, and Task Force findings and recommendations (8.2.5)
Office of Surveillance, Epidemiology, and Laboratory Services	Public Health Workforce and Career Development	Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies (8.B.4.2)
Office of Surveillance, Epidemiology, and Laboratory Services	Public Health Workforce and Career Development	Maintain the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies (8.B.4.3).

CDC Component	Program	Measure
Center for Global Health	Field Epidemiology and Laboratory Training and sustainable Management Development	Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP) (10.F.1a-b)
Office of Public Health Preparedness and Response	Division of State and Local Readiness	Increase the percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners (13.5.3)

ADDITIONAL MEASURES TO BE INCLUDED IN FY 2013 HHS PERFORMANCE PLAN

CDC Component	Program	Candidate Measure(s)
National Center for Immunization and Respiratory Diseases	Immunization (Section 317)	Sustain immunization coverage of at least 90% in children 19 to 35 months of age for one dose of MMR vaccine (1.2.1c)
National Center for Immunization and Respiratory Diseases	Immunization (Section 317)	Increase the rate of influenza vaccination among adults 18 to 64 (1.3.2a)
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Domestic HIV/AIDS prevention and research	Increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AIDS) (2.1.4)
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Domestic HIV/AIDS prevention and research	Increase the number of states that report all CD4 and HIV viral load values for surveillance purposes (2.2.4)
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Tuberculosis	Decrease the rate of cases of TB among U.S.-born persons (per 100,000 population). (2.8.1)
National Center for Emerging and Zoonotic Infectious Diseases	Antibiotic Resistance	Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (3.2.1)
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers (4.6.3)
National Center for Chronic Disease Prevention and Health Promotion	Coordinated Chronic Disease Grant	Increase the proportion of adults who engage in leisure time physical activity (4.11.9)
National Center for Injury Prevention and Control	Unintentional Injury	Motor vehicle deaths per 100 million vehicle miles traveled (7.2.4)
Center for Global Health	Parasitic Diseases and Malaria	Increase the proportion of children under five years old who slept under an insecticide treated net the previous night in PMI target countries. (10.C.1)

DISCONTINUED MEASURES TABLE FOR FY 2013

IMMUNIZATION AND RESPIRATORY DISEASES

Discontinued Measure	FY	Target	Result
1.1.1a: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following: Paralytic Polio (Outcome)	2010	0	0 (Target Met)
	2009	0	1 (all ages) (Target Not Met)
	2008	0	0 (all ages) (N/A)
	2007	0	0 (all ages) (Target Met)
	2006	0	0 (Target Met)
	2005	0	0 (Target Met)
	2004	0	0 (Target Met)
1.1.1b: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following: Rubella *(Outcome)*	2010	0	2 (Target Not Met)
	2009	5	2 (all ages) (Target Met)
	2008	8	8 (all ages) (Target Met)
	2007	8	12 (all ages) (Target Not Met)
	2006	15	11 (Target Exceeded)
	2005	15	7 (Target Exceeded)
	2004	15	7 (Target Exceeded)
	2003	15	7 (Target Exceeded)
1.1.1c: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following: Measles *(Outcome)*	2010	0	25 (Target Not Met but Improved)
	2009	25	51 (Target Not Met)
	2008	35	115 (all ages) (Target Not Met)
	2007	45	14 (all ages) (Target Exceeded)
	2006	50	24 (Target Exceeded)
	2005	50	42 (Target Exceeded)
	2004	50	10 (Target Exceeded)
1.1.1d: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following:	2010	0	222 (Target Not Met)
	2009	75	213 (Target Not Met)

Discontinued Measure	FY	Target	Result
Haemophilus influenzae *(Outcome)*	2008	150	193 (b + unknown) (children under 5) (Target Not Met but Improved)
	2007	150	202 (b + unknown) (children under 5) (Target Not Met)
	2006	150	208 (b + unknown) (Target Not Met)
	2005	150	226 (Target Not Met)
	2004	150	196 (Target Not Met)
1.1.1e: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following: Diphtheria *(Outcome)*	2010	0	0 (Target Met)
	2009	3	0 (Target Exceeded)
	2008	4	0 (persons <35 years of age) (Target Exceeded)
	2007	4	0 (persons <35 years of age) (Target Exceeded)
	2006	5	0 (Target Exceeded)
	2005	5	0 (Target Exceeded)
	2004	5	0 (Target Exceeded)
	2003	5	0 (Target Exceeded)
1.1.1f: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following: Congenital rubella Syndrome *(Outcome)*	2010	0	0 (Target Met)
	2009	2	1 (children under one) (Target Met)
	2008	3	0 (children under one) (Target Exceeded)
	2007	4	0 (children under one) (Target Exceeded)
	2006	5	0 (Target Exceeded)
	2005	5	0 (Target Exceeded)
	2004	5	0 (Target Exceeded)
	2003	5	1 (Target Exceeded)
1.1.1g: Reduce or maintain the number of indigenous cases at 0 by 2010 for the following: Tetanus *(Outcome)*	2010	0	9 (Target Not Met)
	2009	8	7 (Target Exceeded)
	2008	10	6 cases (persons under 35 years of age) (Target Exceeded)
	2007	13	6 (persons under 35 years of age) (Target Exceeded)

Discontinued Measure	FY	Target	Result
	2006	25	12 (Target Exceeded)
	2005	25	5 (Target Exceeded)
	2004	25	6 (Target Exceeded)
	2003	25	6 (Target Exceeded)
1.1.2: Reduce the number of indigenous cases of mumps in persons of all ages from 666 (1998 baseline) to 0 by 2010. *(Outcome)*	2010	0	2572 (Target Not Met)
	2009	100	1965 (all ages) (Target Not Met)
	2008	200	418 (Target Not Met but Improved)
	2007	200	800 (Target Not Met but Improved)
	2006	200	6,584 (Target Not Met)
	2005	200	314 (Target Not Met)
	2004	200	258 (Target Not Met)
	2003	250	231 (Target Exceeded)
1.1.3: Reduce the number of indigenous cases of pertussis among children under 7 years of age. *(Outcome)*	2010	2,000	10,199 (Target Not Met)
	2009	2,150	4,799 (Target Not Met)
	2008	2,300	4,166 (Target Not Met)
	2007	2,300	3,106 (Target Not Met but Improved)
	2006	2,300	3,841 (Target Not Met but Improved)
	2005	2,300	7,347 (Target Not Met)
	2004	N/A	6,850 (Target Not In Place)
1.1.4: Reduce or eliminate indigenous cases of Varicella (persons 17 years of age and under). *(Outcome)*	2010	223,000	242,231 (Target Not Met)
	2007	Baseline	582,535
1.2.1a: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine (*Output*)	2008	90%	85% (Target Not Met)
	2007	90%	85% (Target Not Met)
	2006	90%	85% (Target Not Met)
	2005	90%	86% (Target Not Met)
	2004	90%	86% (Target Not Met)

Discontinued Measure	FY	Target	Result
1.2.1b: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 3 doses Hib vaccine (*Output*)	2010	At least 90% coverage	90% (Target Met)
	2009	At least 90% coverage	84%[1] (Target Not Met)[2]
	2008	At least 90% coverage	91% (Target Exceeded)
	2007	At least 90% coverage	93% (Target Exceeded)
	2006	At least 90% coverage	93% (Target Exceeded)
	2005	At least 90% coverage	94% (Target Exceeded)
	2004	At least 90% coverage	94% (Target Exceeded)
1.2.1d: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 3 doses hepatitis B vaccine (*Output*)	2010	At least 90% coverage	92% (Target Exceeded)
	2009	At least 90% coverage	92% (Target Exceeded)
	2008	At least 90% coverage	94% (Target Exceeded)
	2007	At least 90% coverage	93% (Target Exceeded)
	2006	At least 90% coverage	93% (Target Exceeded)
	2005	At least 90% coverage	93% (Target Exceeded)
	2004	At least 90% coverage	92% (Target Exceeded)
1.2.1e: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 3 doses polio vaccine (*Output*)	2010	At least 90% coverage	93% (Target Exceeded)
	2009	At least 90% coverage	93% (Target Exceeded)
	2008	At least 90% coverage	94% (Target Exceeded)
	2007	At least 90% coverage	93% (Target Exceeded)
	2006	At least 90% coverage	93% (Target Exceeded)
	2005	At least 90% coverage	93% (Target Exceeded)
	2004	At least 90% coverage	92% (Target Exceeded)
1.2.1f: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 1 dose varicella vaccine (*Output*)	2010	At least 90% coverage	90% (Target Met)
	2009	At least 90% coverage	90% (Target Met)
	2008	At least 90% coverage	91% (Target Exceeded)
	2007	At least 90% coverage	90% (Target Met)
	2006	At least 90% coverage	88% (Target Not Met)
	2005	At least 90% coverage	88% (Target Not Met)

Discontinued Measure	FY	Target	Result
	2004	At least 90% coverage	88% (Target Not Met)
1.2.1g: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses of pneumococcal conjugate vaccine (PCV7). (*Outcome*)	2010	At least 90% coverage	83% (Target Not Met But Improved)
	2009	At least 90% coverage	80% (Target Not Met)
	2008	At least 90% coverage	80% (Target Not Met but Improved)
	2007	At least 90% coverage	75% (Target Not Met but Improved)
	2006	At least 90% coverage	68% (Target Not Met)
1.2.2: Achieve or sustain immunization coverage of at least 90% in adolescents 13 to 15 years of age for: 1 dose Td containing vaccine. (*Intermediate Outcome*)	2010	At least 90% coverage	81% (Target Not Met But Improved)
	2009	At least 90% coverage	75% (Target Not Met but Improved)
	2008	At least 90% coverage	71% (Target Not Met but Improved)
	2007	At least 90% coverage	69% (Target Not Met but Improved)
	2006	Baseline	56.7%
1.3.2a: Increase the rate of vaccination among non-institutionalized high-risk adults aged 18 to 64 years to 60% by 2010 for: influenza *(Output)*	2010	60%	N/A
	2009	40%	N/A
	2008	40%	39% (Target Not Met but Improved)
	2007	32%	36% (Target Exceeded)
	2006	32%	34% (Target Exceeded)
1.4.1a: By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults 65 years and older to 42 per 100,000 children under 5 years of age *(Outcome)*	2010	46	18 (Target Exceeded)
	2009	46	20.0 (Target Exceeded)
	2008	46	20.9 (Target Exceeded)
	2007	47	21.9 (Target Exceeded)
	2006	48	20.8 (Target Exceeded)
	2005	Baseline	21
1.4.1b: By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults 65 years and older to 42 per 100,000 adults 65 years and older *(Outcome)*	2010	42	37 (Target Exceeded)
	2009	42	40.1 (Target Exceeded)
	2008	42	37.6 (Target Exceeded)
	2007	45	39.2 (Target Exceeded)
	2006	47	40.5 (Target Exceeded)
	2005	Baseline	39
1.5.1: Improve capacity to conduct immunization	2010	10,000,000	9,200,000 (Target Not Met)

Discontinued Measure	FY	Target	Result
safety studies by increasing the total population of managed care organization members from which the Vaccine Safety Datalink (VSD) data are derived annually to 13 million by 2010. *(Output)*	2009	10,000,000	9,100,000 (Target Not Met but Improved)
	2008	10,000,000	9,100,000 (Target Not Met but Improved)
	2007	10,000,000	9,000,000 (Target Not Met)
	2006	10,000,000	9,000,000 (Target Not Met)
	2005	10,000,000	9,000,000 (Target Not Met but Improved)
	2004	10,000,000	7,500,000 (Target Not Met)
	2003	10,000,000	7,500,000 (Target Not Met)
	2002	Baseline	7,500,000
1.6.2: Increase the percentage of Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees (SLTTs) that meet the standard for surveillance and laboratory capability criteria. *(Output)*	2010	80%	97% (Target Exceeded)
	2009	70%	NA*see narrative - Did Not Report
	2008	50%	67% (Target Exceeded)
	2007	Baseline	32%

[1]Children who were given ≥3 doses.

[2] Beginning in 2009, coverage estimates are reported based on a more accurate measurement of Hib vaccination status that takes into account vaccine product type (Hib vaccine products vary in the number of recommended doses). For additional background, please see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5933a3.htm.

Performance Measures 1.1.1-1.4

CDC, working with state and local partners, provides the most significant contribution to the reduction of vaccine preventable diseases in the United States by achieving and maintaining high immunization coverage. However, the vaccine preventable disease (VPD) measures are influenced by factors outside of CDC's program, operations, and resource investment decisions. Therefore, they do not provide the most meaningful measures by which to hold CDC accountable for the Government Performance and Results Act (GPRA). CDC continually monitors cases of vaccine preventable diseases to identify disease outbreaks and changes in incidence. Appropriate response to such changes could include assessing vaccine effectiveness or duration of protection and revision of vaccine policy recommendations. Although retiring this as a CDC measure, CDC will continue to monitor and report on vaccine preventable disease measures through Healthy People 2020.

Performance Measure 1.3.2a

CDC has replaced this measure based on updated Advisory Committee on Immunization Practices (ACIP) recommendations to expand influenza vaccination among all adults ages 18-64. Rates for 2009 and 2010 will be reported in the revised measure.

Performance Measure 1.5

This measure is owned by CDC but is not meaningful to drive program performance. The nature of the program's work in relation to this measure is to conduct surveillance to identify adverse events and conduct research as warranted, and the research timeframe does not lend itself to annual or more frequent reporting.

Performance Measure 1.6.2

CDC has replaced this measure with more efficient measures of criteria for improvement plans. In FY 2011, a new baseline of performance for Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees was established based on new methods of assessments criteria, resulting from lessons learned through the 2009 H1N1 pandemic.

HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

Discontinued Measure	FY	Target	Result
2.1.2: Decrease the number of pediatric AIDS cases. *(Outcome)*[1]			
	2011	<75	Nov 30, 2012
	2010	<75	Nov 30, 2011
	2009	<75	March 31, 2011
	2008	<75	41 (Target Exceeded)
	2007	<100	28 (Target Exceeded)
2.1.3: Reduce the black:white rate ratio of HIV diagnoses. *(Outcome)*[2]	2012	8.2:1	Nov 30, 2013
	2011	8.2:1	Nov 30, 2012
	2010	8.2:1	Nov 30, 2011
	2009	8.2:1	March 31, 2011
	2008	8.4:1	9.22:1 (Target Not Met)
	2007	8.4:1	8.51:1 (Target Not Met but Improved)
	2006	8.7:1	8.88:1 (Target Not Met)
2.1.4: Reduce the Hispanic: white rate ratio of HIV diagnoses. *(Outcome)*	2012	3.3:1	Nov 30, 2013
	2011	3.3:1	Nov 30, 2012
	2010	3.3:1	Nov 30, 2011
	2009	3.3:1	March 31, 2011
	2008	3.4:1	3.49:1 (Target Not Met)
	2007	3.4:1	3.46:1 (Target Not Met but Improved)
	2006	3.5:1	3.49:1 (Target Exceeded)
2.1.6: Increase the percentage of HIV prevention program grantees using Program Evaluation and Monitoring System (PEMS) to monitor program implementation. *(Output)*	Out-Year Target	100% (2015)	Nov 30, 2016
	2012	100%	Nov 30, 2013
	2011	100%	Nov 30, 2012
	2010	100%	Nov 30, 2011
	2009	65%	97% (Target Exceeded)
	2008	45%	95% (Target Exceeded)
	2007	20%	67% (Target Exceeded)
	2006	Baseline	0
2.1.7: Increase the number of evidence-based prevention interventions that are packaged and available for use in the field by	2012	21	Jan 31, 2013
	2011	21	Jan 31, 2012
	2010	20	Jan 31, 2011
	2009	20	21

Discontinued Measure	FY	Target	Result
prevention program grantees. *(Output)*			(Target Exceeded)
	2008	18	17 (Target Not Met but Improved)
	2007	15	16 (Target Exceeded)
	2006	N/A	14
2.2.1: Reduce the HIV transmission rate per 100 persons living with HIV. *(Outcome)*	Out-Year Target	3.5% (2015)	Nov 30, 2016
	2012	4.7%	March 31, 2014
	2011	N/A	March 31, 2013
	2007	Baseline	Apr 30, 2011
	2006	Baseline	5.0%
2.2.2: Decrease risky sexual and drug using behaviors among persons at risk for transmitting HIV. *(Outcome)*	2012	TBD	Nov 30, 2014
	2011	N/A	Nov 30, 2013
	2010	N/A	Nov 30, 2012
	2009	Baseline	March 31, 2011
2.3.1a: Decrease risky sexual and drug-using behaviors among persons at risk for acquiring HIV. Men who have sex with Men (MSM) *(Outcome)*	2011	47%	Jun 30, 2012
	2008	47%	54% (Target Not Met)
	2004	Baseline	47%
2.3.1b: Decrease risky sexual and drug-using behaviors among persons at risk for acquiring HIV. Human Resources for Health (HRH) *(Outcome)*	2010	N/A	Dec 31, 2012
	2007	Baseline	86%
2.3.1c: Reduce the proportion of IDU who reported risky sexual and drug-using behaviors. *(Outcome)*	2012	69.4%	Jun 30, 2014
	2009	N/A	Jun 30, 2011
	2005	Baseline	72%
2.3.2a: Increase the proportion of persons at risk for HIV who received HIV prevention interventions. MSM *(Outcome)*	2011	20%	Nov 30, 2012
	2008	20%	17.6% (Target Not Met)
	2004	Baseline	18.9%
2.3.2b: Increase the proportion of persons at risk for HIV who received HIV prevention interventions. HRH *(Outcome)*	2010	N/A	Nov 30, 2011
	2007	Baseline	12.5%
2.3.2c: Increase the proportion of persons at risk for HIV who received HIV prevention interventions. Infectious Disease unit (IDU) *(Outcome)*	2012	28.8%	Jun 30, 2014
	2009	N/A	Jun 30, 2011
	2005	Baseline	29.7%
2.4.2: Increase the proportion of persons with HIV-positive test results from CDC-funded counseling and testing sites who receive their test results. *(Outcome)*	2012	90%	Oct 31, 2014
	2011	90%	Oct 31, 2013
	2010	90%	Oct 31, 2012
	2009	90%	Oct 31, 2011
	2008	88%	92% (Target Exceeded)
	2007	87%	88% (Target Exceeded)
	2006	86%	86% (Target Met)
2.4.3: Increase the proportion of	2012	82%	Nov 30, 2013

Discontinued Measure	FY	Target	Result
people with HIV diagnosed before progression to AIDS. *(Outcome)*	2011	81%	Nov 30, 2012
	2010	80%	Nov 30, 2011
	2009	80%	Feb 28,2011
	2008	79%	82.1% (Target Exceeded)
	2007	79%	82.2% (Target Exceeded)
	2006	78%	79.7% (Target Exceeded)
2.6.4: Increase the number of areas reporting chronic hepatitis C virus infections to CDC to 50 states and New York City and District of Columbia. *(Output)*	2009	35	36 (Target Exceeded)
	2008	33	33 (Target Met)
	2007	N/A	33
	2006	N/A	34
	2005	N/A	29
	2004	N/A	24
	2003	Baseline	19
2.7.6a: Reduce the incidence of P&S syphilis: in men (per 100,000 population). *(Outcome)*[1]	2012	10.7/100,000	Oct 31, 2013
	2011	10.2 /100,000	Oct 31, 2012
	2010	9.4/100,000	Oct 31, 2011
	2009	6.4/100,000	7.8/100,000 (Target Not Met)
	2008	5.5/100,000	7.6/100,000 (Target Not Met)
	2007	4.5/100,000	6.6/100,000 (Target Not Met)
	2006	New baseline	5.6/100,000
2.7.5: Eliminate syphilis in the U.S. *(Outcome)*	Out-Year Target	7.6/100,000 (2015)	Oct 31, 2016
	2012	6.4/100,000	Oct 31, 2013
	2011	6.0 /100,000	Oct 31, 2012
	2010	5.5 /100,000	Oct 31, 2011
	2009	N/A	4.6/100,000
	2008	N/A	4.5/100,000
	2007	N/A	3.8/100,000
2.7.8: Reduce the racial disparity of P&S syphilis (reported ratio is black: white). *(Outcome)*	Out-Year Target	11.5:1 (2015)	Oct 31, 2016
	2012	10:1	Oct 31, 2013
	2011	9.5:1	Oct 31, 2012
	2010	9.0:1	Oct 31, 2011
	2009	6.3:1	9.0:1 (Target Not Met)
	2008	5.5:1	8.1:1 (Target Not Met)
	2007	5.6:1	7.1:1 (Target Not Met)
	2006	5.6:1	5.9:1 (Target Not Met)

[1]Original baseline for measure 2.1.2 is 241 cases in 1998.

[2]CDC will propose new or revised measure based on restructuring of HIV Performance Plan to align with CDC and National HIV/AIDS Strategy Priorities.

Long Term Objective 2.1, 2.2, 2.3, 2.4, Measures 1.2, 1.7, 2.1, 2.2, 2.4, 3.1, 3.2, 4.2

In keeping with the priorities set by the National HIV/AIDS Strategy (NHAS), CDC has revised its HIV performance measures. Long-term targets have been established at levels consistent with the NHAS for objectives to reduce HIV incidence and transmission and to increase knowledge of serostatus among those infected. Other measures have been retained in their current form or slightly revised to reflect changes that better align them with NHAS (e.g., expanding effective interventions beyond behavioral interventions) or incorporate lessons learned from measuring these indicators to better focus them on CDC priorities (e.g., focusing on unprotected sex with serodiscordant partners rather than all partners). CDC is working to develop better methods to monitor other priorities identified in the Strategy, such as early diagnosis (percentage of newly diagnosed persons with CD4 counts of 200 cells/µl or higher), linkage and access to care (percentage of persons diagnosed with HIV who have a CD4 or viral load result reported within three months of diagnosis), and, disparities in community viral load (percentage of HIV-diagnosed MSM, Blacks and Hispanics with undetectable viral load). This performance plan will be amended to reflect the transition of the HIV school health program.

Long Term Objective 2.6, Measure 4

The measure does not provide critical information needed to monitor the impact of the Hepatitis C virus in the US. In 2007, 72 percent of states did not report sufficient information to identify behaviors and/or exposures that increased risk for acquiring viral hepatitis. In 2011, best practices will be documented and disseminated to all state and local programs. The new measure is more efficient and effective for program monitoring and evaluation.

Long Term Objective 2.7, Measure 5

This measure is being retired; CDC is changing its programmatic focus from eliminating P&S syphilis to eliminating congenital syphilis. Congenital syphilis is preventable with current testing and treatment, and its occurrence represents a public health failure in addition to its negative impact on perinatal health.

Long Term Objective 2.7, Measure 6a

This measure is a subcategory of the goal to eliminate syphilis. The Syphilis Elimination Plan has been successful in reducing syphilis, primarily in heterosexual populations but most challenging in men who have sex with men (MSM). CDC is changing its programmatic focus from eliminating P&S syphilis to eliminating congenital syphilis; congenital syphilis is preventable with current testing and treatment, and its occurrence represents a public health failure in addition to its negative impact on perinatal health.

Long Term Objective 2.7, Measure 8

This measure is being retired; CDC is shifting the programmatic focus from racial disparities in syphilis to focusing on disparities in gonococcal infections. The racial disparities in gonorrhea rates are the most severe of all reportable STDs.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

Discontinued Measure	FY	Target	Result
3.1.1a: By 2020, reduce the incidence of infection with four key foodborne pathogens: Campylobacter *(Outcome)*	2012	12.06	May 31, 2013
	2011	12.18	May 31, 2012
	2010	12.30	13.6 (Target Not Met)
	2009	13.25	12.93 (Target Exceeded)
	2008	14.20	12.68 (Target Exceeded)
	2007	15.14	12.79 (Target Exceeded)
	2006	16.10	12.71

Discontinued Measure	FY	Target	Result
			(Target Exceeded)
3.1.1c: By2020, reduce the incidence of infection with four key foodborne pathogens: Listeria monocytogenes *(Outcome)*	2012	0.23	May 31, 2013
	2011	0.23	May 31, 2012
	2010	0.23	0.3 (Target Not Met)
	2009	0.27	.34 no change (Target Not Met)
	2008	0.29	0.29 (Target Met)
	2007	0.31	0.27 (Target Exceeded)
	2006	0.33	0.31 (Target Exceeded)
3.3.1: Reduce the rate of central line associated bloodstream infections in medical/surgical ICU patients. *(Outcome)*	2010	.05	1.1 (Target Not Met)*
	2009	1[1]	1.4 (Target Not Met)*
	2008	3.19	1.4 (Target Exceeded)
	2007	3.54	1.8 (Target Exceeded)
	2006	3.58	2.2 (Target Exceeded)
	2005	3.62	N/A
	2004	3.66	3.6 (Target Exceeded)
	2003	Baseline	3.7
3.3.2: Reduce the estimated number of cases of invasive Methicillin-resistant Staphylococcus aureus (MRSA) infection. *(Outcome)*	2012	74,740	Sep 30, 2014
	2011	83,045	Sep 30, 2013
	2010	92,272	Sep 30, 2012
	2009	95,126	Sep 30, 2011
	2008	98,068	89,785 cases (Target Exceeded)
	2007	101,101	94,897 cases (Target Exceeded)
	2006	Baseline	103,850 cases
3.4.1: Prevent the importation and spread of infectious diseases to the U.S. in mobile populations and non-human-primates, as measured by meeting 4 of 4 targets for the following measures *(Outcome)*	Out-Year Target	4 of 4 (2015)	Aug 31, 2016
3.4.E.1: Decrease the cost of notifying state health departments of disease conditions in incoming refugees and immigrants by implementing the electronic disease notification system. *(Efficiency)*	2013	$760,000	Dec 31, 2013
	2012	$490,000	Dec 31, 2012
	2011	$760,000	$752,304 (Target Exceeded)
	2010	$511,000	$490,000 (Target Met)
	2009	$534,500	$404,404 (Target Exceeded)
	2008	$884,000	$838,426 (Target Met)

Discontinued Measure	FY	Target	Result
3.4.5: Maintain low mortality in nonhuman primates (NHP) imported to the U.S. for science, exhibition, and education. *(Outcome)*	2012	<1%	Dec 31, 2012
	2011	<1%	<1% (Target Met)
	2010	<1%	<1% (Target Met)
	2009	<1%	<1% (Target Met)
	2008	<1%	<1% (Target Met)
	2007	Trend data	<1%
	2006	Trend data	<1%
3.4.6: Increase the number of hospitals with Memorandums of Agreement (MOAs) in priority 1 cities. (Outcome)	2012	190	Jan 31, 2013
	2011	185	Jan 31, 2012
	2010	180	175 (Target Not Met)
	2009	175	175 (Target Met)
	2008	170	175 (Target Exceeded)
	2007	Trend data	163
	2006	Trend data	149
3.4.7: Increase the number of illnesses in persons arriving in the United States that are reported to CDC Division of Global Migration and Quarantine (DGMQ) by conveyance operators, Customs and Border Protection (CBP), and others. (Outcome)	2012	3,100	Dec 31, 2012
	2011	2,800	1,804 (Target Not Met)
	2010	2,500	2,960 (Target Exceeded)
	2009	1,692	3,156 (Target Exceeded)
	2008	1,651	1,677 (Target Exceeded)
	2007	Trend data	1,543
	2006	Trend data	1,464

[1] In 2009, there was an attempt to revise the measure such that targets were reported as standardized infection ratio (SIR) and not incidence. The target revision was not approved in 2009, however, but the results for the years 2009 and 2010, are reported as incidence rates (number of infections/1,000 central line days). If the targets for 2009 and 2010 were converted from SIR (1 and 0.05) to incidence, they would be 2.58 and 2.09, respectively, and the results for those years would have exceeded the targets. See FY2010 Performance Detail, Infectious Diseases, Measure 4.2.1, p.63-64 for full explanation).

Long-Term Objective 3.1, Measure 1a

Since progress has been made in reducing Campylobacter infections while no progress has been made in reducing Salmonella infections, CDC, along with other federal partners, have made commitments to focus on Salmonella: It is a High Priority Performance Goal (HPG) for DHHS and for USDA. CDC proposes retirement of this measure to allow for focusing on a few key measures that exemplify long term program goals. CDC will continue to track this measure internally to ensure continued progress on reducing the incidence of Campylobacter.

Long-Term Objective 3.1, Measure 1c

Targets set for 2011 and 2012 are the same as for 2010 (0.23), so in the near term this measure becomes a "maintenance" measure. Since progress has been made in reducing Listeria infections while no progress has been made in reducing Salmonella infections, CDC, along with other federal partners, have made commitments to focus on Salmonella (it is a HPG for DHHS and for USDA). CDC proposes retirement of this measure to allow for focusing on a few key measures that exemplify long term program goals.

Long-Term Objective 3.3, Measure 1

CDC is retiring this measure and replacing it with the Central Line-Associated Blood Stream Infection (CLABSI) standardized infection ratio (SIR) measure 3.3.3. These changes are due in part to improved science, which has allowed CDC to revise the existing measures for CLABSIs and incorporate them in to both the HHS Action Plan and Healthy People 2020. In addition to aligning with the HHS Action Plan and Healthy People 2020, measure 3.3.3 also provides a better indication of DHQP activities to reduce CLABSIs.

Long-Term Objective 3.3, Measure 2

This measure is being revised to provide more useful data, depicting a more accurate and focused national estimated rate of invasive healthcare-associated MRSA infections. The revised measure narrows the scope of the measure to healthcare-associated infections and is consistent with the measures and targets that have been put forth in the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs) and Healthy People 2020.

Long-Term Objective 3.4.E, Measure 1

Through FY 2010, CDC consistently exceeded its target of decreasing the cost of notifying state health departments of disease conditions in incoming refugees and immigrants. The FY 2011 target reflected implementation of a paperless visa system by the Department of State, which would initially increase the cost of notifying state health departments. However, the paperless visa system was delayed until at least FY 2012, but CDC maintained the FY 2011 target that reflected initial increased cost associated with this system. While CDC exceeded its FY 2011 target, the cost of notifying state health departments rose from $490,000 in FY 2010 to $752,304 in FY 2011. The FY 2012 target reflects the costs under the current system because of implementation delays with the paperless visa system. The FY 2013 target reflects costs under the paperless visa system. Achieving additional efficiencies are beyond CDC's control with the expected, but delayed, implementation of the paperless system. Therefore, CDC is retiring this measure as of FY 2013.

Long-Term Objective 3.4, Measure 1

This measure was developed during the PART process and is a long-term measure that measures progress based on four sub-measures that are reported annually. CDC proposes retirement of this composite measure. CDC would like to place a larger focus on a few key measures (3.1.1b,3.1.1d, 3.4.2,3.4.3,3.4.4,3.2.1,3.3.2,3.3.3,3.3.4) that exemplify long term program goals versus this overarching measure. In addition, CDC has proposed retirement of one of the sub-measures, 3.4.5 (maintain low morbidity in non-human primate shipments), which would change the composition of the measure.

Long-Term Objective 3.4, Measure 5

For over five years, CDC has attained the target of maintaining low mortality in non-human primates (NHP) imported to the United States for science, exhibition, and education. It is not possible to reach a mortality rate of zero as animals will die for a variety of reasons that are outside regulatory control. The program would like to place a larger focus on a few key measures that exemplify long-term program goals. This measure represents a relatively small allocation of resources, yet success has continued to be demonstrated over the past several years.

Long-Term Objective 3.4, Measure 6

Challenges exist for making further process on this measure, including economic and policy changes. CDC proposes retirement of this measure in order to focus on a few key measures that exemplify long term program goals (3.1.1b,3.1.1d, 3.4.2, 3.4.3, 3.4.4, 3.2.1, 3.3.2, 3.3.3, 3.3.4). To continue to protect the public's health, CDC will continue to work to maintain the current 175 Memorandums of Agreement (MOAs) and to resolve the barriers that exist to initiating additional MOAs.

Long-Term Objective 3.4, Measure 7

CDC has continued to exceed targets set for this measure over the past few years. This progress illustrates the accomplishment of CDC in building successful partnerships to identify and report illness in travelers. CDC proposes retirement of this measure in order to focus on a few key measures that exemplify long term program goals (3.1.1b,3.1.1d, 3.4.2, 3.4.3, 3.4.4, 3.2.1, 3.3.2, 3.3.3, 3.3.4). CDC will continue, as needed, conducting the activities associated with maintaining the critical partnerships required to carry on illness reporting at ports of entry in the United States.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND DISABILITY AND HEALTH

Discontinued Measure	*FY*	Target	Result
5.1.1: Identify and evaluate the role of at least five new *risk* factors for birth defects and developmental disabilities. *(Output)*	2012	Evaluate association between pregestational diabetes and prepregnancy obesity and major birth defects	Yes (Target Met)
	2011	Complete data collection for developmental disabilities research sample	Yes (Target Met)
	2010	Establish large statistically powerful sample for developmental disabilities research	Yes (Target Met)
	2009	Publish findings on occupational exposures	Yes (Target Met)
	2008	Publish findings on maternal medications	Yes (Target Met)
	2007	Publish findings on alcohol, caffeine use, and nutrition	Yes (Target Met)
	2006	Finalize research agenda for birth defects and publish findings on smoking, obesity, and other exposures with high potential impact	Yes (Target Met)
5.1.2: Reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of these conditions among Hispanics. *(Outcome)*	2012	4.4	Feb 23, 2016
	2011	4.5	Feb 23, 2015
	2010	4.6	Feb 23, 2014
	2009	4.7	Feb 23, 2013
	2008	4.8	Feb 23, 2012
	2007	4.9	5.7/10,000 (Target Not Met)
	2006	5.0	5.5/10,000

Discontinued Measure	*FY*	Target	Result
			(Target Not Met but Improved)
5.1.3: Increase the percentage of health providers who screen women of childbearing age for risk of an alcohol-exposed pregnancy and provide appropriate, evidence-based interventions for those at risk. *(Outcome)*	2012	Increase provider-based screening and intervention by 3% from baseline.	Dec 31, 2012
	2011	Increase provider-based screening and intervention by 2.5% from baseline.	Dec 31, 2011
	2010	Increase provider-based screening and intervention by 2% from baseline	Yes (Target Met)
	2009	Increase provider-based screening and intervention by 1% from baseline.	Yes (Target Met)
	2008	Implement ongoing provider education programs and establish baseline rates of provider-based screening and intervention.	Yes (Target Met)
	2007	Assess the screening and intervention practices of nationally representative samples of provider groups.	Yes (Target Met)
	2006	Develop and disseminate screening and intervention tools for health care providers serving women of childbearing age.	Yes (Target Met)
5.1.4: Improve the quality and usability of birth defects surveillance data. (*Outcome*)	Out-Year Target	Publish results from 3 collaborative projects related to birth defects surveillance, research, and public health interventions. (2015)	Dec 31, 2015
	2012	Develop and promote the use of minimal standards for surveillance in 10 state-based birth defects programs	Dec 31, 2012
	2011	Disseminate guidelines for incorporating surveillance of stillbirth into birth defects monitoring systems. Evaluate the feasibility of conducting	Yes (Target Met)

Discontinued Measure	*FY*	Target	Result
		population-based surveillance for fetal alcohol syndrome	
	2010	Estimate the prevalence of spina bifida by race and sex among children and adolescents in 10 regions of the U.S. Publish results of collaborative research projects on clubfoot and pyloric stenosis.	Yes (Target Met)
	2009	Use a new data linkage software tool developed at CDC to evaluate the association of childhood cancer and birth defects.	No (Target Not Met)
	2008	Complete a collaborative multi-state study on the association of birth defects with preterm delivery. Evaluate the association of maternal diabetes and birth defects using a multi-site case control study based on surveillance data.	Yes (Target Met)
	2007	Estimate the prevalence of Down syndrome by race and sex among children and adolescents in metropolitan Atlanta.	Yes (Target Met)
5.2.2: Identify an effective public health intervention to ameliorate the effects of poverty on the health and well-being of children. *(Outcome)*	2012	Data collection and analysis for age 8 year	Dec 31, 2012
	2011	Publish findings to demonstrate intervention effectiveness in improving developmental outcomes for children in low-income families	Dec 31, 2011
	2010	Data collection and analysis for age 5 year	Yes (Target Met)
	2009	Data collection and analysis for age 4 year	Yes (Target Met)
	2008	Data collection and analysis for age 3 year	Yes (Target Met)
	2007	Data collection and analysis for age 2 year	Yes (Target Met)
	2006	Data collection and analysis for age 1 year	Yes (Target Met)

Discontinued Measure	*FY*	Target	Result
5.2.4: Increase the mean lifespan of patients with Duchenne and Becker Muscular Dystrophy (DBMD) by 10% as measured by the Muscular Dystrophy Surveillance, Tracking and Research Network. *(Outcome)*	2012	Report the percentage of individuals aged 20-24 who have Duchenne muscular dystrophy that are surviving through 2007, which indicates that survival has increased by more than 2 years (10% of survival for the cohort born during the 1970s).	Sept 23, 2012
	2011	Publish findings demonstrating trends in mortality and morbidity in patients with DBMD using MD STARnet data.	Feb 23, 2012
	2010	Increase the percentage of patients with DBMD who have access to treatments based on national standards of care to 80% as measured by MD STARnet and national or nationally representative data collection methods	Feb 23, 2011
	2009	Identify and report on (1) the trends on incidence and prevalence of secondary complications related to DBMD annually based on MDSTARnet data and (2) the trends of service utilization by people with DBMD and their families based on MD STARnet data.	Yes (Target Met)
	2008	Report on the impact of clinic use on morbidity and mortality in DBMD using MD STARnet data	Yes (Target Met)
	2007	Identify and report on (1) the incidence and prevalence of DBMD in the United States based on MD STARnet data (2) early signs and symptoms of DBMD based on MD STARnet and (3) cost of health care of people with DBMD.	Yes (Target Met)

Discontinued Measure	*FY*	Target	Result
	2006	Conduct data analysis on MD STARnet data collected in the 4 current sites and include one additional state.	Yes (Target Met)

Long Term Objective 5.1, Measure 1

This measure supports a CDC Priority to "Prevent congenital heart defects and other major birth defects attributable to modifiable maternal factors." Targets and the data source have been revised to reflect this priority.

Long Term Objective 5.1, Measure 2

This measure was written for a national level reduction in the birth prevalence of spina bifida and anencephaly. Data used to measure this objective are available on a state and national level. However, limited programmatic resources restricted program efforts and activities to small scale interventions. While program evaluations showed that these interventions were successful in increasing awareness of folic acid, knowledge about how to prevent birth defects, and consumption of folic acid, the program was unable to tie them broadly to state/national level birth defect prevalence data. To reach a greater number of women of reproductive age, programmatic focus has shifted to a large scale policy level intervention related to folic acid fortification of corn masa flour (flour used to make corn tortillas).

Long Term Objective 5.1, Measure 3

This outcome measure remains in place, but updates "health providers" with "primary care providers (PCPs)." Findings from the previous measure reveal improvements in screening and brief intervention but also support the ongoing need for provider education as trends vary across provider groups. Continued efforts to increase and improve these practices and to establish alcohol screening and brief intervention as an element of routine primary care are greatly needed. Modifications to this measure will provide information about alcohol screening and brief intervention among all women of reproductive age as screening and brief intervention decrease risks for multiple outcomes (e.g., motor vehicle crashes, STDs), including alcohol-exposed pregnancy (AEP).

Long Term Objective 5.1, Measure 4

NCBDDD recently revised the Center's strategic priorities. Enhanced and expanded surveillance systems were identified as a key goal in the plan. Because the former output-based targets were completed or are near completion, the measure was revised to include new targets that reflect priority efforts to improve the quality and usefulness of birth defects surveillance data.

Long Term Objective 5.2, Measure 2

This measure is being retired. CDC conducted a multi-site, randomized controlled trial of the Legacy for Children™ intervention to examine Legacy's impact on child health and development. Implementation of the intervention has been limited to the two research sites. A current study is examining feasibility of broader implementation through the Early Head Start. However, because of fiscal constraints, this study is not engaging in data collection that will meet this measure. CDC will not be prepared to propose a new performance measure based on Legacy until the end of the 3 year feasibility study in FY 2013.

Long Term Objective 5.2, Measure 4

CDC is retiring this measure; MDSTARnet has previously focused exclusively on Duchenne and Becker muscular dystrophy. At this point, the intent of the original MDSTARnet work has largely been met. MDSTARnet will be reconfigured in mid-2011, based on a new cooperative agreement funding

announcement. This announcement is for a three year pilot test expanding the MDSTARnet project to do more targeted data collection on seven additional forms of muscular dystrophy and no longer focus exclusively on Duchenne Becker. The funding opportunity announcement is for 2012-2014. Results of the pilot will be used to determine the future course of MDSTARnet.

CDC will not be prepared to propose a new performance measure based on MDSTARnet data until the end of the three year pilot project in 2014. Results of the pilot will help inform the future directions of the project.

ENVIRONMENTAL HEALTH

Measure	FY	Target	Result
6.2.2: Number of children under age 6 with elevated blood lead levels	2012	67,000	June 30, 2014
	2011	67,000	June 30, 2013
	2010	79,000	77,100 (Target Exceeded)
	2009	95,000	77,100 (Target Exceeded)
	2008	104,000	255,000 (Target Not Met)
	2007	112,000	255,000 (Target Not Met)
	2006	190,829	121,000 (Target Exceeded)

Long-Term Objective 6.2, Measure 2

This measure is being retired because of the small NHANES sample size which causes difficulties in determining stable national prevalence estimates. . In the 2005-2006 and 2007-2008 National Health and Nutrition Examination Survey (NHANES) cycles, there were eleven and nine survey participants respectively under age six with blood lead levels greater than or equal to 10 micrograms per deciliter. This small sample size presents considerable challenges in attempting to extrapolate a national estimate.

INJURY PREVENTION AND CONTROL

Measure	FY	Target	Result
7.1.1: Reduce youth homicide rate by 0.1 per 100,000 annually. *(Outcome)*	2012	8.6/100,000	Aug 31, 2014
	2011	8.7/100,000	Aug 31, 2013
	2010	8.7/100,000	Aug 31, 2012
	2009	8.8/100,000	7.1/100,000 (Target Exceeded)
	2008	8.8/100,000	7.4/100,000 (Target Exceeded)
7.1.2a: Reduce victimization of youth enrolled in grades 9-12 as measured by: a reduction in the lifetime prevalence of unwanted sexual intercourse *(Outcome)*	2011	6.4%	Dec 31, 2012
	2009	6.7%	7.4% (Target Not Met but Improved)
	2007	6.9%	7.8% (Target Not Met)
7.1.2c: Reduce victimization of youth enrolled in grades 9-12 as measured by: the 12-month incidence of physical fighting. *(Outcome)*	2011	28.4%	Dec 31, 2012
	2009	29.3%	31.5% (Target Not Met but Improved
	2007	30.3%	35.5% (Target Not Met but Improved)
7.2.2: Achieve an age-adjusted fall fatality rate among persons age 65+	2012	56.5/100,000	Oct 31, 3014
	2011	54.3/100,000	Oct 31, 2013
	2010	52.1/100,000	Oct 31, 2012

Measure	FY	Target	Result
of no more than 69.6 per 100,000. *(Outcome)*	2009	50.0/100,000	Oct 31, 2011
	2008	47.8/100,000	Oct 31, 2010
	2007	45.6/100,000	47.1/100,000 (Target Not Met)
	2006	43.4/100,000	44.4/100,000 (Target Not Met)
7.2.3: Decrease the estimated percent increase of age-adjusted fall fatality rates among persons age 65+ years. *(Outcome)*	2012	9.73% reduction	Dec 31, 2014
	2011	9.66% reduction	Dec 31, 2013
	2010	9.56% reduction	Dec 31, 2012
	2009	9.45% reduction	Dec 31, 2011
	2008	9.30% reduction	Oct 31, 2010
	2007	9.10% reduction	-1.05% (Target Not Met)
	2006	8.82% reduction	0.87% (Target Not Met but Improved)

Long Term Objectives 7.1 and 7.2

CDC is replacing these measures related to Intentional and Unintentional Injury prevention to better reflect CDC's priority activities to address youth and unintentional injuries through surveillance, research, and evaluating promising strategies. CDC efforts on fall prevention have helped to translate and disseminate proven fall prevention interventions to key partners, and studies on cost effectiveness have helped states identify which programs are the best investments for limited prevention resources. Further efforts to change these trends are beyond the scope of CDCs work, and will likely be dependent on the work of other agencies.

PUBLIC HEALTH SCIENTIFIC SERVICES

Discontinued Measure	FY	Target	Result
8.A.1.1d: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance. data users conference attendees *(Outcome)*	2012	Increase Excellent from 43% to 45%	Dec 31, 2012
	2010	Conduct survey/increase Excellent from 38% to 43%	June 30, 2011
	2007	Baseline	91% (38% Excellent/53% Good)
8.A.1.2: The number of new or revised charts and tables and methodological changes in Health, United States, as a proxy for continuous improvement and innovation in the scope and detail of information. *(Output)*	2012	20	Dec 31, 2012
	2011	15	Dec 31, 2011
	2010	15	Feb 28, 2011
	2009	15	3 new detailed Trend Tables and 20 new charts (Target Exceeded)
	2008	15	4 new detailed trend tables and 26 new charts (Target Exceeded)
	2007	15	5 new detailed trend tables and 21 new charts (Target Exceeded)
	2006	15	5 new detailed trend tables and 19 new charts (Target Exceeded)
8.A.1.3a: Number of improved user tools	2012	5	Dec 31, 2012

Discontinued Measure	FY	Target	Result
and technologies and web visits as a proxy for the use of National Center for Health Statistics (NCHS) data. Number of improved user tools and technologies *(Output)*	2011	5	5 (Target Met)
	2010	5	7 (Target Exceeded)
	2009	5	6 (Target Exceeded)
	2008	5	6 (Target Exceeded)
	2007	5	5 (Target Met)
	2006	5	5 (Target Met)

Long Term Objective 8.A, Measure 1.1

This measure is being retired; information captured is duplicative of other 8.A.1 measures; annual results are not available; and survey results are often delayed due to delayed OMB clearance.

Long Term Objective 8.A, Measure 1.2

This measure is being retired, as the measure has not been found to be useful; increasing numbers of new or revised charts/tables is not an indicator of quality, nor does it communicate broad programmatic accomplishments; and establishing targets proves to be difficult and irrelevant.

Long Term Objective 8.A, Measure 1.3a

This measure is being retired; defining what constitutes an "improved user tool" is challenging. The National Center for Health Statistics (NCHS) continually changes and improves the website based on information received from the satisfaction surveys and calls from users. Therefore, setting annual targets for improved user tools is somewhat arbitrary and does not clearly communicate program accomplishments, which are better captured through customer satisfaction of NCHS data quality and relevance.

Discontinued Measure	FY	Target	Result
8.B.1.1: Increase the number of States that can send electronic messages to CDC in compliance with published standards.	2012	42	Dec 31, 2012
	2011	30	28 (Target Not Met)
	2010	10	28 (Target Exceeded)
	2009	5	22 (Target Exceeded)
	2008	Baseline	0
8.B.2.3: Increase the number of annual Community Guide reviews.	*2012*	15	Dec 31, 2012
	2011	12	9 (Target Not Met)
	2010	9	18
	2009	6	10
8.B.2.4: Increase the number of	*2012*	See Narrative	N/A
	2011	10	See Narrative

Discontinued Measure	FY	Target	Result
counties/communities that implement evidence-based policies/interventions as a result of their county health ranking ((Mobilizing Action Toward Community Health) MATCH County Rankings program)	2010	Baseline	5

Long-Term Objective 8.B.1, Measure 1

This measure is being retired and will be replaced with measure 8.B.4.3 which will include D.C. and Puerto Rico within the denominator; therefore "states" has been changed to "jurisdictions." Also, the data source should rely only on validation and assessment activities from Public Health Information Network (PHIN) Certification. In measure 8.B.1.1, the inclusion of National Electronic Disease Surveillance System (NEDSS) as part of the data source makes it harder to differentiate between differing program requirements and counts for the jurisdictions. The new measure will also take into account the new strategic plan that will shift the program's focus towards harmonization with the Nationwide Health Information Network and expansion of the national Health IT framework.

Long-Term Objective 8.B.2, Measure 3

This measure is being retired and will be replaced with measure 8.B.2.5. The actual number of reviews initiated and completed each year is variable and dependent on numerous factors that make target setting impractical. This includes the complexity of the reviews undertaken, whether the reviews are updates or new, and requests for reviews by other CDC programs late in the fiscal year using supplemental resources, which cannot be anticipated in advance. The proposed developmental measure would instead focus on awareness and use of Task Force findings and recommendations for decision making.

Long-Term Objective 8.B.2, Measure 4

This measure uses data from the Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health Officials (NALBO). This measure is being retired because each of these surveys anticipates collecting data periodically, rather than annually, and the surveys are administered to different group of respondents. Consequently, results are not comparable from year to year. ASTHO manages and administers the questionnaire that was identified as the data source for FY 2010. The specific data collected to establish the baseline was the number of states reporting that had, "Developed partnerships across multiple sectors to improve community health." This data was a proxy for county/community data, which was not available before FY 2011 and does not directly correspond to the measure. In FY 2011, CDC was able to use data from the National Association of County and City Health Officials survey, and found that 641 counties and communities were using the Country Health Rankings. In FY 2012, data will be collected through the National Association of Local Boards of Health Profile Survey.

OCCUPATIONAL SAFETY AND HEALTH

Discontinued Measure	FY	Target	Result
9.1.3: Percentage of NIOSH programs that will have completed	2012	100%	Sep 30, 2012
	2011	90%	100% (Target Exceeded)

Discontinued Measure	FY	Target	Result
program-specific outcome measures and targets in conjunction with stakeholders and customers. *(Output)*	2010	90%	90% (Target Met)
	2009	80%	80% (Target Met)
	2008	70%	80% (Target Exceeded)
	2007	60%	61% (Target Exceeded)
	2006	50%	52% (Target Exceeded)
9.2.2b: Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors: Reduction of fatal injuries among youth 15–17. *(Output)*	2012	2.6/100,000 FTE	Dec 31, 2012
	2011	2.5/100,000 FTE	2.1/100,000 FTE (Target Exceeded)
	2010	2.5/100,000 FTE	2.7/100,000 FTE (Target Exceeded)
	2009	3.0/100,000 FTE	2.3/100,000FTE (Target Exceeded)
	2008	2.5/100,000 FTE	2.0/100,000 FTE (Target Exceeded)
	2007	2.5/100,000 FTE	2.0/100,000 FTE (Target Exceeded)
	2006	3.2/100,000 FTE	3.2/100,000 FTE (Target Met)
9.2.3b: Reduce occupational illness and injury as measured by: Percent reduction in the number of construction workers killed in roadway construction work zones due to being struck by construction vehicles or equipment *(Outcome)*	Out-Year Target	40% reduction (2014)	Dec 31, 2014
9.2.3c: Reduce occupational illness and injury as measured by: Percent of firefighters and first responders' with access to CBRN respirators. *(Outcome)*	Out-Year Target	75% of firefighters and first responders have CBRN respirators available (2014)	Dec 31, 2014

Long Term Objective 9.1, Measure 3

This measure is being retired because the target for this measure was exceeded for FY 2011, effectively meeting the FY 2012 target one year early. One hundred percent of NIOSH research programs have established Steering Committees and drafted strategic plans with goals, measures, and targets. Therefore, this measure has been met.

Long Term Objective 9.2, Measure 2.b

OMB has recommended that this measure be retired due to target fluctuations. Fluctuations from year to year in the actual rates of fatal injuries may be a reflection of the relatively small number of fatal injuries that occur on an annual basis (30 to 50 injuries) where even a small change can significantly impact the number of fatal injuries per 100,000 FTE.

Long Term Objective 9.2, Measure 3b

This measure is being revised in order to be consistent with the goals set for the 2013 performance agenda which calls for data that are available and can be reported annually. The performance measure defines the frequency of fatal occupational injuries resulting from a specific event type in a specific work setting. However, the measure does not define the risk (rate) of fatal occupational injury because the number of workers who work in work zones is not known. The performance measure is meaningful as a measure of the impact of NIOSH research specific to preventing injuries in roadway construction work zones resulting from ground workers being struck by construction vehicles and equipment. Previously, this measure required a special data analysis by CDC/NIOSH that was labor intensive and conducted periodically. Through collaboration with the Bureau of Labor Statistics, this measure is now provided annually to CDC/NIOSH by the Bureau of Labor Statistics.

Long Term Objective 9.2, Measure 3c

This measure is being revised in order to be consistent with the goals set for the 2013 performance agenda which calls for data that are available and can be reported annually. The original measure was established as a long-term measure. Adverse audit findings enable the program to direct resources toward corrective actions to address product inadequacies to enhance workplace safety. Favorable audit findings validate product compliance and increase user confidence in NIOSH certified respirators.

GLOBAL HEALTH[1]

Discontinued Measure	FY	Target	Result
10. D.1.1: The in-hospital mortality ratio per 100,000 caesarean sections at Rabia Balkhi Women's Hospital (RBH) in Kabul, Afghanistan. *(Outcome)*	2010	105	Feb 26, 2011
	2009	110	117 (Target Not Met)
	2008	120	157 (Target Not Met)
	2007	130	129.5 (Target Not Met)
	2006	170	136.5 (Target Not Met)
	2005	140	146 (Target Not Met)
10. D.1.2: The percent of trainees enrolled in courses. *(Output)*	2010	99%	Feb 26, 2011
	2009	99%	98% (Target Not Met)
	2008	85%	95% (Target Exceeded)
	2007	80%	99% (Target Exceeded)
	2006	50%	70% (Target Exceeded)
	2005	40%	60% (Target Exceeded)
10. D.1.3: The time to hire and deploy essential staff trainers. *(Output)*	2010	1.5 mos	Feb 26, 2011
	2009	2 mos	2 mos (Target Met)
	2008	2.5 mos	2 mos (Target Exceeded)
	2007	3 mos	4.5 mos (Target Not Met)
	2006	2.5 mos	4.2 mos (Target Not Met)
	2005	2 mos	3 mos (Targt Not Met)
10. D.1.4: The percentage of staff trainers who fulfill the agreed upon in-country contract. *(Output)*	2010	95%	Feb 26, 2011
	2009	95%	93% (Target Not Met)
	2008	92%	90% (Target Not Met)
	2007	89%	87.5% (Target Not Met)
	2006	40%	85% (Target Exceeded)
	2005	60%	80% (Target Exceeded)
10. D.1.5: The rate of fetal deaths occurring during labor or delivery among newborns who weigh at least 2500 grams	2011	5.0	Feb 26, 2012
	2010	5.2	Feb 26, 2011
	2009	5.8	3.4 (Target Exceeded)
	2008	6.0	14.3 (Target Not Met)
	2007	6.3	7.8 (Target Not Met)

Discontinued Measure	FY	Target	Result
at birth at Rabia Balkhi Women's Hospital in Kabul, Afghanistan per 1,000 such births. *(Outcome)*	2006	5.8	8.7 (Target Not Met)
	2005	4.8	5.2 (Target Not Met)
10. D.1.6: The newborn pre-discharge mortality rate for Babies weighing at least 2500 grams at birth at Rabia Balkhi Women's Hospital in Kabul, Afghanistan per 1,000 births. *(Outcome)*	2010	1.8	Feb 26, 2011
	2009	1.9	1.9 (Target Met)
	2008	2.0	1.9 (Target Exceeded)
	2007	2.2	2.50 (Target Not Met)
	2006	2.2	2.54 (Target Not Met)
	2005	2.0	2.2 (Target Not Met)
10. D.1.7: The percentage of nurse midwives at Rabia Balkhi Women's Hospital (RBH) who meet the selected competency measures of the 37 Afghanistan Standards of Practice. *(Outcome)*	2010	95%	Feb 26, 2011
	2009	92%	90% (Target Not Met)
	2008	88%	80% (Target Not Met)
	2007	85%	71% (Target Not Met)
	2006	50%	75% (Target Exceeded)
	2005	30%	40% (Target Exceeded)
10. D.1.8: The percentage of women who have a caesarean section delivery who subsequently develop a post-operative infection at Rabia Balkhi Women's Hospital in Kabul, Afghanistan. *(Outcome)*	2010	2.2%	Feb 26, 2011
	2009	2.4%	4% (Target Not Met)
	2008	2.7%	4% (Target Not Met)
	2007	3.0%	1.8% (Target Exceeded)
	2006	3.0%	6.3% (Target Not Met)
	2005	2.8%	3.75% (Target Not Met)

[1] Due to cancelation of the Afghanistan Health Initiative and subsequent removal of monitoring mechanisms, the most recent results are unavailable for Measures 10.D.1.2- 10.D.1.4 and 10.D.1.6- 10.D.1.7

Long Term Objective 10.D.1 Measures 1-8

The Afghan Health Initiative (AHI) began as a Secretarial Initiative in the Office of Global Health Affairs (OGHA) in 2004. After conducting a programmatic review of the initiative, CDC has modified measures to more accurately reflect current and future programmatic activities including maternal mortality, fetal deaths, and post-operative infection rates. Beginning in FY 2012, the program will be eliminated.

PUBLIC HEALTH LEADERSHIP AND SUPPORT

Discontinued Measure	FY	Target	Result
11.B.1.1a: Provide health information to the public in order to educate, inform and improve health outcomes. a. User satisfaction with CDC.gov (Outcome)	2012	82.5%	Dec, 31, 2012
	2011	82%	72% (Target Not Met)
	2010	82%	72% (Target Not Met)
	2009	81%	81% (Target Met)
	2008	Set Baseline	81% (Baseline)
11.B.1.1.b: Percentage of inquirers making a behavior change as a result of information gained from their experience with CDC-INFO (Outcome)	2012	52.5%	Dec 31, 2012
	2011	52%	89% (Target Exceeded)
	2010	50%	44% (Target Not Met)
	2009	Set Baseline	48% (Baseline)

Long-Term Objective 11.B.1, Measure 1a

This measure is being retired because it is already captured in programs with dedicated communications efforts and campaigns.

Long-Term Objective 11.B.1, Measure 1b

This measure is being retired because it is already captured in programs with dedicated communications efforts and campaigns.

Discontinued Measure	FY	Target	Result
11.B.2.1: Increase the number of minority students participating in programs, such as the Hispanic Serving Health Professions Internship and Fellowships Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, Research Initiatives for Student Enhancement (RISE) and Project IMHOTEP.	2011	95	December 31, 2012
	2010	95	74 (Target Not Met)
	2009	95	112 (Target Exceeded)
	2008	95	112 (Target Exceeded)
	2007	87	106 (Target Exceeded)
	2006	87	106 Target (Exceeded)
11.B.3.1: Identify program and organizational infrastructure needs (i.e., policy analysis, program	2011	250	October 31, 2012
	2010	250	173 (Target Not Met)
	2009	100	240 (Target Exceeded)
	2008	100	240 (Target Exceeded)
	2007	85	240 (Target Exceeded)

Discontinued Measure	FY	Target	Result
assessment and development, and evaluation) of public health agencies/organizations serving minority communities and provide technical assistance to improve the health status and access to programs for racial and ethnic minority populations.	2006	Baseline	477

Long-Term Objective 11.B.2, Measure 1

This measure is being retired because it is based on a Funding Opportunity Announcement (FOA) that ends in FY 2011. A new FOA is under development but will not be released until the end of CY 2011. It will be very different from the current cooperative agreement, with new goals, objectives, programmatic activities, and data collection and reporting methodologies. Consequently, it will not be possible to report out on the current measure after FY 2011. New GPRA measures will be proposed for FY 2014 that reflect the new FOA once it has been approved.

Long-Term Objective 8.B.4, Measure 1

This measure is being retired because it is based on a FOA that ends in FY 2011. A new FOA is under development but will not be released until the end of CY 2011. It will be very different from the current cooperative agreement, with new goals, objectives, programmatic activities, and data collection and reporting methodologies. Consequently, it will not be possible to report out on the current measure after FY 2011. New GPRA measures will be proposed for FY 2014 that reflect the new FOA once it has been approved.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

Measure	FY	Target	Result
13.1.2: The BioSense program will reduce the time needed from a triggering biosurveillance event (the identification of a potential disease event or public health emergency event) to initiate event-specific standard operating procedures (the initiation of a public health investigation and, if needed, subsequent public health intervention) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. *(Outcome)*	2012	6.0 days	Dec 31, 2012
	2011	6.11 days	7.32 days (Target Not Met but Improved)
	2010	6.26 days	6.74 days (Target Not Met)
	2009	7.26 days	6.97 days (Target Exceeded)
	2008	Baseline	7.78 days
13.1.4: Reduce the time needed for a Laboratory Response Network (LRN) laboratory to enter and message LRN-related standardized results to the CDC. (*Outcome*)	2012	A) Chemical - 7 minutes B) Biological - 4 minutes	Dec 31, 2012
	2011	A) Chemical -7 minutes B) Biological - 4 minutes	A) Chemical- 2 minutes B) Biological- 4 minutes (Target Exceeded)

Measure	FY	Target	Result
	2010	A) Chemical – 10 minutes B) Biological – 5 minutes (2010)	A) Chemical – 10 minutes B) Biological – 5 minutes (Target Met)
	2009	A) Chemical – 17 minutes B) Biological – 16 minutes	A) Chemical – 13 minutes B) Biological – 7 minutes (Target Exceeded)
	2008	A) Chemical – 23 minutes B) Biological – 27 minutes	A) Chemical - 20 minutes B) Biological - 20 minutes (Target Exceeded)
	2007	Baseline	A) Chemical – 30 minutes B) Biological – 37 minutes
Measure 13.4.4: The number of successful annual exercises that test response to multiple events with a 12-hour response time. (Outcome)	2012	1	Dec 31, 2012
	2011	1	1 (Target Met)
	2010	1	1 (Target Met)
	2009	1	1 (Target Met)
	2008	1	1 (Target Met)
Measure 13.5.1: Percentage of states that have level three chemical lab capacity, and have agreements with and access to (specimens arriving within 8 hours) a level-one chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins. (Output)	2012	Unable to report	N/A
	2011	100%	100% (Target Met)
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100 % (Target Met)
13.5.5: Increase the percentage of the Public Health Preparedness and Response (PHPR) (formerly Terrorism Preparedness and Emergency Response (TPER)) allocation for which budget execution matches strategic funding priorities. *(Output)*	2012	100%	Dec 31, 2012
	2011	100%	100% (Target Met)
	2010	100%	100% (Target Met)
	2009	98%	99% (Target Exceeded)
13.5.6: Improve the on-time achievement of individual project milestones for Epidemiology, Laboratories and Emergency Response. *(Outcome)*	2012	96%	Dec 31, 2012
	2011	96%	95% (Target Not Met but Improved)
	2010	96%	94% (Target Not Met)
	2009	95%	93% (Target Not Met but Improved)
	2008	93%	89% (Target Not Met but Improved)
	2007	90%	84% (Target Not Met)
	2006	Baseline	87%
13.5.7: Achieve progressive improvements in the quality of projects submitted for PHPR (formerly TPER) Upgrading CDC Capacity funding consideration..	2012	90%	Dec 31, 2012
	2011	N/A	N/A
	2010	87%	N/A
	2009	85%	Dec 31, 2009 (Did Not report)

Measure	FY	Target	Result
(Output)	2008	78%	83% (Target Exceeded)
	2007	Baseline	74%

In order to enhance the quality and ensure that the performance measures are representative of the current and future state of CDC Preparedness activities, CDC is taking a multi-phase effort to revise the performance plan. This is the first of a multi-phase efforts to ensure that the GPRA performance plan reflective of key influential preparedness planning and strategies across the federal government.

Long-Term Objective 13.1, Measure 2

CDC proposes retiring this measure because the data does not adequately reflect the intent of the measure as written, and the measure itself is not meaningful to drive program improvement. Currently, the BioSense program is engaged in a redesign effort to improve the system's capability to provide nationwide and regional situational awareness for all-hazard health threats (beyond bioterrorism) and to support national, state, and local responses to those threats. CDC's existing GPRA measure 13.1.1, which conveys increasing emergency department visits captured for public health surveillance, represents an intended outcome of the redesign efforts.

Long-Term Objective 13.1, Measure 4

The usefulness of this measure has reached the end of its lifecycle, as the target will be at maximum potential by 2012. From 2007-2010, LRN-Biological and Chemical results met or exceeded their targets, in large part resulting from software developments that enhanced the speed of data entry. Little more can be done to surpass the performance that has already been attained. A more meaningful measure will be proposed for the for the FY2014 budget cycle as CDC reviews options and addresses data source challenges for replacement.

Long-Term Objective 13.5, Measure 5

In the past, all Public Health Preparedness and Response (PHPR) funded projects underwent an objective review to examine their strategic alignment. Due to the increasing number of ongoing projects and per the recommendation of the PHPR Board of Scientific Counselors (BSC), only newly proposed activities are reviewed for funding via the objective review process. Newly proposed activities must align to one of the PHPR funding priorities to receive funding. PHPR revises the funding priorities on a yearly basis based on gaps identified in preparedness. Given the fluid nature of the funding priorities and strategy, it is recommended that this measure be retired.

Long-Term Objective 13.5, Measure 6

This measure is based on each project's self reported progress. The justification for removing this measure is due to a yearly shift in priorities beyond Epidemiology, Laboratories, and Emergency Response. PHPR regularly modifies and expands these priorities to reflect the newest gaps in preparedness. Furthermore, the inconsistencies in the reporting of this measure result from some projects not uniformly establishing milestones that span a fiscal year. Moreover, many projects that may be delayed at the end of the fiscal year will eventually complete milestones, and follow-up to capture these late achievements is difficult and retracts from the meaningfulness of this measure.

Long-Term Objective 13.5, Measure 7

Under advisement from its Board of Scientific Counselors, CDC has moved from an annual review of projects to a two-year project cycle. As a result, no competitive reviews were conducted for FY 2009 for funding consideration. In FY 2010, only new projects went through the competitive review process. Due to shifting funding priorities and criteria, it is difficult to develop objective and quantifiable criteria to

measure and account for progressive improvements in the quality of projects submitted for PHPR funding consideration.

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA) WORKSHEET

Physicians' Comparability Allowance Table

		PY 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs		26	21	21
2) Number of Physicians with One-Year PCA Agreements		1	1	1
3) Number of Physicians with Multi-Year PCA Agreements		25	20	20
4) Average Annual PCA Physician Pay (without PCA payment)		129495	129519	129519
5) Average Annual PCA Payment		16154	15619	15619
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position			
	Category II Research Position	26	21	21
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.			

*FY 2013 data will be approved during the FY 2014 Budget cycle.

If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not Applicable.

Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

$30,000. All of CDC's physicians who are eligible for PCA funds are in Category II, Research. CDC employs a few SES and GS-15 level physicians for whom this PCA amount is appropriate and necessary.

Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)
The number of physicians who received a PCA during FY 2011 at CDC (26) includes 3 accessions and 1 departure. The use of PCA funds has allowed CDC to successfully retain physicians in its workforce. It is anticipated that failure to offer PCA funds to CDC physicians would likely result in an increase in turnover.

Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)
In FY 2010, CDC had 52 physicians who received PCA funds. The significant change in the number of physicians who received a PCA in FY 2011 is entirely due to the conversion of physicians from PCA to title 38 market pay. The rate of accessions and departures among the remaining physicians was fairly steady which indicates CDC's use of PCA funds is successful regarding recruitment and retention issues.

Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

Although it is expected that the accession and departure rates will remain steady during FY 2012 and FY 2013, the slight drop in the number of expected PCAs is due to final conversions of some of the physicians from title 5 pay plus PCA to title 38 market pay. Budget projections for FY 2012 and FY 2013 take into account the movement of additional conversion of physicals from PCA to market pay since this information was last updated.

Page left intentionally blank

SIGNIFICANT ITEMS

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS - SENATE

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2013 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
SENATE REPORT
CENTERS FOR DISEASE CONTROL AND PREVENTION

Item

Global Immunization Activities- The bill provides not less than $111,597,000 for CDC's global polio eradication activities. The Committee strongly supports the dramatic progress being made in the international partnership to eradicate polio. Although resources are limited, the Committee is well aware of the aligning of technical skill, vaccine availability and strong country engagement taking place in the four countries still plagued by this disease. The Committee encourages CDC and its partners to take advantage of this historic opportunity. (p. 81)

Action taken or to be taken

The Global Polio Eradication Initiative (GPEI) was launched in 1988 and is a public and private international partnership led by the World Health Organization (WHO), Rotary International, the United Nations Children's Fund (UNICEF), and the U.S. Centers for Disease Control and Prevention (CDC), with support from other partners including the Bill and Melinda Gates Foundation (BMGF). It represents a coordinated, global effort with Ministries of Health to eradicate polio. Since the GPEI began in 1988, the number of polio cases around the world has fallen by more than 99%, from more than 350,000 that year to fewer than 1,300 in 2010. In order to achieve eradication, CDC is expanding and streamlining its scientific expertise for polio to support the GPEI as a global public health emergency, including activation of the CDC Emergency Operations Center (EOC) on December 2, 2011. This activation will allow CDC to provide enhanced technical assistance for polio eradication through the deployment of teams to support field activities in immunization and surveillance, management training, and strengthening routine immunization. CDC and its partners will also continue to ensure the availability of the widely-accepted vaccine for polio immunization activities. This scale-up effort requires sustained commitment by the U.S. government to achieve success. As long as transmission continues in any nation, polio remains a threat.

Item

Hepatitis B - The Committee continues to encourage CDC to consider expanding global programs to increase the rate of vaccination, reduce mother-child transmission and promote educational programs to prevent hepatitis B and to reduce discrimination targeted against individuals with the disease. (p. 81)

Action taken or to be taken

CDC has partnered with the World Health Organization (WHO) and UNICEF to help increase hepatitis B vaccination globally. In order to improve hepatitis B birth dose vaccination, CDC has conducted health facility assessments to help ensure that all children are given vaccine within 24 hours of birth to prevent mother-to-child transmission. CDC also works with routine immunization services in countries to promote full-series vaccination with three doses of hepatitis B vaccine. CDC supports the evaluation of hepatitis B vaccination programs by providing technical assistance and funding for seroprevalence studies, to measure vaccine program impact. CDC has full time staff members located in Manila and the WHO headquarters to support countries in reducing the prevalence of chronic hepatitis B virus infection

among children and to promote educational programs to prevent hepatitis B and to reduce discrimination targeted against individuals with the disease.

Item

Parasitic Diseases and Malaria - The Committee is pleased with the CDC's ongoing efforts to fight global malaria and neglected tropical diseases through the Center for Global Health. Despite progress, much still needs to be done to address malaria and neglected topical diseases [NTDs] on a global scale. In 2009 more than 700,000 people died from malaria. NTDs, including enteric diseases, continue to affect more than 1 billion people worldwide. CDC research plays an essential role in the continued progress towards control and elimination efforts of global malaria and NTDs. The Committee encourages CDC to continue its research, monitoring and evaluation efforts for malaria and NTDs and its collaboration with other agencies as part of the Global Health Initiative. (Page 81)

Action taken or to be taken

CDC science has been integral to current global and USG programmatic efforts to address malaria and NTDs, through the development and evaluation of interventions that are the cornerstones of these programs and serve as the basis for global guidelines. CDC remains committed to providing technical leadership to the global health community, by evaluating and refining current interventions, developing new tools to accelerate progress, and ensuring effective use of U.S. Government investments to help save lives.

CDC has a congressional mandate (Lantos-Hyde Act of 2008) to "advise the U.S. Government Malaria Coordinator on priorities for operations and implementation research" and "on monitoring surveillance, and evaluation activities" and "be a key implementer of such activities." Current strategic research priorities include participating in the Phase III vaccine trial of the RTS,S malaria vaccine in Kenya; the interaction of 2 current interventions (indoor residual spraying and insecticide-treated nets); strengthening the role and use of rapid diagnostic tests; exploring the use of insecticide-treated wall linings and alternative strategies to combat insecticide resistance; developing and testing novel targets for malaria diagnosis; and providing timely answers to address bottlenecks in effective delivery of malaria control interventions. CDC malariologists work closely with other HHS agencies and USAID to ensure a comprehensive strategy and set of activities is presented to the USG Malaria Coordinator.

CDC is also committed to supporting current NTD efforts, specifically by providing assistance to countries and global partners to advance NTD programs and by conducting critical operational research to improve NTD programs. Programmatic and research priorities include interruption of transmission of lymphatic filariasis in Haiti, assisting countries in conducting Transmission Assessment Surveys to determine if transmission of lymphatic filariasis has been interrupted, documenting the health impact of integrated NTD programs, and improving methods to monitor programs, including those for lymphatic filariasis, onchocerciasis, schistosomiasis, and trachoma.

Item

Product Development Partnerships [PDPs] - PDPs enable critical research and development in the global health arena while creating jobs in the United States. The Committee encourages CDC to cultivate public-private partnerships like PDPs and to work in collaboration with the National Institutes of Health and U.S. Aid for Institutional Development to identify and pursue other innovative research and development opportunities. (Page 81)

Action taken or to be taken

CDC has participated in several successful PDPs - below are two models. Moving forward, CDC's preliminary plans include continuing current PDPs and pursuing future PDPs. Preliminary discussions will be used at the program level to assess the needs in the field as well as the expertise that CDC possesses that could be useful for future PDPs.

Successful models for PDP engagement with CDC have included:

- Diagnosing Cysticercosis and Taeniasis.
- Developing novel ways to diagnose cysticercosis and taeniasis, two parasitic diseases that are acquired by eating contaminated foods.
- Neurocysticercosis, which is the most severe form of cysticercosis and occurs when the organisms affect the central nervous system, is the most frequent cause of preventable epilepsy worldwide.

CDC is working to develop two novel assays—the QuickELISA and lateral flow based assays—that are needed for global efforts to control these diseases. These assays will serve as critical tools to estimate the burden of the disease in countries where these parasites are common and to identify at-risk populations.

Category: Improved laboratory diagnostics

Private partners: Immunetics, Inc (Boston, MA) and Diagnostic Innovations (Scarborough, ME)

Local partners: Ministries of Health

Influenza Reagent Resource (IRR). The IRR was established by CDC to provide registered users with reagents, tools and information for the analysis and detection of the influenza virus. American Type Culture Collection (ATCC) manages the IRR under contract which employs various subcontracts with biotechnology companies in the U.S. These companies provide diagnostic reagents and utilize state of the art processes to produce antibodies, proteins, enzymes and other necessary components of influenza diagnostic preparedness and response. During the global pandemic of the novel 2009 H1N1 influenza A virus, the IRR allowed for surge quantities of diagnostic tests to be rapidly manufactured by contractors and shipped to over 500 laboratories, allowing the monitoring of the pandemic rapidly around the world.

Category: Improved laboratory diagnostics

Private partners: American Type Culture Collection (ATCC) (Manassas, VA)

Local partners: MOH laboratories

Through regular meetings with NIH and USAID, CDC will continue to pursue partnerships for innovative research and development opportunities based upon needs in the field and utilizing the comparative advantages of each agency. Examples of successful research and development projects are below.

The Federal TB Task Force, which includes NIH, FDA, HRSA, the Federal Occupational Health, OGAC, and USAID meets twice annually, and has frequent informal communications to coordinate Federal TB Elimination activities across agencies. These activities include TB clinical studies, assuring availability of drug and diagnostic technologies, and providing technical assistance and operational research

CDC and NIH have a memorandum of understanding that addresses TB research, "JUPITER," (Joint US Partnership In TB Elimination Research") which resulted in NIAID and CDC staff have been having weekly conference calls for nearly 2 years. This communication has greatly enhanced understanding and has directly led to multiple collaborations between the two agencies in areas of TB clinical trials and studies (e.g., co-enrollment of children and HIV+ in TBTC S26; quantitative bacteriology studies in Kampala through NIAID's TB Research Unit; co-enrollment in US in ACTG 5295 (Cepheid Gene Xpert)

NIAID Adult Clinical Trials Group (ACTG) CDC is increasingly collaborating with ACTG (see above). There is cross-membership in ACTG and the Tuberculosis Trials Consortium (TBTC) at several sites and by several prominent investigators, and this helps to assure communication and coordination.

CDC is working in conjunction with NIH and FDA to develop and implement strategies to expedite the evaluation of new rapid molecular diagnostics for tuberculosis.

In collaboration with NIH, BARDA, and FDA, CDC is working to have better and faster-developed vaccine viruses for manufacturers to use. CDC is developing high-growth reassortant viruses to allow for more vaccine to be developed more quickly.

CDC collaborates with NIH to evaluate new technologies, create development strategies, and implement development projects that leverage our individual strengths. Rapid Influenza Immunity Testing (RIIT) is an example of one of the projects implemented with input from BARDA and NIH.

Item

Duchenne Muscular Dystrophy [DMD] - The Committee commends CDC for developing the DMD Care Considerations. The Care Considerations serve as a milestone for the DMD community, as they provide a framework for recognizing the multisystem primary manifestations and secondary complications of DMD and for providing coordinated multidisciplinary care to improve the lives of those individuals living with DMD. The Committee encourages CDC to continue its work to enhance the Care Considerations by convening a meeting of scientific experts to identify what gaps still exist in the current guidelines and additional areas where further research is critical. Following the completion of the expert meeting, CDC is encouraged to publish the areas of consensus from the meeting. (Page 73)

Action taken or to be taken

CDC acknowledges the importance of having a framework like the DMD Care Considerations to promote quality of care for people impacted by Duchenne muscular dystrophy. CDC is currently expanding its focus to other muscular dystrophies and convened a meeting in November, 2011 of experts in the muscular dystrophy community to provide input on priority public health actions most needed for this population including potential gaps in health care services and future research needs.

Item

Fragile X-Associated Disorders [FXD] - The Committee encourages CDC to focus its efforts on identifying ongoing needs, effective treatments and positive outcomes for families through epidemiological research, surveillance, screening and the promotion of early interventions and supports for individuals living with FXD. The Committee commends CDC for its efforts to establish the Fragile X Clinical & Research Consortium. The Committee encourages CDC to work with the National Institute of Child Health and Human Development to consolidate and coordinate Federal investments in data collection efforts related to Fragile X. Additionally, the Committee encourages CDC to focus on improving access to clinical services for underserved populations and to effectively disseminate information on promising practices related to diagnosis and early intervention to healthcare entities working with underserved populations. (Page 73)

Action taken or to be taken

CDC acknowledges the importance of efforts to identify ongoing needs, effective treatments, and positive outcomes for families living with Fragile-X Associated Disorders (FXD). CDC continues to support ongoing epidemiological research efforts and activities promoting early identification. CDC maintains a strong relationship with the National Institute of Child Health and Human Development and plans to continue collaborative efforts on behalf of the FXD community. CDC acknowledges the importance of

access to appropriate clinical services for all people living with FXD and currently supports two projects evaluating access to clinical services, with emphasis on underserved populations. CDC will continue efforts to effectively disseminate information related to diagnosis and early intervention through partnerships with physician and patient advocacy groups.

Item

Hereditary Hemorrhagic Telangiectasia [HHT] - The Committee encourages CDC to develop a sentinel network of surveillance utilizing HHT Centers that are currently co-located with Hemophilia Treatment Centers [HTCs]. The Committee hopes that the existing infrastructure at the HTCs can be used to collect data and conduct surveillance on HHT. The committee also encourages CDC to increase outreach and education to the public and health care professionals accessed by HHT patients. (Page 74)

Action taken or to be taken

HHT has been subject to under reporting and under diagnosis for many years due in large part to lack of public and health care provider awareness of the disorder. In the past year, CDC has assessed prevalence of HHT through the analysis of administrative datasets and will use these datasets to identify the incidence of co-morbid conditions in persons with HHT. Other existing data sources and networks, such as HHT Centers and HTCs, will be identified and, to the extent possible, used for surveillance and epidemiological research. CDC will continue providing HHT Foundation International technical assistance and outreach through our federal and private sector partners to increase public and health care professionals' knowledge of HHT symptoms, diagnosis and treatment.

Item

Maternal Infections - The Committee encourages CDC to continue its activities to prevent Cytomegalovirus [CMV] infection among women. These activities should include research to address gaps in knowledge, and the development of tools to prevent and reduce disease burden and disability from CMV in infants born to mothers with CMV infection. Research directed at congenital CMV prevention strategies will allow CDC to better understand how to prevent CMV transmission during pregnancy, support prenatal and newborn CMV testing and intervention for infants born to women with CMV infection, and work with providers on recommendations for CMV and infection during pregnancy. The Committee encourages CDC to develop evidence-based guidance to prevent congenital CMV and to continue research for more effective interventions, including longer-range options such as vaccines, aimed at preventing congenital CMV and reducing disease burden among children born to women with CMV infection during pregnancy. (Page 74)

Action taken or to be taken

CDC is continuing activities to prevent CMV infection among women and congenital CMV in their children including research to address gaps in knowledge, and the development of tools to prevent and reduce disease burden and disability in infants due to CMV infection. CDC is supporting research on prenatal and newborn CMV testing and intervention for infants born to women with CMV infection, working with providers on evidence-based recommendations for preventing CMV infection during pregnancy, conducting a pilot study to investigate CMV shedding among children in their homes, and encouraging development of a vaccine.

CMV testing of newborns: CDC successfully implemented a study to demonstrate the feasibility of testing newborns and detecting CMV using improved specimen collection and laboratory methods. To better understand the potential impact of CMV prevention strategies and identify the resources and

interventions needed for children affected by CMV infection, CDC is actively analyzing novel data on long-term outcomes of children born with CMV infection.

CMV awareness and guidance during pregnancy: CDC is working on improving awareness of CMV infection among pregnant women and on developing evidence-based guidance to prevent CMV infections during pregnancy. In 2012, CDC will convene a group of experts and liaisons to partner groups such as the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists to advise CDC on evidence-based prevention recommendations. Other planned activities include focus groups and other audience research to better understand how to effectively present and frame prevention messages, and a pilot study of a screening tool and brief intervention for changing behaviors related to CMV transmission among women at prenatal clinics.

CMV vaccine development: During 2011, CDC co-organized a national meeting with FDA and NIH to be held January 10-11, 2012 at NIH in Bethesda, Maryland to accelerate progress on development of a CMV vaccine. To further support CMV prevention through vaccination, CDC rapidly developed an infectious disease model that identifies elements of a vaccine that are critical to developing a vaccination program that will successfully reduce CMV infections.

Item

Marfan Syndrome - Many people affected by Marfan syndrome, a genetic connective tissue disorder that can result in sudden loss of life from aortic dissection, remain undiagnosed or misdiagnosed until they experience a cardiac complication. The Committee encourages CDC to increase awareness of this disease among the general public and healthcare providers. (Page 75)

Action taken or to be taken

CDC is aware of the public health concerns regarding Marfan syndrome and shares the Committee's concerns. Marfan syndrome is included in CDC's Partnership group. The Partnership group encourages collaboration with other groups interested in disabling conditions. CDC also invited the National Marfan Foundation, along with other partner groups, to participate in an open house to increase awareness among all participants.

Item

Spina Bifida - The Committee encourages CDC to work with the FDA to establish folic acid fortification levels of corn products grown and consumed both domestically and internationally to ensure that women of child-bearing age benefit from the advantages of folic acid contained in enriched foods. The Committee also recommends continued support of a data collection initiative to improve the efficacy and quality of care. (Page 75)

Action taken or to be taken

Although rates of neural tube defects in the United States have declined since the fortification of enriched cereal grain products with folic acid, disparities remain. Hispanic women continue to have the highest rates of neural tube defect-affected pregnancies compared to women of other races/ethnicities. In an effort to expand the reach of fortification to products typically consumed by many Hispanic women, CDC partners formed a Corn Masa Flour Working Group to develop a petition to FDA to allow fortification of corn masa flour with folic acid. These partners asked that CDC provide technical assistance to help inform development of the petition to FDA. To this end, researchers from NCBDDD conducted (1) a comprehensive review of the current literature on the safety of folic acid and (2) an estimate of how folic acid intake might change if corn masa flour were fortified with folic acid. CDC's technical assistance package has been submitted to the Corn Masa Flour Working Group to inform development of the overall

petition. The Corn Masa Flour Working Group expect to submit the final comprehensive petition to FDA in early 2012.

CDC is working with global partners to develop guidelines for the fortification of wheat and maize flour, and rice, and on building in-country and regional capacity for surveillance of neural tube defects, in an effort to further expand efforts related to birth defects prevention. CDC is also providing technical assistance and support in southeast Asia to advance regional strategies for the prevention of birth defects to reduce newborn mortality and morbidity and build regional birth defects surveillance capacity, including the implementation, expansion, and harmonization of fortification efforts. In addition, CDC is providing technical assistance to the Central American region on harmonization of policies, standards, and regulations of food fortification with micronutrients; development and implementation of a reciprocal quality control system of fortified foods; and establishment of national and regional surveillance systems to monitor the fortification impact on NTDs, folate concentration levels and B12.

CDC has established and implemented a multi-site National Spina Bifida data collection process to collect data on the health status, health services and functional status (e.g., mobility, education, employment) on patients who attend spina bifida clinics in the US. To date data have been collected and analyzed on more than 1800 individuals living with spina bifida from 17 clinics.

These data will be collected on a yearly basis. Data will be analyzed to describe the population and to determine associations between population characteristics, interventions and important health and functional outcomes. Interventions associated with better outcomes will be identified and shared with the participating clinics and other health professionals in order to improve care for the entire population.

Item

Obesity - The Committee strongly urges CDC to reevaluate the obesity- related grant programs and take administrative steps to improve their alignment. (Page 65)

Action taken or to be taken

CDC is working to improve alignment for obesity-related grant programs (nutrition, physical activity and obesity, diabetes, heart disease and stroke, cancer, and arthritis) by strengthening coordination and collaboration across individual programs, better defining the interventions and activities within each program that support and reinforce the overarching goals of chronic disease prevention and health promotion, and working with state grantees to identify efficiencies and improve the effectiveness of program investments consistent with the model proposed previously and with partner recommendations.

Currently, CDC is supporting essential chronic disease public health functions and improving the coordination of chronic disease prevention in states and at CDC. These efforts include the Coordinated Chronic Disease Prevention and Health Promotion Program, funded in FY 2011,that awarded funds to the 50 states, Washington, D.C., and seven U.S. territories. CDC investments in states through the Coordinated Chronic Disease Program are substantial, with individual state awards ranging from $400,000 to nearly $2,000,000. By approaching chronic disease prevention in a more coordinated manner, CDC is enabling states to address interrelated risk factors, including nutrition, physical activity, and obesity, and to have the flexibility they need to enhance program efficiency.

In addition, CDC is working across categorical funding lines to promote coordinated strategies in states that focus on:

Addressing the key risk factors for chronic disease; including poor nutrition, physical inactivity and tobacco use; improving the risk factor profile of the population and ultimately avert or delay onset of type 2 diabetes; improving cardiovascular health; reducing the incidence of the major cancers; and improving quality of life for individuals with arthritis.

Health system investments to improve risk factor detection and management and improve delivery of quality clinical and other preventive services to detect diseases early and manage conditions like high blood pressure, high cholesterol, diabetes, and cardiovascular disease.

Clinical and community linkages to ensure individuals with or at high risk for chronic conditions have access to resources and supports to avert or better manage those conditions, including arthritis, diabetes, and heart disease. These include programs like the National Diabetes Prevention Program, chronic disease self-management programs and a number of arthritis management programs delivered in community settings.

Critical to the success of these efforts will be on the ability of individual states to have sufficient capacity and funding, whether federal or other funding, to support program efforts. Overall, these programmatic improvements have the potential to accelerate obesity prevention strategies at the state and local level, leading to greater health impacts.

Item

Breastfeeding - The Committee is aware of research showing that suboptimal breastfeeding rates are a significant contributor to our Nation's epidemic of obesity, increasing risks of several acute and chronic diseases and conditions, including diabetes and cardiovascular disease. The Committee supports the Surgeon General's Call to Action to Support Breast Feeding. The Committee has included funding through the PPH Fund to support hospitals that promote breastfeeding and non-governmental organizations that assist breastfeeding mothers. The Committee urges CDC to collaborate with the Maternal and Child Health Bureau's doula best practices initiative. (Page 66)

Action taken or to be taken

CDC and the Health Resources Services Administration (HRSA) have a long history of collaboration and mutual support for breastfeeding programming with a focus on improving health system supports for mothers to breastfeed and monitoring and evaluating interventions to improve maternity practices.

CDC collaborates with HRSA by offering guidance and advice to the Community Doula Program. For example, CDC provides technical support regarding clinical outcomes of doula assisted births; facilitates coordination between the Community Doula Program and related community partners, and reviews the Maternal and Child Health Bureau’s novel approaches to meet the needs of participating mothers.

Additionally, CDC convenes the U.S. Breastfeeding Committee, of which HRSA is a participating member. The purpose of the committee is to facilitate collaboration and coordination across related federal breastfeeding programs and activities.

CDC looks forward to maintaining its relationship with HRSA while exploring new opportunities to effectively leverage federal leadership in improving perinatal support for mothers to breastfeed.

Item

Chronic Disease Innovation Grants - Of the amounts provided in the PPH Fund for Innovation grants, the Committee has included $10,000,000 to expand the National Diabetes Prevention program authorized in section 399V-3 of the PHS Act. The Committee recognizes that approximately one-third of people with diabetes do not know that they have it, while another 57 million have pre-diabetes and are at high risk for developing this deadly disease. The Committee strongly supports efforts to curb the growing cost of healthcare by targeting populations known to be at risk of developing disease. (Page 67)

Action taken or to be taken

CDC established the National Diabetes Prevention Program in 2010 to reach individuals at greatest risk for type 2 diabetes.CDC is continuing to implement the program through four program levers: providing training, assuring program quality, supporting intervention sites, and health marketing. Inaugural partners of the National Diabetes Prevention Program were CDC, the YMCA of the USA (Y) and United Health Group (UHG). Currently the National Diabetes Prevention Program is available in 41 sites, including 34 CDC-funded sites and 7 United Health Group-supported sites in Ys across the country.

With an investment of $10 million, the National Diabetes Prevention Program estimates reaching approximately 15,000 high-risk individuals with pre-diabetes with the evidence-based, type 2 diabetes prevention lifestyle intervention. The intervention emphasizes improving dietary choices, increasing physical activity, improving coping skills, and provides group support to help participants lose five to seven percent of their body weight and get at least 150 minutes per week of moderate physical activity. In the coming years, these figures are expected to increase exponentially with infrastructure enhancements, growing program participation, and leveraged private insurer reimbursement opportunities.

In January 2012, CDC will launch the Diabetes Prevention Recognition Program, a component of the National Diabetes Prevention Program. This program recognizes faith-based organizations, community health organizations, government entities, and others seeking to be a part of the National Diabetes Prevention Program that have the infrastructure best suited to deliver evidence-based type 2 diabetes interventions. CDC recognition will assure program quality and indicate to insurers with an interest in paying for evidence-based diabetes prevention programs in a scalable and sustainable manner, maximize the public health benefit, and model the health and economic utility of this approach for third-party payers. CDC will extend the reach of the program, with the additional resources, to include new intervention sites, insurers, and participants.

Item

Chronic Obstructive Pulmonary Disease [COPD] -The Committee recognizes that COPD is now the third-leading cause of death in the United States. The Committee encourages CDC to work with the National Heart, Lung, and Blood Institute to prepare a national action plan to address COPD, including public awareness and surveillance activities. (Page 67)

Action taken or to be taken

CDC; in consultation with the National Heart, Lung, and Blood Institute and other federal agencies, academia, the health care sector, national organizations, and other COPD stakeholders; released "Public Health Strategic Framework for COPD Prevention" (http://www.cdc.gov/copd/pdfs/Framework_for_COPD_Prevention.pdf) in June 2011. This document presents goals, objectives, strategies, and potential actions for the public health community to address COPD. In addition to heightening awareness of COPD and improving the collection, analysis and reporting of COPD-related data, the Framework also seeks to improve our understanding of COPD development, prevention and treatment and increase effective collaboration among stakeholders with COPD-related interests. CDC is actively working to update its COPD surveillance summary, which will be published during FY 2012 to maximize use of currently available data. CDC will continue to partner with the National Heart, Lung, and Blood Institute (NHLBI) on respiratory measures in the National Health and Nutrition Examination Survey (NHANES) and the Behavioral Risk Factor Surveillance System (BRFSS).

Item

Community Transformation Grants - In addition, the Committee has included statutory language requiring that the $135,000,000 increase over the fiscal year 2011 level must be awarded through a new competition that will differ from the first one in several ways. In particular, this competition will allow applicants to propose catchment areas that are smaller than the minimum of 500,000 people required in the original competition. Grantees will have greater flexibility regarding the scope of the evidence-based interventions they wish to pursue; however, they must all relate to the prevention of chronic diseases. The Committee encourages the CDC to maintain the 5 percent reduction goal for the chronic disease or diseases targeted by a grantee. (Page 67)

Action taken or to be taken

CDC concurs with the Senate's desire to promote public health interventions at the local level and will identify opportunities for governmental and nongovernmental entities, as well as tribes serving populations smaller than 500,000, in upcoming CTG Funding Opportunity Announcements.

The current CTG program funds 61 state and local government agencies, tribes and territories, and nonprofit organizations in 36 states through capacity building and implementation awards. State and local implementation grantees are required to distribute at least 50% of their funds to local community entities to ensure local participation, support, and effective program implementation and sustainability. Potential examples of these entities include: non-governmental organizations, county or city health departments, local hospitals, local planning organizations, community and migrant health centers, public school systems, community based organizations, primary care associations, local universities, department of parks and wildlife, public housing authorities, and local parks and recreation.

CDC is also targeting smaller communities through the CTG National Dissemination and Support Initiative's Acceleration component. Under this program, CDC funds national non-governmental organizations that in turn compete out funding to communities. Funded organizations are required to award at least 50% of their funds to local affiliates and other organizations to support communities in assessing and addressing CTG health priorities.

The CTG program allows a great deal of flexibility in how states and communities implement the program. CTG-funded states and communities select evidence- and practice-based activities from among five strategic directions, with a focus on tobacco free living, healthy eating, active living and interventions to improve blood pressure control in order to address chronic disease. Work aligned in these areas should continue to advance CDC's efforts to meet the 5% reduction goals for chronic diseases.

Item

Diabetes in Native Americans/Native Hawaiians - The high incidence of diabetes and kidney disease among Native American, Native Alaskan, Native Hawaiian and Filipino populations persists. The Committee urges CDC to continue its efforts to target this population within Community Transformation grants and the REACH program. (Page 68)

Action taken or to be taken

CDC shares the Committee's concerns. Diabetes rates vary by race and ethnicity, with American Indian, Alaska Native, and Asian/Pacific Islander adults about twice as likely as white adults to have type 2 diabetes.

Through the Racial and Ethnic Approaches to Community Health Across the U.S. (REACH U.S.) program, CDC is working with the Wai'anae Coast Comprehensive Health Center's E Ola Koa project to target Native Hawaiians and other Pacific Islanders living in Wai'anae with type 2 diabetes and cardiovascular disease. The program facilitates a health restoration movement among this population to

encourage the return to the basics of diet and exercise once practiced as part of daily life by traditional Hawaiians. The program also works to improve health screening, access to healthcare, and the utilization of primary care services.

Launched in FY 2011, the Community Transformation Grants (CTG) program is supporting community-level efforts to reduce chronic diseases such as diabetes, heart disease, cancer, and stroke. By promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, these grants will help improve health, reduce health disparities, and control health care spending. By focusing on the community level, these approaches will also make inroads on addressing chronic disease disparities. Through the CTG program, CDC is funding the Southeast Alaska Regional Health Consortium, the Confederated Tribes of The Chehalis Reservation (Washington), Great Lakes Inter-Tribal Council, Inc. (Wisconsin), Sophie Trettevick Indian Health Center (Washington), Toiyabe Indian Health Project (California), Sault Ste. Marie Tribe of Chippewa Indians (Michigan), Ulkerreuil A Klengarn (Republic of Palau) and Yukon-Kuskokwim Health Corporation (Alaska) to address active living and healthy eating, tobacco free-living and evidence based quality clinical and other preventive services among minority populations.

In addition to these efforts, CDC's Native Diabetes Wellness Program (NDWP) supports 17 tribes and tribal organizations to promote community use of traditional foods and sustainable ecological approaches for diabetes prevention and health promotion in American Indian and Alaska Native communities. The program is designed to engage communities in identifying and developing support for healthy traditional ways of eating and being active and communicating health information and support for diabetes prevention and wellness.

CDC is also funding the Association of Asian Pacific Community Health Organization to mobilize partnerships and initiate interventions with the broadest impact possible.

Item

Farm-to-School Programs - The Committee is strongly supportive of farm-to-school programs, which work to improve school nutrition through partnerships with local farms. The Committee urges CDC to give priority to applicants that propose to establish this type of partnership through the Healthy Communities and Community Transformation Grant programs. Further, the Committee is aware that the U.S. Department of Agriculture [USDA] will establish a mandatory funding stream for these programs in fiscal year 2013. The Committee further urges CDC to collaborate with USDA as the guidelines for this new program are established. (Page 68)

Action taken or to be taken

CDC is a strong proponent of Farm-to-School Programs, which improve children's access to nutritious foods while benefiting communities and local farmers. CDC provides guidance and technical support to states, communities, tribal organizations, and other entities to champion farm-to-school programs, promote state and local farm-to-school coalitions, offer guidance on food safety regulations to school districts, and develop farm-to-preschool resource guides. CDC will continue to support farm-to-school initiatives through the Community Transformation Grant (CTG) program.

CDC values its ongoing collaborations with USDA and welcomes an opportunity to assist in developing guidelines for a new mandatory funding stream. As an example of current collaborations, CDC and USDA regularly share information, data, and materials to support implementation of various provisions of the Healthy, Hunger-Free Kids Act of 2010. CDC also participates in the USDA *Know Your Farmer, Know Your Food* Taskforce, which has a farm-to-school subcommittee.

Item

Food Allergy - The Committee encourages CDC to develop a comprehensive plan to provide healthcare providers with better information about food allergies. In addition, the Committee encourages CDC to collaborate with other relevant agencies to assure the broadest possible dissemination of the NIAID Guidelines for the Diagnosis and Management of Food Allergy. (Page 68)

Action taken or to be taken

CDC is leading the development of food allergy guidance for children and youth in schools and early childhood settings per Section 112 of the Food Safety Modernization Act. Guidance is anticipated to be released in early 2012. In addition, CDC is working with the National Association of School Nurses to develop and disseminate guidance to improve school nurse food allergy management practices and the Food Allergy & Anaphylaxis Network (FAAN) to develop and disseminate guidance to improve the working relationship between parents and school personnel to improve management of students with food allergies.

The National Institute of Allergy and Infectious Diseases (NIAID) has already implemented a plan to provide the Guidelines for the Diagnosis and Management of Food Allergy to health care providers. This plan included utilizing the same partners and reaching the same constituency as CDC. The CDC Healthy Youth – Food Allergy web page includes a link to NIAID's Food Allergy Home Page. Moving forward, CDC will place a specific link on its webpage to the NIAID Guidelines for the Diagnosis and Management of Food Allergy and enhance other web-based materials on food allergies.

Item

Inflammatory Bowel Disease - The Committee notes CDC's history of supporting epidemiology research on inflammatory bowel disease and encourages CDC to facilitate opportunities for renewed support of current research in this area within the Comprehensive Chronic Disease and Prevention Program. The Committee requests a report on progress made on this issue in the fiscal year 2013 congressional budget justification. (Page 69)

Action taken or to be taken

CDC's previous epidemiologic studies have made significant contributions to the field of Crohn's disease and ulcerative colitis, the two most common inflammatory bowel diseases. Although CDC did not receive funding for IBD during FY 2011, research from previous funding continues to be published in the literature and contributes to the evidence-base of knowledge on the incidence and prevalence of IBD; the demographic and clinical characteristics of persons with IBD; the impact of IBD on the health of the population; and the impact of clinical practices in the management of IBD. Recent work has focused on racial and ethnic differences in health care utilization, as well as outcomes and review of evaluation of possible IBD by primary care physicians.

In addition, preliminary results from the Ocean State Crohn's and Colitis Registry, an incident cohort of all newly diagnosed IBD patients in the state of Rhode Island, are expected to be published in 2012. The registry's purpose is to gain insight into the etiology of IBD, to learn why the course of illness varies among individuals, and to determine what factors may improve outcomes.

Item

Interstitial Cystitis -The Committee has included funding to continue its interstitial cystitis education and awareness activities and requests an update in the fiscal year 2013 congressional budget justification. (Page 69)

Action taken or to be taken

Although CDC did not receive funding for interstitial cystitis (IC) during FY11, CDC continues to include information about IC on the CDC.gov website to promote public awareness of the condition and provide resource information to the general public. CDC also continues to be available to consult with IC partners on an informal basis about appropriate public health strategies to address awareness of this disease.

Item

Oral Health - The Committee recognizes that reducing disparities in oral disease will require investments in proven prevention strategies at the State and local levels. The Committee strongly supports broad-based community programs that can result in significant cost savings. The Committee recommendation assumes that CDC will support grants to States at no less than last year's level to strengthen oral health infrastructure and community prevention programs. The Committee remains concerned about the high incidence of tooth decay among American Indian/Alaska Native [AI/AN] children and is pleased by the work CDC has done to support effective oral health messages in these communities. CDC is encouraged to continue pursuing collaborative efforts with the Indian Health Service and through the National Oral Health Surveillance System to assess early childhood caries [ECC] epidemiology in AI/AN children. The Committee encourages CDC to work with key external stakeholders to identify and fill strategic information gaps about age of onset, prevalence, severity and microbiology to improve and accelerate existing and novel approaches to prevent ECC. (Page 71)

Action taken or to be taken

CDC remains committed to strengthening state oral health infrastructure. In FY 2011, CDC increased the number of states funded to monitor oral diseases and implement and evaluate disease prevention initiatives such as community water fluoridation and school-based sealant programs to 20. CDC also works collaboratively across programs to enhance community health programming, which includes oral health prevention as part of the Community Transformation Grants program. CDC will use state-based surveys to measure progress in expanding coverage of community water fluoridation, increasing the number of high risk children receiving dental sealants, and reducing levels of tooth decay and untreated tooth decay. States will continue to prioritize sealant programs in schools with a high percentage of students on free and reduced cost meal programs in order to reach underserved children.

CDC continues to enhance the effectiveness of oral disease prevention by reviewing scientific evidence, studying the cost-effectiveness of interventions, identifying the most efficient ways to deliver interventions, and demonstrating intervention impact. As part of these efforts, CDC is actively working to reduce and eliminate health disparities in oral disease among American Indian and Alaska Native (AI/AN) children through its collaboration with the Indian Health Service (IHS). CDC supports the IHS Early Childhood Caries (ECC) Initiative by providing technical support on a national-level screening survey to determine caries (decay) prevalence and severity in this population. CDC also assists IHS in the development of a long-term oral health surveillance plan to assess age of onset, prevalence, and severity of oral diseases in AI/AN children and adults.

In addition to supporting IHS's ECC initiative, CDC collaborates with external stakeholders to identify and fill strategic information gaps about ECC at the state and national levels. For example, the National Oral Health Surveillance System (NOHSS), developed with the collaboration of CDC and the Association of State and Territorial Dental Directors (ASTDD), allows states to compare their ECC prevalence rates with other states and track the effectiveness of ECC prevention activities over time. NOHSS will expand to include state-by-state and IHS data on ECC, including severity, gathered from surveys of Head Start children. CDC will also continue to work with the National Institute of Dental and Craniofacial Research (NIDCR) at the National Institutes of Health to monitor ECC at the national level through the National

Health and Nutrition Evaluation Survey (NHANES). CDC is seeking ways to increase the visibility of disparities data contained in NHANES. CDC, CMS, HRSA, and IHS are also working together to develop oral health clinical quality measures and exploring additional opportunities for collaboration in programmatic efforts.

Item

Pre-school Programs - The Committee strongly supports efforts to build good nutrition and exercise habits early in life, to more effectively combat rising rates of childhood obesity. The Committee directs CDC to give priority within the Community Transformation Grants to interventions aimed at pre-school populations. (Page 71)

Action taken or to be taken

CDC's Community Transformation Grant funding opportunity announcement recommended applicants consider improving jurisdiction-wide nutrition, physical activity, and screen time practices in early child care settings as a key strategy. CTG Implementation grantees are currently finalizing their Community Transformation Implementation Plans and CDC expects that some of the plans could include interventions focused on pre-school populations.

Early Care and Education (ECE) providers can play a key role in the fight against obesity by building good nutrition and exercise habits. CDC supports ECE initiatives through the Nutrition, Physical Activity, and Obesity state-based program, Communities Putting Prevention to Work, and Community Transformation Grants. CDC is also working to identify effective health care and community strategies to support healthy eating and active living and help combat childhood obesity among children ages two to twelve through the Childhood Obesity Demonstration Research Project. In addition, CDC is empowering ECE providers to change early care and education environments by developing tools, policies, and procedures for program improvement, and offering technical support to facilitate implementation.

Item

Safe Motherhood and Infant Health - The Committee encourages the Safe Motherhood and Infant Health program to collaborate with the National Center for Health Statistics to explore how the implementation of the electronic death certificate might be used to expand the effort to collect information on pregnancy-related deaths, information about women's health and behaviors around pregnancy, and the translation of findings and guidelines on preconception care into everyday practice and healthcare policy. (Page 71)

Action taken or to be taken

CDC recognizes the need for state and local programs to receive timely and accurate information on maternal deaths to develop preventable approaches to the reduction of maternal deaths and associated racial/ethnic disparities. CDC efforts to obtain accurate and consistent vital record data include the provision of technical support to promote the adoption of the most recent revisions to the U.S. Standard Death and Birth Certificates as issued by the National Center for Health Statistics, including information relative to pregnancy status as included on the 2003 death certificate. CDC also provides technical assistance to promote state adoption of electronic birth and death registration to improve data quality and timeliness. CDC's efforts to enhance vital record data will improve the surveillance data available to inform key public health decisions.

In FY 2011, CDC funded three states to establish state-wide perinatal quality collaboratives among obstetrical and pediatric care providers in health care facilities to identify processes of care that improve pregnancy outcomes for women and newborns and reduce maternal and perinatal deaths. Among their

activities, these states are implementing improvements to state vital record information and processes aimed at rapid reporting. This program will serve as a model to other states in identifying processes of care that improve pregnancy outcomes for women and newborns as well as reduce maternal and perinatal deaths.

CDC will continue to be actively involved in offering technical support and analyses of existing maternal and infant health data systems and programs to provide evidence-based practices which inform public health and clinical practice in the areas of preconception, prenatal, intrapartum and postpartum care of women and their infants.

Item

Sleep Disorders - The Committee is pleased with the activities of the National Sleep Awareness Roundtable and encourages CDC to continue to promote awareness of the importance of sleep and sleep disorders. (Page 72)

Action taken or to be taken

CDC partnered with the National Sleep Foundation (NSF) to develop the National Sleep Awareness Roundtable (NSART), a coalition of about 40 governmental and professional organizations. Since FY 2008, CDC has funded the NSF to support NSART to raise public awareness about sleep and sleep outcomes; disseminate science-based policies; and promote recognition of insufficient sleep as a public health problem, including the need for care for individuals with sleep disorders. Moving forward, CDC will continue to work with a group of sleep experts to promote system changes to school start times for high school students, who have the greatest need for a later start time.

Item

Small Business Wellness Grants - The Committee recommendation transfers $10,000,000 from the PPH Fund to continue the small business wellness grant program at no less than last year's level. The Committee is aware of the struggle that small businesses face meeting the rising cost of health insurance premiums. For that reason, the Committee directs CDC to focus this program on small businesses, as authorized in section 10408 of the Patient Protection and Affordable Care Act. (Page 72)

Action taken or to be taken

The National Healthy Worksite Program is an initiative to establish and evaluate comprehensive workplace health programs to improve the health of workers and their families. Over a two to five year period, comprehensive worksite health programs that use evidence-based and best practices can yield an average return of $3 for every dollar spent. The National Healthy Worksite Program will enable employers to implement targeted programs, practices, and policies to address employee lifestyle risk factors related to physical activity, nutrition, and tobacco use.

During FY 2012, the program is expected to help an estimated 70 to 100 small (100 or less full-time employees), mid-size (101–250 employees), and large (251–1,000) employers located in seven counties nationwide to build comprehensive workplace wellness programs. While businesses of a variety of sizes will be included, two-thirds of the participants will represent small or mid-size employers, and participating large employers will be asked to commit some of their own funds into the program.

Item

Environmental Health Tracking Network - The Committee is aware of research suggesting that many diseases and conditions with rising rates may have environmental triggers. The Committee directs CDC to

work with NIH and the ALS Registry to explore how the Environmental Health Tracking Network could map and help researchers evaluate potential environmental risk factors to autoimmune diseases, neuro-degenerative diseases and autism. (Page 93)

Action taken or to be taken

The investment of Congress in CDC's Environmental Public Health Tracking Network over the past ten years has established the necessary infrastructure to identify and respond to emerging health and environmental issues, such as the committee's concerns regarding autoimmune diseases, neuro-degenerative diseases and autism.

CDC's National environmental Public Health Tracking Network incorporates data from CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network. The ADDM Network monitors autism spectrum disorders (ASDs) and related conditions for several sites across the country, but not for the entire United States (U.S.). Additionally, some data from the Department of Education's Individuals with Disabilities Education Act will also be available soon on the Tracking Network.

Immediate Action CDC will take:

- By early 2012, make available data for seven developmental disabilities on the Tracking Network. These disabilities were selected, because there is some scientific evidence that suggests exposure to an environmental contaminant may play a role in developing these conditions and include:
    - autism spectrum disorders,
    - intellectual disabilities (mental retardation),
    - speech or language impairment,
    - emotional disturbance,
    - specific learning disability,
    - developmental delay, and
    - hearing impairments/hearing loss.
- Collaborate with CDC's sister agency, the Agency for Toxic Substances and Disease Registry, to identify opportunities to create a nexus between the Tracking Network and ATSDR's Amyotrophic Lateral Sclerosis (ALS) registry.

Future Action CDC will take:

- Draw upon the earlier state pilot projects to identify best practices to explore how the tracking network could map and help researchers evaluate potential environmental risk factors.
- Consult with CDC's Lupus Registries Program to learn about the experiences of their state grantees trying to address the needs for better data about SLE.
- Connect with the National Institutes of Health (NIH) to learn more about their portfolio of research on autoimmune diseases, neuro-degenerative diseases and autism and identify opportunities for translating that research to public practice.

Item

Asthma- The Committee is concerned that CDC's proposal to consolidate the asthma program with the Healthy Homes/Childhood Lead Poisoning Program would jeopardize the Federal response to asthma at a time when asthma rates are rising. Asthma is a large public health problem in the country, affecting 25 million Americans, of whom 7 million are children. The Committee supports science-based, effective asthma interventions and management implemented by the National Asthma Control Program. The Committee directs CDC to continue its support of the program, its approach to asthma control, its community partners and its successful interventions. (Page 77)

Action taken or to be taken

CDC will continue to support robust efforts by state health departments to reduce and control asthma. The program model in states will not change. CDC continues to support the most efficient program models to implement these programs and will seek new models to streamline funding mechanisms and program oversight.

Item

Baseline Community Health Data for Gas Drilling Sites - The Committee encourages CDC to develop a wide variety of baseline community health data that will be tracked over time. As drilling for natural gas increases across the Nation, this information will allow communities to monitor the impact of current and future drilling sites on the health of individuals living nearby. (Page 77)

Action taken or to be taken

The investment of Congress in CDC's Environmental Public Health Tracking Network over the past ten years has established the necessary infrastructure to identify and respond to emerging health and environmental issues, such as questions regarding natural gas drilling that the Committee poses.

Activities CDC will undertake include:

- Jointly convene an expert panel workshop with the ATSDR in 2012 to discuss the state of the science on public health effects of hydraulic fracturing and to identify the data and measures needed to track and evaluate health concerns related to hydraulic fracturing
- Continue partnership with sister agency ATSDR, which is studying the public health concerns related to hydraulic fracturing issue with EPA, both through site-specific environmental exposure assessments and broader efforts including the National Hydraulic Fracturing Study
- Partner with EPA around environmental monitoring to do what specifically?

The Tracking Network is poised to receive health and environment data related to hydraulic fracturing and currently, CDC's Tracking Program funds 11 states with shale reserves. However, 18 other states with shale reserves are not currently funded. To establish baseline health data for all communities impacted by drilling, CDC will need to provide technical assistance to currently unfunded states that wish to join or provide surveillance data on hydraulic fracturing to the Tracking Network, as no national data are currently available to evaluate potential health or environmental effects of hydraulic fracturing.

To nationally track and evaluate the potential health effects of hydraulic fracturing will require CDC to:

- Work with state partners and non-governmental organizations to define appropriate metrics to track.
- Expand data collection and reporting of currently funded states.
- Disseminate information to non-funded states once appropriate metrics are defined. The Tracking Network can serve as the infrastructure for non-funded states to submit data, if they choose.
- Provide technical assistance to states that contain shale reserves to enable them to report data to the Tracking Network.

Item

Biomonitoring - The Committee strongly supports quality assurance in current biomonitoring program efforts aimed at ensuring that results are accurate and comparable across the many different State programs. CDC is encouraged to explore the feasibility of developing reference methods and materials for several cardiovascular disease biomarkers, including apolipoprotein B, high-sensitivity C-reactive protein, small LDL and troponion. The Committee recognizes both the need for reference methods for these biomarkers and the potential return on investment in the form of cost savings for Federal health care programs, like Medicare and Medicaid, and other programs. (Page 77)

Action taken or to be taken

CDC appreciates the Committee's continued support of our work in biomonitoring quality assurance and cardiovascular disease biomarkers. In late 2011, the Environmental Health Laboratory began preliminary work to develop a high quality, accurate reference method for small LDL. CDC is also exploring the feasibility of developing analytic methods to measure apolipoprotein B, high-sensitivity C-reactive protein, and troponin. In early 2012, CDC's Environmental Health Laboratory will begin a pilot quality assurance program for state laboratories that receive CDC funding for biomonitoring. CDC will provide laboratories with quality assurance materials and technical assistance for tests for selected phthalates, phenols and polycyclic aromatic hydrocarbons.

Item

Blood Lead Proficiency Testing - The Committee encourages CDC to collaborate with the Health Resources and Services Administration to ensure continued support for the National Blood Lead Proficiency Testing Program. Since 1988, this program has played an important role in combating childhood lead poisoning by assuring and improving the accuracy of lead poisoning screenings. (Page 77)

Action taken or to be taken

CDC will collaborate with the Health Resources and Services Administration in its mission to ensure accurate testing for lead in states by assisting with technical expertise in laboratory proficiency testing and blood lead measurements.

Item

Environmental Health Tracking Network - The National Tracking Network was launched in July 2009, and CDC continues to expand the quality and quantity of health and environmental information and data available through the network. The network includes data for cancer, reproductive health outcomes, birth defects, demographics, socioeconomic status, outdoor air quality, drinking water quality, hospitalizations for asthma, cardiovascular disease, carbon monoxide poisoning and childhood lead poisoning.

Action taken or to be taken

CDC is committed to making the Environmental Public Health Tracking Network a premier online resource that monitors broad environmental public health concerns which affect people nationwide, and provides timely, integrated environmental and health data. In FY 2011, the Tracking Network expanded in scope and functionality to allow a broad range of public health officials to improve our nation's understanding of how the environment affects health and to deliver more effective policies and prevention actions that protect people and save money. New additions included data related to climate change and extreme heat, motor vehicle fatalities, types of transportation to work, asthma prevalence from Behavioral Risk Factor Surveillance System, and updates to existing content areas. A cutting edge new mapping and query system was also implemented which allows greater flexibility for mapping, sorting, and graphing

data. Expanded national maps, side by side map comparisons, and faster results are a few of the enhancements now available.

In FY 2012, the Tracking Network will expand to include: health effects of fine particulates (PM2.5) in air; seven developmental disabilities including autism spectrum disorders; four new cancers: mesothelioma, melanoma, kidney, and liver; biomonitoring – 12 environmental chemicals, updated community water, and more. In addition, the Tracking Network will expand the repository of tools, methods, and other resources available to state and local health departments to examine data trends, assess the impact of the environment on health, identify susceptible populations, and respond to community concerns.

Item

Healthy Homes and Lead Poisoning Prevention Program - The Committee notes that $350,000,000 will be spent by DHS to conduct home visiting programs in fiscal year 2012 through the Maternal, Infant, and Early Childhood Home Visiting Program; this funding appropriated by the Patient Protection and Affordable Care Act, is $100,000,000 more than the fiscal year 2011 level. The Committee intends the Health Resources and Services Administration and CDC to work together to ensure that activities previously funded through Healthy Homes will be fully incorporated into the Home Visiting Program. (Page 78)

Action taken or to be taken

CDC's program previously funded Healthy Homes and Lead Poisoning prevention programs and staff in state health departments (HD). Funding provided in the CDC's 2012 appropriation (P.L. 112-74, Division F) will provide funding for surveillance systems and technical expertise only. CDC looks forward to formalizing a pecuniary relationship with HRSA to ensure the continuation of these unique and critical public health activities needed to protect the nation's children.

Item

Blood Safety Surveillance- The Committee supports the National Healthcare Safety Network [NHSN], a surveillance tool used by hospitals and other health care facilities to better understand and prevent healthcare-associated infections. With the addition of a hemovigilance module in fiscal year 2010, NHSN also became a tool to collect and analyze national data on adverse events and medical errors occurring during blood transfusions. The Committee encourages CDC to broaden its outreach to increase hospital participation, undertake measures to assure the quality of the data collected and disseminate the data in ways that support the development of effective interventions. (Page 64)

Action taken or to be taken

In February 2010, CDC launched the Hemovigilance Module, a national, voluntary public health surveillance system to detect and monitor adverse events associated with blood transfusions in hospitals. The Hemovigilance Module is the first release of the Biovigilance Component of the National Healthcare Safety Network (NHSN) and was developed through a public-private partnership between CDC and subject matter experts. The Hemovigilance Module is designed for transfusion services staff in healthcare facilities to monitor recipient adverse reactions and quality control incidents related to blood transfusion. The Hemovigilance Module provides standard criteria and definitions to participating facilities to report adverse events related to blood transfusion that will result in aggregate data suitable for trend analyses and benchmarking. CDC will analyze the national surveillance data collected in the Hemovigilance Module to inform the development of evidence-based interventions and recommendations to prevent transfusion-related adverse events. CDC plans to publish a public health report of aggregate data when sufficient data is available.

There are approximately 125 facilities enrolled in the Hemovigilance Module. Participating facilities are able to independently analyze their data within NHSN and will be able to compare their data with national aggregate rates in a confidential manner through NHSN in the future. CDC plans to increase enrollment in the Hemovigilance Module by collaborating with accreditation organizations, public health agencies, state health departments and medical facilities that are using NHSN. CDC developed a website that provides the NHSN Hemovigilance Module, Hemovigilance Module protocol, data collection forms and instructions. CDC will also give presentations and trainings on the Hemovigilance Module at scientific meetings.

Item

Infection Control -The Committee is concerned by ongoing exposures and outbreaks caused by the reuse of syringes and misuse of vials in healthcare facilities. These outbreaks are entirely preventable when well-known infection control practices are practiced. The Committee urges CDC to continue its injection safety activities in three areas: provider education and awareness, detection and tracking, and response. (Page 64)

Action taken or to be taken

Ensuring the safety of healthcare for patients in all settings is a priority for CDC. Prevention of unsafe infection control practices, such as syringe reuse and misuse of vials in healthcare settings, requires a multifaceted approach that relies upon surveillance, outbreak response, oversight, research, education and training, and implementation of prevention practices. CDC is working with Centers for Medicare & Medicaid Services to enhance infection control surveyor capacity to assess compliance with CDC evidence-based guidelines and recommendations during healthcare facility inspections. CDC has developed infection control surveyor worksheets to assess infection control practices in ambulatory care settings and is developing similar tools for acute care and dialysis facilities. CDC will continue to support states with outbreak response and expertise so they can solve local healthcare quality problems. Such outbreak investigations identify gaps in standard infection control practices, serve as educational opportunities for healthcare personnel, and inform future recommendations for assessing and improving adherence to infection control practices.

Education initiatives targeting healthcare providers and patients are conducted by the Safe Injection Practices Coalition, a CDC-led partnership of healthcare organizations with a shared interest in promoting and advancing safe injection practices. CDC continues to develop new prevention strategies and guidance, and works with partner agencies such as the U.S. Food and Drug Administration to implement policy changes, with private partners to develop engineering solutions, and with patient advocates to promote safe practices that prevent the transmission of infections in all care settings. In May 2011, CDC published and disseminated a "Guide to Infection Prevention for Outpatient Settings: Minimum Expectation for Safe Care" and an accompanying infection prevention checklist for outpatient settings. The recommendations included in this guide are not new, but rather reflect existing evidence-based guidelines produced by CDC and the Healthcare Infection Control Practices Advisory Committee. This summary guide is based primarily upon elements of Standard Precautions and represents the minimum infection prevention expectations for safe care in ambulatory care settings.

Item

Food Safety- The Committee directs that CDC spend no less than last year's level on food safety activities. The Committee strongly supports the CDC program to ensure food safety through surveillance outbreak response. The Committee supports an expansion of OutbreakNet to all 50 States in order to

increase capacity and speed of food-borne outbreak detection and response. In addition, CDC is encouraged to support efforts to build a faster and more comprehensive public health laboratory and epidemiological surveillance and investigations. (Page 64)

Action taken or to be taken

CDC's food safety program continues to support: 1) science-driven surveillance systems that track human illness and guide food safety interventions led by the regulatory agencies and industry; and 2) improving our nation's capacity to detect, investigate and stop foodborne outbreaks to prevent illnesses, hospitalizations, and deaths. For example, CDC's PulseNet system is a nationwide laboratory-based surveillance system that helps states and CDC identify and investigate clusters of ill people, which may constitute foodborne outbreaks. This information is used by CDC to identify multi-state outbreaks and then to coordinate national investigations and responses. Recent multi-state outbreaks detected by PulseNet include the Listeria outbreak associated with cantaloupes and the Salmonella outbreak associated with the recall of ground turkey. The many hospitalizations and deaths associated with the outbreak of *E. coli* in Germany during the summer of 2011 demonstrate the importance of a national foodborne disease detection and reporting surveillance system.

In addition to PulseNet, CDC's OutbreakNet is a national network of state and local officials (currently in all 50 states), who investigate foodborne outbreaks. CDC has expanded OutbreakNet to all 50 states as a first step in improving outbreak investigations and responses. As a complement to OutbreakNet and as a way to improve outbreak investigations and responses, CDC coordinates the operation of seven unique research sites called FoodCore sites (formerly referred to as OutbreakNet Sentinel Sites), which serve to implement and assess new methods, tools and practices in participating state and local food safety programs. FoodCORE focuses on improving public health laboratory surveillance practices, epidemiological interviews and investigation techniques, and environmental health assessments. Best practices identified by these FoodCORE sites may then be shared and implemented in other localities across the Nation, through the OutbreakNet group of state and local public health workers.

Item

Vector-Borne Diseases - As international travel becomes more commonplace, new pathogens can be introduced into new environments more quickly than ever before, as the Nation has seen with SARS, avian influenza and dengue fever. Arboviruses like chikungunya and others are a constant threat to travelers and to Americans overall. The Committee urges CDC to continue surveillance and monitoring of vector-borne diseases within the agency's new structure. (Page 64)

Action taken or to be taken

A national surveillance system for arboviral diseases, ArboNet, has been in place since 2000. CDC funds staff in 49 states, Puerto Rico, and six large municipalities to conduct case investigations, field collection and analysis of mosquitoes and other specimens, laboratory analysis, and submission of near real-time data electronically to CDC. This provisional data on West Nile virus (WNV), dengue, eastern equine encephalitis, and other arboviruses is analyzed and posted weekly at county-level resolution, enabling health departments and mosquito control programs to evaluate and respond quickly to emerging outbreaks. The past 12 years of investment in vectorborne disease capacity at state and local health departments has been critical to developing U.S. defenses against endemic and exotic pathogens, such as the chikungunya virus. In addition, CDC works with health departments in Arizona, California, Minnesota and Tennessee to develop sentinel surveillance sites with increased ability to recognize patterns in disease transmission and plan for mitigation and response.

CDC supports vector-borne diseases through the extramural ArboNet program; maintains comprehensive national surveillance, such as gold-standard laboratory diagnostic testing; produces and distributes

laboratory testing reagents; develops new laboratory diagnostics, which are more effective and efficient; maintains epidemiology and ecology staff able to mount rapid investigations and interventions to disease outbreaks; and develops and tests new plant-based insecticides.

Item

Hepatitis Testing- The Committee recognizes that early diagnosis of hepatitis is a cost-effective way to reduce morbidity and mortality rates and encourages CDC to implement plans for risk-based hepatitis testing, including baby-boomers, injection drug users, and ethnic minorities such as Native Hawaiians, Native Alaskans, African Americans, and Asian and Pacific Islanders. (Page 61)

Action taken or to be taken

In FY 2012, CDC is working to increase the proportion of persons living with viral hepatitis who are aware of their infection and referred for prevention and clinical care services. An estimated 3.5-5.3 million persons are living with viral hepatitis in the United States and millions more are at risk for infection. Because as many as 65-75 percent of infected Americans are unaware of their infection and not receiving care and treatment, CDC is providing needed resources to 10-12 state and local health departments to increase testing for at risk populations in multiple settings including STD clinics, HIV/AIDS settings, correctional settings, IDU treatment centers, and federally qualified health centers. Efforts are targeted to reach persons at highest risk for severe HCV-related morbidity and mortality, communities experiencing health disparities related to hepatitis B (e.g., foreign born populations and their children) and hepatitis C (African-Americans and current former incarcerated populations) and young persons at risk for HCV related to drug use.

Item

HIV Prevention - The Committee commends CDC for conducting evaluations into a number of new locally developed and investigator-developed interventions for men who have sex with men [MSM], particularly African-American MSM, and conducting research to adapt existing effective behavioral interventions for additional populations such as women and other racial and ethnic minorities. The Committee looks forward to the results of this research and encourages CDC to develop a plan for disseminating any new proven interventions, including technical assistance and training opportunities for community-based organizations. (Page 62)

Action taken or to be taken

CDC is using several different methods to increase prevention programming and the number of evidence-based interventions available for prevention programs for minorities, MSM, and women. CDC is evaluating a number of new locally-developed and investigator-developed interventions for MSM, particularly African-American MSM, and is conducting research to adapt existing effective behavioral interventions (EBIs) for additional populations. CDC will continue to provide funds to support the development of trainings by capacity building assistance providers and to deliver trainings to community-based organizations serving high-risk populations.

Item

HIV Testing - The Committee commends CDC for recently expanding the Heightened Awareness HIV Testing program to include additional jurisdictions and risk groups. The Committee requests an update on the implementation of this expansion in the fiscal year 2013 congressional budget justification. (Page 62)

Action taken or to be taken

In FY 2012, CDC is supporting 34 health departments to increase testing among groups at highest risk for HIV acquisition (MSM, African Americans, injecting drug users, and Latinos) through the Enhanced Testing Program (ETP). This effort will provide more than 1.3 million HIV tests and will identify at least 6,500 persons with newly diagnosed HIV infection annually.

Item

Tuberculosis [TB] - The Committee notes that TB, including drug-resistant TB, remains a public health concern and that there are significant barriers to optimal diagnosis and treatment and national shortages of second-line TB drugs. The committee urges the Federal Tuberculosis Task Force to work with the Food and Drug Administration and other partners to accelerate the introduction of new rapid diagnostic tests and to alleviate national shortages of TB drugs. (Page 62)

Action taken or to be taken

CDC agrees that better drugs and diagnostics are needed to eliminate TB in the U.S. CDC and FDA, both members of the Federal TB Task Force, are working together to identify long-term solutions to TB drug shortages and to accelerate introduction of new rapid diagnostic tests.

Item

TB in High-Risk Areas - The Committee is aware that the TB program distributes supplemental funding based on outbreaks. The Committee is concerned that areas with persistently high rates of TB and drug-resistant TB experience outbreak conditions routinely. The Committee directs CDC to review the epidemiology of TB in States and territories with more than double the average rate of TB cases to determine if a visit from CDC's TB outbreak response team or an outbreak supplemental grant could jumpstart significant improvement in TB prevention and control in these high-risk areas. (Page 62)

Action taken or to be taken

TB disease is more likely to affect racial and ethnic minorities, persons born outside the U.S., homeless persons, alcohol or substance users, the incarcerated, and those experiencing medical conditions such as diabetes and HIV infection. CDC allocates prevention and control cooperative agreement funds based the five-year average number of cases and the complexity of cases in jurisdictions. Technical assistance and supplemental awards are available for responding to outbreaks.

Item

Viral Hepatitis- The Committee directs that $10,000,000 transferred from the PPH Fund be prioritized to support Division efforts to expand identification of those chronically infected persons who do not know their status and their referral to medical care, particularly focusing on groups disproportionately affected by chronic hepatitis B and hepatitis C. In particular, the Committee notes that hepatitis B and hepatitis C testing guidelines are not aligned across HHS operating divisions, and expects CDC to work expeditiously with the Assistant Secretary for Health, AHRQ and the U.S. Preventive Services Task Force to develop a consistent national testing guideline by early 2012 to improve testing rates. As noted in the HHS action plan, the effectiveness of risk-based approaches to testing is hindered by the reluctance of providers and patients to discuss behaviors not connected with the patient's chief complaint. The Committee urges CDC to update and implement HHS recommendations for viral hepatitis testing as a standard of care in CDC-sponsored HIV/STD prevention programs, correctional health, and other programs serving populations with high disease prevalence. The Committee further encourages CDC to

conduct prevention research to identify and disseminate best practices for screening and the prompt linkage to needed medical management and treatment. (Page 62)

Action taken or to be taken

A mix of activities is needed to increase screening for viral hepatitis. CDC would award most of the increase appropriated in 2012to state and local health departments to supplement the work of viral hepatitis coordinators. The health departments would be authorized to select locally appropriate strategies to improve testing including: staff to identify and fill in gaps in testing, lab capacity, direct provision of testing services, and outreach and education conducted through community-based organizations. These coordinators work to leverage existing programs serving populations at risk for HBV and HCV in order to promote viral hepatitis screening and vaccination services. They also promote HBV and HCV screening and vaccination in correctional settings, as recommended in current CDC guidelines.

CDC would provide direction and leadership to this effort, finalize a national education campaign to increase awareness, support additional provider education and program research, evaluate the effectiveness of these efforts and identify best practices. CDC is also working to update HCV screening guidelines. CDC is working to promote the integration of HBV and HCV screening, HBV vaccination, and other viral hepatitis prevention services, as medically appropriate, into HIV and STD programs.

Through its PCSI initiative, CDC is working to promote HBV and HCV screening and vaccination, as medically appropriate, in the context of HIV and STD programs.

Item

Viral Hepatitis - The Committee recognizes that the Adult Viral Hepatitis Prevention Coordinator program is the only Federal hepatitis prevention program operating in all States and understands that the program does not include any dedicated funding for direct services. The Committee encourages the Division of Viral Hepatitis to maintain this program in all previously funded jurisdictions to build the Federal response for both low- and high-impacted areas. (Page 63)

Action taken or to be taken

CDC works to improve viral hepatitis screening and referral to medical care and hepatitis surveillance. CDC currently provides funding for Adult Viral Hepatitis Prevention Coordinators in 49 state and six local health departments to provide leadership in the integration of viral hepatitis prevention activities such as public and provider education, screening and counseling for persons at risk of infection, and referral of infected persons to appropriate medical care, into existing public health programs. CDC anticipates maintaining this program structure in FY 2012 as part of the department-wide initiative on viral hepatitis prevention and control.

Item

Viral Hepatitis - The Committee further encourages CDC to continue to validate interventions focused on mother-child transmission. As the hepatitis B virus is the single greatest health disparity impacting the Asian and Pacific Islander [API] populations in the United States, the Committee urges a targeted and increased effort to address this issue, including the funding of replicable demonstration projects to help reach the API populations.

Action taken or to be taken

Screening for hepatitis B virus (HBV) infection in pregnant women to identify newborns who will require prophylaxis against perinatal infection is a well-established, evidence-based standard endorsed by the

U.S. Preventive Services Task Force. In FY 2008, CDC published chronic hepatitis B screening recommendations that identify the populations in greatest need of HBV testing. The recommendations also address the public health management needed to delay or halt the progression of HBV-related liver disease and to prevent HBV transmission to others

CDC works with multiple governmental and Asian American/ Pacific Island community partners to implement these recommendations and promote appropriate screening, referral and treatment for viral hepatitis in outreach, clinical and public health settings. CDC currently funds 5 cooperative agreements to assess and improve public health programs to prevent perinatal HBV and ensure all infants born to HBV-infected women are protected from HBV infection. CDC also has contracted with the Institute of Medicine to study viral hepatitis prevention in the United States and identify effective strategies for screening to prevent and control disease and death associated with chronic hepatitis infection.

Item

Viral Hepatitis - Finally, the Committee encourages CDC to develop and implement a standard curriculum to train the multiple disciplines of the public health and clinical care workforce to deliver viral hepatitis prevention, screening and referral for care. CDC is also urged to help reduce health disparities by implementing a national education campaign targeting at risk communities, strengthening the capacity of community-based organizations to provide viral hepatitis prevention services and observing May 19 of each year as Viral Hepatitis Testing Day to raise awareness of the importance of viral hepatitis screening. (Page 63)

Action taken or to be taken

CDC recently awarded a one-year supplement to an existing grantee to develop a standard curriculum for the delivery of viral hepatitis prevention, screening, and referral to care. CDC will also continue work to develop a national education campaign targeting both health care providers and populations at risk for viral hepatitis. This campaign will emphasize improving the capacity of healthcare providers and community-based organizations to screen populations at risk for chronic viral hepatitis (HCV and HBV) infection as well as increasing demand for HCV and HBV testing among at-risk persons. Efforts will be undertaken to develop and disseminate viral hepatitis training and educational materials targeting public and private sector health care professionals to build capacity to assess, test, and medically manage populations at risk for chronic HCV and HBV infection.

Item

Tuberculosis (TB) - The Committee is concerned about the growth in cases of drug-resistant forms of TB, including 114 cases of multi-drug-resistant TB in the United States in 2009. The Committee notes that timely and effective treatment regimens are necessary to reduce transmission of drug-resistant TB. Therefore, the Committee strongly supports the ongoing collaboration between CMS and CDC that has thus far resulted in multi-level communication to States about options in Medicaid. The Committee encourages CMS to continue this collaboration.

Action taken or to be taken

CDC has worked closely with CMS to inform state and local awardees of TB prevention, control, and laboratory cooperative agreements of the Medicaid option for TB. While the decision to implement this option belongs to the State, CDC and CMS have provided TB programs with the materials necessary for proposing the option to state Medicaid offices.

Item

Preserving Integrity of Seminal Surveys - The Committee encourages NCHS to fully support its ongoing seminal health surveys, in particular the National Health Interview Survey and National Health and Nutrition Examination Survey. The Committee urges NCHS to protect these core surveys without comprising data quality or accessibility, particularly with regard to minority populations.

Action taken or to be taken

Data obtained from NCHS data collections, including the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES), are essential to monitoring our Nation's health. The NHIS and the NHANES are robust, widely supported data collections that obtain crucial data on a broad range of health indicators. These data are used to identify and address critical health problems, including longstanding efforts to document and monitor disparities in minority populations. The NHIS and NHANES have routinely oversampled minority populations to obtain useful health measures for these groups. With information at the core of the NCHS mission, activities are continually underway to maintain and improve the quality, as well as the analytic potential, of all data collections. Accessibility is also a priority - NCHS makes its data readily accessible, using a variety of mechanisms to maximize the availability of the data and meet the needs of a wide range of interested data users.

Item

Sexual and Gender Identity Inclusion in Health Data Collection - The Committee encourages CDC to consider expanding the National Health Interview Survey to include questions relating to sexual orientation and gender identity to better enable government agencies to understand and meet the unique health needs of lesbian, gay, bisexual, and transgender individuals. (Page 75)

Action taken or to be taken

CDC's National Center for Health Statistics (NCHS) is taking steps to expand the National Health Interview Survey (NHIS) to include questions related to sexual identity. Developmental work conducted by NCHS' Questionnaire Design Research Laboratory provided the foundation for a series of field tests of new survey questions. These field tests – being conducted in collaboration with the Census Bureau - are designed to determine the best approach to asking sexual identity in the context of the NHIS, an in-person survey of households. In addition to testing the questions, the field tests will also test the audio computer assisted self-interviewing (ACASI) technique whereby the respondent listens to questions via headphones and directly enters responses into the computer without the interviewer's assistance. This technique is known to improve responses to sensitive questions. The first field test, conducted in November 2011, was a small test intended to debug the new ACASI system. Additional testing will continue through 2012 to improve the technical procedures and determine the impact of these questions and ACASI on the NHIS.

NCHS also has been working with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to determine the most appropriate way to obtain accurate data on gender identity. ASPE is conducting a series of listening sessions with the LGBT research/advocacy community so that transgender and transsexual research is designed and conducted in scientifically appropriate ways.

Item

Standardized Obesity Measurements - The Committee is strongly supportive of the 2010 Institute of Medicine recommendation in `For the Public's Health: The Role of Measurement in Action and Accountability' that calls on CDC to develop a standardized set of measurements for obesity reduction

and other public health programs. A standardized set of measurements would provide the Federal Government and other grant-making institutions with a consistent way to evaluate and compare the effectiveness and outcomes of obesity-reduction programs and other public health initiatives. The Committee urges NCHS to undertake this effort, in consultation with State and local health departments, medical and public health professional associations, charitable foundations, the academic and research communities, and other nonprofit and community-based organizations. (Page 76)

Action taken or to be taken

CDC's National Center for Health Statistics (NCHS) will consult with other components within CDC and the Department of Health and Human Services that are involved in activities related to evaluation and measurement of the impact of public health activities, particularly obesity reduction programs. A workgroup made up of the organizations as suggested by the Committee will be convened to further develop work already underway in this area. As a starting point, NCHS will conduct a more in-depth analysis of trend data (including a variety of different indicators) for the group to use in identifying measurements that would be useful for assessing the effectiveness of obesity reduction programs and other public health programs.

It is important to develop measures other than Body Mass Index (BMI) for monitoring and evaluating the effectiveness of public health programs. This will allow for assessing changes in behaviors that contribute to obesity. Efforts already underway illustrate other types of measures that could be useful in evaluating obesity reduction programs.

With regard to childhood obesity, workgroup efforts can build on activities initiated by the Childhood Obesity Task Force in 2010. In addition to using BMI data from the National Health and Nutrition Examination Survey (NHANES) to track the overall goal of driving obesity rates down, this group endorsed monitoring two other key health indicators to assess progress in addressing childhood obesity – the percent of children eating a healthy diet and the percent of children meeting current physical activity guidelines.

- Healthy diet: NCHS can determine how much added sugar children are currently consuming. A second indicator related to healthy diet was eating more fruits and vegetables. Both these measures are tracked in NHANES.
- Physical activity: The NHANES National Youth Fitness Survey, to be conducted in 2012, will be useful in establishing targets for levels of physical activity.

For adults, NHANES data on diet and weight (obtained routinely) and physical activity data obtained from several sources can provide a starting point for discussions on developing a standardized set of measurements for assessing public health program impact.

Item

Vital Statistics- Vital statistics provide complete and continuous data on births, deaths and fetal deaths that are essential for understanding our Nation's health. The Committee encourages CDC to obtain data items currently collected by States and territories and collect 12 months of these data within the calendar year.

Action taken or to be taken

Data from the National Vital Statistics System (NVSS) provide continuous and essential information to assess and track overall population health; to plan, implement, and evaluate health and social services for children, families, and adults; and to set health policy at the national, State and local levels. Vital statistics data on access to prenatal care, maternal risk factors, pre-term delivery, infant mortality, cause of death, life expectancy, and other pregnancy and mortality indicators provide the foundation for public policy and

programmatic debates on improving overall health status and health service delivery. To facilitate analysis and dissemination of these important data in a timely manner, CDC's National Center for Health Statistics has provided enhanced technical assistance to States and territories which are responsible for registering births and deaths. For example, NCHS has provided onsite and targeted assistance based on recommendations for improving registration procedures, and has taken over the state responsibility for coding of mortality data. These efforts and others have resulted in improvements in States' and territories' ability to provide 12 months of high quality vital statistics data in a timely manner in recent years. NCHS expects such improvements to continue in future years.

Item

Vital Statistics Infrastructure - The Committee understands that not all States and territories have adopted the more comprehensive 2003 standard certificates of births and deaths, which have the potential to expand the scope and quality of vital statistics collected on a national basis. The Committee urges NCHS to sustain the National Vital Statistics System to support States and territories in implementing these certificates and modernizing their infrastructure to collect these data electronically. (Page 76)

Action taken or to be taken

Supporting state efforts to adopt the 2003 standard birth and death certificates remains a priority of CDC's National Center for Health Statistics (NCHS). State adoption of the U.S. standard certificates as the basis for state certificates provides the foundation for a high quality National Vital Statistics System. Of the 57 registration jurisdictions (50 States, New York City, District of Columbia, and 5 U.S. Territories), 42 jurisdictions are using the 2003 standard certificate for births as of November 2011; 38 are using the 2003 standard certificate for deaths; and 33 are using the 2003 standard certificate for fetal deaths. NCHS continues to use a variety of mechanisms, including onsite technical assistance and evaluation, to assist States and territories in the transition from the 1989 to the 2003 standard certificates.

Item

Falls Prevention Interventions - The Committee has included $3,000,000 from the PPH Fund to expand older adult falls prevention activities at CDC, in coordination with the Administration of Aging [AOA]. The Committee intends that CDC use the funding to conduct research to evaluate and disseminate the most effective fall prevention interventions and that AOA use the funding provided that agency to conduct outreach and demonstration programs to expand the implementation of effective interventions. In addition, the Committee is aware that osteoporosis is a chronic condition that puts individuals at risk for more serious injuries in a fall. The Committee encourages CDC to develop an education and outreach plan in consultation with the patient and medical community to focus public health strategies on osteoporosis. (Page 79)

Action taken or to be taken

CDC is the only federal agency that addresses falls among older adults using the public health model and focusing on primary prevention. CDC develops, disseminates, and supports proven strategies that prevent older adult falls. CDC supports state health departments and other key partners in developing and implementing evidence-based community fall prevention programs, as well as, linking clinical care with community programs. CDC uses the best available scientific data to identify effective fall interventions and to determine the optimal strategies to promote widespread adoption of proven programs. CDC's current activities to prevent falls include, developing *Stopping Elderly Accidents, Deaths and Injuries (STEADI)* a comprehensive resource for healthcare providers to help them address falls through fall risk assessment, treatment and referral. CDC is partnering with AOA's Aging Services Network to disseminate and evaluate STEADI. CDC also supports three states through the Core Violence and Injury

Prevention Program (Core VIPP) to offer a comprehensive community fall prevention approach by connecting clinical care, public health, and the aging/community services network.

With Prevention and Public Health Funds, CDC plans to expand our falls prevention research agenda to: enhance surveillance and epidemiology of fall risk factors; improve both the collection and analysis of falls data; develop, adopt/translate, disseminate, and evaluate evidence-based fall prevention interventions delivered through clinical practice and community programs.CDC plans to address new and emerging opportunities in fall-related research activities, such as developing an osteoporosis education and outreach plan in collaboration with the National Osteoporosis Foundation.

Item

Violence against Women – The Committee applauds CDC's development of the National Institute Partner and Sexual Violence Surveillance System to monitor State and national trends and to inform public policies and prevention strategies. The Committee urges more research on the psychological impact of violence against women in order to increase and improve evidence-based interventions to support the recovery of women from the trauma of violence. (Page 79)

Action taken or to be taken

CDC conducts research to address the psychological consequences of violence against women. For example, in collaboration with the National Institute of Justice and the Department of Defense, CDC developed the National Intimate Partner and Sexual Violence Survey (NISVS). NISVS provides data at state and national levels to monitor trends, inform public policies and prevention strategies, and help guide and evaluate progress toward reducing the substantial health, social, and economic burdens associated with intimate partner violence, sexual violence, and stalking. CDC released the findings from NISVS in December 2011.

CDC works to strengthen and broaden the evidence base for the prevention of teen dating violence. CDC funded four local public health departments for its new teen dating violence prevention initiative, Dating Matters™: Strategies to Promote Healthy Teen Relationships. The funding will aid local health departments in leading their communities in developing, implementing, and evaluating a comprehensive approach to promote respectful, nonviolent relationships and prevent teen dating violence before it starts. The funded communities include Baltimore, Maryland; Ft. Lauderdale, Florida; Chicago, Illinois; and Oakland/Hayward, California.

Item

Youth Violence Prevention - the Committee remains supportive of efforts to reduce youth violence through evidence-based prevention strategies. The Committee notes that the Office of Juvenile Justice and Delinquency Prevention Programs [OJJDP] at the Department of Justice conducts a comprehensive suite of prevention programs aimed at youth in high-risk categories and exhibiting high-risk behaviors. The Committee urges CDC to continue providing technical assistance to OJJDP with the data gained from the National Violent Death Reporting System and other surveillance activities. (Page 79)

Action taken or to be taken

Youth violence is preventable, not inevitable. CDC provides a unique approach to youth violence by working to prevent violence before it occurs. CDC's public health approach includes collecting and utilizing data to inform prevention efforts, identifying promising prevention strategies, evaluating these strategies, and working with partners and grantees to ensure these evidence-based strategies are implemented on a widespread scale.

CDC works closely with Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP), DOJ, and the Department of Education to coordinate and collaborate on youth violence prevention. CDC and OJJDP have similar goals of reducing youth violence, but use different strategies. The focus of the OJJDP is on the juvenile justice system and youth who may become system-involved. CDC's approach involves working with communities to address the underlying factors that may foster youth violence by creating an environment that promotes positive youth development and engagement. Because there are multiple factors that contribute to the development of violent attitudes and behaviors, there is not one approach or one group that can effectively prevent violence. A comprehensive and coordinated violence prevention approach is needed from public health, education, justice, public safety, and human service systems. CDC will continue to collaborate with OJJDP and provide technical assistance to the agency along with sharing the data from the National Violent Death and Reporting System (NVDRS) and other youth violence surveillance activities.

Item

Immunization Infrastructure - As investments are made to modernize the immunization infrastructure, and as the Nation's health care delivery system continues to evolve though enhanced health insurance coverage, the Committee recommends that CDC develop strategies to (1) modernize immunization information systems; (2) prepare public health departments for changes in the health care delivery system, including new billing procedures related to privately insured patients; and (3) strengthen the evidence base to inform immunization policy and program monitoring, including vaccine-preventable disease surveillance, vaccine coverage assessment, and laboratory training. The strategy should also address how CDC will maintain and expand partnerships with the healthcare sector to provide routine and emergency immunization services. (Page 60)

Action taken or to be taken

CDC recognizes that a strong public health infrastructure is vital to ensuring high vaccination coverage levels and low incidence of vaccine-preventable diseases, as well as maintaining adequate public health preparedness for response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. Regardless of whether a vaccine is publically or privately purchased, public health at the federal, state, and local levels plays a critical role in ensuring a safe and effective national immunization system.

CDC is currently investing in several activities to transition and strengthen the immunization infrastructure for the full implementation of health insurance reforms. CDC is using its Public Health and Prevention Fund (PPHF) funding to make improvements to immunization information systems, including Health Level Seven (HL7) compliance; to develop and/or implement strategic plans for billing of immunization services in health department clinics; and to identify new and effective strategies to increase national vaccine coverage, such as adult immunization programs and school-located vaccination clinics. These partnerships will also help strengthen routine and emergency immunization services. In addition, CDC is using PPHF funding to support important evaluations of effectiveness and impact on disease for recent vaccine recommendations. This information is critical to informing the evidence-base for immunization programs and policies.

Item

Cost Efficiency- The Committee strongly encourages NIOSH to continue to use existing Federal research facilities and Federal property to conduct its existing research programs. The Committee recognizes the advantages of using existing federally owned property to fulfill NIOSH's mandate and believes this approach will help NIOSH realize the most efficient use of Federal funds possible. (Page 80)

Action taken or to be taken

Ninety four percent of NIOSH's workforce works in federally owned property. CDC-owned property houses NIOSH laboratories in four major cities: Cincinnati, Ohio; Morgantown, West Virginia; Pittsburgh, Pennsylvania and Spokane, Washington. NIOSH research conducted in Cincinnati includes field research studies of occupational exposures and disease, engineering controls research, exposure assessment research, occupational disease and injury surveillance, research on the work-related hazards of nanotechnology, and translational research. CDC is pursuing a plan to consolidate the two separate Cincinnati laboratory sites to decrease spending for security, health and safety, and general operations, as well as to improve collaboration among scientists and other staff. In Morgantown, NIOSH research includes laboratory research; statistical design and analysis; workplace safety; laboratory and field research; and surveillance, laboratory, and field studies of occupational respiratory diseases. Research in Pittsburgh focuses on the development and evaluation of personal protective equipment, such as respirators, and mine safety and health research. NIOSH's Mining program also operates in Spokane, where scientists are also tracking injuries and fatalities, conducting laboratory and field research, developing practical solutions, and developing timely communication products to address hazards in other high risk industries such as Agriculture.

Item

Centers of Excellence - The Committee supports the work of the Preparedness and Emergency Response Learning Centers and the Advanced Practice Centers. These centers provide training and support for the public health system to prepare for, respond to, and recover from public health emergencies. The Committee encourages CDC to support these centers to the extent of CDC's ability. (Page 82)

Action taken or to be taken

The Centers for Excellence serve 39 states. CDC realizes the value these Centers provide in meeting research and training objectives focused on domestic preparedness for public health professionals involved in public health preparedness and response. CDC strives to improve health outcomes while achieving the greatest return on public health resources and investments. CDC will continue to do our best to support the goals of the Centers and to seek opportunities to leverage the work of the Centers with the state/local preparedness and response efforts.

Item

Strategic National Stockpile - In addition, the Committee encourages CDC to continue efforts to ensure that vaccines, medications, and equipment in the SNS are replenished and upgraded as needed. In particular, the Committee encourages CDC to review the supply of antiviral medications remaining since the H1N1 outbreak, including a review of the supply in light of the needs of special populations, such as children. (Page 82)

Action taken or to be taken

CDC is committed to the goal of ensuring that medical countermeasures are available for populations potentially affected by public health emergencies and follows the procurement recommendations and priorities of the Public Health Emergency Medical Countermeasure Enterprise (PHEMCE). Children and other vulnerable populations would be covered by the PHEMCE recommendations and priorities. The stockpile of antivirals currently exceeds the inventory levels available in 2009. The existing formulary of the Strategic National Stockpile can protect vulnerable populations: for children and others with difficulty swallowing pills, we have the ability to advise healthcare providers and care-givers to crush and dispense dosages of medications not currently available in suspension form to vulnerable populations as was done

during the 2009 H1N1 influenza pandemic. SNS ‘s annual review ensures that CDC knows the status of its antivirals inventory.

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – CONFERENCE

SIGNIFICANT ITEMS FOR INCLUSION IN

THE FY 2013 CONGRESSIONAL JUSTIFICATION

CONFERENCE REPORT

CENTERS FOR DISEASE CONTROL AND PREVENTION

Item

Lyme Disease - The conferees encourage CDC to expand its activities related to developing sensitive and more accurate diagnostic tools and tests for Lyme disease, including the evaluation of emerging diagnostic methods and improving utilization of diagnostic testing to account for the multiple clinical manifestations of acute and chronic Lyme disease. CDC is encouraged to expand its epidemiological research activities on tick-borne diseases, to include an objective to determine the long-term course of illness for Lyme disease and to improve surveillance and reporting of Lyme and other tick-borne diseases in order to produce more accurate data on their prevalence. Finally, the conferees encourage CDC to evaluate the feasibility of developing a national reporting system on Lyme disease, including laboratory reporting; and to expand prevention of Lyme and tick-borne diseases through increased community-based public education and creating a physician education program that includes the full spectrum of scientific research on the diseases. (Page 16)

Action taken or to be taken

CDC has been working in all of the general areas highlighted in the conference report and will continue to work diligently to expand these activities. In To address the conferees encouragement of CDC to expand its activities related to developing sensitive and more accurate diagnostic tools and tests for Lyme disease, CDC is funding two cooperative agreements aimed at developing diagnostic tests that would be simpler and more sensitive in detecting infection in Lyme disease cases, compared to current two-tiered testing. CDC will continue efforts aimed at identifying unique diagnostic biomarkers of active infection and will work with the National Institutes of Health and the Food and Drug Administration to facilitate development and approval of improved Lyme diagnostic tests.

To address the conference language that CDC expand epidemiological research activities on tick-borne diseases, to include an objective to determine the long-term course of illness for Lyme disease and to improve surveillance and reporting of Lyme and other tick-borne diseases in order to produce more accurate data on their prevalence, CDC continues to support a 5-year research study aimed at identifying and characterizing long-term and potentially chronic complications associated with Lyme disease infection.

Lyme disease has been a nationally notifiable disease since 1991, and cases are reported to CDC each year through the National Notifiable Diseases Surveillance System or NNDSS. Thus, the principal challenge for surveillance is not the lack of a reporting system but rather assuring that cases are captured and entered into the system. To this end, CDC is funding health departments in over a dozen high incidence states to improve surveillance and reporting for Lyme and other tick-borne illnesses. This funding supports improved reporting by both physicians and laboratories. In addition, through our Emerging Infections Program, CDC is funding research studies in three states to better determine why and to what degree Lyme disease cases are under-reported. This work is designed to yield better estimates of the national burden of Lyme disease and to identify fundamental ways in which reporting can be made more complete and accurate (e.g., through use of electronic medical records). CDC continues to fund and conduct research to validate the most effective prevention methods and approaches for use by individuals and communities, to distribute newly-developed prevention resources and toolkits for prevention

education, and to develop a healthcare provider education program based on validated, scientifically-proven research.

Item

Congenital Heart Disease - The conferees are concerned that there is a lack of rigorous epidemiological and longitudinal data on individuals of all ages with congenital heart disease and has included funding to begin to compile this information. The conferees are particularly interested in information on prevalence, barriers to effective care, survival outcomes and neurocognitive outcomes. (Page 21)

Action taken or to be taken

CDC is committed to supporting activities to better monitor and understand congenital heart defects (CHD) across the lifespan. CDC supports state-based surveillance of CHDs among infants, and builds on this data to assess survival of persons affected by CHDs in childhood and adolescence. In metropolitan Atlanta, the CHD surveillance data has been linked to data on use of special education services to assess educational outcomes, and a manuscript of this work is currently being prepared. CDC has recently developed estimates of the prevalence of CHDs across the lifespan building on work from Canada, and anticipates these estimates will be published in CDC's MMWR currently anticipated for release on February 10, 2012. CDC is also currently working with Emory University on a pilot project to determine the potential of using electronic health records (EHRs) for the surveillance of CHDs among adults.

With the provision of funding, some additional steps that CDC plans to take to improve our understanding of the impact of CHDs across the lifespan include: 1) convene an expert panel to develop a prioritized, public health action plan for CHDs using the core public health functions as a framework to address assessment and monitoring, knowledge gaps, development of informed policies, and assurance of equal access to quality care; and 2) develop and publish a funding opportunity announcement (FOA) to support one or more extramural projects to develop innovative approaches to the surveillance of CHDs across the lifespan, to determine age-specific prevalence and address issues related to assessment of health care utilization, neurocognitive outcomes, and survival.

Item

Lead Poisoning - The conferees intend that the funds provided for the CDC lead poisoning program be used to maintain expertise and analysis at the national level and to provide a resource for States and localities. (Page 23)

Action taken or to be taken

CDC's Healthy Homes and Lead Poisoning Prevention Program will continue to provide lead expertise and analysis at the national level and remain a valuable resource to state and local agencies by providing the following:

- Surveillance Technical Assistance: Provide software and technical assistance to support the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS), which gathers information related to lead and other health hazards in homes. CDC will not fund state-based surveillance systems.
- Training Support: Continue to be a Federal Partner with the National healthy Homes Training Center and Network (HHTC). HHTC provides training to public health, environmental health and housing professionals to recognize and address housing related health hazards.
- Epidemiological Support: Maintain staff to provide expertise and epidemiological support in response to a lead poisoning outbreak.

- Customer Service Support: Provide Project Officer Support to the 35 funded cooperative agreement partners through the remainder of the current project period and assist in subsequent close out activities. The current project period is scheduled to end August 30, 2012.
- Subject Matter Expert Support: Maintain the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP). The ACCLPP advises and guides the Secretary and Assistant Secretary of the U.S. Department of Health and Human Services and the Director of the Centers for Disease Control and Prevention regarding new scientific knowledge and technical developments and their practical implications for childhood lead poisoning prevention efforts.

Item

Working Capital Fund - The conferees have included bill language that allows CDC to begin creating a Working Capital Fund (WCF) to achieve greater cost efficiencies across the administrative operations of the agency. The conferees expect this WCF to begin making disbursements no sooner than fiscal year 2014. CDC shall notify the House and Senate Committees on Appropriations prior to any funds being transferred to or deposited in the WCF.

The conferees direct CDC to create a strong auditing system for the WCF, which shall include annual auditing of the calculation by which programs are charged to ensure that WCF funds are used solely for administrative costs and that CDC Centers and Offices are not over-charged for services. The conferees instruct that the structure of the WCF shall assume no more than a 2 year availability of any funds within it, that no construction of facilities shall be allowable costs, and that all allowable costs are clearly defined. The conferees further direct that the governance system be designed to include a role for all Center Directors in overseeing the costs incurred. The Committees on Appropriations expect quarterly briefings on the progress being made in drafting the charter and the methodology being used to set up the WCF. (Page 28)

Action taken or to be taken

CDC appreciates the Committee's support for a working capital fund and will move forward with plans to develop and test a methodology and structure to support the transition of the Business Services and Support line to the WCF structure that will be implemented no sooner than FY 2014. CDC plans to put in place a governance structure that will be overseen by a board with representation from each center, institute, and office (CIO), as well as the Chief Operating Officer, Chief Financial Officer and Chief Information Officer. The board will convene prior to the WCF launch to ensure CIO involvement and input in critical design decisions. In particular, the governance board will provide input and leadership regarding fund operations, BSO budgets, billing methodologies and rates to recovery costs. In addition, the governance board will ensure accountability, cost controls, and a focus on administrative costs. All costs will be clearly defined and will not include construction of facilities. CDC is committed to ensuring that CIOs are not over-charged and is working to create a strong internal controls structure and cost tracking system. CDC will keep the Committee informed of its plans for a working capital fund through quarterly briefings.