DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2012

Centers for Disease Control and Prevention

Justification of Estimates for Appropriation Committees

INTRODUCTION

The FY 2012 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS FY 2010 Summary of Performance and Financial Information. These documents are available at http://www.hhs.gov/asrt/ob/docbudget/index.html.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain performance summaries and performance strategic plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

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) 2012.

Public health is credited with extraordinary accomplishments, including extending life expectancy in the United States by 25 years. For more than 60 years, CDC has been the leading public health agency in the United States and the world. CDC is dedicated to protecting health and promoting quality of life through the prevention and control of disease, injury and disability. We are committed to reducing the health and economic burden of the leading causes of death and disability, and ensuring a productive, healthy life for all people.

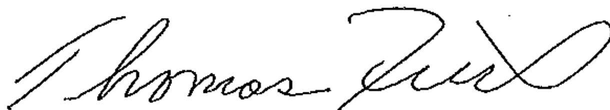
CDC priorities are grounded in scientific excellence and require well-trained public health practitioners and leaders dedicated to high standards of quality and ethical practice. The following agency-wide strategic priorities underscore the work of CDC:

- excellence in surveillance, epidemiology, laboratory services
- strengthen support for state, tribal, local, and territorial public health
- increase global health impact
- use scientific and program expertise to advance policies that promote health
- better prevent illness, injury, disability, and death

In building on our accomplishments and prioritizing our investments, the FY 2012 budget request reinforces CDC's position as our nation's health-protection leader and conveys our vision for continuing this life-saving and life-enhancing work in the future. Maintaining the agency's investments into FY 2012 for critical programs will allow CDC to advance our core public health mission while providing the leadership and investment needed to improve Americans' health.

I'm confident in our ability to preserve and protect the health and lives of Americans, and to further strengthen CDC's capacity to carry out our mission.

Sincerely,



Thomas R. Frieden, MD MPH
Director, Centers for Disease Control
and Prevention /Administrator,
Agency for Toxic Substances and
Disease Registry

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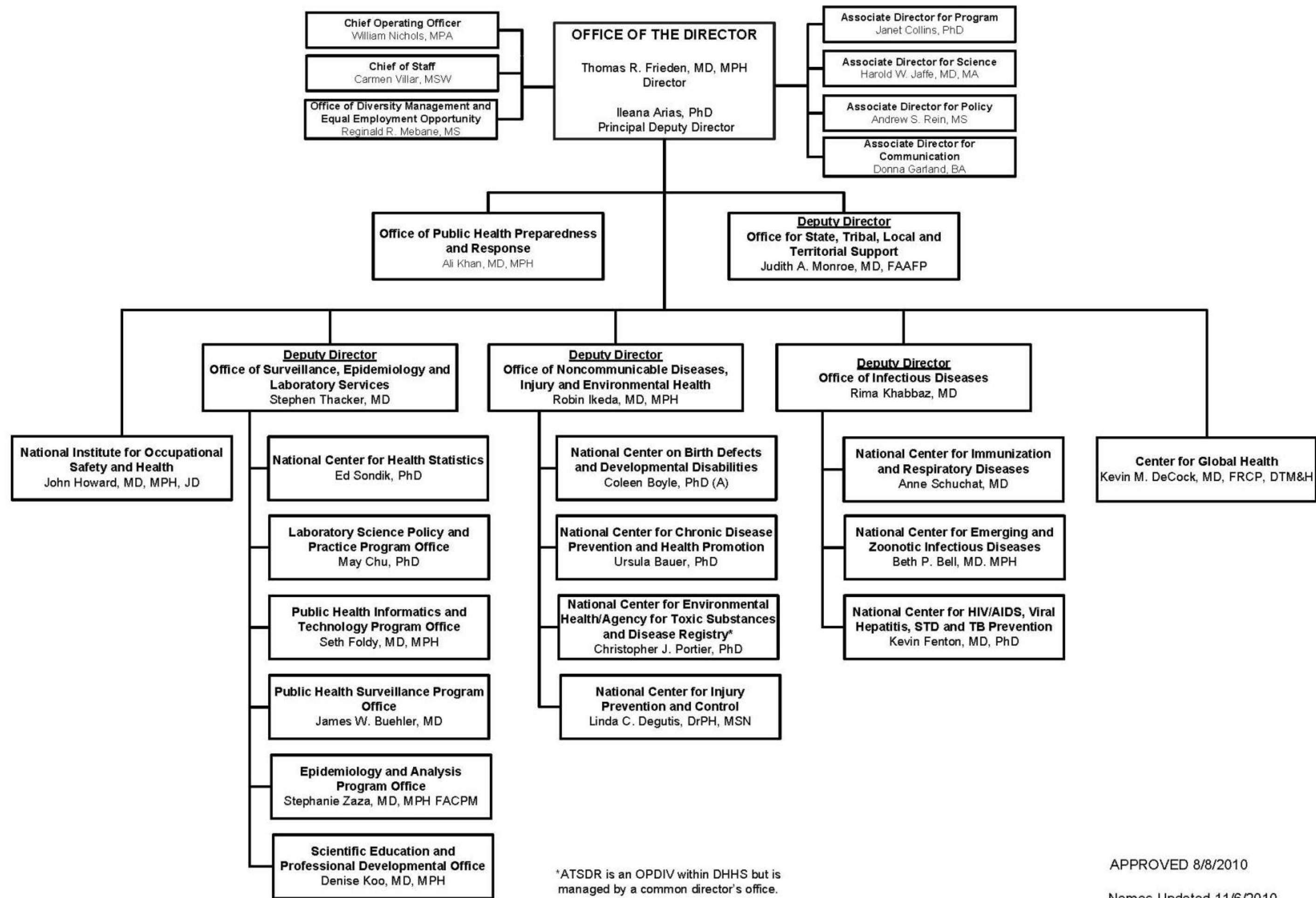

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EXECUTIVE SUMMARY

INTRODUCTION AND MISSION

Founded in 1946, the Centers for Disease Control and Prevention (CDC) is an operating division of the Department of Health and Human Services (HHS). As the leading public health agency in the United States and abroad, CDC carries out its mission by working with partners throughout the nation and the world to –

- monitor health,
- detect and investigate health problems,
- conduct research to enhance prevention,
- develop sound 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 are the foundation of CDC's mission, and each CDC program draws on them to conduct specific public health activities across a variety of disciplines. CDC relies on the technical expertise and scientific excellence of its highly trained public health practitioners and leaders to carry out its critical mission.

CDC collaborates with a diverse set of local, state, and international partners to prevent, monitor, investigate, and resolve the wide range of complex health issues facing the United States and global communities. CDC seeks to provide essential health information directly to partners and citizens when, where, and how they need it most. CDC is committed to programs that reduce the health and economic consequences of the leading causes of death and disability, thereby ensuring a long, productive, healthy life for all people.

BUDGET OVERVIEW

The fiscal year (FY) 2012 President's budget requests includes a total funding level of $11,255,301,000 in discretionary and mandatory budget authority, Public Health Service Evaluation funds, transfers from the P.L. 111-32 the Supplemental Appropriations Act of 2009, and the Affordable Care Act (ACA) for CDC and ATSDR, an overall increase of $370,899,000 above the FY 2010 enacted level. The budget structure presented in this request is consistent with CDC's organizational improvement effort, and new organizational design. FY 2010 and FY 2011 funding levels have been made comparable to the new budget structure. The request includes a $100,000,000 in targeted administrative savings from FY 2010; these savings are included across the budget request.

This FY 2012 budget request allows CDC to accomplish its mission by working with partners through the nation and the world to protect health and promote quality of life through the prevention and control of disease, injury and disability. CDC is committed to reducing the health and economic burden of the leading causes of death and disability, and ensuring a productive, healthy life for all people. This budget request also provides sufficient funding for CDC to continue to conduct research to enhance prevention, develop and promote sound public health policies, prevention strategies, and healthy behaviors.

INCREASED PROGRAM INVESTMENTS

Increases in this section represent the net increase for CDC, which includes budget authority and Public Health Service Evaluation funds, as well as resources from the ACA Prevention and Public Health Fund, and Transfers from P.L. 111-32.

Affordable Care Act in Prevention and Public Health Funds (+$560.700 million)

The FY 2012 budget request includes an increase of $560.700 million for CDC from the Affordable Care Act Prevention and Public Health Fund. Of the $1.000 billion available in the Fund, HHS has allocated a total of $752.000 million for CDC. These activities invest in prevention and public health programs to improve health and to help restrain the rate of growth in public and private sector health care costs. More information regarding this allocation can be found in the following section of the Overview.

Vaccines for Children – Mandatory Funding (+$270.358 million)

The FY 2012 budget request includes an increase of $270.358 million above the FY 2010 level, and an increase of $125.352 million above the FY 2011 estimate for the Vaccines for Children Program. The FY 2012 estimate includes an increase over the FY 2011 estimate 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 the necessary program support to reach uninsured and underinsured populations. A comprehensive immunization program also requires a strong foundation of science—from establishing and implementing vaccine policy to monitoring the effectiveness, impact, coverage, and safety of routinely-recommended vaccines.

Strategic National Stockpile (+$59.339 million)

The FY 2012 budget request includes an increase of $59.339 million for the Strategic National Stockpile, which includes $30.000 million of unobligated balances from the FY 2009 pandemic influenza supplemental. These funds will be used to replace expiring medical countermeasures in high priority public health preparedness categories, as well as provide funds for storage and management of products included in the Strategic National Stockpile. The SNS is a national repository of life-saving pharmaceuticals, medical supplies, Federal Medical Station units, and equipment available and managed for rapid delivery in the event of a catastrophic health event.

Domestic HIV/AIDS (+$58.305 million)

The FY 2012 budget request includes an increase of $58.305 million to the Domestic HIV/AIDS budget for activities consistent with the National HIV/AIDS Strategy. CDC, as the nation's lead HIV/AIDS prevention agency, will remain at the forefront of preventing new infections by providing leadership and guidance to other agencies, other levels of government, and community stakeholders to demonstrate how to incorporate the best evidence and ensure national investments in HIV/AIDS prevention activities are used most effectively. Within the Domestic HIV/AIDS budget, there is an increase of $10.000 million for the Enhanced Comprehensive HIV/AIDS Prevention program for metropolitan areas most affected by the HIV epidemic. In FY 2012, CDC will redirect $51.000 million to higher impact activities aligned with interventions outlined in the National HIV/AIDS Strategy and revise the funding formula for the flagship health department cooperative agreement.

Business Services Support (+$50.759 million)

The FY 2012 budget request includes an increase of $50.759 million for Business Services Support. Funds from the FY 2012 budget request are critical to CDC's ability to accomplish its mission and maintain significant business services to support program operations. Increased funding will be used to replace expiring leases for non-CDC owned buildings, as well as cover increases in rates for leased properties. Funds will also support increased costs for operation and maintenance contracts to maintain the current level of service for a full twelve months.

Polio Eradication (+$10.656 million)

The FY 2012 budget request includes an increase of $10.656 million to support the United States Government's endorsed plan to eradicate polio endemic countries by the end of FY 2012. CDC's global immunization activities primarily focus on children under five years of age in developing countries who are at the greatest risk for mortality and morbidity from polio, measles, and other vaccine-preventable diseases.

Viral Hepatitis (+5.222 million)

The FY 2012 budget request includes an increase of $5.222 million for viral hepatitis. Funds will expand and strengthen surveillance capacity, develop and execute viral hepatitis awareness and training programs for public health, clinical care professionals to implement and scale-up viral hepatitis screening and care referral.

Quarantine Migration (+1.000 million)

The FY 2012 budget request includes an increase of $1.000 million to remain available until expended for quarantine related medical and transportation costs. Payment for isolation and quarantine of travelers can occur across fiscal years, CDC will have the ability to pay the necessary expenses for any persons quarantined by the Federal Government under Title III of the Public Health Service Act.

PROGRAM REDUCTIONS AND ELIMINATIONS

Reductions and eliminations in this section represent the net decrease for CDC, which includes budget authority and Public Health Service Evaluation funds, as well as resources from the ACA Prevention and Public Health Fund.

Preventive Health and Health Services Block Grant (-$100.255 million)

The FY 2012 budget request reflects an elimination of the Preventive Health and Health Services Block Grant program. Through CDC's existing and expanding activities there is substantial funding to State Health Departments. These activities may be more effectively and efficiently implemented through the new Chronic Disease Prevention and Health Promotion Grant Program and ACA Prevention and Public

Health 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.

Public Health Emergency Preparedness Grant Program (-$71.579 million)

The FY 2012 budget request reflects a reduction of $71.579 million to Public Health Emergency Preparedness (PHEP) Program. The PHEP program will provide nearly $9 billion in funding from 2001-2012. Great progress in preparing for public health emergencies has been made with the Federal investment at the State and local level. As localities take on a greater role in preparedness, less support from the Federal government should be required. These grants support local public health preparedness efforts, and are coordinated with the Hospital Preparedness grants administered by the Assistant Secretary for Preparedness and Response.

World Trade Center (-$70.712 million)

The FY 2012 budget request reflects an elimination of discretionary funding for World Trade Center activities ($70.712 million). In FY 2012, $313.000 million in mandatory funding will be provided to the Department of Health and Human Services Office of the Secretary for the World Trade Center Health Program as result of the passage of the James Zadroga 9/11 Health and Compensation Act of 2010.

Racial and Ethnic Approach to Community Health (-$39.274 million)

The FY 2012 budget request reflects an elimination of the Racial and Ethnic Approach to Community Health program ($39.274 million). The goal and activities of this program will be integrated into the new Community Transformation Grants, as part of the ACA Prevention and Public Health Fund.

Academic Centers for Public Health Preparedness and Advanced Practice Centers (-$35.270 million)

The FY 2012 budget request reflects a reduction of $35.270 million for the elimination of the Academic Centers for Public Health Preparedness and Advanced Practice Centers. These programs have not demonstrated a large return on investment or significant impact improving public health.

Healthy Homes/Childhood Lead Poisoning Prevention/Asthma (-$33.045 million)

The FY 2012 budget request reflects a reduction of $33.045 million for the Asthma, Lead, and Healthy Homes programs. In FY 2012, CDC proposes to consolidate remaining funds into one new comprehensive program. CDC is transitioning to a healthy homes approach that recognizes and mitigates not only lead and asthma but also an expanded range of home based hazards such as the absence of radon, smoke, and the presence of asthma triggers.

Education and Research Centers (-$24.370 million)

The FY 2012 budget request reflects a reduction of $24.370 million, for the elimination of the Education and Research Centers (ERCs). The ERCs were created in the mid-1970s to provide seed money for academic institutions to develop or expand occupational health and safety training programs for specialists currently practicing in the field. CDC has met the intended goals of this program to provide occupational health and safety training programs.

National Occupation Research Agenda (-$23.000 million)

The FY 2012 budget request reflects a reduction of $23.000 million, eliminating the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupation Research Agenda (NORA). Research from the AgFF sector of NORA has not developed relevant and effective results to impact the safety and health of workers in the agricultural, forestry and fishing industries and these activities overlap with wither Federal efforts.

Healthy Communities (-$22.609 million)

The FY 2012 budget request reflects a reduction of $22.609 million for the elimination of the Healthy Communities program. The goal and activities of this program will be addressed through the new Community Transformation Grants, as part of the ACA Prevention and Public Health Fund.

Genomics (-$11.558 million)

The FY 2012 budget request reflects a reduction of $11.558 million to the Genomics budget, maintaining an investment of $0.749 million for a program office to provide expertise on issues as they arise. CDC genomic activities overlap with other Federal agencies and CDC will focus the staff on the implementation of proven applications of genomics to areas of public health importance.

Prion Disease (-$5.473 million)

The FY 2012 budget request reflects an elimination of the Prion Disease budget ($5.473 million). This program takes a disease-specific approach rather than a broad public health approach to infectious and zoonotic diseases. In addition, CDC is not able to demonstrate significant impact on public health within this program.

Built Environment (-$2.683 million)

The FY 2012 budget request reflects an elimination of Built Environment activities ($2.683 million). CDC will aim to integrate these activities into the Community Transformation Grants, supported by the ACA Prevention and Public Health Fund to have a more integrated approach.

Climate Change (-$0.972 million)

The FY 2012 budget request reflects a reduction of $0.972 million to the climate change budget. CDC has identified a programmatic cost savings resulting in the need for less funding in FY 2012.

KEY PROGRAMMATIC CHANGES

Chronic Disease Prevention and Health Promotion

The FY 2012 budget requests of $705.378 million, including $157.740 million from the ACA Prevention and Public Health Fund, for the new Chronic Disease Prevention and Health Promotion Grant Program, is $72.383 million above the FY 2010 level. The Chronic Disease Prevention and Health Promotion Grant Program (CCDPP) will improve coordination and health outcomes and reduce the national burden of chronic disease by integrating the Heart Disease and Stroke, Diabetes, Cancer, Arthritis and other Conditions, Nutrition, Health Promotion, Prevention Centers, and non-HIV/AIDS DASH activities into one competitive program. The program will consist of five main components: 1) Competitive grant awards to all State health departments, Territories and some Tribes to establish or strengthen leadership, expertise, and coordination of overarching chronic disease prevention programming, surveillance, epidemiology and evaluation, policy, and communication; 2) Competitive grant awards to State health departments, Territories and some Tribes to establish core activities addressing: policy and environmental approaches to improve nutrition and physical activity in schools, worksites and communities; interventions to improve delivery and use of selected clinical preventive services; and community programs to support chronic disease self management to improve quality of life for people with chronic disease and to prevent diabetes, heart disease and cancer among those at high risk; 3) Competitive Performance Incentive awards to state and territorial health departments, based on performance, to implement or expand effective programs addressing the leading chronic disease causes of death and disability; 4) Support for academic institutions and national organizations; and 5) CDC program leadership and subject matter expertise.

CDC, working with states, may continue some existing programs as currently structured, expand others, redirect resources to more effective activities, change the scope of existing activities based on effectiveness and need, and if appropriate, use existing program resources to start new activities or end existing programs. Through CCDPP, all grantees are expected to achieve population level change in the specified outcomes and to identify populations disproportionately affected by the condition being addressed and to implement strategies to narrow gaps in health status between these special populations and the population as a whole. Grantees will also address evaluation and delivery of evidence-based interventions in their annual plan to CDC. Within the total program level, up to 20 percent is dedicated for CDC technical assistance, evaluation, oversight, and management activities.

Birth Defects and Developmental Disabilities

The FY 2012 budget request of $143.899 million for Birth Defects and Development Disabilities is $273,000 below the FY 2010 level. The FY 2012 request consolidates disease specific funding into three new budget lines: Child Health and Development, Health and Development for People with Disabilities, and Public Health Approach to Blood Disorders. These budget lines represent new comprehensive programs that refocus activities to integrated and competitive grant programs that facilitate more effective approaches. This approach gives CDC greater flexibility to address critical public health challenges and allocate resources to maximize the public health impact. CDC, working with external stakeholders, may continue some existing programs as currently structured, expand others, redirect resources to more effective activities, change the scope of existing activities based on effectiveness and need, and if appropriate, use existing program resources to start new activities or end existing programs.

Healthy Home and Community Environments

The FY 2012 budget request of $32.674 million for the Healthy Home and Community Environments program is $33.045 million the FY 2010 level. Within the request is a consolidation of two specific budget lines (asthma and childhood lead poisoning/healthy homes) into 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. This approach will aim to mitigate health hazards in homes such as lead poisoning hazards, second-hand smoke, asthma triggers, radon, mold, safe drinking water, and the absence of smoke and carbon monoxide detectors.

AFFORDABLE CARE ACT: PREVENTION AND PUBLIC HEALTH FUND

The FY 2012 budget request includes an increase of $560,700,000 from the Prevention and Public Health Fund, Affordable Care Act (ACA). Of the $1,000,000,000 available in the Prevention and Public Health Fund, HHS has allocated a total of $752,000,000 for CDC. These activities are described in the three sections below:

Promote Information for Action – $45,000,000

Build Essential Public Health Detection and Response – $134,200,000

Prevent the Leading Causes of Death – $573,300,000

Information for action

Summary of Activities

HHS is proposing to allocate to CDC $45,000,000 from the Prevention and Public Health Fund (PPHF) in FY 2012 to support select investments that will aid in the description of the health, wellness, and disease of populations. The objectives of the proposal are to: 1) advance state and community epidemiology, surveillance, and policy environments, 2) develop public health clinical decision support tools for infectious and non-communicable diseases, 3) track a wide range of measures of health status, health risk factors, insurance coverage, access to care, unmet needs and use of services for critical subgroups, 4) provide information about the organizations and providers that supply health care, the services rendered, and the patients they service across diverse clinical and community settings, and 5) accelerate the adoption and implementation of evidence-based recommendations at the state and local levels. These activities meet the purpose of the Prevention and Public Health Fund by using funds to invest in prevention and public health programs to improve health and to help restrain the rate of growth in public and private sector health care costs.

Community Guide/Community Preventive Task Force and Prevention Effectiveness Research: Within CDC's PPHF allocation, $10,000,000 in FY 2012 will support the reauthorization of the Community Guide/Community Preventive Task Force, to accelerate the movement of research to practice, and to disseminate evidence-based, proven interventions for wellness and prevention, which is $5,000,000 above the FY 2010 level from the PPHF. This activity will implement section 4003 of the ACA. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Healthcare Statistics/Surveillance: Within CDC's allocation, $35,000,000 in FY 2012 will support the agency's health care surveillance activities, which is $15,142,000 above the FY 2010 level from the PPHF. This request includes increases above the FY 2012 base request to the National Health Interview Survey, selected surveys of providers, and the Behavioral Risk Factor Surveillance System (BRFSS). Funding in FY 2012 will be used to track the impact of the ACA on access to and utilization of health care resources and to evaluate the impact of ACA on prevalence estimates for diseases, health conditions, and risk behaviors for the leading causes of death and disability. The BRFSS is uniquely structured to facilitate the timely collection, processing, reporting, and dissemination of data critical for decision making at the state level and is an optimal resource for monitoring the impact of health care reform legislation. The flexibility of BRFSS provides an advantage by filling a critical need for timely, relevant, and reliable surveillance data to programs that would otherwise wait years to receive. The requested funds would cover the cost to: 1) add approximately six questions to the BRFSS yearly cycle to address components of the ACA as they are implemented, 2) apply small area estimation to produce estimates for all US counties, and 3) increase population coverage of the BRFSS by expanding multimode protocol implementation to reach populations currently underrepresented in the landline BRFSS and to produce estimates at state level. The new data in combination with the other information routinely collected by

the survey will help establish a timely baseline for the initial ACA provisions and assist in evaluating the effects on a yearly basis. FY 2012 funds will be used to develop, program, and implement this data collection in calendar year 2013.

Build Essential Public Health Detection and Response

Summary of Activities

HHS is proposing to allocate to CDC $134,200,000 from the Prevention and Public Health Fund (PPHF) to support select investments to strengthen federal, state, tribal, local, and territorial public health infrastructure. The objectives of the request are to: 1) support improvements in the quality, effectiveness and efficiency of the public health infrastructure that supports the delivery of public health services and programs, 2) advance state and community epidemiology, surveillance, laboratory, policy and management environments to strengthen prevention and control of infectious and non-communicable diseases and injuries, including congenital heart defects, and 3) strengthen the state and federal public health workforce. These activities meet the purpose of the ACA by investing in prevention and public health programs to improve health and help restrain the rate of growth in public and private sector health care costs. Specifically, this initiative builds on CDC's extensive experience and demonstrated impact of investing in the public health sciences of medical epidemiology, laboratory services, health education, evaluation, public health surveillance, workforce development, and public health practice.

Public Health Infrastructure: Within CDC's allocation, $40,200,000 in FY 2012 will support public health infrastructure, which is $9,800,000 below the FY 2010 level from the PPHF. The activity will have a focus on enhancing state, tribal, and local by investing in technology modernaization and performance management to do more with less. This activity will support section 5314, "Fellowship training in public health" of the ACA, and 301 and 317 of the Public Health Service Act (PHS Act), 42 USC, 241 and 247b. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Public Health Workforce: Within CDC's allocation, $25,000,000 in FY 2012 will support public health workforce initiatives, which is $17,500,000 above the FY 2010 level from the PPHF. This investment in the public health workforce aims to increase the number and types of competency trained public health professionals in the field. This activity will support section 5314, "Fellowship training in public health" of the ACA. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts. Funding is also included to support fellows' salaries, and associated costs.

Epidemiology and Laboratory Capacity: Within CDC's allocation, $40,000,000 in FY 2012 will support epidemiology and laboratory capacity activities, which is $20,000,000 above the FY 2010 level from the PPHF. The ELC program aims to increase the capacity of health departments to improve and evaluate the effectiveness of their organizations, practices, partnerships, programs and use of resources and the impact those system improvements have on the public's health. This activity will support section 4304, "Epidemiology and Laboratory capacity grants" of the ACA, and includes the Emerging Infections Program. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Healthcare-Associated Infections**:** Within CDC's allocation, $20,000,000 in FY 2012 will support the prevention and monitoring of healthcare-associated infections (HAI) across the health care system. By building on the success of the HAI American Recovery and Reinvestment Act funding in preventing HAIs through the leadership and coordination of state health departments, these funds will be used to aggressively expand HAI prevention and data collection activities in all healthcare settings, investing in sustainable local HAI prevention programs that collaborate with other healthcare partners such as CMS quality improvement organizations, hospital associations, and consumer groups. This activity will support the Value Based Purchasing program of the Affordable Care Act (section 3001). Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Environmental Public Health Tracking Network: Within CDC's allocation, $9,000,000 in FY 2012 will fund states and cities to build local tracking networks to develop and expand CDC's National Environmental Health Tracking Network. The national and state tracking networks provide information about health effects, environmental hazards, exposures, and data on other factors that help put the relationships between exposures and health effects in context. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Prevent Leading Causes of Death

Summary of Activities

HHS is proposing to allocate to CDC $573.299 million in FY 2012 from the PPHF to support Community Transformation Grants (CTG) and other activities to address the Leading Causes of Death (LCD): heart disease, stroke, cancer, chronic lower respiratory disease and unintentional injury and the Leading Causes of Years of Potential Life Lost (LCYPLL): unintentional injury, cancer, and heart disease. These activities use PPHF for its intended purpose by investing in prevention and public health programs to improve health and to help restrain the rate of growth in public and private sector health care costs. Chronic diseases and injuries are responsible for the majority of morbidity, disability and premature death and constitute a large part of the unsustainable growth in health care costs. By reducing the poor health behaviors that lead to chronic diseases and injuries through the new CTGs, specifically the LCD, and increasing delivery and use of clinical preventive services, this initiative will reduce the burden of chronic diseases, injuries and their associated health care costs.

Community Transformation Grants: Within CDC's allocation, $221.060 million in FY 2012 will support CTG with a focus on advancing state, territorial, local, and tribal policies and systems to reduce the Leading Causes of Death (LCD) and health disparities. This program implements section 4201, "Community Transformation Grants" of the ACA. The CTGs will also incorporate best practices and lessons learned from the Healthy Communities and REACH programs. FY 2012 activities include:

- Fund, through competition, state or local governmental agencies, territories, national networks of community based organizations; state or local non-profit organizations and Indian tribes or tribal organizations to implement policy, environmental, programmatic and infrastructure changes to promote healthy living and reduce health disparities.
- Provide sustained investments to reduce tobacco use, increase physical activity, increase healthy nutrition (such as consumption of fruits and vegetables, increases in low-fat milk consumption, and reductions in salt consumption) and reduce the severity and impact of chronic diseases among adults and youth.
- Fund national organizations to provide training and technical assistance to mobilize funded and non-funded communities and assist them to effectively plan, develop, implement and evaluate community-based interventions to reduce the risk factors that influence the burden of chronic disease in communities.

Tobacco Use Prevention and Control: Within CDC's allocation, $79.000 million will support the Tobacco Media campaign, and support state quit lines, which is $64.500 million above the FY 2010 level from the PPHF. This activity will not implement any specific section of the ACA. This activity is authorized under 301 (a), and 317 (k) (2) of the Public Health Service Act, [42 U.S.C. section 241 (a) and 247b (k) (2), as amended], and the Comprehensive Smoking Education Act of 1984, Comprehensive Smokeless Tobacco Health Education Act of 1986, and the American Recovery and Reinvestment Act of 2009 (Recovery Act) [Public Law 111.5]. Extramural funds will be allocated to continue and expand the Tobacco Media Campaign to develop and implement a campaign to support state and local efforts

intended to increase cessation and reduce initiation. The effort will place existing effective ads in states and communities that are implementing successful program initiatives. Funds will also supplement existing cooperative agreements to support states in expanding quit lines. States will implement plans to reduce tobacco use through legislative, regulatory, and educational arenas, as well as enhance and expand the national network of tobacco cessation quit lines to significantly increase the number of tobacco users who quit.

Other Chronic Disease Activities: Within CDC's allocation, $161.240 million will support chronic disease activities including the new Chronic Disease Prevention and Health Promotion Grant Program ($157.74 million), dissemination and evaluation of the National Prevention and Health Promotion Strategy ($1 million), and support for Baby Friendly USA ($2.5 million) which is $116.840 million above the FY 2010 allocation. The allocation for the National Prevention and Health Promotion Strategy is $0.858 million above FY 2010, and is authorized under section 4001 of the ACA. The remaining activities will not implement any specific provision of the ACA, they are authorized under 301(a) and 317(k)(2) of the Public Health Service Act (PHS Act), 42 USC, 241 and 247b. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Unintentional Injury Prevention: Within CDC's allocation, $20.000 million in FY 2012 will support State and Tribal implementation of unintentional injury prevention programs, partner engagement, evaluation of promising interventions and ensuring proper monitoring and surveillance of unintentional injuries. CDC has not previously received or requested funds from the PPHF for this activity. This activity will not implement any specific section of the ACA. This activity is authorized under 301(a) and 317(k)(2) of the Public Health Service Act (PHS Act), 42 USC, 241 and 247b. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

Section 317 Immunization: Within CDC's allocation, $61.599 million will support 317 immunization activities. These funds will be used to prepare the immunization program for the full implementation of the ACA health insurance reforms by strengthening immunization systems and capabilities, including billing for immunization services, assuring vaccine delivery, and improving the information technology infrastructure of immunization programs. Extramural funds will be distributed through cooperative agreements and grants, as well as contracts.

Domestic HIV/AIDS Activities: Within CDC's allocation, $30.400 million will support domestic HIV/AIDS activities consistent with the FY 2010 spend plan and the National HIV/AIDS Strategy. Important changes have occurred in the field of HIV prevention in the last year creating exciting, new opportunities to lower the number of new HIV infections that occur each year in the United States. CDC has proposed several specific projects to leverage these new opportunities including provision of additional funds for the Expanded and Comprehensive Prevention Planning program, demonstration projects to support the use of CD4 and viral load data by prevention programs, new demonstration programs to evaluate innovative models for incorporating new biomedical advances and prevention with positives, HIV prevention with tribal organizations and training to support realigned efforts. Extramural funds will be distributed through competitive cooperative agreements and grants, as well as contracts.

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (RECOVERY ACT)

The summary below reflects an investment of $1,000,000,000 from the American Recovery and Reinvestment Act Prevention and Public Health Fund for core prevention activities across the Department of Health and Human Services.

The Act appropriated $50,000,000 to the Department of Health and Human Services (HHS) to provide funding for states to carry out activities related to the implementation of Healthcare-Associated Infections (HAI) reduction strategies by: (1) creating or expanding state-based HAI prevention collaboratives; (2) enhancing states' abilities to assess where HAIs are occurring and evaluate the impact of hospital-based interventions in other health care settings; and (3) supporting targeted efforts to monitor and investigate the changing epidemiology of HAIs in populations as a result of prevention collaboratives.

CDC was appropriated $300,000,000 in the American Recovery and Reinvestment Act for the Section 317 Immunization program. Immunization is one of the most important public health tools for preventing death and disability from vaccine-preventable diseases. In the U.S., immunization recommendations target seventeen vaccine-preventable diseases across the lifespan. Despite this achievement, some vaccine-preventable diseases continue to place significant burden on the public's health. Section 317 currently funds sixty-four immunization programs, including all fifty states, the District of Columbia, five urban areas, the U.S. territories, and selected Pacific Island nations. Activities will focus on four focus areas: (1) reaching more children and adults to expand the number of people vaccinated and thus protected from vaccine preventable disease in the U.S.; (2) conducting innovative initiatives for improving reimbursement, and enhancing the interoperability of electronic immunization data exchange between Electronic Health Record systems and immunization registries to develop specifications to harmonize clinical decision support algorithms; (3) increasing national public awareness and knowledge about the benefits and risks of vaccines and vaccine-preventable diseases; and (4) strengthening the evidence base for current vaccine policies and programs, with a focus on recently recommended vaccines.

The American Recovery and Reinvestment Act Prevention and Public Health Fund includes $650,000,000 for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes. In the U.S. today, chronic diseases such as obesity, diabetes, and cardiovascular disease are the cause of seven out of ten deaths and the vast majority of serious illness, disability, and health care costs. Key risk factors, such as lack of physical activity, poor nutrition, and tobacco use, are major contributors to the nation's leading causes of death. In FY2010, CDC launched the Communities Putting Prevention to Work (CPPW) initiative to improve access to nutrition, increase physical activity, decrease obesity prevalence and reduce the consumption and initiation of tobacco use and exposure to secondhand smoke through policy and environmental changes at the state and local levels. CPPW will expand the use of evidence-based strategies and programs, mobilize local resources at the community-level, and strengthen the capacity of states.

SUMMARY OF THE RECOVERY ACT OBLIGATIONS AND PERFORMANCE

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
Recovery Act Obligations
(dollars in thousands)

Implementation Plan	Total Resources Available	FY 2009/FY 2010 Outlays	FY 2011 Outlays	FY 2012 Outlays
Section 317 Immunization	$300,000	$201,800	$97,800	$0
Health Care Associated Infections (HAI)[1]	$50,000	$10,100	$29,900	$10,000
Communities Putting Prevention to Work (CPPW)	$650,000	$32,000	$355,000	$187,000
Total Discretionary Obligations -	***$1,000,000***	***$243,900***	***$460,700***	***$219,000***

[1] Of the $50,000,000, $10,000,000 was allocated to the Centers for Medicare and Medicaid Services.
[2] Funds will be available for activities supported into FY 2011. In particular, the CPPW funds will support communities through FY 2012.

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
Recovery Act Performance

Performance Measure*	FY 2009 Result	FY 2010 Result	FY 2011 Target/Date	FY 2012 Target/Date
Section 317 Immunization				
Recovery Act-funded vaccine doses providers will administer to children (0-18 years)	37%	100%	100%/Sept 30, 2011	100%/March 31, 2012
Recovery Act-funded vaccine doses providers will administer to adults (19 years and older)	45%	100%	100%/Sept 30, 2011	100%/March 31, 2012

* Implementation Data Source: Data extracted by CDC staff from the Vaccine Central Distribution Data Warehouse

Narrative

- All projected vaccine doses have been delivered to end user providers or pre-booked for influenza, meeting performance goals.
- The program has strengthened federal, state, and local vaccine programs, efficiently delivered vaccines to the providers of the intended populations, and enabled programs to reach a larger population.
- The successful distribution of the vaccine doses program has expanded access to vaccines and vaccination services at the federal, state, and local levels by making more vaccines available. The program has expanded access to vaccinations by: making recommended vaccines available in all states through the existing network of private and public immunization providers and supporting and expanding the network of providers. In

addition, the program expanded access to the childhood vaccine series and influenza vaccines through innovative vaccine delivery strategies.

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION Recovery Act Performance				
Performance Measure*	**FY 2009 Result**	**FY 2010 Result**	**FY 2011 Target/Date**	**FY 2011 Target**
Health Care Associated Infections				
% of all hospitals participating in National Health Care Safety Network, among states funded for Detection and Reporting of Healthcare Associated Infection Data	42.7%	55%	60%/Sept 30, 2011	60%/March 31, 2012

* Implementation Data Source: Reported by State Health Departments to NHSN

Narrative

- The states funded for Detection and Reporting of HAI data are able to establish the appropriate framework to participate in NHSN. As a result, the HAI program is continually trending above the targeted measure as recipients implement programs and achieve project milestones.
- In December of 2010, Alabama became the 22nd state to mandate public reporting through NHSN. As a result of the NSHN mandates, states are recognizing an increase in NHSN participation and utilizing the data to inform prevention efforts and standards for HAI control.
- The program continues to enhance the NHSN program to encourage participation. For example, health care facilities can choose to join NHSN groups and confidentially report data. Currently, the program is working to develop a data use agreement between CDC and state health departments.

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION Recovery Act Performance				
Performance Measure*	**FY 2009 Result**	**FY 2010 Result**	**FY 2011 Target/Date**	**FY 2012 Target/Date**
Communities Putting Prevention to Work				
Tobacco - Increase to 85% the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new smoke-free policies and improved the comprehensiveness of existing policies. [1]	N/A	9%	75% / Sept 30, 2011	85% March 31, 2012
Obesity (Nutrition): Increase to 85% the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new policies or improved the comprehensiveness of existing policies to limit the availablity of unhealthy food or drink and/or increase the availablity of healthy food or drink.	N/A	7%	75%/Sept 30, 2011	85%/March 31, 2012
Obesity (Physical Activity): Increase to 85% the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new policies or improved the comprehensiveness of existing policies to increase access to physical education in schools or physical activity in afterschool or daycare settings.	N/A	5%	75%/Sept 30, 2011	85%/March 31, 2012

* Implementation Data Source: Reported by recipients to CDC using a standardized instrument, the Recovery Act - adapted CHANGE tool.

Narrative

- Each of the three CPPW performance measures is progressing above targeted levels. The program has established an effective program management structure that includes frequent performance discussions between the program and recipients.
- CPPW projects are making progress on program milestones and goals. States, Counties, and Cities across the nation are making strides to improve access to nutrition, increase physical activity, and increase tobacco cessation. These projects are making impacts through policy and environmental changes and community based programs targeted at common risk factors for tobacco initiation and obesity.

PERFORMANCE OVERVIEW

As the nation's prevention agency and a leader in improving public health across the world, CDC's efforts have saved lives and improved the quality of life for millions of people. CDC also leads efforts to reduce health disparities and lower health care costs. Consistent with its commitment to continuous improvement, the agency embraces the challenge to realize ever greater public health impact.

CDC's vision for a safer, healthier nation is accomplished through five strategic priorities:

1. **Excellence in surveillance, epidemiology and laboratory services** – Quality surveillance data serve as the foundation for program planning and evaluation in public health practice. CDC's data collection, analysis and dissemination serves as a key resource nationally and across the globe in detecting emerging threats, monitoring ongoing health issues and their risk factors, and evaluating the impact of strategies to prevent disease and promote health.
2. **Strengthening support for state, tribal, local, and territorial public health** - Strong state and local systems, the cornerstone of public health practice across the country, are critical to meeting public health needs in a timely, efficient, and effective manner. CDC supports state and local systems through delivery of expert scientific and technical assistance; provision of data collection, analysis and reporting tools and resources; and numerous grants and cooperative agreements to build capacity, conduct surveillance and implement evidenced-based public health interventions.
3. **Increase global health impact –** With international travel, interdependent food systems, and global migration, the health of people across the world increasingly impacts the health and safety of Americans. As the world becomes even more interconnected, CDC plays a key role in US contributions to global health that, in turn, serve to strengthen and protect the health of our nation. Our vision for global health is healthier, safer, and longer lives worldwide through science-based public health action.
4. **Use scientific and program expertise to advance policy change that promotes health** – As we further develop our understanding of effective ways to improve the health of our nation, it has become increasingly clear that the policies we promote and implement nationally as well as at state and local levels have an important impact on risk for poor health outcomes. Policy has the potential to make the broadest impact on the largest portion of the public. Our goal is to promote evidence-based policies that result in demonstrable improvements in population health.
5. **Better prevent the leading causes of death and disability** – Through a focus on the leading causes of premature death, disability, and injury and the health disparities associated with these health outcomes, CDC can substantially impact the health of the nation overall.

The agency's budget reflects these priorities, which support the effective implementation of our scientific and programmatic activities. Essential to these strategic priorities is a commitment to scientific excellence, the highest standards of quality and ethical practice, the elimination of health disparities, and the preparation of skilled public health practitioners and scientists.

Agency Performance Plan Changes

CDC has embarked on an effort to ensure that the measures included in its performance plan are meaningful and useful to program leadership and management, ultimately to drive program improvement and yield greater public health outcomes. The Office of Management and Budget's *Analytical Perspectives* guidance document, released with the FY 2011 President's Budget, was instrumental in spurring a Meaningful Measures GPRA pilot with two programs: 1) Immunization and Respiratory Disease and 2) Tobacco Control and Prevention. These revised performance plans are included in the accompanying Online Performance Appendix (OPA) and illustrate the use of performance measures that meet meaningful measures criteria used for the pilot as well as an updated performance plan structure that places these measures in a broader context of relevant population health trends. Two additional program performance plans (Health Statistics and Birth Defects and Developmental Disabilities) also reflect the new format for the FY 2012 OPA.

In FY 2013, CDC's meaningful measures criteria will be applied to the remainder of the Agency in a phased approach to transform its OPA, such that programs are represented by a limited set of measures reflecting key efforts.

Additionally, internal agency Quarterly Program Reviews have been instituted to monitor progress on a broader set of programmatic activities. The agency's focus on meaningful measures will yield useful data on a more frequent basis to better equip leadership and management to make timely and informed decisions regarding program design and resource allocation.

Alignment to Administration Priorities and Initiatives

CDC has several measures included within the 2010 – 2015 HHS Strategic Plan (*for more detail, please see CDC Linkages to HHS Strategic Plan*). Key areas for CDC include strengthening public health surveillance and epidemiology, enhancing support of the public health infrastructure at the State, Tribal, Local and Territorial levels, and increasing impact in global health. Additionally, CDC supports several of the Secretary's Strategic Initiatives including:

- Transforming health care: coverage, cost, and quality outcomes
- Addressing obesity through childhood nutrition, food labeling, and physical fitness
- Preventing and controlling use of tobacco
- Protecting Americans in public health emergencies
- Enhancing food safety
- Implementing the Global Health Initiative

CDC also leads or collaborates to achieve three of the Department's High Priority Goals (HPG) - Tobacco, Preparedness, and Food Safety. Through its American Recovery and Reinvestment Act (ARRA)-funded *Communities Putting Prevention to Work* program, the National Center for Chronic Disease Prevention and Health Promotion is supporting 21 communities to implement evidence-based interventions to reduce tobacco consumption. The Office for Public Health Preparedness and Response's HPG tracks progress on states' ability to assemble trained responders with decision-making authority within 60 minutes of notification of an event. Lastly, in collaboration with FDA and USDA to reduce

cases of Salmonella Enteritidis (SE), the National Center for Emerging and Zoonotic Diseases provides surveillance of SE infections and coordinates outbreak investigations.

CDC also supports the President's stated goals and priorities to expand Health Information Technology infrastructure and capacity through the Health Information Technology for Economic and Clinical Health Act (HITECH) under ARRA. In collaboration with the Office of the National Coordinator for Health Information Technology (ONC) in the Department of Health and Human Services (HHS), and the Office of Management and Budget (OMB), CDC funds cooperative agreements to ensure meaningful use of health IT for improved public health. These funds support 1) immunization registries for improved interoperability with Electronic Health Records (EHR), including exchange of vaccination records, and 2) development of interoperable laboratory information systems enabling information flows between EHRs, hospital and public health labs, as well as epidemiologic responses in public health departments, for the purpose of surveillance, pandemic preparedness and response, and nationally notifiable case reporting.

In alignment with the First Lady's Let's Move campaign to combat the epidemic of childhood obesity, and the President's Task Force on Childhood Obesity, CDC funds school health programs to improve food and beverage policies, particularly through the removal of junk food and sugar-sweetened beverages, as well as policies that increase physical activity and formal physical education.

In support of the National Prevention, Public Health, and Health Promotion Council (National Prevention Council) chaired by the Surgeon General, CDC has taken an important role in the development of the National Prevention and Health Promotion Strategy. More specifically, we are providing technical and content expertise, participating in stakeholder engagement and coordinating development and review of recommendations and actions. We will continue in this role through 2012 as the Strategy is finalized and the Council moves toward implementation.

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

Agency Accomplishments

Strengthening epidemiology and surveillance and supporting state and local public health:

The new offices of Surveillance, Epidemiology and Laboratory Services (OSELS) and State, Tribal, Local, and Territorial Support (OSTLTS) are designed to better address CDC's strategic priorities and to focus and strengthen the agency's work in these areas. Multiple efforts are underway within these new offices to address critical needs in public health. OSELS is engaging in a series of timely data releases, *CDC Vital Signs,* intended for policy-makers and public health practitioners with the latest information on the leading causes of mortality and their associated risk factors. OSTLTS is expanding the Public Health Apprentice Program, initiated in 2007, which will bolster the public health infrastructure at state and local levels. This includes an increased emphasis on tribal host sites, Native American and Hispanic apprentices. Additional accomplishments include:

- Published three *CDC Vital Signs* reports in the *MMWR Weekly*. The first feature report on the screening of colorectal and breast cancer—two leading causes of death in the United States--was distributed broadly to the general public as a result of widespread media attention, including reports as lead stories on prime time ABC and NBC television news and by the print media through the Associated Press, Reuters, and Wall Street Journal. In FY 2011 and beyond, twelve issues of *CDC Vital Signs* will be released, and the increase from three to twelve issues is anticipated to result in a substantial expansion of media reach between Fiscal Years 2010 and 2011.
- In coordination with HHS, launched the development of the HHS Health Indicators Warehouse, —a single, user-friendly source for national, state, and community health indicators.
- Launched the National Public Health Improvement Initiative, funding 76 state, tribal, local and territorial public health agencies to improve the quality, effectiveness and efficiency of the public health infrastructure through: 1) performance management, 2) policy and law, 3) public health systems and 4) public health workforce development.
- Hosted the inaugural CDC Orientation for New State Health Officials as part of broader CDC efforts to strengthen relationships with state health officials and increase learning, collaboration and knowledge sharing.

- The *CDC Health Disparities and Inequalities Report*, released in January 2011 is the first in a series of periodic, consolidated assessments that highlight health disparities by sex, race and ethnicity, income, education, disability status and other social characteristics in the United States. Released as a special MMWR supplement, the report provides analysis and reporting of the recent trends and ongoing variations in health disparities and inequalities in selected social and health indicators, both of which are important steps in encouraging actions and facilitating accountability to reduce modifiable disparities by using interventions that are effective and scalable. The report addresses disparities in health-care access, exposure to environmental hazards, mortality, morbidity, behavioral risk factors, disability status, and social determinants of selected health problems at the national level.

Increase global health impact:

CDC has established a new Center for Global Health to 1) coordinate and expand agency global health improvement efforts including disease eradication and elimination targets, and 2) expand CDC's global health programs, especially chronic disease and injuries.

- CDC continues its collaborative work with the Department of State and USAID to implement the Global Health Initiative to address HIV/AIDS, TB, and Malaria.
- Through Global Immunization's efforts and its collaboration with the World Health Organization, the goal to reduce measles by 90 percent in 2010 was met four years early for Africa.

Use scientific and program expertise to advance policy change that promotes health:

As CDC gathers the evidence base for public health issues, policy proves to be an effective lever. Programs such as Tobacco Control and Prevention, Nutrition and Physical Activity, and Motor Vehicle Safety are three areas where significant public health impact can be achieved through policy changes. CDC collaborates with partners and provides the research, tools, and technical assistance to educate decision makers. Policy achievements include:

- In 2010, Michigan, Kansas, South Dakota and Wisconsin became the most recent states to implement comprehensive smoke-free laws that prohibit smoking in indoor workplaces and public places, including restaurant and bars. Currently 25 states and the District of Columbia have similar comprehensive laws that protect individuals from the negative health effects of secondhand smoke exposure
- Assisting the US Office of Personnel Management to expand the Federal Employee Health Benefit (FEHB) to provide standardized, comprehensive smoking cessation coverage for all Federal employees beginning January 1, 2011.
- A substantial increase in the percentage of schools that do not sell less nutritious foods and beverages. School Health Profiles data from 47 states (MMWR October 9, 2009 / 58(39);1102-1104) reported large differences among states across a 6-year period. States that have been funded by CDC for coordinated school health accounted for nine of the 10 highest ranked states reporting not selling such food and beverages.
- A 75 percent increase in tribal seatbelt use from 2005-2009.

Addressing the leading causes of death and disability:

Focusing on the leading causes of premature death, disability, and injury and the health disparities associated with these health outcomes, CDC identified six "Winnable Battles" that present a significant opportunity to achieve public health impact through *proven* interventions within four years:

- Tobacco control
- Reducing healthcare-associated infections
- Improving nutrition, physical activity, and food safety
- Preventing motor vehicle injuries;
- Teen pregnancy prevention;
- HIV prevention.

Programmatic achievements in these areas include:

- Identification of 19 new methods for measuring toxic or chemical substances in tobacco products
- Reductions in Healthcare-Associated Infections, including an 18 percent national reduction in Central Line-Associated Bloodstream Infections (CLABSIs)
- Increase in the proportion of those diagnosed with high blood pressure who have it controlled (44 percent, a increase of 12 percent over the 2002 baseline);

- Achieved the HP 2010 goal to reduce E. coli O157:H7 infections by 50 percent;
- Collaboration with staff at the University of North Carolina and in Michigan to strengthen the Graduated Driver License law in Michigan. Governor Granholm is expected to sign a bill that limits novice drivers to one passenger and improves nighttime limits with restriction from 10 p.m. – 5 a.m. (current restriction starts at midnight).
- Collaboration with the President's Teen Pregnancy Initiative and release of a $10 million funding opportunity as part of the innovative models portion of the initiative.
- Expanded HIV Testing Initiative (1.5 million tests; 10,500 new positives); globally, HIV prevented in 100,000 infants; 2.4 million HIV+ on treatment.

While the number of total targets or measures that CDC is responsible for has increased, CDC has continued to increase the percentage of targets that have been met since 2007. For 2010, only 45 percent of targets have results reported and 68 percent of these targets were met. Most of the outstanding 2010 data have not been reported due to data lag. Additionally, in 2010 CDC began efforts to reduce the total number of measures in CDC's performance plan, and proposed budget consolidations have impacted reporting for certain programs. It is likely that the percentage of targets met will increase once the remaining 2010 data become available.

As the nation's prevention agency and a leader in improving public health across the world, CDC has implemented strategic, focused efforts to improve stewardship of the public's resources and achieve greater public health impact through evidence-based science, policy and program planning and implementation. CDC is proud of the achievements described above and is confident that the foundation has been laid to realize ever greater public health impact and advance the state of public health domestically and abroad.

SUMMARY OF TARGETS AND RESULTS

The table below provides a summary of targets and results for CDC performance measures. [1]

Fiscal Year	Total Targets	Target with Results Reported	Percent of Targets with Results Reported	Total Targets Met	% of Targets Met
2007	112	111	99%	64	57%
2008	140	128	91%	85	66%
2009	149	113	76%	76	68%
2010	158	72	46%	48	68%
2011CR	159	N/A	N/A	N/A	N/A
2012	171	N/A	N/A	N/A	N/A

[1] Table does not reflect discontinued measures

ALL PURPOSE TABLE

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
ALL PURPOSE TABLE
(DOLLARS IN THOUSANDS)

Revised Budget Activity/Description	FY 2010 Comparable Appropriation [1]	FY 2011 Continuing Resolution	FY 2012 President's Budget
Immunization and Respiratory Diseases	**$721,180**	**$821,285**	**$721,663**
Immunization and Respiratory Diseases - BA	$708,316	$708,421	$647,200
Nat'l Immun Survey - PHS Evaluation Transfer	*$12,864*	*$12,864*	*$12,864*
Immunization and Respiratory Diseases - PPHF	$0	$100,000	$61,599
HIV/AIDS, Viral Hepatitis, STD and TB Prevention [2]	**$1,118,712**	**$1,088,500**	**$1,187,533**
HIV/AIDS, Viral Hepatitis, STD and TB Prevention - BA	$1,088,345	$1,088,500	$1,157,133
HIV/AIDS, Viral Hepatitis, STD and TB Prevention - PPHF	$30,367	$0	$30,400
Emerging and Zoonotic Infectious Diseases	**$281,174**	**$312,965**	**$349,118**
Emerging and Zoonotic Infectious Diseases - BA	$261,174	$261,215	$289,118
Emerging and Zoonotic Infectious Diseases - PPHF	$20,000	$51,750	$60,000
Chronic Disease Prevention and Health Promotion [2]	**$924,378**	**$1,166,531**	**$1,185,508**
Chronic Disease Prevention and Health Promotion -BA	$865,445	$865,581	$725,207
Chronic Disease Prevention and Health Promotion - PPHF	$58,933	$300,950	$460,301
Birth Defects, Developmental Disabilities, Disability and Health	**$143,626**	**$143,646**	**$143,899**
Environmental Health	**$181,004**	**$216,030**	**$137,715**
Environmental Health - BA	$181,004	$181,030	$128,715
Environmental Health - PPHF	$0	$35,000	$9,000
Injury Prevention and Control	**$148,790**	**$148,812**	**$167,501**
Injury Prevention and Control - BA	$148,790	$148,812	$147,501
Injury Prevention and Control - PPHF	$0	$0	$20,000
Preventive Health and Health Services Block Grant	**$100,240**	**$100,255**	**$0**
Public Health Scientific Services	**$440,709**	**$490,370**	**$493,616**
Public Health Scientific Services - BA	$160,582	$160,601	$205,942
Public Health Scientific Services - PHS Evaluation Transfer	*$247,769*	*$247,769*	*$217,674*
Public Health Scientific Services - PPHF	$32,358	$82,000	$70,000
Occupational Safety and Health	**$374,607**	**$374,649**	**$259,934**
Occupational Safety and Health - BA	$282,883	$282,925	$0
Occupational Safety and Health - PHS Evaluation Transfer	*$91,724*	*$91,724*	*$259,934*
Global Health	**$354,403**	**$354,453**	**$381,245**
Public Health Leadership and Support	**$194,379**	**$185,460**	**$162,568**
Public Health Leadership and Support - BA	$144,237	$144,260	$121,368
Public Health Preparedness and Response - PPHF	$50,142	$41,200	$41,200
Buildings and Facilities	**$69,140**	**$69,150**	**$30,000**
Business Services Support	**$366,707**	**$366,762**	**$417,466**
Public Health Preparedness and Response	**$1,522,339**	**$1,522,565**	**$1,452,618**
Public Health Preparedness and Response - BA	$1,522,339	$1,522,565	$1,422,618
Public Health Preparedness and Response - PHSSEF	$0	$0	$30,000
Total, L/HHS/ED -BA	***$6,397,231***	***$6,398,176***	***$5,817,412***
Total, L/HHS/ED (includes PHS Evaluation Transfers) -	***$6,749,588***	***$6,750,533***	***$6,307,884***
Program Level, (includes BA, PHS Eval, PHSSEF & PPHF) -	***$6,941,388***	***$7,361,433***	***$7,090,384***
Agency for Toxic Substances and Disease Registry	***$76,792***	***$76,792***	***$76,337***
Public Health and Social Services Emergency Fund (Transfer) (non-add)	***$0***	***$0***	***$30,000***
Affordable Care Act	***$48,000***	***$0***	***$0***
Affordable Care Act- Prevention Fund Transfer (non-add)	***$191,800***	***$610,900***	***$752,500***
Vaccines for Children [3,4]	**$3,760,638**	**$3,899,093**	**$4,030,996**
Energy Employees Occupational Illness Compensation Program Act (EEOICPA)	**$55,358**	**$55,358**	**$55,358**
World Trade Center (Mandatory)	***$0***	***$0***	***$0***
PHS Evaluation Transfers (non-add)	**$352,357**	**$352,357**	**$490,472**
Other User Fees	***$2,226***	***$2,226***	***$2,226***
Total, CDC/ATSDR Program Level -	***$10,884,402***	***$11,394,902***	***$11,255,301***

1 The FY 2010 Appropriation was made comparable to the FY 2012 President's Budget to reflect CDC's organizational improvement effort and new organizational design.

2 The FY 2010 HIV/AIDS and Chronic Diseases Prevention budget lines reflect a comparability adjustment to reflect the transfer of School Health budget ($40 million) from Chrnic Diseases Prevention to Domestic HIV/AIDS.

3 The FY 2011 VFC estimate of $3,899.093 million represents the estimated non-expenditure transfer amount from CMS. The total FY 2011 VFC Program estimate is $3,905.644 million, which includes $6.551 million in unobligated balances and recoveries brought forward.

4 The FY 2012 VFC estimate is a net increase of $125.352 million above the FY 2011 estimate for obligations by the mandatory VFC Program.

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BUDGET EXHIBITS

APPROPRIATIONS LANGUAGE

CENTERS FOR DISEASE CONTROL AND PREVENTION APPROPRIATION LANGUAGE
DISEASE CONTROL, RESEARCH, AND TRAINING

To carry out titles II, III, VII, XI, XV, XVII, XIX, XXI, XXIII, and XXVI of the Public Health Service Act (`PHS Act'), sections 101, 102, 103, 201, 202, 203, 301, 501, and 514 of the Federal Mine Safety and Health Act of 1977, section 13 of the Mine Improvement and New Emergency Response Act of 2006, sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970, titles II and IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, sections 4001, 4004, and 4201 of the Affordable Care Act of 2010, section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002, and for expenses necessary to support activities related to countering potential biological, nuclear, radiological, and chemical threats to civilian populations; including purchase and insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft, $5,817,412,000 of which $30,000,000 shall remain available until expended for acquisition of real property, equipment, construction and renovation of facilities; of which $625,000,000 shall remain available until expended for the Strategic National Stockpile under section 319F-2 of the PHS Act; of which $118,023,000 for international HIV/AIDS shall remain available through September 30, 2013 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: Provided, That in addition, such sums as may be derived from authorized user fees, which shall be credited to this account and shall be available until expended: Provided further, That in addition to amounts provided herein, the following amounts shall be available from amounts available under section 241 of the PHS Act: (1) $12,864,000 to carry out the National Immunization Surveys; (2) $161,883,000 to carry out the National Center for Health Statistics surveys; (3) $55,791,000 to carry out Public Health Scientific Services; and (4) $259,934,000 to carry out research activities within the National Institute for Occupational Safety and Health: Provided further, That Centers for Disease

Control and Prevention and State grant recipients may transfer up to five 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: Provided further, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used, in whole or in part, to advocate or promote gun control: Provided further, That of the funds made available under this heading, up to $1,000 per eligible employee of the Centers for Disease Control and Prevention shall be made available until expended for Individual Learning Accounts: Provided further, That the Director may redirect the total amount made available under authority of Public Law 101-502, section 3, dated November 3, 1990, to activities the Director may so designate: Provided further, That the Committees on Appropriations of the House of Representatives and the Senate are to be notified promptly of any such redirection: Provided further, That funds appropriated to the Centers for Disease Control and Prevention may be available for making grants under section 1509 of the PHS Act for up to 21 States, tribes, or tribal organizations: Provided further, That of this amount, $5,789,000 shall be to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002: Provided further, That of the funds appropriated, $10,000 shall be for official reception and representation expenses when specifically approved by the Director of the Centers for Disease Control and Prevention: Provided further, That employees of the Centers for Disease Control and Prevention 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 the Department of Health and Human Services during the period of detail or assignment.

In addition, for necessary expenses to administer the Energy Employees Occupational Illness Compensation Program Act, $55,358,000, to remain available until expended: 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: Provided further, That funds made available for the Epidemiology-Laboratory Capacity Grants program shall be available notwithstanding paragraphs (1)-(3) of subsection (b) of section 2821 of the PHS Act.

APPROPRIATIONS LANGUAGE ANALYSIS

CENTERS FOR DISEASE CONTROL AND PREVENTION LANGUAGE ANALYSIS

LANGUAGE ANALYSIS

LANGUAGE PROVISION	EXPLANATION
Title II (of the Immigration and Nationality Act)	Title II of the Immigration and Nationality Act is listed to provide consistency of authorizations for ongoing CDC work. This title provides CDC the authority to detain aliens for physical and mental examination.
Title XXIII (of the Public Health Service Act)	Title XXIII of the Public Health Service Act is listed to provide consistency of authorizations for ongoing CDC work. This title provides CDC the authority to support international efforts for AIDS and to establish fellowship and training programs to enable health professionals and personnel to acquire skills to prevent, diagnose, and treat HIV in national and international efforts.
sections 4001, 4004, 4201 of the Affordable Care Act of 2010	CDC's FY 2012 budget request incorporates programs authorized but not appropriated for in the Affordable Care Act of 2010. This language ensures that CDC has the authority to use its base appropriation for these programs.
section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002	CDC's FY 2012 budget request proposes to move the Afghanistan Health Initiative from the Office of Global Health Affairs to CDC. This change will allow this initiative to be better integrated into CDC's broader global health work.
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 ensures CDC has the ability to pay the necessary expenses for any persons quarantined by the Federal Government under Title III of the Public Health service Act.
[and of which $150,137,000 shall be available until expended to provide screening and treatment for first response emergency services personnel, residents, students, and others related to the September 11, 2001 terrorist attacks on the World Trade Center:]	The World Trade Center Health Program is now a mandatory program as a result of passage of the James Zadroga 9/11 Health and Compensation Act (2010).

LANGUAGE PROVISION	EXPLANATION
Provided, That in addition, such sums as may be derived from authorized user fees, which shall be credited to this account and [: *Provided further*, That with respect to the previous proviso, authorized user fees from the Vessel Sanitation Program] shall be available [through September 30, 2011]*until expended*	Due to the variability surrounding the collection of authorized user fees for selected CDC activities, this phrase provides specific authorization to allow all user fees collected to be available without funding year restriction.
Provided further, That in addition to amounts provided herein, the following amounts shall be available from amounts available under section 241 of the PHS Act: (1) $12,864,000 to carry out the National Immunization Surveys; (2) [138,683,000]$161,883,000 to carry out the National Center for Health Statistics surveys;[(3) $30,880,000 for Public Health Informatics;](3) $55,791,000 to carry out Public Health Scientific Services; and[; (4) $17,151,000 for Health Marketing; (5) $31,170,000 to carry out Public Health Research; and (6) $91,724,000] (4) $259,934,000 to carry out research activities within the National [Research Agenda]Institute for Occupational Safety and Health:	This language has been rewritten in order to align with the recent organizational and budget structure changes within CDC. Additionally the changes to item (6) reflect the incorporation of other occupational safety and research activities outside of NORA
Provided further, That Centers for Disease Control and Prevention and State grant recipients may transfer up to five 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.	This language has been added to provide additional flexibility to CDC and jurisdictions receiving funds for HIV/AIDS, STDs, Hepatitis and TB by allowing them to transfer up to five percent of their grant awards to improve program collaboration and service integration for populations with or at risk for at least two or more of the following infections: HIV, STDs, viral hepatitis or TB.
That [not to exceed $20,787,000] *funds* may be available for making grants under section 1509 of the PHS Act *for up to* [not less than] 21 States, tribes, or tribal organizations:	Due to the proposed transition to a competitive and comprehensive grant program for Chronic Disease and Health Promotion, this language has been modified to reflect CDCs need for greater flexibility in the awarding of grants for the WISEWOMAN program authorized in PHSA 1509.

LANGUAGE PROVISION	EXPLANATION
[“…of which $20,620,000 shall be used for the projects, and in the amounts, specified under the heading `Disease Control, Research, and Training' in the statement of the managers on the conference report accompanying this Act”**]**;	The FY 2012 Budget request for CDC does not include one-time project costs included in the FY 2010 enacted appropriation.
[“: *Provided further*, That notwithstanding any other provision of law, the Centers for Disease Control and Prevention shall award a single contract or related contracts for development and construction of the next building or facility designated in the Buildings and Facilities Master Plan that collectively include the full scope of the project”**]**	This language is eliminated because funding of the Buildings and Facilities Master Plan.
Provided further, That of this amount, $5,789,000 shall be to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002	The FY 2012 Budget request proposed to move the Afghanistan Health Initiative from the Office of Global Health Affairs to CDC. This change will allow this initiative to be better integrated into CDC’s broader global health work.
[Provided further, That with respect to grants to States authorized under Sections 301, 307, 310, 311, 304, and 317 of the PHS Act, any State may redirect up to 10 percent of any fiscal year 2011 grant program allocation to supplement other grants the State receives from funds provided under this heading to address one or more *of the* top five leading causes of death within such State: Provided further, That each State choosing to redirect funds under the preceding proviso shall submit a detailed plan to the Secretary not less than 30 days prior to such redirection, and, not later than 30 days after the close of the fiscal year, provide a final report in the format specified by the Secretary on the amounts so redirected and how such amounts were used to improve the performance of State public health programs: Provided further, That such redirections may not be used to supplant State funds for such activities.]	This language proposed in the FY 2011 CDC Budget is eliminated due to the newly proposed Comprehensive Chronic Disease Prevention Program which will accomplish similar goals of reducing the leading causes of death by awarding competitive grants to states.
Provided further, That funds made available for the Epidemiology-Laboratory Capacity Grants program shall be available notwithstanding paragraphs (1)-(3) of subsection (b) of section 2821 of the PHS Act.	This language will allow CDC to request funding for the Epidemiology-Laboratory Capacity Grants Program less than the floor created by (1)-(3) of subsection (b) of section 2821 of the PHS Act.

AMOUNTS AVAILABLE FOR OBLIGATION

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DISEASE, CONTROL, RESEARCH AND TRAINING AMOUNTS AVAILABLE FOR OBLIGATION [1, 2]			
	FY 2010 Actual	FY 2011 Annualized CR	FY 2012 President's Budget Request
Discretionary Appropriation:			
Annual	$6,390,387,000	$6,390,387,000	$5,817,412,000
HHS Secretary's Transfer	($945,000)	$0	$0
Subtotal, adjusted Appropriation	**$6,389,442,000**	**$6,390,387,000**	**$5,817,412,000**
Mandatory and Other Appropriations:			
Transfers from Other Accounts (Health Reform Appropriation)	$192,000,000	$610,900,000	$752,000,000
Appropriation (Health Reform)	$25,000,000	$0	$0
Receipts from CRADA	$1,507,469	$2,000,000	$2,000,000
Appropriation (EEOICPA)	$55,358,000	$55,358,000	$55,358,000
Subtotal, adjusted Mandatory and Other Appropriations	**$273,865,469**	**$668,258,000**	**$809,358,000**
Recovery of prior year Obligations	$7,780,012	$0	$0
Unobligated balance start of year	$559,958,083	($283,198,327)	($286,000,000)
Unobligated balance expiring	($10,128,252)	$0	$0
Unobligated balance end of year	$283,198,327	$286,000,000	$287,000,000
Total Obligations	**$ 7,504,115,639**	**$ 7,061,446,673**	**$ 6,627,770,000**

[1] Excludes Vaccine for Children.

[2] Excludes the following amounts for reimbursements: FY 2010 $564,543,000; FY 2011 $575,000,000; and FY 2012 $774,000,000.

SUMMARY OF CHANGES

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
SUMMARY OF CHANGES
(DOLLARS IN THOUSANDS)

	Dollars	FTEs
FY 2012 Budget (Budget Authority (BA) & Prevention and Public Health Fund (PPHF))	**$6,569,912**	**10,075**
FY 2010 Enacted (Budget Authority & Prevention and Public Health Fund)	**$6,589,031**	**9,875**
Net Change	**($19,119)**	**200**

	FY 2010 Appropriation		Change from Base	
	FTE	**BA/PPHF**	**FTE**	**BA/PPHF**
Increases:				
Immunization & Respiratory Diseases	---	**$708,316**	---	**$483**
Section 317 (PPHF) (non-add)		$0		$61,599
HIV/AIDS, Viral Hepatitis, STD, & TB Prevention	---	**$788,681**	---	**$68,821**
Domestic HIV/AIDS Prevention and Research (non-add)	---	$768,903	---	$58,305
Viral Hepatitis (non-add)	---	$19,778	---	$5,222
Emerging and Zoonotic Infectious Diseases	---	**$281,174**	---	**$73,643**
Quarantine - Federal Isolation and Quarantine (non-add)	---	$0	---	$1,000
Epi and Lab Capacity program (PPHF) (non-add)	---	$20,000	---	$20,000
Healthcare-Associated Infections (PPHF) (non-add)	---	$0	---	$20,000
Chronic Disease Prevention, Health Promotion, & Genomics	---	**$924,378**	---	**$445,801**
Tobacco (PPHF) (non-add)	---	$14,500	---	$64,500
Chronic Diseases Prevention and Health Promotion Grants (includes PPHF) (non-add)	---	$632,995	---	$72,383
Community Transformation Grants (PPHF) (non-add)	---	$0	---	$221,061
Baby Friendly (PPHF) (non-add)	---	$0	---	$2,500
Birth Defect, Developmental Disabilities, Disability & Health	---	**$143,626**	---	**$273**
Environmental Health	---	**$181,004**	---	**$9,006**
Environmental and Health Outcome Tracking Network (PPHF) (non-add)	---	*$0*	---	$9,000
Injury Prevention and Control	---	**$148,790**	---	**$20,000**
Unintentional Injury (PPHF) (non-add)	---	*$0*	---	$20,000
Public Health Scientific Services	---	**$192,940**	---	**$94,560**
Healthcare Surveillance/ Health Statistics (PPHF) (non-add)	---	*$19,858*	---	$15,142
Community Guide (PPHF) (non-add)	---	*$5,000*	---	$5,000
Public Health Workforce Capacity (PPHF) (non-add)	---	*$7,500*	---	$17,500
Global Health	---	**$354,403**	---	**$26,842**
Polio Eradication (non-add)	---	$101,785	---	$10,656
Public Health Leadership and Support	---	**$194,379**	---	**$858**
National Prevention Strategy (PPHF) (non-add)	---	$142	---	$858
Business Services Support	**---**	**$366,707**	**---**	**$50,759**
Public Health Preparedness & Response	---	**$1,522,339**	---	**$29,339**
Strategic National Stockpile (non-add)	---	$595,661	---	$29,339
Total Increases	**N/A**	**$5,806,737**	**N/A**	**$820,385**

CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF CHANGES (Cont.) (DOLLARS IN THOUSANDS)				
Decreases:				
Emerging and Zoonotic Infectious Diseases	---	**$281,174**	---	**($5,699)**
Prion Disease (non-add)	---	$5,473	---	($5,473)
Chronic Disease Prevention, Health Promotion, & Genomics	---	**$924,378**	---	**($184,671)**
Racial and Ethnic Approach to Community Health (REACH) (non-add)	---	$39,271	---	($39,274)
Healthy Communities (non-add)	---	$22,609	---	($22,609)
Communities Putting Prevention to Work(PPHF) (non-add)		*$44,433*		*($44,433)*
Environmental Health	---	**$181,004**	---	**($52,295)**
Built Environment (non-add)	---	$2,683	---	($2,683)
Climate Change (non-add)	---	$7,539	---	($972)
Healthy Homes/Childhood Led Poisoning/Asthma (non-add)	---	$34,800	---	($33,045)
Injury Prevention & Control	---	**$148,790**	---	**($1,289)**
Preventive Health and Health Services Block Grant	---	**$100,240**	---	**($100,240)**
Public Health Scientific Services	---	**$192,940**	---	**($11,558)**
Genomics	---	$12,307	---	($11,558)
Occupational Safety & Health	---	**$282,883**	---	**($282,883)**
World Trade Center	---	$70,712	---	($70,712)
Education and Research Centers	---	$24,370	---	($24,370)
National Occupation Research Agenda AgFF	---	N/A	---	($23,000)
All Other Occupational Safety & Health	---	$164,801	---	($164,801)
Public Health Leadership and Support	---	**$194,379**	---	**($32,669)**
Congressional Projects (non-add)	---	$20,620	---	($20,620)
Public Health Infrastructure (PPHF) (non-add)	---	$50,000	---	($9,800)
Buildings and Facilities	---	**$69,140**	---	**($39,140)**
Public Health Preparedness & Response	---	**$1,522,339**	---	**($129,060)**
Public Health Emergency Preparedness Grant Program (non-add)	---	$714,843	---	($71,579)
Academic Centers for Public Health Preparedness and Advanced Practice Centers (non-add)	---	$35,270	---	($35,270)
Total Decreases	**N/A**	**$3,897,267**	**N/A**	**($839,504)**
Built-In:				
1. Annualization of Jan - 2010 Pay Raise	---	---	---	$0
2. Changes in Day of Pay	---	---	---	$0
3. Within-Grade Increases	---	---	---	$0
4. Rental Payments to GSA and Others	---	---	---	$34,448
Total Built-In	**9,875**	**$6,589,031**	**200**	**$34,448**
1. Absorption of Current Services	---	---	---	($34,448)
Total	---	---	---	($34,448)
Total Increases (BA & PPHF)	**9,875**	**$6,589,031**	**200**	**$854,833**
Total Decreases (BA & PPHF)	**N/A**	**N/A**	**0**	**($873,952)**
NET CHANGE - L/HHS/ED BUDGET AUTHORITY & PPHF	**9,875**	**$6,589,031**	**200**	**($19,119)**
Program Level Changes				
1. Vaccines for Children	---	$3,760,638	---	$270,358
2. ATSDR	311	$76,792	0	($455)
3. PHS Evaluation Transfers	---	352,357	---	$138,115
4. Strategic National Stockpile - Balances from P.L. 111-32	---	$0	---	$30,000
5. PPACA	---	$48,000	---	($48,000)
Total - Program Level Net Increase	**311**	**$4,189,787**	**0**	**$390,018**
NET CHANGE: BUDGET AUTHORITY & PROGRAM LEVEL	**10,186**	**$10,778,818**	**200**	**$370,899**

BUDGET AUTHORITY BY ACTIVITY (ALL PURPOSE TABLE)

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
BUDGET AUTHORITY BY ACTIVITY (APT)
(DOLLARS IN THOUSANDS)

Revised Budget Activity/Description	FY 2010 Comparable Appropriation [1]	FY 2011 Continuing Resolution	FY 2012 President's Budget
Immunization and Respiratory Diseases	$708,316	$708,421	$647,200
HIV/AIDS, Viral Hepatitis, STD and TB Prevention [2]	$1,088,345	$1,088,500	$1,157,133
Emerging and Zoonotic Infectious Diseases	$261,174	$261,215	$289,118
Chronic Disease Prevention and Health Promotion [2]	$865,445	$865,581	$725,207
Birth Defects, Developmental Disabilities, Disability and Health	$143,626	$143,646	$143,899
Environmental Health	$181,004	$181,030	$128,715
Injury Prevention and Control	$148,790	$148,812	$147,501
Preventive Health and Health Services Block Grant	$100,240	$100,255	$0
Public Health Scientific Services	$160,582	$160,601	$205,942
Occupational Safety and Health	$282,883	$282,925	$0
Global Health	$354,403	$354,453	$381,245
Public Health Leadership and Support	$144,237	$144,260	$121,368
Buildings and Facilities	$69,140	$69,150	$30,000
Business Services Support	$366,707	$366,762	$417,466
Public Health Preparedness and Response	$1,522,339	$1,522,565	$1,422,618
CDC Total, L/HHS/ED -BA	*$6,397,231*	*$6,398,176*	*$5,817,412*
Agency for Toxic Substances and Disease Registry	$76,792	$76,792	$76,337
Total, CDC/ATSDR Budget Authority -	*$6,474,023*	*$6,474,968*	*$5,893,749*

1 The FY 2010 Appropriation was made comparable to the FY 2012 President's Budget to reflect CDC's organizational improvement effort and new organizational

2 The FY 2010 HIV/AIDS and Chronic Diseases Prevention budget lines reflect a comparability adjustment to reflect the transfer of School Health budget ($40 million) from Chrnic Diseases Prevention to Domestic HIV/AIDS.

AUTHORIZING LEGISLATION

Dollars in Thousands	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Budget
Immunization and Respiratory Diseases	Indefinite	$4,720,378	Indefinite	$4,752,659
PHSA §§ 317(a), 317(j), 317(k), 317(l), 317(m), 319C, 319E, 319F, 325, 340C, 2102(a)(6), 2102(a)(7), 2125, 2126, 2127, 2821 Section 1928 of Social Security Act (42 U.S.C 1396s) The Affordable Care Act of 2010 § 4204 (P.L. 111-148) Pandemic Influenza: PHSA §§ 317N, 317S, 319, 319F, 322, 325, 327 Immigration and Nationality Act § 212 (8 U.S.C. 1182) Immigration and Nationality Act § 232 (8 U.S.C. 1222) Pandemic and All Hazards Preparedness Act (PAHPA) of 2006 (P.L. 109-417)				
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	Indefinite	$1,088,500	Indefinite	$1,187,533
PHSA §§ 306, 308, 317E, 317N, 317P, 317T, 318, 318A, 318B, 322, 325, 2315, 2320, 2341 Departments of Labor, HHS, Education & Related Agencies Appropriations Act of 2010 § 213 (P.L. 111-117, Division D) Tuskegee Health Benefits: P.L. 103-333				
Emerging Zoonotic Infectious Diseases	Indefinite	$312,965	Indefinite	$349,118

Dollars in Thousands	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Budget
PHSA §§ 308(d), 317P, 317R, 317S, 319E, 319F, 319G, 321, 322, 325, 353, 361-369, 1102, 2821, Immigration and Nationality Act § 212 (8 U.S.C. 1182) Immigration and Nationality Act § 232 (8 U.S.C. 1222)				
Chronic Disease Prevention, Health Promotion	Indefinite	$1,266,786	Indefinite	$1,185,508
PHSA §§ 317D, 317H, 317K, 317L, 317M, 330E, 399B-399D, 399E, 399W-399Z, 1501-1508, 1701, 1702, 1703, 1704, 1706, Title XIX* 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 Fertility Clinic Success Rate And Certification Act Of 1992, P.L. 102-493 The Affordable Care Act of 2010, § 4201 (P.L. 111-148)				
Birth Defects, Developmental Disabilities, Disabilities & Health	Indefinite	$143,646	Indefinite	$143,899
PHSA §§ 317C, 317J, 317K, 317L 317Q, 399M, 399Q, 399S, 399T, 399AA, 399BB, 399CC, 1108-1115 The Prematurity Research Expansion And Education For Mothers Who Deliver Infants Early Act §§ 3,5 (P.L. 109-450)				
Environmental Health	Indefinite	$216,030	Indefinite	$137,715

Dollars in Thousands	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Budget
PHSA §§ 317A, 317B, 317I, 361, 366 Housing and Community Development Act, § 1021 (15 U.S.C. 2685) Chemical Weapons Elimination Activities (50 U.S.C. 1512, 50 U.S.C. 1521) Housing and Community Development (Lead Abatement) Act of 1992 (42 U.S.C. 4851 et seq.)				
Injury Prevention and Control	Indefinite	$148,812	Indefinite	$167,501
PHSA §§ 391, 392, 393, 393A, 393B, 393C, 393D, 394, 394A, 399P Traumatic Brain Injury Act of 2008 (P.L. 110-206) Safety of Seniors Act of 2007 (P.L. 110-202) Family Violence Prevention and Services Act § 413 (42 U.S.C. 10418)				
Public Health Scientific Services	Indefinite	$490,370	Indefinite	$493,616
PHSA §§ 306, 308, 317G, 318, 319A, 353, 391, 399V, 778, 2315, 2341, 2521 Food Conservation And Energy Act of 2008, § 4403 (7 U.S.C. 5311a) Confidential Information Protection and Statistical Efficiency Act, Title V (44 U.S.C. 3501) Intelligence Reform and Terrorism Prevention Act of 2004, § 7211 (P.L. 108-458) National Nutrition Monitoring and Related Research Act of 1990, § 5341 (7 U.S.C. 5341) Affordable Care Act of 2010 (P.L. 111-148)				
Occupational Safety and Health	Indefinite	$430,007	Indefinite	$315,292

Dollars in Thousands	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Budget
PHSA §§ 317A, 317B, 399M, 2695 Occupational Safety and Health Act of 1970 §§20-22, P.L. 91-596 as amended by P.L. 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) Workers' Family Protection Act § 209, P.L. 102-522 (29 U.S.C.671(a)) 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 (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 P.L. 102-550 (15 U.S.C. 2682, 2685) Prohibition of Age Discrimination Act (29 U.S.C. 623 *note* and 29 U.S.C. 657) 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 Prohibition of Age Discrimination Act (29 U.S.C. 623note); Ryan White HIV/AIDS Treatment Extension Act of 2009 § 2695, P.L. 111-87 (42 U.S.C. 300ff-131)				
Global Health	Indefinite	$354,453	Indefinite	$381,245

Dollars in Thousands	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Budget
PHSA §§ 307, 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) P.L. 107-116 § 215 P.L. 106-554 § 220 P.L. 111-117 § 213				
Public Health Leadership and Support	Indefinite	$185,460	Indefinite	$162,568
PHSA §§ 301, 304, 3061, 307, 308, 310, 311, 317, 317F, 319, 319A3, 322, 325, 327, 352, 361 -369, 391, 399G, 1102, 2315, 2341 Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517 Clinical Laboratory Improvement Amendments of 1988 § 4 (42 U.S.C. 263a)				
Buildings and Facilities	Indefinite	$69,150	Indefinite	$30,000
PHSA §§ 304(b)(4), 319D, 321(a)				
Business Services Support	Indefinite	$366,762	Indefinite	$417,466
PHSA §§ 301, 304, 307, 310, 3172, 317F1, 319, 327, 361, 362, 368 Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517				

Dollars in Thousands	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Budget
Public Health Preparedness and Response	Indefinite	$1,522,565	Indefinite	$1,452,618
PHSA §§ 319C-1, 319D, 319F, 319F-2, 319G, 351A, 352, 369				
ATSDR	Indefinite	$76,792	Indefinite	$76,337
The Great Lakes Critical Programs Act of 1990, 33 U.S.C. § 1268 Comprehensive Environmental Response, Compensation and Liability Act of 1980 § 104(i), as amended by the Superfund Amendments and Reauthorization Act of 1986 (42 U.S.C § 9604(i)) The Defense Environmental Restoration Program, 10 U.S.C. § 2704 The Resource Conservation and Recovery Act, as amended, 42 U.S.C § 6939 The Clean Air Act, as amended, 42 U.S.C. § 7401 et seq. Social Security Act § 2009 (42 U.S.C. 1397h)				
CDC General Authorities	N/A	N/A	N/A	N/A
PHSA § 207, 208, 214, 215, 222, 231, 234, 237, 240, 242, 301, 304, 308d, 307, 310, 317, 319, 319D, 327, 352, 399G, 1102 Stevenson-Wydler Tech Innovation Act Of 1980, as amended (15 U.S.C. 3710) Bayh-Dole Act of 1980 (P.L. 96-517)				
Total Appropriation		**$11,394,902**		**$11,255,301**

*The FY 2012 President’s Request does not include funding for Preventive Health and Health Services Block Grant

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APPROPRIATIONS HISTORY

FY 2012 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
2002	3,878,530,000	4,077,060,000	4,418,910,000	4,293,151,000 [1]
2002 Rescission	--	--	--	(1,894,000)
2002 Rescission	--	--	--	(2,698,000)
2003	4,066,315,000	4,288,857,000	4,387,249,000	4,296,566,000
2003 Rescission	--	--	--	(27,927,000)
2003 Supplemental [2]	--	--	--	16,000,000
2004 [3]	4,157,330,000	4,538,689,000	4,494,496,000	4,367,165,000
2005 [3, 4]	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 [4]	--	--	--	15,000,000
2006 [3, 5]	3,910,963,000	5,945,991,000	6,064,115,000	5,884,934,000
2006 Rescission	--	--	--	(58,848,000)
2006 Suplemental[6]	--	--	--	275,000,000
2006 Supplemental[7]	--	--	--	218,000,000
2006 Section 202 Transfer to CMS	--	--	--	(4,002,000)
2007 [5, 6, 8]	5,783,205,000	6,073,503,000	6,095,900,000	5,736,913,000
2008 [5]	5,741,651,000	6,138,253,000	6,156,169,000	6,156,541,000
2008 Rescission [5]	--	--	--	(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[9]				950,000,000
2009 H1N1 Influenza Supplemental, HHS[10]	473,000,000	--	--	473,000,000
2010 H1N1 Influenza Supplemental, CDC[10]	200,000,000	--	--	200,000,000
2010 Public Health Prevention Fund[11]	--	--	--	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	--
2011 Public Health Prevention Fund[11]	--	--	--	610,900,000
2012	6,397,231,000	--	--	--

[1] Includes Retirement accruals of +$57,297,000; Management Reform Savings of -$27,295,000

[2] Emergency Wartime Supplemental Appropriations Act, 2003 PL 108-11 for SARS

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

[4] 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.

[5] 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 f 2006

[6] 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

[7] 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.

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

[9] The FY 2009 American Reinvestment & Recovery Act (P.L. 111-5) amount reflects $300M direct appropriation to CDC for Section 317 and $650M in Transfer from HHS OS for CPPW.

[10] 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.

[11] 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.

CENTERS FOR DISEASE CONTROL AND PREVENTION

PROGRAM	LAST YEAR OF AUTHORIZATION	AUTHORIZATION LEVEL	APPROPRIATIONS IN LAST YEAR OF AUTHORIZATION	APPROPRIATIONS IN FY 2011
Sexually Transmitted Diseases Grants	FY 1998	Such Sums…	$113,671,000	$154,640,000
Strategic National Stockpile	FY 2006	Such Sums…	$524,700,000	$595,749,000
WISEWOMAN	FY 2003	Such Sums…	$12,419,000	$20,784,000
Safe Motherhood/Infant Health Promotion	FY 2005	Such Sums…	$44,738,000	$44,873,000
Oral Health Promotion	FY 2005	Such Sums…	$11,204,000	$15,002,000
Birth Defects, Developmental Disability, Disability and Health	FY 2007	Such Sums…	$122,242,000	$143,646,000
Asthma Prevention	FY 2005	Such Sums…	$32,422,000	$30,924,000
Lead Poisoning Prevention	FY 2005	Such Sums…	$36,474,000	$34,805,000
Injury Prevention and Control	FY 2005	Such Sums…	$138,237,000	$148,812,000
National Center for Health Statistics	FY 2003	Such Sums…	$125,899,000	$138,683,000

NARRATIVE BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012+/- FY 2010
Budget Authority	$708,316	$708,421	$647,200	-$61,116
PHS Evaluation Transfer	*$12,864*	*$12,864*	*$12,864*	*$0*
ACA/PPHF	$0	$100,000	$61,599	+$61,599
Total	**$721,180**	**$821,285**	**$721,663**	**+$483**
FTEs	705	719	719	+14

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $721,663,000 for Immunization and Respiratory Diseases, including $61,599,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an overall increase of $483,000 above the FY 2010 level. As health insurance reforms of the Affordable Care Act are implemented, the size of the current priority population for Section 317 Immunization Grant Program (Section 317) vaccines is likely to decrease. In 2011, the U.S. Department of Health and Human Services (HHS) estimates that 41 million people in new health plans will benefit from the new prevention provisions. By 2013, a total potential of 88 million Americans are expected to have greater prevention coverage due to the new policy. This is expected to result in savings in the amount of Section 317 Vaccine Purchase funding needed to serve the current population of underinsured children not eligible for vaccine through the mandatory Vaccines for Children (VFC) Program. FY 2012 funds will support continuation of CDC's efforts to prevent vaccine-preventable disease by assuring high immunization coverage levels, and to control respiratory and related diseases such as influenza.

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 near record lows. Maintaining and enhancing these program successes in vaccination is critical to prevent recurrent epidemics of diseases that could result in preventable illness, disability, and death. The two primary federal programs that support immunization in the United States are Section 317 and the VFC Program. Taken together, these programs provide vaccines and the necessary program support to reach uninsured and underinsured populations. A comprehensive immunization program also requires a strong foundation of science—from establishing and implementing vaccine policy to monitoring the effectiveness, impact, coverage, and safety of routinely-recommended vaccines. Persons in every age group are also impacted by acute respiratory infections, including pneumonia and influenza. Influenza is a major public health problem in the United States and globally, presenting an ever-evolving threat. CDC supports critical public health surveillance, laboratory infrastructure, and response capacity to minimize illness and death from respiratory diseases.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 307, 310, 311, 317, 319, 327, 352

Specific Authorities: PHSA §§ 317(a), 317(j), 317(k), 317(l), 317(m), 317N, 317S, 319C, 319E, 319F, 322, 325, 340C, 2102(a)(6), 2102(a)(7), 2125, 2126, 2127, 2821; Immigration and Nationality Act §§ 212 (8 USC Sec. 1182), 232 (8 USC Sec. 1222); § 1928 of Social Security Act (42 USC 1396s); Pandemic and All-Hazards Preparedness Act of 2006 (P.L. 109-417); The Affordable Care Act of 2010 § 4204 (P.L. 111-148).

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year*	Section 317
FY 2002	$493,567,000
FY 2003	$502,765,000
FY 2004	$468,789,000
FY 2005	$493,032,000
FY 2006	$517,199,000
FY 2007	$512,804,000
FY 2008	$527,359,000
FY 2009	$557,359,000
FY 2010*	$561,459,000
FY 2011CR	$661,541,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

Fiscal Year*	Immunization and Respiratory Diseases
FY 2007	$585,430,000
FY 2008	$684,634,000
FY 2009*	$716,048,000
FY 2010**	$721,180,000
FY 2011CR	$821,285,000

*Amount does not include $200,000,000 appropriated for Pandemic Influenza from the Public Health and Social Services Emergency Fund (PHSSEF) nor $300,000,000 for Section 317 from the American Recovery and Reinvestment Act Prevention and Public Health Fund.
**Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

The table below reflects the sources of VFC funding and estimates of total VFC obligations. The FY 2012 estimate is a net increase of $270,358,000 above the FY 2010 level, and a net increase of $125,352,000 above the FY 2011 estimate. The FY 2012 estimate includes an increase over the FY 2011 estimate 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 2010 Actual	FY 2011 Estimate	FY 2012 Estimate
Unobligated Balances Brought Forward/Recoveries	$23M	$7M	N/A
Non-expenditure Transfer from CMS	$3.744M	$3.899M	$4.031M
Total VFC Obligations[1]	$3.761M	$3.906M	$4.031M

[1]In FY 2010, total VFC obligations do not equal total available resources.

BUDGET REQUEST

Section 317 Immunization Program and Program Implementation and Accountability

CDC's FY 2012 request of $561,991,000 for the Section 317 Immunization Program and Program Implementation and Accountability, including $61,599,000 from the Affordable Care Act Prevention and Public Health Fund, is $532,000 above the FY 2010 level. According to regulations released by the U.S.

Departments of HHS, Labor, and the Treasury, new health plans enrolling individuals or families on or after September 23, 2010, are required to cover recommended preventive services without charging a deductible, copayment, or coinsurance.[1] This reform includes coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) with no copayments or other cost sharing when these services are provided by an in-network provider. As this reform is fully implemented over the next several years, it is expected to improve access for the current priority population for Section 317 vaccines—underinsured children and adolescents not eligible for vaccines through the VFC Program, and result in some cost savings to Section 317 Vaccine Purchase.

CDC expects to leverage implementation of the health insurance reforms of the Affordable Care Act (ACA) to continue its progress in reaching national immunization coverage goals. The funding will be used for vaccine purchase and immunization infrastructure, with a focus on adult and recently recommended vaccines for adolescents and children. Funding will allow CDC to continue making immunizations available to priority populations of underinsured and uninsured Americans, continue identifying and implementing strategies to increase influenza vaccination coverage, and continue addressing low vaccination rates for adolescents and adults. At the federal level, operations funding will support the overall management of the immunization grant program to ensure program implementation and effectiveness, as well as essential vaccine-preventable disease surveillance and research to assess the effectiveness, impact, and safety of national vaccine policies and programs. The FY 2012 request does not include resources to expand coverage through non-traditional providers (e.g., schools and pharmacies) to give free vaccines to many individuals that already have coverage through private insurance.

In FY 2012, CDC will:

- Continue existing services for uninsured and underinsured adults and older children provided by non-traditional venues, such as pharmacies, retail-based clinics, and school-based settings, to promote and offer vaccinations.
- Heighten its efforts to provide adequate hepatitis vaccinations through Section 317.
- Continue to provide funding and technical assistance to immunization grantees to develop, enhance, and maintain immunization information systems capable of identifying individuals in need of immunization, measuring vaccination coverage rates, producing reminder and recall notices, and interfacing with electronic medical records.
- 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 in order 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.
- Support the systems required for ordering and distributing all public sector vaccines through the Vaccine Management Business Improvement Project (VMBIP).

[1] http://www.healthcare.gov/news/factsheets/affordable_care_act_immunization.html

- Provide the evidence-base for immunization through surveillance, epidemiology, and laboratory services and research. This effort includes providing technical assistance and expertise for the development of vaccine recommendations and other programmatic decisions, monitoring post licensure vaccine effectiveness, monitoring changes in vaccine-preventable diseases, identifying outbreaks of vaccine-preventable diseases and providing guidance for prevention and control measures in vaccine-preventable outbreaks, assisting and training state public health laboratories, and providing training to states on surveillance and epidemiology.
- Continue to fund immunization programs to develop plans that will allow additional state and local health department clinics to develop the capacity for billing health insurance plans for services provided to health plan members. The savings in Section 317 funds can then be used to enhance efforts to vaccinate more high-need individuals. CDC's FY 2012 request includes $7,000,000 for continuation of the billables demonstration project to reduce vaccine-preventable diseases and increase coverage for recommended vaccines.

Performance: Immunization continues to be one of the most cost-effective public health interventions. For each birth cohort who receives seven of the vaccines[2] given as part of the routine childhood immunization schedule, society saves $9.9 billion in direct medical costs; over 33,500 lives are saved; and 14 million cases of disease are prevented.

Cost-Effectiveness of Childhood Vaccines

For every $1.00 spent on an individual vaccine:

- Diphtheria-tetanus-acellular Pertussis (DTaP) saves $27.00
- Measles, mumps, and rubella (MMR) saves $26.00
- Perinatal hepatitis B saves $14.70
- Varicella saves $5.40
- Inactivated polio (IPV) saves $5.45

For every $1.00 spent:

- Childhood Series[1] (7 vaccines) saves $16.50

[1] Series includes DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella

Source: various peer reviewed publications. Direct and indirect savings included.

Creating an effective national immunization program requires investments in infrastructure for vaccine delivery and sound scientific information to inform vaccine policy decisions. CDC supports the implementation of state-based immunization programs that make vaccines available to financially vulnerable children, adolescents, and when funds are available, adults. Since the adoption of this strategy, the United States has seen record high childhood vaccination levels and record low levels of vaccine-preventable diseases.

The cost to fully vaccinate a child will increase from $1,382 in FY 2011 to $1,427 in FY 2012. Over the coming years, CDC will leverage the private and public health insurance reforms of the ACA to improve access to vaccination in the United States. CDC's efforts to date have resulted in the reduction of several vaccine-preventable diseases, increased immunization coverage rates, and improved vaccine safety

[2] These vaccines include DTaP, Td, Hib, Polio, MMR, Hepatitis B, and Varicella.

monitoring and research. The targets have been met or exceeded for five out of nine diseases for which there are routinely-recommended childhood vaccines (paralytic polio, measles, diphtheria, congenital rubella syndrome, and tetanus). CDC has made significant progress in meeting the performance measure that monitors progress in achieving or sustaining immunization coverage of at least 90 percent in children 19-35 months of age with appropriate vaccinations. For the seven recommended childhood vaccines, four (hepatitis B, MMR, polio, and varicella) have met or exceeded the target 90 percent coverage rate as of 2009.

Despite increases in influenza vaccination coverage, the performance targets have not been met. Coverage remains well below the 2010 target of 90 percent. To reach these ambitious targets, in FY 2012 CDC and its partners will continue to aggressively promote annual vaccination. Efforts will encourage health care providers to recommend influenza vaccine to their patients and will focus on getting health care providers vaccinated, a recommended group with consistently low vaccination coverage. (Measures 1.2.1c, 1.2.1h, 1.2.1i, 1.2.2a-1.2.2b, 1.3.1a-1.3.1b, 1.3.2a-1.3.2b and 1.A-1.I)

Program Description and Recent Accomplishments: Section 317 supports 64 grantees, including the 50 states, six large cities (including Washington DC), and eight territories and former territories. The Section 317 grant provides federal funds for vaccines for children not eligible for the VFC Program and for uninsured and underinsured adults. The grant also provides the majority of federal funding for program operations and infrastructure.

Recent accomplishments include:

- Conducted the National Immunization Survey-Teen and documented increases in adolescent vaccination coverage rates. This survey of more than 20,000 teens found, in 2009, an increase in the percent of 13-15 year olds who had received routinely-recommended adolescent vaccines. Specifically, for one dose of the Tdap vaccine, coverage rates increased by 15 percentage points to 62 percent; for one dose of meningococcal conjugate vaccine, coverage rates increased 11 percentage points to 55 percent; and for girls who received at least one dose of HPV vaccine, coverage increased four percentage points to 41 percent.
- Strengthened state and local health departments' existing influenza vaccination infrastructure and developed new approaches to vaccinate school-aged children and pregnant women. These approaches led to estimated monovalent 2009 H1N1 influenza vaccination coverage of 37 percent among children and 30-40 percent among pregnant women, with some states vaccinating up to 80 percent of children. Trivalent seasonal influenza vaccination coverage reached a new high of 40 percent among children aged six months to 17 years, a 16 percent increase from 2008-2009, with some states vaccinating up to 67 percent of children.
- Demonstrated, within three years of rotavirus vaccine implementation, an 85 percent reduction in severe rotavirus disease which translates to a decline of more than 50,000 hospitalizations and hundreds of thousands of emergency room and physician visits for rotavirus, with reductions in direct medical costs of more than $200,000,000.

Pandemic and Seasonal Influenza

CDC's FY 2012 request of $159,672,000 for the Influenza Program reflects a decrease of $49,000 below the FY 2010 level for administrative savings. CDC works with international partners, policy makers, tribal leaders, state and local health departments, the medical community, private sector partners, academic institutions, and other parts of the federal government to support core influenza infrastructure and activities. This program supports influenza prevention and control in all U.S. states, the Global Influenza Surveillance Network, the United Nations Global Initiative to Combat Avian Influenza, and the

Global Initiative on Sharing Avian Influenza Data. Pandemic influenza funding also supports activities in CDC's global health, public health scientific services, and quarantine programs.

In FY 2012, CDC will prevent and control influenza infections globally through vaccination, surveillance, and response to influenza emergencies including pandemics, provide support to State and local health departments, and work with partner organizations at all levels.

Vaccination

- Improve influenza vaccination to reach all Americans as part of a new national policy for universal influenza vaccination. Specific activities include facilitating school-located vaccination activities with private health insurers, vaccination of healthcare workers and pregnant women, and targeted communication.
- Shorten the interval between the identification of novel influenza viruses and the delivery of effective vaccines. Specific activities include improving methods for virologic surveillance, improving vaccine seed strain selection, and monitoring vaccine safety measures.
- Identify and prepare vaccine viruses for use in the 2012 southern hemisphere and 2012-13 northern hemisphere seasonal influenza vaccines.

Surveillance

- Provide grant support to states, territories, and countries 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.
- Work with domestic and international partners in the areas of human and animal health to improve surveillance for emerging influenza viruses with pandemic potential.
- Monitor influenza viruses and infections through a comprehensive multi-component surveillance system to determine the burden of influenza-associated clinic visits, hospitalizations, and deaths. These data are updated weekly and more frequently as needed, and will be provided to decision-makers, clinicians, and the public through electronic, interactive, and social media mechanisms (www.cdc.gov/flu).
- Increase the number of U.S. State/local public health partner laboratories approved by CDC to:
  - Perform antiviral testing, from three laboratories in FY 2010 to 12 laboratories in FY 2012.
  - Perform sequencing using a newly-developed process for detecting influenza viruses with significant genetic changes, from zero in FY 2010 to three in FY 2012.
  - Participate in CDC-sponsored evaluations of new diagnostic tests to detect novel viruses, from six in FY 2010 to 10 in FY 2012.
- Support qualified laboratories in the United States and internationally with U.S. Food and Drug Administration (FDA)-approved reagents for influenza diagnostic testing using the Influenza Reagent Resource (IRR). CDC will continue to add influenza viruses to the IRR Virus Library for use in possible pre-pandemic vaccines and will work with public health partners and manufacturers to develop and distribute new influenza diagnostic tests.

- Internationally monitor and evaluate core capacities for influenza surveillance, laboratory testing, and preparedness and response; identify effective practices for sharing among countries to improve and facilitate preparedness and response to influenza emergencies.

Response to Influenza Emergencies

- Maintain compliance with World Health Organization's International Health Regulations reporting requirements for human influenza caused by new subtypes.
- Develop, test, and maintain a scalable capability to detect and define the epidemiology of infection with novel influenza viruses, including rapid assessment of populations most affected, determining clinical severity, and emphasizing the development of improved laboratory tests for influenza, as well as improved partnerships with commercial laboratories for influenza testing.
- Further define CDC staffing, communications, and information management requirements to support a pandemic response, and implement policies that will ensure responses are adequately staffed with properly trained personnel.

State and Local Support and Coordination

- Support the States' ability to comply with Council of State and Territorial Epidemiologists National Notifiable Diseases Surveillance System requirements for reporting to CDC of persons infected with novel influenza A viruses and children who died from influenza.
- Develop models for more effective public health response at state and local levels and identify and publish useful and promising practices for state and local pandemic response.
- Monitor antiviral use, effectiveness, and safety to inform prescription guidance and use of strategic national stockpile assets. Assess and enhance distribution models for medical countermeasures.
- Develop and test effectiveness of interventions and plans to implement community measures, including school closures, to mitigate the impact of influenza emergencies.
- Develop and implement strategies to improve countermeasure distribution to hard-to-reach or at-risk populations.
- Through financial and technical assistance, develop domestic and international capacities and inform stakeholders, partners, and the public on issues related to influenza vaccine recommendations and benefits, monitoring, detection, preparedness, and response. Efforts will consist of media activities, campaigns to promote vaccination and disease prevention, and training.

Performance: Even with the success of routine vaccination, seasonal influenza illnesses continue to cost society an estimated $10,400,000,000 annually in estimated direct medical costs.[3] The efforts of CDC's influenza program are focused on reducing illness, hospitalization, and death associated with seasonal and pandemic influenza viruses. Expansion of influenza surveillance to inform composition of influenza vaccines and broadening of the use of influenza vaccines and antiviral medications are central to this effort. CDC laboratories analyzed 2,978 influenza viruses to identify and develop vaccine virus strains for

[3] Molinari NA, Ortega-Sanchez IR, Messonnier ML, Thompson WW, Wortley PM, Weintraub E, Bridges CB. 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.

production of the 2010-2011 seasonal influenza vaccine and tested 5,232 viruses to monitor for the emergence of antiviral resistance.

To strengthen influenza detection and surveillance, in FY 2010, CDC supported the assessment of 20 state public laboratories' capacity and provision of individual guidance for how each of those labs could increase their surge capacity. Although comprehensive antiviral testing (for oseltamivir and zanamivir resistance) is currently performed only at CDC, three public health laboratories have been approved to perform surveillance for antiviral resistance. To improve rapid reporting methods, CDC worked with six public health laboratories to report their laboratory results electronically to CDC. CDC also continued to provide training on diagnostic and serologic testing techniques to staff from partner countries. (Measure 1.6.1)

To facilitate influenza vaccine development, in FY 2010, CDC developed 16 high-growth reassortant viruses with pandemic potential for inclusion in an influenza virus library and tested pre-clinical pre-pandemic and pandemic vaccine strategies. To improve influenza prevention and response, CDC supported, in FY 2010, activities in over 40 countries to monitor and evaluate their ability to prevent and control influenza disease. Preliminary analysis of data from the CDC National Inventory of Core Capacities for Pandemic Influenza Preparedness and Response indicates that 94 percent of countries had a five percent or greater increase in their score compared to their previous score in 2008. To increase demand for seasonal influenza vaccine, CDC provided resources to states to develop outreach and communication strategies, especially for high-risk populations. For 2009-2010, seasonal vaccination rates were at an all-time high, reaching 41 percent of people aged six months and over, and by November 2010 that increased uptake continued; 43 percent of persons six months and over had been vaccinated or definitely intended to be vaccinated with the 2010-2011 seasonal influenza vaccine. (Measures 1.3.1a, 1.3.2a and 1.6.3)

Program Description and Recent Accomplishments: CDC's influenza program focuses on the prevention of illness, suffering, and death from influenza in the United States and around the world. To reduce the impact of influenza disease resulting from novel, annual, and pandemic influenza virus strains, CDC is strengthening influenza detection and surveillance to maximize the opportunities for prevention and mitigation of human disease; facilitating influenza vaccine development to improve timely production and immunogenicity; and, improving influenza prevention and response through a stronger evidence base that enhances policies and practices. CDC carries out its goals through critical epidemiologic and viral surveillance, state-of-the-art laboratory techniques for virus isolation and vaccine strain development, education and outreach supporting vaccination campaigns, investigation of disease outbreaks, and responses to influenza emergencies. These emergencies include outbreaks, epidemics, pandemics, vaccine shortages, situations when there is a suboptimal vaccine match, and the emergence and spread of antiviral resistance. The lessons learned from the 2009 H1N1 influenza pandemic and response to human infections from novel animal-origin H3N2 influenza viruses inform CDC's influenza prevention efforts and research activities for seasonal influenza epidemics and other influenza emergencies. This work includes building epidemiology and laboratory capabilities of state, local, and international public health programs, developing better vaccine technologies, improving public and provider awareness and demand for influenza vaccines, and encouraging appropriate use of antivirals.

The influenza program coordinates domestic and global prevention and control activities and serves as a leading expert on influenza emergencies for the U.S. Government, the World Health Organization (WHO), and numerous other public health partners. The influenza program supports operations in all U.S. States and in 47 countries. Assistance to these partners is provided through a variety of funding mechanisms including cooperative agreements with WHO offices, bilateral cooperative agreements with ministries of health and ministries of agriculture, and a number of cooperative agreements with all state health departments and other public health partners.

Recent accomplishments include:

- Achieved highest-ever vaccination coverage rate (119 million U.S. residents vaccinated against seasonal influenza; 80 million vaccinated against pandemic influenza) during the 2009-2010 influenza season.

- Identified and prepared influenza virus strains used in the 2010-11 seasonal influenza vaccines for the northern hemisphere and the 2010 seasonal vaccines for the southern hemisphere.

- Posted, since October 2009, over 5,068 sequences from 817 pandemic 2009 H1N1 viruses, 163 avian influenza viruses, and 518 seasonal influenza viruses to support researchers, and developers of new vaccines, antiviral drugs, and diagnostic devices.
  - Expanded influenza surveillance for enhanced monitoring of illness in outpatient and hospitalized populations. Increased utility of surveillance data for clinician and public use through interactive websites and clinical algorithms. These enhancements are being utilized for seasonal influenza response efforts.
  - Evaluated influenza surveillance data from new sources including: electronic health record vendors; large healthcare provider information systems; and commercial health data aggregators to enhance ongoing surveillance efforts, including use of BioSense and Distributed Surveillance Taskforce for Real-time Influenza Burden Tracking and Evaluation (DiSTRIBuTE), which is a new effort with the International Society for Disease Surveillance.
  - Increased the number of countries participating in WHO's Global Influenza Surveillance Network, and in the number of influenza isolates sent to WHO Collaborating Centers (such as in CDC's Influenza Division) for inclusion in the strain selection process for annual vaccine design. This support also enabled countries to respond more rapidly and effectively to the 2009 H1N1 influenza pandemic and to other infectious disease threats in their countries.
  - Provided data and technical support that has allowed countries to understand the disease burden associated with influenza, the risk groups, and the most efficient vaccination strategies. The expansion of local and global data on the need for influenza prevention, along with steady global increases in vaccine supply, should result in expansion of the use of influenza vaccines worldwide.

- Implemented a comprehensive communication and outreach campaign aimed at creating high awareness of CDC's new universal vaccination recommendation, fostering knowledge and favorable beliefs regarding influenza vaccination recommendations, maintaining and extending confidence in influenza vaccine safety, and promoting vaccination throughout the influenza season. Campaign elements include formative research and message testing, partner outreach and activities, television, radio, and print products, web and social media, education and outreach to health care professionals, and process evaluation. Also conducted a separate campaign encouraging a range of Hispanic populations, including less acculturated groups, to be vaccinated.

- Obtained FDA approval of the CDC developed real-time PCR (polymerase chain reaction) test that was previously given approval under an Emergency Use Authorization. Continued support through the IRR to manufacture, procure, and distribute diagnostic reagents for influenza surveillance testing.

- Shipped, through CDC's IRR, approximately 2,100 test kits (each able to perform 1,000 test reactions) to 545 laboratories in 150 countries. Provided viruses and other reagents to developers of new vaccines, antiviral drugs, and diagnostic devices.
- Enhanced genetic sequencing capacity to allow for rapid detection of significant changes in the pandemic strain and to allow for much faster detection of virus reassortants that could indicate the emergence of a new pandemic strain.
- Developed and implemented, in collaboration with the Association of Public Health Laboratories, a laboratory capacity review in more than 35 countries. The results are used to develop country-specific plans for improving laboratory capabilities and capacities.
- Improved awareness of appropriate antiviral use, particularly for persons with severe complications from influenza illness. As a consequence, 75 percent of children and adults with laboratory-confirmed influenza were treated with antivirals within 24 hours of admission to a hospital participating in the Emerging Infections Program (a catchment population of 24 million).

IT INVESTMENTS

CDC has made several investments in information technology 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, 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). The Vaccine Tracking System or VTrckS is an enterprise system that enables the tracking of federally contracted vaccine orders between manufacturers, distributor, and health care providers. VTrckS pilot implementation began in December 2010 with four pilot sites. Evaluation of this pilot will take place in early 2011 which will determine the timeline for the national transition to this new system. As a Web-based system for provider ordering and automated approvals that will improve operational efficiency and internal controls, VTrckS is a comprehensive IT solution that eliminates current legacy system limitations, provides a scalable platform, and facilitates central administration of vaccine management. The system will allow providers to order directly from the internet, improve internal controls, significantly reduce manual processes, and provide transparency into provider usage patterns improving data analysis capability. This real-time inventory visibility will improve preparedness, allow for a greater focus on public health, and reduce time and resources devoted to managing vaccines and funding (for funding information, see Exhibit 53).

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activity is included:

- Section 317 Immunization – $61,599,000

Funds will be used to prepare the immunization program for the full implementation of the ACA health insurance reforms by strengthening immunization systems and capabilities, including billing for immunization services, assuring vaccine delivery, and improving the information technology infrastructure of immunization programs.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012+/- FY 2010
Immunization and Respiratory Diseases	**$721,180**	**$821,285**	**$721,663**	**+$483**
- Section 317 Immunization Program	$497,525	$497,599	$495,102	-$2,497
- ACA/PPHF (non-add)	$0	$100,000	$61,599	+$61,599
- Program Implementation and Accountability	$63,934	$63,942	$66,889	+$2,955
- Pandemic and Seasonal Influenza	$159,721	$159,744	$159,672	-$49

MEASURES TABLE[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2010: 98% reduction (Target Met)	Maintain 98% reduction in inventory depots	Maintain 98% reduction in inventory depots	Maintain
Long Term Objective 1.2: Ensure that children and adolescents are appropriately vaccinated.				
1.2.1c: Achieve or sustain immunization coverage of at least 90% in children 19 to 35 months of age for: 1 dose MMR vaccine (Intermediate Outcome)	FY 2009: 90% (Target Met)	90%	90%	Maintain
1.2.1h: Achieve immunization coverage of at least 90% in children 19to 35 months of age for at least 4 doses pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2009: 80% (Target Not Met)	84%	90%	+6%
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 2009: 44% (Baseline)	44%	60%	+16%
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 2009: 62% (Target Exceeded)	64%	70%	+6%
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 2009: 55% (Target Exceeded)	61%	70%	+9%
Long Term Objective 1.3: Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.				
1.3.1a: Increase the rate of influenza and pneumococcal vaccination in persons 65 years of age and older to 90% by 2010: Influenza (Intermediate Outcome)	FY 2008: 67% (Target Not Met)	90%	90%	Maintain
1.3.1b: Increase the rate of influenza and pneumococcal vaccination in persons 65 years of age and older to 90%: Pneumococcal (Intermediate Outcome)	FY 2008: 60% (Target Not Met but Improved)	90%	90%	Maintain
1.3.2a: Increase the rate of vaccination among non-institutionalized high-risk adults aged 18 to 64 years to 60% for: Influenza (Intermediate Outcome)	FY 2008: 39% (Target Not Met but Improved)	60%	60%	Maintain
1.3.2b: Increase the rate of vaccination among non-institutionalized high-risk adults aged 18 to 64 years to 60% for: Pneumococcal (Intermediate Outcome)	FY 2008: 25% (Target Not Met but Improved)	60%	60%	Maintain

Long Term Objective 1.6: Protect Americans from infectious diseases – Influenza.				
1.6.1: Increase the number of public health laboratories monitoring influenza virus resistance to antiviral drugs (Output)	FY 2010: 3 (Target Not Met)	5	12	+7
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)	FY 2010: 100% (Target Exceeded)	80%	90% [2]	+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)	50%	75%	+25%

[1]Targets reflect impact of funding from ACA/PPHF. Measures do not reflect the impact of American Recovery and Reinvestment Act funding.
[2]FY 2011 will be used to establish a baseline of performance based on new planning assumptions and guidance developed from lessons learned through the 2009 H1N1 influenza pandemic.

OTHER OUTPUTS[1]

Outputs	Most Recent Result [5]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.A: Number of grantees with 95% of the children participating in fully operational, population-based registries	FY 2009: 23	27	29	+2
1.B: Number of grantees achieving 45% coverage for ≥ 2 doses hepatitis A vaccine (19-35 months of age)[2]	FY 2009: 31	21	40	+19
1.C: Number of grantees achieving 65% coverage for 1 birth dose hepatitis B vaccine (19-35 months of age)[2]	FY 2009: 25	30	40	+10
1.D: Number of grantees achieving 30% coverage for influenza vaccine (6-23 months of age)[2]	FY 2009: 16	18	29	+11
1.E: Number of grantees achieving 25% coverage for ≥ 3 doses human papillomarivus vaccine (13-17 years of age)[2]	FY 2009: 33	16	40	+24
1.F: Number of grantees achieving 45% coverage for ≥ 1 dose Tdap vaccine (13-17 years of age)[3]	FY 2009: 42	22	46	+24
1.G: Number of grantees achieving 45% coverage for ≥ 1 dose meningococcal conjugate vaccine (13-17 years of age)[3]	FY 2009: 33	22	40	+18
1.H: Number of grantees achieving 70% coverage for annual influenza vaccine (65 years of age and older)[4]	FY 2009: 24	39	34	-5
1.I: Number of influenza networks established globally	44 networks	45 networks	45 networks	Maintain

[1] Targets reflect impact of funding from ACA/PPHF. Outputs do not reflect the impact of American Recovery and Reinvestment Act funding.
[2] Fully vaccinated; National Immunization Survey (2009).
[3] National Immunization Survey-Teen (2009).
[4] Behavioral Risk Factor Surveillance System and the National 2009 H1N1 Flu Survey, end of January 2010.
[5] Based on the 50 state grantees and the District of Columbia.

STATE TABLES

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Section 317[1]

State/Territory/Grantee	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Alabama	$7,075,363	$7,085,164	$6,897,466	-$177,897
Alaska	$5,179,104	$5,185,125	$4,526,990	-$652,114
Arizona	$9,482,051	$9,495,746	$9,496,763	$14,712
Arkansas	$4,226,332	$4,232,471	$4,248,565	$22,233
California	$53,627,419	$53,704,177	$53,397,790	-$229,629
Colorado	$8,022,378	$8,033,517	$7,832,197	-$190,181
Connecticut	$5,642,845	$5,650,882	$5,600,650	-$42,195
Delaware	$1,215,913	$1,218,077	$1,402,264	$186,351
District of Columbia	$2,315,139	$2,318,651	$2,394,777	$79,638
Florida	$24,504,364	$24,537,903	$23,704,811	-$799,553
Georgia	$14,421,816	$14,441,197	$13,789,104	-$632,712
Hawaii	$2,969,180	$2,973,532	$3,002,729	$33,549
Idaho	$3,900,371	$3,905,332	$3,602,266	-$298,105
Illinois	$6,962,588	$6,972,383	$6,855,544	-$107,045
Indiana	$3,868,102	$3,873,166	$3,637,872	-$230,229
Iowa	$4,542,440	$4,548,964	$4,533,249	-$9,191
Kansas	$4,381,870	$4,388,087	$4,338,323	-$43,547
Kentucky	$6,093,992	$6,102,166	$5,819,484	-$274,509
Louisiana	$7,358,249	$7,366,506	$6,297,096	-$1,061,153
Maine	$3,052,968	$3,057,850	$3,271,790	$218,822
Maryland	$6,323,825	$6,333,474	$6,567,058	$243,233
Massachusetts	$9,329,780	$9,342,223	$8,877,571	-$452,209
Michigan	$14,294,086	$14,313,475	$13,748,303	-$545,784
Minnesota	$8,111,201	$8,122,666	$8,010,789	-$100,413
Mississippi	$4,113,966	$4,120,060	$4,189,067	$75,101
Missouri	$6,993,650	$7,002,774	$6,562,477	-$431,174
Montana	$1,533,489	$1,535,693	$1,531,244	-$2,245
Nebraska	$2,869,258	$2,873,427	$2,885,385	$16,127
Nevada	$4,105,191	$4,111,030	$4,070,966	-$34,224
New Hampshire	$2,200,694	$2,203,789	$2,166,724	-$33,970
New Jersey	$10,510,198	$10,524,520	$10,138,512	-$371,687

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2012 DISCRETIONARY STATE/FORMULA GRANTS
Section 317[1]

State/Territory/Grantee	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
New Mexico	$3,613,313	$3,618,907	$3,789,228	$175,915
New York	$14,004,718	$14,026,492	$14,727,095	$722,377
North Carolina	$11,736,252	$11,753,156	$11,733,692	-$2,560
North Dakota	$2,356,548	$2,359,717	$2,253,992	-$102,557
Ohio	$15,651,600	$15,672,530	$14,917,972	-$733,628
Oklahoma	$4,895,660	$4,902,958	$5,005,999	$110,339
Oregon	$5,886,007	$5,894,327	$5,812,995	-$73,012
Pennsylvania	$11,945,665	$11,961,960	$11,530,656	-$415,009
Rhode Island	$2,400,908	$2,404,419	$2,424,312	$23,404
South Carolina	$6,561,053	$6,570,121	$6,386,371	-$174,682
South Dakota	$2,608,547	$2,611,775	$2,368,813	-$239,734
Tennessee	$7,833,979	$7,843,727	$7,137,399	-$696,580
Texas	$30,273,388	$30,314,868	$29,305,892	-$967,496
Utah	$4,238,749	$4,244,891	$4,254,378	$15,629
Vermont	$2,349,968	$2,353,086	$2,228,599	-$121,369
Virginia	$10,734,618	$10,749,237	$10,351,357	-$383,261
Washington	$11,921,675	$11,936,654	$10,926,998	-$994,677
West Virginia	$3,324,407	$3,328,980	$3,226,154	-$98,253
Wisconsin	$9,753,972	$9,766,655	$9,133,413	-$620,560
Wyoming	$1,517,550	$1,519,792	$1,542,788	$25,238
Chicago	$5,907,487	$5,916,209	$6,003,000	$95,513
Houston[2]	$2,010,245	$2,014,315	$2,541,540	$531,295
New York City	$13,186,045	$13,205,074	$13,199,923	$13,878
Philadelphia	$2,795,574	$2,799,891	$2,926,715	$131,141
San Antonio	$2,250,893	$2,254,546	$2,436,428	$185,535
American Samoa	$587,786	$588,827	$675,765	$87,978
Guam	$1,299,174	$1,301,347	$1,435,678	$136,504
Marshall Islands	$2,010,779	$2,013,743	$2,041,172	$30,393
Micronesia	$3,581,181	$3,586,032	$3,441,476	-$139,705
Northern Mariana Islands	$974,518	$976,294	$1,142,460	$167,942
Puerto Rico	$5,065,876	$5,073,682	$5,295,336	$229,460
Republic Of Palau	$507,658	$508,371	$499,300	-$8,359
Virgin Islands	$1,016,009	$1,017,971	$1,241,661	$225,652

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2012 DISCRETIONARY STATE/FORMULA GRANTS Section 317[1]				
State/Territory/Grantee	**FY 2010 Actual**	**FY 2011 Continuing Resolution**	**FY 2012 President's Budget**	**FY 2012 +/- FY 2010**
Total States/Cities/Territories	**$454,029,627**	**$454,664,582**	**$445,336,381**	**-$8,693,245**
Other Adjustments[3]	$42,817,374	$42,894,418	$49,765,619	+$6,948,245
Total Resources [4,5]	**$496,847,000**	**$497,559,000**	**$495,102,000**	**-$1,745,000**

[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 2012 includes Affordable Care Act Prevention and Public Health Fund (ACA/PPHF) request of $61,599,000. ACA/PPHF funding will be made available to grantees through a process separate from the immunization infrastructure/operations grant.
[5]The FY 2010 and FY 2011 levels do not include American Recovery and Reinvestment Act funding.

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2012 MANDATORY STATE/FORMULA GRANTS Vaccines for Children Program (VFC)				
State/Territory/Grantee	**FY 2010 Actual**	**FY 2011 Continuing Resolution[3]**	**FY 2012 President's Budget**	**FY 2012 +/- FY 2011**
Alabama	$54,438,469	$56,907,777	$58,629,528	$1,721,751
Alaska	$10,892,797	$11,384,539	$11,713,357	$328,818
Arizona	$80,911,031	$84,582,084	$87,139,087	$2,557,003
Arkansas	$38,414,041	$40,157,609	$41,370,204	$1,212,594
California	$369,245,876	$385,984,288	$397,684,403	$11,700,115
Colorado	$39,484,634	$41,280,259	$42,519,411	$1,239,151
Connecticut	$27,473,688	$28,729,517	$29,578,316	$848,799
Delaware	$9,678,720	$10,122,746	$10,418,406	$295,660
District of Columbia	$8,443,285	$8,832,944	$9,086,038	$253,095
Florida	$172,441,528	$180,261,060	$185,719,854	$5,458,794
Georgia	$133,535,817	$139,589,896	$143,819,673	$4,229,777
Hawaii	$12,888,279	$13,487,183	$13,864,938	$377,756
Idaho	$25,138,091	$26,280,211	$27,071,366	$791,155
Illinois	$89,191,268	$93,240,771	$96,053,678	$2,812,907
Indiana	$87,085,278	$91,034,102	$93,791,166	$2,757,065
Iowa	$21,320,298	$22,292,247	$22,956,382	$664,136

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2012 MANDATORY STATE/FORMULA GRANTS Vaccines for Children Program (VFC)				
State/Territory/Grantee	**FY 2010 Actual**	**FY 2011 Continuing Resolution[3]**	**FY 2012 President's Budget**	**FY 2012 +/- FY 2011**
Kansas	$21,230,831	$22,199,723	$22,858,938	$659,215
Kentucky	$40,775,638	$42,624,547	$43,915,553	$1,291,006
Louisiana	$72,380,764	$75,659,299	$77,958,187	$2,298,887
Maine	$9,740,128	$10,191,711	$10,479,345	$287,634
Maryland	$57,918,545	$60,546,018	$62,377,188	$1,831,170
Massachusetts	$54,987,313	$57,487,296	$59,214,330	$1,727,034
Michigan	$91,956,660	$96,130,001	$99,033,714	$2,903,713
Minnesota	$31,991,765	$33,448,646	$34,448,458	$999,811
Mississippi	$40,721,892	$42,568,913	$43,857,069	$1,288,155
Missouri	$52,264,137	$54,636,793	$56,285,648	$1,648,855
Montana	$7,048,521	$7,372,526	$7,586,498	$213,972
Nebraska	$17,348,530	$18,137,369	$18,682,056	$544,686
Nevada	$26,487,013	$27,694,162	$28,519,953	$825,790
New Hampshire	$9,267,397	$9,693,424	$9,974,700	$281,277
New Jersey	$61,993,261	$64,812,454	$66,758,096	$1,945,643
New Mexico	$29,855,808	$31,216,555	$32,147,239	$930,684
New York	$80,323,826	$83,989,584	$86,483,433	$2,493,849
North Carolina	$103,322,607	$108,009,214	$111,277,184	$3,267,970
North Dakota	$5,743,258	$6,006,346	$6,182,609	$176,263
Ohio	$88,617,833	$92,630,597	$95,447,782	$2,817,186
Oklahoma	$50,370,353	$52,660,676	$54,242,180	$1,581,503
Oregon	$27,502,087	$28,760,744	$29,607,221	$846,477
Pennsylvania	$73,329,702	$76,675,485	$78,953,818	$2,278,333
Rhode Island	$12,132,116	$12,687,977	$13,060,083	$372,107
South Carolina	$52,864,147	$55,268,286	$56,927,204	$1,658,917
South Dakota	$8,559,019	$8,950,122	$9,214,829	$264,707
Tennessee	$71,415,794	$74,654,713	$76,914,403	$2,259,690
Texas	$353,629,399	$369,659,788	$380,865,293	$11,205,505
Utah	$24,053,278	$25,150,426	$25,898,425	$747,998

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2012 MANDATORY STATE/FORMULA GRANTS
Vaccines for Children Program (VFC)

State/Territory/Grantee	FY 2010 Actual	FY 2011 Continuing Resolution[3]	FY 2012 President's Budget	FY 2012 +/- FY 2011
Vermont	$5,801,941	$6,072,835	$6,240,206	$167,371
Virginia	$50,410,803	$52,695,325	$54,294,062	$1,598,737
Washington	$78,306,967	$81,880,718	$84,311,870	$2,431,152
West Virginia	$16,842,916	$17,607,388	$18,139,077	$531,689
Wisconsin	$41,322,178	$43,198,831	$44,500,952	$1,302,121
Wyoming	$7,241,085	$7,572,694	$7,795,117	$222,423
Chicago	$50,071,901	$52,351,704	$53,917,466	$1,565,763
Houston[1]	$703,717	$744,492	$748,249	$3,757
New York City	$128,523,164	$134,357,727	$138,412,554	$4,054,826
Philadelphia	$25,310,045	$26,467,881	$27,247,936	$780,055
San Antonio	$24,748,609	$25,874,638	$26,650,184	$775,546
American Samoa	$939,212	$982,058	$1,010,389	$28,331
Guam	$2,201,970	$2,303,771	$2,366,227	$62,456
Northern Mariana Islands	$1,214,046	$1,269,864	$1,305,368	$35,504
Puerto Rico	$48,217,191	$50,410,529	$51,922,511	$1,511,982
Virgin Islands	$2,021,616	$2,122,141	$2,167,641	$45,499
Total States/Cities/Territories	**$3,242,292,082**	**$3,389,603,224**	**$3,491,617,049**	**$102,013,824**
Other Adjustments[2]	$518,345,918	$516,040,776	$539,378,951	$23,338,176
Total Resources	**$3,760,638,000**	**$3,905,644,000**	**$4,030,996,000**	**$125,352,000**

[1]Funding for Houston only includes funding for operations, not the cost of vaccines. Funding for Texas includes the cost of vaccines for Houston.
[2]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.
[3]The FY 2011 estimate for VFC represents estimated total obligations, including $6.551 million in unobligated balances and recoveries brought forward and $3.899 billion in transfer from CMS.

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

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$1,088,345	$1,088,500	$1,157,133	+$68,788
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$30,367	$0	$30,400	+$33
Total	**$1,118,712**	**$1,088,500**	**$1,187,533**	**+$68,821**
FTEs	1,389	1,407	1,407	+18

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $1,187,533,000 for HIV/AIDS, Viral Hepatitis (VH), Sexually Transmitted Diseases (STDs), and Tuberculosis (TB) Prevention, including $30,400,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an overall increase of $68,821,000 above the FY 2010 level. The FY 2012 request also includes a transfer of $40,000,000 from the Chronic Disease Prevention and Health Promotion budget for the comprehensive school health program to achieve closer coordination with CDC's HIV programs and activities.

The FY 2012 request reflects a substantial investment to achieve the goals of the National HIV/AIDS Strategy (NHAS). CDC is investing new and continuing resources to address priorities outlined in the NHAS. In addition, this request responds to the Institute of Medicine's recommendations to prevent viral hepatitis and prevent the occurrence of cancer and liver disease in the three to five million persons with chronic VH infection.

CDC will continue to work to eliminate TB in the United States, building on the substantial achievements made in TB control in the United States in the past 15 years despite high levels of TB globally. CDC will continue to reduce health conditions related to STDs, including HIV and infertility, building upon recent advances in STD prevention including declines in gonorrhea, increased provision of chlamydia testing in young women, and newly available vaccines for HPV. Finally, CDC will continue to address challenges posed by resistant gonorrhea, increases in syphilis, and continued high level of infections among vulnerable populations, such as young women.

CDC provides national leadership to prevent and control HIV, VH, STDs, and TB in the United States. CDC monitors these infections and related risk factors; implements effective prevention and control programs; and, conducts prevention research, demonstration and evaluation efforts to refine prevention approaches. Program activities are conducted in partnership with other institutions in the United States and around the globe. Efforts focus on populations most affected, including racial and ethnic minorities, men who have sex with men (MSM) of all races, the foreign born, and young, sexually active adults. A Social determinants of health, which considers the structural, contextual, socioeconomic status (SES), healthcare service access and quality, and environmental factors, in addition to individual risks, is used to address these disparities in health.

In FY 2012, CDC will continue to enhance program coordination and service integration (PCSI) across HIV, VH, STD, and TB. Through PCSI, CDC is working to strengthen collaborative work across disease areas and integrate services that are provided by related programs at the client level. 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. CDC requests authority to allow CDC and grant recipients to transfer up to five percent of funds across HIV/AIDS, VH, STD, and TB prevention activities. 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.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 307, 310, 311, 317, 327, 352

Program Specific Authorities: PHSA §§ 306, 308, 317E, 317N, 317P, 317T, 318, 318A, 318B, 322, 325, 2315, 2320, 2341; P.L. 103-333; Section 213 of the Departments of Labor, HHS, Education & Related Agencies Appropriations Act of 2010 (P.L. 111-117, Division D)

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year*	Amount
FY 2007	$1,002,513,000
FY 2008	$1,002,130,000
FY 2009	$1,006,375,000
FY 2010*	$1,118,712,000
FY 2011CR	$1,088,500,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Domestic HIV/AIDS Prevention and Research

Important changes have occurred in the field of HIV prevention in the last year which have created exciting, new opportunities to lower the number of new HIV infections that occur each year in the United States. CDC, as the nation's lead HIV prevention agency, will remain at the forefront of preventing new infections by providing leadership in adapting to these events and providing guidance to other agencies, other levels of government, and community stakeholders demonstrating how to incorporate the best evidence to ensure that national investments in HIV prevention are leveraged to maximum effect.

Significant research developments point to new effective approaches for preventing new HIV infections. In July 2010, at the International AIDS Conference in Vienna, Austria, researchers involved with the Centre for the AIDS Programme of Research in South Africa (CAPRISA) vaginal microbicide trial provided proof of concept that a microbicide containing antiretroviral medications can be effective at preventing infections. Results showed moderate effectiveness. Additional studies are needed to confirm effectiveness before FDA approval, improve effectiveness in practice, and to better understand how to implement this approach for both vaginal and rectal intercourse. Data from British Columbia, Denmark and San Francisco found substantial reductions in HIV incidence associated with maximizing viral suppression among a high proportion of HIV-positive individuals. Moreover, the investigators in British Columbia and San Francisco found that community viral load, the mean viral load of all HIV positive individuals receiving care in a given area, is associated with HIV incidence. In November 2010, investigators supported by the National Institutes of Health (NIH) announced findings of a study of pre-exposure prophylaxis (PrEP) 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 44 percent, and had even higher rates of

effectiveness, up to 73 percent, among those participants who adhered most closely to the daily drug regimen. This is one of several PrEP studies that are taking place in the United States and around the world. CDC is funding other trials and is working collaboratively with NIH on other studies. While no single HIV prevention method is 100 percent effective, and a combination of approaches including correct and consistent condom use will be necessary to prevent HIV infection. These studies provide encouraging new evidence that antiretroviral medications are a valuable addition to the HIV prevention tool chest.

In July 2010, the Obama Administration released the first comprehensive *National HIV/AIDS Strategy for the United States (NHAS)*. In releasing NHAS, President Obama wrote the following, "Our country is at a crossroads. Right now, we are experiencing a domestic epidemic that demands a renewed commitment, increased public attention, and leadership…this moment represents an opportunity for the Nation. Now is the time to build on and refocus our existing efforts to deliver better results for the American people. I look forward to working with Congress, State, tribal, and local governments, and other stakeholders to support the implementation of a Strategy that is innovative, grounded in the best science, focuses on the areas of greatest need, and that provides a clear direction for moving forward together." The NHAS was the result of unprecedented public input, including 14 HIV/AIDS community discussions held across the country, as well as an online suggestions process, various expert meetings and other inputs. Senior leaders at CDC were involved in a Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS, which focused on three overarching goals: reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities. The NHAS set three specific metrics for measuring our nation's collective success at reducing new infections.

Over the next five years, from 2010-2015 in the U.S., the NHAS aims to: 1) lower the annual number of new infections by 25 percent (from 56,300 to 42,225, per year); 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 (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV); and 3) increase from 79 to 90 the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

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 recognizes the importance of pivoting toward a more effective HIV prevention response and seeks to focus the nation's HIV prevention investments on achieving these three essential goals. CDC's FY 2012 request of $857,608,000 for Domestic HIV/AIDS Prevention and Research, including $30,400,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an increase of $58,338,000 above the FY 2010 level. CDC will transfer one percent of its domestic HIV/AIDS budget to the Department of Health and Human Services (HHS) to support cross-cutting efforts to implement the National HIV/AIDS Strategy. The FY 2012 request also includes $40,000,000 transferred from the Chronic Disease Prevention and Health Promotion for the HIV school health program to achieve closer coordination of CDC's HIV prevention programs.

CDC's FY 2012 efforts will continue to align with its assigned NHAS activities, including improving core surveillance and use of community viral load, enhancing prevention among most affected communities, integrating care and prevention, expanding HIV testing and linkage to care services, building capacity, developing evidence-based social marketing campaigns, and improving the quality and monitoring of all programs. CDC will continue to work with other federal agencies, state and local health

departments, national organizations, community-based organizations, the private sector, and advocates to reduce the spread of HIV in the U.S. In FY 2012, CDC will:

- Institute a new funding formula for the FY 2012 flagship health department cooperative agreement over three-years to focus on high risk populations.
- Use information gained from early experiences with the Enhanced Comprehensive HIV Prevention Planning project (ECHPP) to inform and develop the new FY 2012 Health Department cooperative agreements to maximize reductions in incidence.
- Expand flexibility by allowing CDC and States to transfer up to five percent across CDC HIV/AIDS, VH, STDs, and TB activities for program collaboration and service integration.

The FY 2012 budget request reflects a substantial investment in the priorities outlined in the NHAS, with new and redirected funds focused on priorities outlined in the Strategy. New investments include:

- Expand implementation and monitoring of enhanced HIV prevention plans developed by the 12 health jurisdictions with the greatest burden of HIV/AIDS as part of the Enhanced Comprehensive HIV Prevention Planning (ECHPP) project ($10,000,000 allocation from the ACA/PPHF).
- Expand the reach and impact of HIV prevention activities for MSM by supporting demonstration projects that will employ cost effective evidence-based approaches to reduce HIV incidence, improve the sexual health of MSM, and conduct research to develop and test innovative prevention interventions. MSM population represents only two percent of the U.S. population, but 53 percent of HIV infections. CDC will support a multi-faceted approach involving health departments, community-based organizations, and other organizations (an increase of $20,400,000 above the FY 2010 level as follows: $10,400,000 for HIV Prevention with Health Departments; $5,000,000 for National, Regional, Local, Community and Other Organizations; and $5,000,000 for Improving Program Effectiveness). This amount does not reflect the total funding spent by CDC and its grantees on prevention among MSM.
- Decrease risky behaviors among HIV-infected persons and among high risk populations, including MSM, injection drug users (IDUs), and high-risk heterosexuals, and support the reduction in individual and community viral load among HIV-infected persons. Specifically, CDC will expand efforts begun in FY 2010 to support the improved use of CD4 and HIV viral load data to reduce HIV incidence, improve the health of people living with HIV and reduce HIV-related disparities (an increase of $11,900,000 above the FY 2010 level as follows: $5,000,000 for HIV Surveillance, $5,000,000 for Improving Program Effectiveness, and $7,500,000 allocated from the ACA/PPHF).
- Integrate program monitoring across HIV, viral hepatitis, STD and TB programs and support the integration of HIV program monitoring. After conducting feasibility assessments of the data systems and data requirements, CDC will plan and pilot integrated use of key, core data elements from all CDC program monitoring systems and provide assistance to selected health departments to develop integrated use of jurisdiction-level data from HIV, STD, TB, and viral hepatitis programs and surveillance (an increase of $10,000,000 above the FY 2010 level for Improving Program Effectiveness).

- Increase, from the FY 2010 base of six to 11, the number of demonstration projects to promote PCSI with prevention programs for VH, STDs, and TB. These PCSI projects will also provide further examples of best and promising practices in the field and will be the source of data on program effectiveness. CDC will conduct studies of PCSI effectiveness, specifically: a meta-analysis of the literature related to PCSI; mathematical models that can estimate the impact of integration on epidemic trajectories; and an evaluation of demonstration projects. Information gleaned from these efforts will further support the identification of PCSI priorities at the national and state levels (an increase of the $10,000,000 above the FY 2010 level for Improving Program Effectiveness).
- Conduct cross-cutting activities in conjunction with HHS and other agencies to implement the agency operational plans to meet NHAS objectives to reduce incidence, improve health outcomes for people living with HIV and reduce disparities in health caused by HIV ($7,905,000 across the domestic HIV/AIDS prevention and research budget).
- Combine biomedical behavioral, and structural approaches and integrate them through program activities and demonstration projects within CDC's HIV prevention portfolio, specifically for six-to-ten high-burden jurisdictions to develop, monitor, and evaluate innovative models for prevention with positives and delivering PrEP to persons at high-risk of HIV infection ($9,700,000 allocation from the ACA/ PPHF).
- Expand the capacity of health departments and community-based organizations to deliver high-impact interventions and strategies to highly impacted populations by providing intense technical assistance ($2,000,000 allocation from the ACA/PPHF).
- Continue work begun in 2010 to prevent HIV, VH and STDs and promote sexual health with Indian Tribal Organizations ($1,200,000 allocation from the ACA/PPHF).

The FY 2012 request also includes the redirections of approximately $51,000,000 from less effective and efficient interventions funded in FY 2010 to interventions that are aligned with the goals and recommendations of the NHAS. This improved efficiency is achieved by:

- Placing greater emphasis on effective interventions for people living with HIV, including linkage to and retention in medical care, adherence to antiretroviral treatment, and focus on interventions that reduce transmission risk (such as Partnership for Health, Healthy Relationships and Willow);
- Placing greater emphasis on effective community-level, structural, and single session interventions and public health strategies (such as increasing condom availability and community-level interventions such as d-up!, Shield, and Mpowerment); and,
- De-emphasizing intensive individual and small group interventions for at-risk populations that are difficult to take to scale (such as Adult Identity Mentoring-school based intervention targeting African-American and Latino youth (AIM), Holistic Health Recovery Program, and Safety Counts).

Program	Estimated Amount to be Realigned
Health Department Cooperative Agreement	$44,000,000
Directly-Funded CBO Program	$3,500,000
Capacity-Building Assistance Program	$3,500,000
Total Estimated Realignment	**$51,000,000**

HIV Prevention by Health Departments

CDC's FY 2012 request for HIV Prevention by Health Departments is $343,318,000. CDC's core HIV prevention programs with state and local health departments provide the foundation for HIV prevention and control nationwide. Successful execution of these programs is a pre-requisite for achieving the prevention goals of the NHAS. Funding dedicated to this activity supports the three primary goals of the NHAS:

1. *Reducing HIV incidence:* Supports health departments to deliver effective, evidence based biomedical and behavioral prevention interventions to reduce HIV incidence; implement interventions with HIV positive individuals; promote HIV testing and linkage to care; and address associated syndemics which drive HIV transmission.
2. *Increasing linkage to quality care and retention in care of previously diagnosed individuals:* Supports health departments to enhance HIV testing, linkage to care efforts in clinical and community settings, and re-engagement of previously diagnosed HIV-infected individuals in care.
3. *Reducing health disparities*: Supports health department activities focused on groups at highest risk for HIV acquisition with scalable, culturally competent interventions that have a public health rather than an individual impact; community mobilization, education and engagement efforts.

In FY 2012, CDC will:

- Ensure a strong network of HIV prevention programs nationwide by providing technical and financial support to 65 health department jurisdictions, and encourage grantee focus on populations most at risk for HIV in their jurisdictions.
- Institute revised funding allocations to health departments' prevention programs, in alignment with the NHAS, to "ensure that Federal HIV prevention funding allocations go to the jurisdictions with the greatest need." CDC is committed to an open, transparent process for soliciting input through ongoing stakeholder engagement. While this stakeholder engagement process is ongoing, CDC has made several determinations based on feedback received thus far:
    - Core funding will be provided to all states to allow basic program activities to continue (e.g., testing of persons at high risk, linkage to care, partner services).
    - Funding above core, which will represent the majority of available funds, will be distributed based upon a funding algorithm based on need.
    - The main criterion used for the algorithm will be the number of people diagnosed and reported to be living with HIV infection during 2008, the latest data available.
    - Funding realignments will be phased in over three years to minimize disruption to grantee activities and allow for planning.
    - At least 50 percent of funds will be realigned in the first year of implementation, with full implementation achieved by the third year.

CDC is still engaging partners to inform other elements of the formula, including:

- Determining the appropriate level for core funding for jurisdictions;
- Providing an appropriate amount of resources to cities and territories; and

- Determining which parts of CDC's HIV prevention portfolio (e.g., core HIV Prevention projects, the expanded testing initiative) should be considered in the algorithm.

Stakeholder engagement is ongoing, and will continue throughout implementation, with total alignment achieved by FY 2014.

In FY 2012, the program will:

- Expand implementation and monitoring of enhanced HIV prevention plans developed by the 12 health jurisdictions with the greatest burden of HIV/AIDS as part of the ECHPP project with support from the ACA/PPHF. ECHPP represents a groundbreaking effort to better coordinate the federal response to HIV at the local level and achieve the NHAS goal of achieving a more coordinated national response to the HIV epidemic in the United States. This furthers the goals of the National HIV/AIDS Strategy by supporting the implementation of these jurisdictions' plans to maximize the impact and efficiency of HIV prevention efforts in their local areas; intensify HIV prevention in communities in the geographic areas and populations where HIV is most heavily concentrated; and expand targeted efforts to reduce HIV incidence, improve health of people living with HIV, and reduce HIV-related disparities by using a combination of cost-effective evidence-based approaches that can be taken to scale. Plans reflect interventions such as testing (routine, opt-out testing in clinical settings and targeted testing for those at high risk), condom distribution programs for persons at high risk and HIV-positive persons, policy and structural interventions, post exposure prophylaxis, and comprehensive prevention with positives including behavioral and biomedical interventions such as anti-retroviral therapy, retention in care, adherence support, condoms, and risk reduction education.

- Further expand the reach and impact of HIV prevention activities for MSM to support the expansion of effective biomedical and behavioral HIV prevention programs including HIV testing, partner services, condom promotion and other newly proven prevention strategies in jurisdictions with large numbers of AIDS cases among MSM. Funding from the prevention with health departments' budget will be used to support eight to twelve health department intensive demonstration projects that employ effective evidence-based approaches to reduce HIV incidence and improve the sexual health of MSM. Additionally, CDC will support research to improve the effectiveness of HIV prevention for MSM and reduce HIV incidence in this population. Community-based organizations (CBOs) have unique access to highly impacted MSM communities; therefore, CBOs and other organizations that work with them will also be supported to improve prevention services delivered to MSM.

- Continue efforts to direct funding and program activities to populations most affected by HIV. CDC's guidance to grantees is to redirect resources to emphasize testing, partner services and education efforts that have maximum impact.

- Provide technical assistance and training to staff of health departments on the implementation of newly published recommendations for HIV testing, counseling, and linkage to health care in non-healthcare settings.

- Redirect funding within the health department cooperative agreement to achieve greater efficiency. Health departments would be required to reallocate approximately 15 percent of their awards from lower to higher impact activities, relative to their FY 2010 allocations. This would include 1) shifting intervention activities to emphasize more scalable Diffusion of Effective Behavioral Interventions (DEBIs) and Public Health Strategies (PHSs), similar to the shift in the CBO and CBA programs (see NRLCO section below); and 2) implementing more cost-efficient strategies for community planning; and 3) implementing more efficient strategies for HIV testing. The total award for this program is approximately $292,000,000. Performance: Interventions such as HIV testing, HIV partner services and counseling and education efforts have been shown to be cost-effective. For every HIV infection prevented, an estimated $355,000 is saved in the cost of providing lifetime HIV treatment[4]— a significant cost-savings for the federal government, which spent an estimated $12.3 billion on HIV-related direct medical costs in 2009. It has been estimated that HIV prevention efforts in the United States. have averted more than 350,000[5] HIV infections and have averted more than $125 billion in medical costs.

Since the beginning of the epidemic, CDC has led national governmental efforts to prevent HIV. Due to federal, state, and local governmental response, community action, increased number and effectiveness of interventions, and public support, HIV incidence has declined significantly from approximately 130,000 cases per year in the mid-1980s to approximately 56,000 cases per year today. While overall rates have been relatively stable for the past decade, rates have declined among certain groups (e.g., IDUs), remained stable in others (high risk heterosexual men and women of all races), while increasing among MSM irrespective of race or ethnicity. HIV transmission rates have declined by approximately 90 percent since the early 1980s, and have continued to decline about 33 percent over the last decade (from an estimated eight transmissions per 100 persons living with HIV in 1997 to five in 2006). CDC has established targets to reduce HIV incidence and HIV transmission and increase knowledge of serostatus, consistent with the NHAS, and will be working to achieve these targets by refocusing its core prevention programs and by expanding efforts aimed at the most vulnerable populations. Disparities in cases of HIV have not declined among African Americans and Hispanics (as measured by rate ratios) since 2007 and both African Americans and Hispanics continue to be diagnosed at rates far higher than whites (9.22 to 1 and 3.49 to 1, respectively). Rates among MSM are approximately over 40 times those of the heterosexual men and women. Reducing risky sexual and drug-using behaviors among MSM and increasing the proportion of MSM who received HIV prevention interventions continues to be a challenge. Risk behaviors among MSM are increasing, and HIV prevention fatigue may be occurring among groups at increased risk for HIV. CDC is refining its measures of health disparities and is undertaking a number of initiatives to further reduce disparities in HIV for MSM, African-Americans and Hispanics. (Measures 2.1.1, 2.1.3, 2.1.4, 2.2.1, 2.3.1, 2.4.2, 2.A, and 2B)

Program Description and Recent Accomplishments: CDC's core domestic HIV prevention cooperative agreement programs are conducted in conjunction with and through 65 state, territorial, and local health departments, and guided by state and local level communities with input from infected and affected persons. Common program components include interventions to educate at-risk individuals and reduce risky behaviors; voluntary counseling and testing services; partner services; prevention services for persons living with HIV, including services intended to prevent perinatal transmission; and utilization of program monitoring data for accountability and program improvement. Additionally, CDC provides capacity building and technical assistance

[4] Schackman BR, Gebo KA, Walensky RP, et al. The lifetime cost of current human immunodeficiency virus care in the United States. *Med Care* 2006 Nov;44(11):990-97.
[5] Farnham PR, Holgrave DH, Sansom, SL, et al. Medical Costs Averted by HIV Prevention Efforts in the United States, 1991–2006. *J Acquir Immune Defic Syndr* 2010 Aug;54(5):565-567.

to health departments through cooperative agreements to ensure that they have the information, training, and infrastructure support necessary to implement effective programs in their communities.

Recent accomplishments include:

- Initiated the Enhanced Comprehensive HIV Prevention Planning (ECHPP) program, a new program, with 12 health departments serving high burden jurisdictions. This program, begun with PPHF funding in FY 2010, will be continued in FY 2012 with funding from CDC's HIV Prevention with Health Departments' budget. Funding will be augmented in FY 2012 with PPHF support, maximizing the implementation of program plans. Upon the conclusion of ECHPP, strategies guiding this program, and lessons learned from its implementation will be transferred to CDC's core prevention programs with health departments.
- Developed implementation guidance to assist state and local health departments choosing to conduct syringe services programs. The guidance was intended to help grantees comply with applicable laws guiding federal funding of such programs.
- Ensured that more than 90 percent of those who tested positive in CDC-funded counseling and testing programs received their results. Historically, a large proportion (up to 50 percent) of persons who tested positive for HIV did not return to the clinic to receive their test results.

HIV Surveillance

CDC's FY 2012 request for HIV Surveillance is $115,803,000. CDC surveillance of HIV and AIDS, related risk behaviors, and access to care are fundamental to the effective direction of prevention, care and treatment programs and serve as the foundation for assessing achievement of NHAS goals. In FY 2010, CDC awarded supplemental funds to all states, territories, and directly funded jurisdictions to implement policies oriented towards comprehensive reporting and use of CD4 cell counts and viral loads. In 2011, CDC and Health Resources and Services Administration (HRSA) will host a consultation to assist with the development of guidance related to the best use of these data for surveillance (e.g., community viral load, linkage to care and retention in care), as well as program improvement related to providing clinicians and patients with appropriate information for improving quality of care and retention in care and reducing viral load.

Jurisdictions involved in the ECHPP program, and those selected from outside this program, will explore the programmatic use of these data to improve the quality of services, monitor the epidemic, target resources, and, in alignment with the NHAS, support reductions in HIV incidence. Funding dedicated to this activity supports the three primary goals of the NHAS:

1. *Reducing HIV incidence:* Supports health departments to effectively track new HIV infections and diagnoses, deaths, care access, and risk behaviors to characterize the domestic epidemic and inform public health action.
2. *Increasing linkage to quality care and retention in care of previously diagnosed individuals:* Supports activities to characterize HIV infected individuals within and outside of care; determine clinical outcomes; provide estimates of disease burden for care planning; and inform priorities for clinical and public health intervention.
3. *Reducing health disparities*: Supports health department activities aimed at monitoring HIV diagnoses by key demographic and behavioral groups; undertake special surveys to characterize health outcomes, access to care and behaviors among highest risk group; assist with projections for current and future burden on disease.

In FY 2012, CDC will:

- Provide financial and technical assistance to 65 project areas to conduct and improve HIV case surveillance. All 50 states are expected to have mature, name-based HIV reporting by the end of FY 2012. All jurisdictions are required to meet annual performance standards, such as completeness and timeliness of reporting.
- Accurately estimate the annual number of new cases of HIV in the United States so that prevention activities can be appropriately targeted and progress towards national goals can be assessed. Twenty-five project areas will be supported to conduct HIV incidence surveillance.
- Continue to provide national leadership and technical assistance to localities to guide the collection of data to calculate community viral load. This project was first funded in FY 2010, with support from the Prevention and Public Health Fund, and will receive partial support from PPHF in FY 2012. CDC will support the improved use of CD4 and HIV viral load data to reduce HIV incidence, improve the health of people living with HIV and reduce HIV-related disparities. Funds will support the ability of all funded health jurisdictions to collect CD4 and viral load data as part of their core surveillance activities and support the development of local community viral load estimates; improve the ability of health departments to use geospatial information to monitor and respond to the local epidemic; and, support the first year of a three-year demonstration projects in three to six health jurisdictions that will develop, monitor, and evaluate models for using CD4, viral load and other surveillance data to improve the effectiveness of local HIV prevention efforts and improve the health of people living with HIV by maintaining linkage and adherence to appropriate and timely medical care and prevention services.
- Continue to implement and analyze the data from an annual internet-based survey of MSM to monitor risk behavior, access to services, and use of services.
- Monitor risk behaviors and clinical outcomes among HIV-infected persons in care through the Medical Monitoring Project, the only source of data representative of all HIV-infected persons in the United States and available to guide treatment policy.
- Continue to fund, as part of the National HIV Behavioral Surveillance system, 20 project areas to conduct surveillance for behavioral risks among three different populations at increased risk for HIV infection (MSM, IDUs, and heterosexuals at increased risk).

Performance: HIV/AIDS case surveillance data are supplemented by HIV incidence data to provide researchers, policymakers, and the public with a timely representation of the HIV epidemic in the U.S. Case surveillance data meet high standards for completeness of reporting (more than 80 percent of diagnosed cases are reported). In addition to being used to target prevention programs, CDC's surveillance data was used to allocate more than $2,000,000,000 of federal resources through Ryan White HIV/AIDS Treatment Modernization Act programs and through Housing Opportunities for Persons with AIDS programs. Adopted by all 50 states, CDC's recommendation to conduct confidential, name-based HIV case surveillance has resulted in a better picture of the epidemic in the U.S., better planning for prevention programs, and improved resource allocation. As states' reporting systems mature, CDC is able to incorporate HIV data from more states in its analyses. CDC's latest surveillance report, released in 2010, provided both HIV and AIDS data from 37 states for the first time, an increase of three states over the previous year. CDC aims for all states to have mature HIV reporting systems by 2012 and is proposing a new objective for its state HIV surveillance programs, reflecting recognition of the importance of community level data on CD4 and viral load in every state. Case surveillance and incidence data are supplemented by special studies and by surveys of risk behavior and receipt of care to guide prevention programs. These data demonstrate continued and severe disparities by race, ethnicity,

and sexual orientation and have guided national, state and local testing programs, social marketing, and health education/risk reduction efforts focusing on severely impacted populations. (Measures 2.1.5, 2.C 2.D, 2.E, and 2.F)

Program Description and Recent Accomplishments: Through a cooperative agreement, CDC supports HIV case surveillance with 65 state and local health departments to describe all reported cases of HIV in the U.S. 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. CDC has recently begun to work with jurisdictions to measure community viral load (CVL), a population-level marker for HIV transmission risk, calculated as the median/mean VL of people living with HIV in a specified area (e.g., census tract, zip code). Data required in surveillance systems for these purposes include all VL test results (including non-detectable) and geocoding information on current address (e.g., county, census tract).

CVL analyses are dependent on several factors: whether the laws support reporting of all VL values and the extent to which laboratories comply with these regulations; whether the data are able to be used (i.e., in electronic format for analysis); whether data are geocoded to reflect current residence; and the extent of missing data (CDC continues to develop statistical guidance regarding if and when VL data can be imputed for persons with missing VL data). CDC recommends that CVL analyses only be completed by areas that have implemented reporting of all CD4 cell counts and VLs; as of June 2010, 33 of 65 jurisdictions have done so. A portion of the proposed new funds for FY 2012 will be used to support the ability of all funded health jurisdictions to collect CD4 and viral load data as part of their core surveillance activities, support the development of local community viral load estimates, and improve the ability of health departments to use geospatial information to monitor and respond to the local epidemic. CDC's comprehensive approach to surveillance provides findings that are critical to successful HIV prevention efforts nationwide.

Recent accomplishments include:

- Released the first-ever estimates of HIV rates among MSM in FY 2010, involving complex denominator calculations. These data underscore the prioritization placed on MSM in NHAS. CDC furthered developed an HIV incidence estimation methodology and training provided to surveillance partners to prepare local incidence estimates.
- Provided guidance in accordance with the NHAS Federal Implementation Plan, to partners to use surveillance data to determine (CVL). In collaboration with HRSA, elicited expert advice through a consultation on laboratory reporting on collection and uses of laboratory data and (CVL) methodology in FY 2011.
- Released initial data, from the National HIV Behavioral Surveillance system in 2010, that provided important information on high-risk behaviors for populations with high rates—IDUs, MSM, and heterosexuals at increased risk. These data are critical to affecting prevention policy.

Enhanced HIV Testing

CDC's FY 2012 request for Enhanced HIV Testing is $66,043,000. HIV testing is one of the most important tools available to fight the epidemic and so 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. In accordance with the Ryan White HIV/AIDS Treatment Extension Act of 2009, the HHS Secretary established a goal of 5,000,000 tests for HIV/AIDS annually through federally-supported HIV/AIDS prevention, treatment, and care programs. Because total test counts are not a

sufficient metric for the effectiveness of testing efforts, CDC also reports on the number of persons diagnosed through testing programs.

Funding dedicated to this activity supports the three primary goals of the NHAS:

1. *Reducing HIV incidence:* Supports health departments to promote HIV testing and linkage to care thereby reducing the undiagnosed prevalent HIV infection; improving awareness of serostatus; and recurring HIV transmission rates.
2. *Increasing linkage to quality care and retention in care of previously diagnosed individuals:* Supports health departments to enhance HIV testing and linkage to care efforts
3. *Reducing health disparities*: Supports health departments to focus increased testing resources among groups at highest risk for HIV acquisition (MSM, African Americans, IDUs, and Latinos) with scaled up HIV testing.

In FY 2012, CDC will:

- Continue to provide HIV testing to reach the goal of providing more than 1.3 million HIV tests and identifying at least 6,500 persons with newly diagnosed HIV infection annually.
- Monitor uptake of HIV testing recommendations for testing in clinical and non-clinical settings.
- Support expanded testing, including reimbursement for HIV screening, in collaboration with providers, health plans, state Medicaid boards, and other partners.
- Develop and distribute operational guidelines to support routine HIV testing in substance abuse treatment centers (in collaboration with the Substance Abuse and Mental Health Services Administration), STD clinics, primary care and inpatient hospital settings, and non-health care settings.

Performance: The past five years have seen progress in increasing the number of persons who ever been tested for HIV, the proportion of HIV-infected people in the United States who know they are infected, and the proportion of people with HIV diagnosed before progression to AIDS. Through the Expanded HIV Testing Initiative (ETI) and other CDC funded testing programs, the proportion of persons aware of their HIV infection is expected to continue to increase. Ultimately, this testing effort is expected to improve the health and longevity of HIV-infected persons, and to decrease HIV transmission, as those who are aware they are HIV-infected are more likely to take steps to protect their partners and less likely to transmit infection. In 2008, CDC exceeded its targets for increasing the proportion of HIV-infected people in the United States who know they are infected and increasing the proportion of people with HIV diagnosed before progression to AIDS. New targets have been set for knowledge of serostatus, consistent with the (NHAS), and better measures of early diagnosis (e.g., the percentage of persons newly diagnosed persons with a CD4 count of 200 cells/µl or higher) are under development. (Measures 2.1.1 through 2.1.4; 2.2.1 and 2.2.2; 2.4.1 through 2.4.3 and measure 2.I)

Program Description and Recent Accomplishments: Under its ETI, CDC has developed guidelines and policies, supported social marketing and training and provided funding to jurisdictions to increase HIV testing opportunities for populations disproportionately affected by HIV, and increased the proportion of HIV-infected persons who are aware of their infection and linked to appropriate services. In 2010, the program was re-competed and expanded to target additional populations including MSM and Hispanics, consistent with the NHAS. In FY 2010, this program was supplemented with funding from the ACA/PPHF. With that supplement in FY 2010, CDC funded 18 jurisdictions to conduct enhanced linkage to medical care and partner services for HIV-infected persons identified through ETI-supported HIV screening programs.

Recent accomplishments include:

- Conducted, during the first two years of the ETI's three year cooperative agreement, over 1.4 million tests and identified over 10,500 persons newly diagnosed with HIV infection. This was accomplished through a combination of routine opt-out screening in healthcare settings and targeted testing in non-healthcare settings. The rate of new positive tests was slightly higher in targeted testing (1.1 percent) compared with routine screening (0.7 percent); however, the majority of new positive tests were in healthcare settings, due to the larger number of tests performed in those settings. This also reflects the fact that the cost of conducting a test and identifying a positive test is lower in routine screening than in targeted testing programs. The yield of positive tests is expected to decline over time as persons with prevalent infections are identified and linked to care. Of the new positives, at least 86 percent received their test results, 75 percent were linked to medical care, and 78 percent were referred to partner services. Grantees conducted testing activities aimed at populations prioritized by the program and as a result, over 60 percent of all those tested (and 70 percent of those newly diagnosed with HIV) were African American. Preliminary data from the third year of the program (September 2009–September 2010) indicates that an additional 1.2 million HIV tests were performed during this 12 month period.
- Initiated with 30 health department grantees, a new project cycle, retooled to better align with NHAS. The program was expanded to address other risk populations including Hispanics and MSM and IDUs of all races, and emphasize linkage to care.
- Launched HIV Screening. Standard Care, a phase of the Act Against AIDS (AAA) campaign designed to help physicians make HIV testing a routine part of medical care. The multi-year, multi-faceted AAA communication campaign utilizes traditional mass media as well as new media and direct-to-consumer communication channels.

National/Regional/Local/Community/Other Organizations

CDC's FY 2012 request for HIV National/Regional/Local/Community/Other Organizations is $141,442,000. The NHAS recognizes the vital role voluntary and other private sector organizations play in reaching and mobilizing affected communities. Voluntary organizations fill important prevention gaps, reaching populations not easily reached directly through government programs and providing leadership necessary to fight stigma and support behavior change. Other private organizations, including research institutions, fill gaps in knowledge, conduct social marketing, and provide training and capacity building.

Funding dedicated to this activity supports two primary goals of the NHAS:

1. *Reducing HIV incidence:* Supports voluntary organizations to deliver and build capacity for effective, evidence based prevention interventions to reduce HIV incidence; implement interventions with HIV positive individuals; promote HIV testing and linkage to care; and address associated syndemics which drive HIV transmission.
2. *Reducing health disparities*: Supports voluntary activities to build capacity; raise awareness; and implement culturally competent interventions targeting groups at highest risk for HIV acquisition.

In FY 2012, CDC will:

- Conduct activities that ensure the implementation and evaluation of interventions, strategies, and technologies to increase testing, linkage to care, and use of antiretroviral therapy (ART).

- Fund 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.
- 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 31 CBA providers.
- Continue to implement the Act Against AIDS (AAA) campaign, a five- year, multi-faceted national communication campaign to refocus national attention on the domestic HIV/AIDS epidemic and mobilize leaders to take steps to prevent AIDS in their own communities, with an emphasis on populations bearing a disproportionate burden of HIV/AIDS, such as African American, Hispanic and Latino communities and MSM of all races and ethnicities.
- Continue to prevent HIV, VH and STDs and promote sexual health with Indian Tribal Organizations.
- Train staff from health departments and CBOs on evidence-based interventions for persons at highest risk of acquiring or transmitting HIV.
- Redirect approximately $7,000,000 from CBO and CBA programs funded in FY 2010 to achieve greater efficiencies in prevention (by deemphasizing intensive individual and small group interventions for at-risk populations that are difficult to take to scale and so may have less impact on HIV incidence) to programs and strategies that are aligned with the goals and recommendations of the National HIV/AIDS Strategy and may have relatively greater impact). The shift in emphasis among DEBIs would be based on the following principles:
    - Greater emphasis should be put on interventions for people living with HIV, especially those that are integrated into medical care (exceptions are interventions with very large numbers of sessions).
    - Greater emphasis should be placed on community-level and single session interventions that have greater potential to reach larger numbers of people.
    - Interventions with large numbers of sessions should be de-emphasized.
    - Interventions that serve populations at lower risk for HIV infection should be de-emphasized.
    - The DEBIs to be de-emphasized account for approximately 17 percent of interventions and PHSs funded through the CBO program. Therefore, the amount redirected through this process would be approximately $3,500,000.
    - The DEBIs to be de-emphasized account for approximately 33 percent of the trainings conducted or scheduled to be conducted between January 2010 and March 2011 (as posted on the training calendar). Therefore, the amount redirected within the CBA program would be approximately $3,500,000.

Performance: Efforts to build the capacity of indigenous organizations to conduct prevention programs have built an infrastructure of voluntary, community organizations serving at risk groups. These organizations have made important contributions to the substantial decreases in HIV transmission rates and improvements in knowledge of serostatus are noted above. CDC has made consistent progress in reducing the Hispanic to white ratio of HIV diagnoses in recent years. While the 2008 target for this measure was unmet, CDC is undertaking a number of initiatives, such as research to adapt evidence-based

interventions to the needs of the Hispanic community, to further reduce this ratio. Racial disparities in HIV cases for African Americans (as measured by black:white rate ratios) have declined since the 2002 baseline of 10.2 to 1. However, this disparity increased from 2007 to 2008. Reasons for this increase are not clear, but may be related to increase testing among African Americans. CDC is developing improved measures of disparities in HIV, consistent with the NHAS, and will report on these measures in future performance reports.

CDC has provided training to agencies to implement proven effective behavioral interventions. In 2009 935 agencies were trained, a number that did not meet the target, but was comparable to performance in the previous year. CDC is revising its capacity building program to focus on a broader array of effective interventions and has revised its performance measure on training to reflect this new direction. CDC recompeted its CBO program in 2010. In the new program, CDC strengthened the requirement for directly-funded CBOs to provide referrals to clients and coordinate certain activities with other service providers. CBOs must link individuals living with HIV to medical care (including screening for STDs, VH, and TB), partner services, prevention services and other support services. The grantee must also implement a tracking system to determine whether or not individuals successfully accessed referral services in a timely manner. All funded CBOs and other prevention service providers are provided the tools and training to collect key evaluation data and submit these to CDC. (Measures 2.1.1 through 2.1.4, 2.1.6, 2.1.8; 2.2.1, 2.2.2; 2.3.1, 2.3.2, 2.G and 2.H)

<u>Program Description and Recent Accomplishments</u>: CDC supports national, regional, community-based and other organizations to increase their capacity to deliver effective interventions to prevent risk behaviors, increased knowledge of HIV infection, and linked HIV-infected persons to care and other critical support services. CDC promotes collaboration and coordination of efforts among CBOs, health departments, and private agencies, and builds the capacity of these organizations to deliver effective interventions tailored to the communities they serve. CDC also supports minority CBOs' capacity to effectively respond to the epidemic. 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. Many of these efforts are supported through the Minority AIDS Initiative.

CDC educates and works to raise awareness of patients, providers and the public about HIV. For example, as part of Act Against AIDS, the Prevention is Care campaign is designed to reach providers who deliver care to patients living with HIV by encouraging these providers to screen their HIV patients for transmission behaviors and to deliver brief prevention messages on the importance of reducing risk behaviors. Similarly, the *I Know* 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 African American men and women aged 18 to 24.

Recent accomplishments include:

- Awarded 133 CBOs to provide HIV prevention services to populations at greatest risk for HIV. Funds were awarded to organizations serving populations disproportionately impacted by the epidemic – including African Americans, MSMs, and Latinos – in the geographic areas with the greatest need (as demonstrated by disease burden).
- Evaluated and published in 2010 the outcome findings of two HIV prevention interventions that were developed by CBOs (Many Men Many Voices [3MV] and Healthy Love Workshop). Both of these interventions targeted under-served high risk populations (African American MSM and African American women) and were found to be effective in reducing HIV risk behaviors or increasing condom use and increasing HIV testing.

Disseminated HIV prevention messages with AAA, and while leveraging CDC assets that include: 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.

Improving Program Effectiveness

CDC's FY 2012 request for HIV Improving Program Effectiveness is $120,602,000. The NHAS clearly describes the need for improvements to behavioral and biomedical interventions to better serve at-risk populations. Improving program collaboration between federal programs is one of the four priorities in the plan. CDC supports these activities, and others**,** which improve the overall effectiveness of HIV prevention efforts.

Funding dedicated to this activity supports the three primary goals of the NHAS:

1. *Reducing HIV incidence:* CDC develops, identifies and adapts effective biomedical and behavioral interventions and provides guidance to prevention partners on their use. Demonstration projects to identify and document best practices, as well as laboratory and epidemiologic studies are supported.
2. *Increasing linkage to quality care and retention in care of previously diagnosed individuals:* CDC conducts epidemiologic, policy and operations research to improve policies and practice which ensure linkage to care and access to appropriate preventive services. Program collaboration and service integration efforts are supported which ensure that appropriate preventive services are provided to at risk persons.
3. *Reducing health disparities*: CDC supports applied research to adapt and translate effective interventions for at risk populations. CDC supports service integration to reduce risk behaviors and address syndemics. Activities are focused on populations and venues where integration efforts can fill in gaps in services.

In FY 2012, CDC will:

- Continue to direct research activities to biomedical and behavioral research projects that address significant unmet public health needs and that have the potential for greatest impact. Examples of research that will continue in FY 2012 include laboratory research on the safety and efficacy of oral and topical antiretroviral medications to prevention HIV transmission, a randomized clinical trial of PrEP efficacy among injection drug users in Thailand, research to improve HIV diagnostic and clinical testing (such as the use of dried blood spots for HIV-treatment resistance testing), cohort studies designed to provide detailed characterization of the course of clinical HIV disease, intervention research with African-American and Latino MSM, and research to improve retention in care and adherence to HIV treatment among people living with HIV.

- Collaborate with external partners on clinical research to identify the safety and efficacy of pre-exposure antiretroviral medications (oral and/or topical) to prevent HIV acquisition. Continue to develop and refine nonhuman primate models for understanding HIV transmission and prevention, particularly with regards to chemoprophylaxis and immune responses that modulate susceptibility and efficacy. Much of the nonhuman primate research will continue to be conducted in a formal collaboration with NIH.

- With support from the ACA/PPHF, implement demonstration projects to evaluate innovative models for incorporating new biomedical advances and comprehensive prevention with positives programs into a comprehensive approach to HIV prevention. Specifically, this three-year project will support six to ten research projects to develop, monitor, and evaluate innovative models for prevention with positives, delivering PrEP to persons at high-risk of HIV infection, and other emerging high-potential prevention strategies.
- Provide financial and technical assistance to 24 state and local health departments to provide HIV testing to TB patients. This testing is a highly recommended intervention strategy as HIV dramatically increases the risk someone infected with TB will develop active disease.
- Provide support to 65 state and local health departments for provision of HIV testing and partner services through STD 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 the evidence that they do or do not reduce incidence of HIV or other sexually transmitted infections.
- Continue to implement, evaluate and scale-up effective behavioral, biomedical, and structural technologies, interventions and strategies. Implementation will be prioritized and targeted to maximally reduce HIV acquisition in high-incidence populations including MSM, African Americans, and Latinos. Staff at health departments and community-based organizations will be trained to implement culturally-competent interventions designed for racial and ethnic minority groups highly impacted by the HIV epidemic.
- Implement randomized controlled trials to test interventions targeting underserved populations such as bisexually active African American men (three different researcher-developed interventions) and Latino and African American MSM (three different community-developed interventions). MSM of color who have unprotected sex are at greater risk for acquiring HIV than those who do not have unprotected sex. It remains critically important to reduce risk behavior as part of a comprehensive approach to HIV prevention that includes biomedical and structural approaches. Develop and evaluate new diagnostic strategies for HIV testing, including multi-test algorithms.
- Provide support to three jurisdictions to evaluate the yield and cost-effectiveness of enhanced partner notification /contact tracing techniques linked to acute HIV infection screening.
- Continue to improve and field test, through cooperative agreements, rapid diagnostics for HIV infection to improve informing individuals of their infection status.
- Collaborate 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 SIV/SHIV 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. Types of studies that may be conducted within this collaboration using the RLD model include: modeling efficacy of different products, dosing regimens, delivery strategies or specific formulations; exploring the correlates of protection and relating efficacy with pharmacokinetic/pharmacodynamic studies; monitoring development of drug resistance and impact on infection dynamics; and evaluating immune responses in protected and infected animals.

- Monitor uptake of its revised prevention with positives recommendations and educational materials regarding prevention strategies for persons living with HIV.
- Continue to conduct multi-site clinical epidemiology cohort studies 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.
- Conclude a research trial with HRSA designed to test an intervention delivered by providers and support staff to increase clinic attendance and adherence to medication therapy among African American HIV-infected patients unstable in care.
- Integrate program monitoring across HIV, VH, STD and TB programs and support the integration of HIV program monitoring. Based on findings from feasibility assessments, CDC will plan and pilot integrated use of key, core data elements from all CDC program monitoring systems and provide assistance to selected health departments to develop integrated use of jurisdiction-level data from HIV, STD, TB, and VH programs and surveillance.
- Continue to support and expand PCSI through the development of models, identification of best practices, and demonstration projects. CDC will increase by five the number of demonstration projects to promote PCSI with prevention programs for VH, STDs, and TB. These PCSI projects will also provide further examples of best and promising practices in the field and will be the source of data on program effectiveness. CDC will conduct studies of PCSI effectiveness, specifically: a meta-analysis of the literature related to PCSI; mathematical models that can estimate the impact of integration on epidemic trajectories; and an evaluation of demonstration projects. Information gleaned from these efforts will further support the identification of PCSI priorities at the national and state levels.

Performance: CDC works to provide training, technical assistance, and guidance on effective public health strategies to reduce HIV transmission and improve the health of people living with HIV (such as HIV testing, linkage to medical care, partner services, increasing condom availability) and to increase behavioral interventions that reduce HIV risk among persons living with and at-risk for HIV infection. CDC has recently expanded its *Compendium of Effective Interventions* to include interventions that increase adherence to HIV treatment among people living with HIV who are in medical care in collaboration with (NIH) and HRSA.

Through the Prevention Research Synthesis (PRS), Replicating Effective Programs (REP), and DEBI programs, CDC identifies, replicates, packages and disseminates evidence-based risk reduction interventions for persons at high risk for HIV. As of mid-2010, there are 28 evidence-based interventions (an increase of eight over 2009) that meet CDC's rigorous criteria of effectiveness are available and show either significant reductions in STDs or self-reported risk behavior. CDC has completed rigorous evaluations of two of these interventions in CBOs and has shown that these interventions resulted in effects that were comparable to those in the original research. One of these evaluations included STD incidence as an outcome and found a significant reduction in new STD diagnoses among those who received the intervention.

CDC is shifting its emphasis away from intensive individual and small group interventions for at-risk populations that are challenging to take to scale and putting greater emphasis on effective interventions for people living with HIV (including linkage to and maintenance in medical care, adherence to antiretroviral treatment, and interventions that reduce transmission risk) and effective community-level, structural, and single session interventions that can be taken to scale.

CDC supported demonstration projects to identify best practices and documented and disseminated emerging models of best practice. Opportunities to expand integration of HIV and STD screening in high-risk populations were identified. A number of jurisdictions have made strides in improving program collaboration and service integration. For example, the Philadelphia Department of Health convened a PCSI work group to assess program services and redesign health department provided services to be more comprehensive for common target populations at risk for multiple infections. The King County Department of Health in Washington developed an integrated surveillance report for HIV, VH, STD, and TB that also provides syndemic data on local levels of co-infection of populations at risk. The Florida State Department of Health has increased their level of HIV and STD partner services and improved their HIV surveillance data completeness thru program collaboration and sharing of surveillance data to provide integrated services. The South Carolina Department of Health has integrated Viral Hepatitis C screening to HIV testing sites that target drug users and have found approximately 30 percent viral hepatitis seropositivity among this population that would otherwise have only received HIV screening in the absence of this integration effort. CDC will expand the network of professionals trained in PCSI strategies. Persons with TB or STDs, who are at risk for HIV, received HIV testing through the STD and TB programs. (Measures 2.1.1 through 2.1.4; 2.1.7, 2.2.1 2.2.2, 2.3.1, 2.4.1, and 2.4.3)

Program Description and Recent Accomplishments: CDC works to develop the knowledge base needed for other evidence-based interventions including the use of antiretroviral treatment for HIV prevention, medication adherence, guidance for the use of PrEP, condom distribution, and male circumcision. In its public health assurance role to support prevention through healthcare, CDC develops and disseminates guidelines and recommendations (such as those for HIV testing), helps ensure reimbursement by third-party payers, develops quality assurance measures, conducts social marketing with providers and the public, supports training and capacity development, monitors and evaluates interventions, and conducts health services research.

CDC works to improve the effectiveness of existing HIV prevention programs and develop new tools for HIV prevention. CDC supports activities to identify additional, effective HIV-preventive interventions to be implemented in the United States, and to adapt existing effective interventions to meet the needs of other at-risk populations. Where feasible, evidence is based on randomized trials or structured studies and evaluations that have outcomes of HIV or STI acquisition. For some interventions, such as HIV testing, linkage to care, retention in care, condom use, and partner reduction, intermediate outcomes are used. Efforts include behavioral research to develop, identify, and assess effective interventions; epidemiologic studies; laboratory studies such as those to develop quicker and more sensitive and specific HIV testing algorithms; policy, economic and operations research to improve program implementation including demonstration projects to test new approaches; and programs to incorporate HIV prevention in other disease prevention programs.

Recent accomplishments include:

- Continued to build the science base for improved HIV testing programs. Successfully evaluated dried blood spots as a cost-saving and non-clinical setting friendly blood sample for incidence testing and drug resistance screening to support expanded HIV testing and surveillance. Completed data collection for two HIV testing projects focused on African Americans (MSM and women) to identify the best testing strategies for identifying unknown infection among these target populations.

- Completed enrollment in clinical trials to identify the safety and efficacy of PrEP to prevent HIV acquisition among IDUs in Thailand and at-risk heterosexuals in Botswana; follow-up is ongoing and results are anticipated in 2011 (Botswana) and 2012 (Thailand). Completed a safety and preliminary efficacy trial of oral tenofovir for prevention of HIV infection among high-risk MSM. CDC PrEP research was validated by both the CAPRISA 004 and iPREX clinical trials which demonstrated significant reductions in HIV acquisition for persons on PrEP.
- Funded six jurisdictions to plan, broaden, and support the implementation of PCSI. Jurisdictions will develop a PCSI plan driven by epidemiological data and operational assessments identifying populations and settings appropriate for integrated services. Jurisdictions developed an evaluation plan and provided data to CDC on elements including, but not limited to: number of tests performed, the yield of tests, and the number of co-infections identified.

HIV School Health

CDC's FY 2012 request of $40,000,000 for HIV School Health was transferred from Chronic Disease Prevention and Health Promotion to achieve closer coordination with other HIV prevention programs. Planning for this transition is ongoing. Implementation plans, program descriptions, and performance measures will be finalized with the release of the FY 2013 President's budget request.

In FY 2012, CDC will:

- Fund state and local education and health agencies to implement school-based HIV prevention activities.
- Fund national non-governmental organizations (NGOs) that focus on HIV prevention and promoting the health of youth, including CDC-funded state, territorial, and large local school district programs, youth serving organizations, and other NGOs.
- Collect national data and enable state and local education and health agencies to collect state and local data to monitor priority health risk behaviors and school health programs and policies through the Youth Risk Behavior Surveillance System (YRBSS).
- Provide guidelines and tools for schools for the prevention of HIV, other STDs and pregnancy. Education agencies use CDC guidelines and tools to assist schools and school districts in implementing evidence-based, effective prevention curricula and instructional practices.

Performance: Scientific reviews have documented that school health programs can have positive impacts on health-risk behaviors, health outcomes, and educational outcomes. Performance on key metrics for assessing school health activities that help reduce risks behaviors is noted below. As the program is transitioned to CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, performance measures important to HIV school health activities will be refined and incorporated into the performance plan. CDC plans to:

- Increase the proportion of adolescents (grades 9 to 12) who abstain from sexual intercourse or use condoms if currently sexually active to 89 percent. Since the baseline year 2007, this rate increased from 86.7 to 86.9 percent in 2009, which is not a statistically significant change.
- Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90 percent or greater. Since the baseline year 2007, this rate decreased from 89.5 to 87 percent in 2009.

Studies led by CDC demonstrate how school health programs can be cost effective, for example, an evaluation of a school-based HIV, STD and unintended pregnancy prevention intervention for high school

students found that for every dollar invested in the program, about $1.33 in direct medical costs were saved.

Program Description and Recent Accomplishments: CDC's HIV School Health program focuses on strengthening the ability of state and local education agencies and schools to address important health issues, including HIV, STDs, and teen pregnancy, by building the capacity of funded partners awarded through five-year cooperative agreements to support science-based, cost-effective health programming.

Recent accomplishments include:

- Supported Florida's Orange County Public Schools (OCPS) HIV prevention program, with the Florida Department of Health and the Orange County Health Department, to identify middle and high schools located in areas disproportionately affected by HIV. OCPS teamed up with Teen Xpress, a mobile health care provider, to offer free medical and mental health care for at-risk youth in four of the priority schools. For teens with parent permission slips, Teen XPress provided confidential pregnancy, STD and HIV testing. This collaboration resulted in more than 120 youth receiving tests.

Viral Hepatitis

CDC's FY 2012 request of $25,000,000 for VH reflects an increase of $5,222,000 above the FY 2010 level. With this increase, CDC will expand and strengthen surveillance capacity in 10 high burden state and local health departments to detect VH transmission, monitor health disparities and implementation and impact of recommended prevention services; develop and execute VH awareness and training programs for public health and clinical care professionals to implement and scale-up VH screening and care referral; and enhance work with global partners to implement VH surveillance and prevention programs in high burden countries.

CDC will track VH incidence, investigate outbreaks, and analyze the unique characteristics of viral strains in order to develop effective evidence-based prevention strategies. FY 2012 funds will sustain and enhance prevention activities broadly grouped under four programmatic priorities: 1) reduce illness and death by identifying persons with viral hepatitis early and referring them to care; 2) eliminate hepatitis B virus (HBV) transmission; 3) develop, test and translate into action tools to decrease the incidence of hepatitis C virus (HCV); and 4) guide and evaluate prevention efforts by improving the monitoring of viral hepatitis.

In FY 2012, CDC will:

- Continue to support adult VH prevention coordinators in state and local health departments to facilitate the implementation of VH prevention and control activities.
- Work through existing state and local coordinators to continue to:
  - Develop and implement science-based community education campaigns to address HBV health issues facing many Asian/Pacific Islanders, and HCV health issues for African Americans and Hispanics.
  - Educate health care providers, public health professionals, and social service providers about prevention and testing strategies for intervening early to reach persons at risk for chronic infection.
  - Provide testing, counseling, and referrals to care for persons chronically infected with HBV and HCV.

- Identify ways to improve hepatitis A (HAV) and HBV vaccination coverage among vulnerable populations.
- Strive to eliminate HBV transmission in the United States by referring pregnant women who are HBsAg+ to appropriate care, providing timely vaccination to their infants and family members, and vaccinating adults at risk of infection in public health settings (e.g., STD and HIV clinics, drug treatment facilities, correctional facilities).

- Publish and implement revised recommendations to guide HCV screening and referral to care.
- Develop and implement a new cooperative agreement to provide direction, and technical and financial assistance to up to five state and local health departments for VH Intervention Projects (VHIPs)., serving as model programs for the comprehensive delivery of prevention, detection, outreach, education, vaccination, screening, and referral to care to persons at risk for or infected with viral hepatitis.
- Provide additional technical and financial assistance to 10 state and local health departments to improve the quality of surveillance for both acute and chronic VH.
- Continue to provide support for all states, as requested, to investigate outbreaks and modes of transmission of VH.
- Continue to conduct prevention research to determine the long-term effectiveness of hepatitis A and hepatitis B vaccine, and to assess the role of vaccination to prevent transmission among populations not currently recommended to receive these vaccinations.
- Continue to participate in national and multi-state surveys to monitor access to and utilization of prevention services.
- Provide additional flexibility to jurisdictions by allowing them to transfer up to five percent of their grant awards to coordinate and integrate services for populations with or at risk for viral hepatitis and at least one of the following infections: HIV, STDs, or TB.

Performance: In the United States, illness from VH is mainly caused by the hepatitis A, B and C viruses. Before the implementation of Advisory Committee on Immunization Practices (ACIP) recommendations for hepatitis A immunization starting in 1996, an estimated average of 271,000 infections occurred and 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 has decreased approximately 92 percent nationwide since 1995. The 2008 rate of 0.9 cases per 100,000 surpasses the Healthy People 2010 goal of 2.4 cases per 100,000, and is the lowest rate of new cases recorded to date. The expansion in 2006 of recommendations for routine hepatitis A vaccination to include all children in the United States aged 12–23 months is expected to reduce hepatitis A rates even further.

Similar declines in new cases of HBV have occurred among all age groups, but are greatest among children under 15 years of age; 95 percent of new cases are now among adults. Declines over the past decade are linked to the successful implementation of vaccination strategies as well as increases in screening and awareness. More than 95 percent of pregnant U.S. women are now screened for HBV infection during pregnancy, reducing the risk for perinatal transmission. In the first half of FY 2010, CDC-funded jurisdictions administered over 130,000 doses of HBV vaccine to at-risk adults and ensured that 87 percent of infants born to HBsAg+ women received HBV vaccine during their first day of life. As a result of these efforts, rates of HBV have been reduced far below the original Healthy People 2010 goal of 4.5 cases per 100,000, and the 2008 rate of 1.3 cases per 100,000 (the latest available) is the lowest rate of new cases recorded. While new cases have declined, the number of persons with chronic HBV infection remains high -- (between 800,000 and 1.4 million). Chronic HBV infection is a significant

cause of cirrhosis and liver cancer among some populations. Published studies have indicated that expanded screening of populations most affected is cost-effective. One such study indicated that expanded screening among Asian Americans would cost $40,000 per quality year of life gained. For these reasons, CDC has established goals to increase screening for HBV among minority populations.

Incidence of HVC has declined from over 45,000 cases per year to an estimated 20,000 per year, largely as a result of successful efforts to screen the U.S. blood supply, and more recently, by reductions of infections among IDUs. Transmission among IDUs and outbreaks of HCV related to health care settings remain an important source of transmission. However, between 2.7 and 3.9 million of Americans have HCV and most are unaware of their infection. CDC has supported research to improve HCV testing and has initiated studies to lay the groundwork for new HCV screening recommendations. (Measures 2.6.1-2.6.3, 2.6.5)

Program Description and Recent Accomplishments: CDC works with state and local health departments to prevent VH through surveillance, screening, education, and vaccination. CDC reduces the rates of new cases of HAV and HBV by supporting the vaccination of infants and at-risk populations. Furthermore, CDC focuses on hepatitis B elimination particularly among infants at highest risk for developing chronic HBV infection, as well as among 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 as well as sources of transmission. CDC provides direction and technical and financial assistance to up to 10 state and local health departments to conduct enhanced surveillance for both acute and chronic VH. Laboratory research is conducted to assess performance of new tests and monitor for the circulation of variant strains that may not be prevented by current vaccines. CDC develops recommendations and for vaccination, screening and prevention programs for HAV, HBV and HCV and supports the integration of hepatitis prevention, including education, screening and vaccination, into other programs for at risk populations including populations at risk for HIV and other STDs and those at risk for healthcare acquired infections.

Recent accomplishments include:

- Accepted delivery of an Institute of Medicine report, "Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C" providing 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 will be critical to monitor the effects of efforts to improve screening of at risk persons. Completed an evaluation of rapid HCV test kits and initiated phase one of an age-based testing approach for HCV screening.
- Monitored and addressed health disparities, funded active surveillance of VH in nine state and local health departments, and conducted a national survey to assess knowledge and receipt of viral hepatitis prevention services among racial and ethnic minority communities across the United States.

Sexually Transmitted Diseases

CDC's FY 2012 request of $161,353,000 for STDs reflects an increase of $6,736,000 above the FY 2010 level. CDC continues to work to reduce the domestic prevalence of STDs such as chlamydia, gonorrhea, and syphilis, and their sequelae, such as pelvic inflammatory disease, infertility, and increased risk of HIV infection.

In FY 2012, CDC will:

- Ensure an effective STD infrastructure nationwide by providing financial support and technical assistance to 65 state and local STD prevention programs, through the Comprehensive STD Prevention Systems (CSPS) program.
- Reduce infertility caused by STDs by providing financial support and technical assistance to 65 state and local project areas for chlamydia and gonorrhea screening and treatment.
- Promote adoption of CDC recommendations for STD prevention and treatment services by strengthening our collaboration with other Federal agencies, such as HRSA, HHS Office of Adolescent Health and HHS Office of Populations Affairs; and nonprofit and private partners, such as the National Association of Community Health Centers, National Family Planning and Reproductive Health Association, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, Association of Maternal and Child Health Programs and Infectious Diseases Society of American, and the National Chlamydia Coalition.
- 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 STD/HIV Prevention Training Centers and developing guidelines for the treatment of STDs and for STD diagnostics and laboratory practice.
- Strengthen STD surveillance and evaluation capacity by supporting 12 sites to participate in the STD Surveillance Network (SSuN), a sentinel clinic and population based surveillance system to monitor behavioral and clinical trends in STDs, HIV, andVH, identify emerging STD/HIV issues, evaluate public health interventions, and improve surveillance capacity for gonorrhea, chlamydia, genital warts, and resistant trichomoniasis.
- Continue to monitor changing resistance patterns in N. *gonorrhoeae* and trends in antimicrobial susceptibilities of strains of *N. gonorrhoeae* in the U.S. by supporting a network of regional laboratories to provide timely antimicrobial susceptibility testing on all isolates using a standard protocol. Prevent reinfection with *C. trachomatis* and *N. gonnorrheae* and increase options available to treat sexual partners of infected women by providing assistance to STD prevention programs with implementation of Expedited Partner Therapy (EPT), and increasing the number of states where EPT is permissible from 27 to 32.[6]
- Work to eliminate syphilis, syphilis-related HIV and congenital syphilis by funding approximately 38 areas that have been targeted for syphilis elimination activities, including enhanced screening, partner services, and other evidence-based interventions.[7]
- Enhance capacity to monitor syphilis elimination activities and improve resource allocation by increasing the number of syphilis elimination activities monitored using the Evidence-based Action Planning process from approximately 50 to 80 percent.
- Continue to develop and implement MSM STD-prevention/control plans for high morbidity project areas; conduct operational research to assess effectiveness of partner service approaches in MSM.

[6] EPT is the practice of providing treatment to partners of persons diagnosed with a STD without clinical examination or encounter with those partners

[7] CDC implemented a new funding formula in 2008 to be more responsive to the evolving syphilis epidemic, wide variation in project area funding, and overall level funding. The formula includes a base award for all high morbidity areas plus additional funding on the basis of the project area's proportion of total primary and secondary (P&S) cases in the previous two years. The formula also includes provision for project areas which have decreased morbidity below the threshold to transition their funding over a two-year period after falling below the threshold.

- Develop training modules for primary care providers.
- Provide technical assistance in the development of a coding guide to increase adoption of non-genital chlamydia and gonorrhea screening using nucleic acid amplification tests in the care of sexually active MSM.
- Pilot surveillance projects that enhance collection of gender of sex partner data for males.
- Provide additional flexibility to jurisdictions by allowing them to transfer up to five percent of their grant awards to coordinate and integrate services for populations with or at risk for STDs and at least one of the following infections: HIV, VH, or TB.

Performance: Reductions in gonorrhea and syphilis from 1990 to 2003 were found to have greatly reduced the economic burden of these diseases and were associated with a savings of $5.0 billion. Published estimates of cost-effectiveness of chlamydia screening in sexually active young women range from about $2,500-$37,000 per quality-adjusted life-year (QALY). Improvement in screening and investment 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 STDs and their sequelae[8].

Targeted STD prevention programs have yielded success 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 participating family planning clinics. In addition, from 1999 to 2009, rates of primary and secondary syphilis among females declined by 30 percent; rates of congenital syphilis declined by 32 percent, and the black to white rate ratio of reported primary and secondary syphilis cases decreased by 70 percent. (Measures 2.7.1 through 2.7.8 and outputs 2L through 2O)

Program Description and Recent Accomplishments: CDC distributes funds to state and local STD programs through the CSPS cooperative agreement. Funded jurisdictions are encouraged to allocate at least five percent of their award to address syndemics of HIV, VH, STDs, and TB through program collaboration and service integration. The National Infertility Prevention Project (IPP) provides direct funding and technical assistance to state and local STD prevention programs to prevent the spread of chlamydia and gonorrhea, which if left untreated can lead to pelvic inflammatory disease, infertility, and ectopic pregnancy in women. Funded programs provide clinical services for young, sexually active women and their sexual partners; support laboratory testing; and develop surveillance and data management systems. Through an inter-agency agreement with the HHS Office of Population Affairs, CDC awards additional funds to ten regional family planning training centers to provide IPP infrastructure support. The infrastructure partners provide centralized project management and coordination of regional IPP activities by assuring project area and regional collaboration among STD prevention programs, family planning programs, the Indian Health Service STD prevention program, public health laboratories, STD/HIV prevention training centers, and other relevant partners. Core activities include administration, coordination, communication, prevalence monitoring and data management, as well as education and program promotion. In addition to its work with funded partners, CDC monitors the occurrence of STDs nationally; provides technical assistance and training on STD prevention and control; develops communications materials for providers, patients and the public; serves

[8]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.

as a national STD reference laboratory; conducts epidemiologic and health services research for STD prevention; and develops guidelines and recommendations for STD prevention and control nationally.

Recent accomplishments include:

- Published an evaluation of National Health and Nutrition Examination Survey (NHANES) data to determine prevalence of MSM behavior and sexual orientation in the U.S. population, as well as the prevalence of HIV and HCV in MSM.
- Provided cost-effectiveness analyses, information on vaccine acceptability and a review of relevant clinical trial and epidemiologic data to support updated recommendations for HPV vaccination, adopted by ACIP in 2010. Revised communication materials on HPV to include the new ACIP vaccine recommendation for the use of a second HPV vaccine (bivalent) in females and use of quadrivalent HPV vaccine in males.
- Published *Sexually Transmitted Diseases Treatment Guidelines—2010*, these guidelines for the treatment of patients who have STDs were developed by CDC after consultation with a group of professionals knowledgeable in the field of STDs and will guide the provision of treatment for STDs by providers across the United States.

Tuberculosis

CDC's FY 2012 request of $143,572,000 for TB reflects a decrease of $1,475,000 below the FY 2010 level for administrative savings. These funds will sustain and enhance work to reduce incidence of TB and achieve its eventual elimination in the United States.

In FY 2012, CDC will:

- Ensure an effective TB control infrastructure nationwide by supporting 68 TB prevention, control, and laboratory programs (in all 50 states, Washington D.C. and nine other cities, and eight dependent areas).
- Support four regional training and medical consultation centers to assure adequate supply of workers with training in TB diagnosis and treatment.
- Fund two TB research consortia to enhance programmatic approaches to TB, and to develop more effective tolerated drug regimens for curing latent TB infection (to prevent future cases) and for TB disease, with special emphasis on improving TB therapy in children, persons with HIV infection, diabetes, or other co-morbidities, and drug-resistant TB.
- Provide technical assistance for building 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.
- Provide additional flexibility to jurisdictions by allowing them to transfer up to five percent of their grant awards to coordinate and integrate services for populations with or at risk for TB and at least one of the following infections: HIV, STDs, or VH.

Performance: Effective control efforts by CDC and its state and local partners have led to the lowest number of U.S. TB cases (11,540 in 2008, or 2.0 per 100,000 population) since national reporting began in 1953. Due to the effectiveness of these programs, the United States consistently ranks among the lowest TB incidence countries in the world. Moreover, while TB drug resistance is a growing problem globally with the World Health Organization reporting 440,000 cases and 150,000 deaths in 2008, numbers of drug resistant cases in the United States remain stable at less than one percent of all cases

(approximately 100 cases per year) and no deaths. CDC monitors key aspects of TB control including completion of treatment within one year, timely laboratory reporting, 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 performance on these indicators, 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 2007, 84.3 percent of patients completed a curative course of treatment for TB. Although a substantial increase over the 1994 baseline of 67.6 percent, the outcome for this measure was not met, but improved. Because completion of TB treatment is the most effective way to reduce the spread of TB and prevent its complications, this objective is the highest priority for CDC's TB program.

Progress toward these measures is attributable to increased efforts of state and local health departments and hospital infection-control practitioners to address the resurgence of TB, as well as increased funding for health department laboratories to purchase state-of-the-art equipment to perform more accurate and rapid laboratory testing and confirmation for TB and multi drug-resistant TB. CDC will continue to work with state partners to improve performance in this area.

Treatment for Latent TB Infection (LTBI) is 70-90 percent effective in preventing TB disease and costs a fraction of hospitalization for a TB case. Direct medical costs of LTBI screening and treatment (without Department of Transportation) for infection by presumed M. tuberculosis strains that can be treated by first-line drugs are approximately $208 to $311 per person (2004 dollars). The direct medical cost of illness due to TB disease is approximately $4,000 per case of drug susceptible TB disease treated by DOT. Costs rise if the case of disease requires hospitalization ($19,000) and even more for treatment of a multi-drug-resistant strain ($15,000 to $137,000), or for hospitalization of an extensively drug resistant TB case (approximately $500,000 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. (Measures 2.8.1 through 2.8.4; 2.P, 2.Q, and 2.R)

<u>Program Description and Recent Accomplishments</u>: State and local TB programs are the vanguard against TB and drug resistant TB in the United States. TB funds support cooperative agreements to the 68 prevention, control, and laboratory programs to conduct surveillance, treat TB cases (curing TB disease requires six to nine months of therapy, and daily observation by specially trained workers), identify and treat infected contacts, and provide training and outreach in communities. CDC distributes funding for TB prevention, control, and laboratory programs according to a formula that considers case numbers and complexity. Funding recipients are also encouraged to allocate at least five percent of their award to address syndemics of HIV, VH, and STDs through program collaboration and service integration. CDC also provides technical assistance, training and education on TB control and elimination; monitors the occurrence of TB in the United States; serves as a national reference laboratory for TB; assists in outbreak investigations across the United States; and supports epidemiologic, laboratory and clinical research to identify factors associated with transmission and to develop and assess faster, more reliable and shorter tests and treatments for TB.

Recent accomplishments include:

- Developed an algorithm for diagnosing TB in HIV-infected persons in low income, high burden settings. Screening HIV infected persons for TB before beginning HIV therapy is recommended, yet evidence was lacking about how to best conduct such screening in resource limited settings. A CDC study found that missed TB diagnoses dropped from two-thirds to less than 10 percent if health care workers asked about three specific symptoms. The CDC findings have been used to update World Health Organization guidelines for TB screening in persons with HIV.
- Evaluated new rapid and innovative diagnostics for multi-drug resistance (MDR) TB.

- Implemented infection control assessments and the development of action plans to improve infection control practices in health care facilities worldwide.

IT INVESTMENTS

Information technology (IT) resources are an essential component of HIV, viral hepatitis, STD, 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. (For funding information, see Exhibit 53.)

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activity is included:

- Domestic HIV/AIDS – $30,400,000

Fund will support domestic HIV/AIDS activities consistent with the FY 2010 spend plan and the National HIV/AIDS Strategy. Important changes have occurred in the field of HIV prevention in the last year which have created exciting, new opportunities to lower the number of new HIV infections that occur each year in the United States. CDC has proposed several specific projects to leverage these new opportunities including provision of additional funds for CDC's Enhanced and Comprehensive HIV Prevention Planning program, demonstration projects to support the use of CD4 and viral load data by prevention programs, new demonstration programs to evaluate innovative models for incorporating new biomedical advances and prevention with positives, HIV prevention with tribal organizations and training to support realigned efforts.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	**$1,118,712**	**$1,088,500**	**$1,187,533**	**+$68,821**
- Domestic HIV/AIDS Prevention and Research	$799,270	$769,011	$857,608	+$58,338
- HIV Prevention by Health Departments	$329,470	$329,519	$343,318	+$13,848
- HIV Surveillance	$109,640	$109,656	$115,803	+$6,163
- Enhanced HIV Testing	$65,380	$65,390	$66,043	+$663
- Improving Program Effectiveness	$89,391	$89,404	$120,602	+$31,211
- National/Regional/Local/ Community/Other Organizations	$135,022	$135,042	$141,442	+$6,420
- HIV School Health	$40,000	$40,000	$40,000	$0
- ACA/PPHF (non-add)	$30,367	$0	$30,400	+$33
- Viral Hepatitis	$19,778	$19,781	$25,000	+$5,222
- Sexually Transmitted Diseases (STDs)	$154,617	$154,640	$161,353	+$6,736
- Tuberculosis (TB)	$145,047	$145,068	$143,572	-$1,475

MEASURES TABLE [1, 2]

In keeping with the priorities set by the NHAS, CDC is revising 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., focus on HIV cases rather than AIDS cases, 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.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.E.1: Increase the efficiency of core HIV surveillance as measured by the cost per estimated case of HIV diagnosed each year. (Efficiency)	FY 2008: $772 (Target Exceeded)	$650	$650	Maintain
Long Term Objective 2.1: Decrease the annual HIV incidence rate.				
2.1.1: Reduce the annual number of new HIV infections (Outcome)[3]	FY 2006: 56,300 (Baseline)	N/A	53,485	N/A
2.1.2: Decrease the rate of perinatally acquired pediatric HIV cases per 100,000 infants (Outcome)[4]	FY 2006: 1.5 (Baseline)	N/A	0.7	N/A
2.1.3: Reduce the disparity in HIV incidence for Blacks versus Whites (Black:white ratio of new infections)(Outcome)[4]	FY 2006: TBD (Baseline)	N/A	TBD	N/A
2.1.4: Reduce the disparity in HIV incidence for Hispanic versus Whites (Hispanic:white ratio of new infections) (Outcome)[4]	FY 2006: TBD (Baseline)	N/A	TBD	N/A
2.1.5: Increase the number of states with mature, name-based HIV surveillance systems (Output)	FY 2009: 39 (Exceeded)	46	50	+4
2.1.6: Increase the number of states that report all CD4 and HIV viral load values for surveillance purposes (Output)[4]	FY 2010: 19 (Baseline)	N/A	25	N/A
2.1.8: Increase the number of agencies trained each year to implement effective biomedical, behavioral, and structural interventions and public health strategies (Output)[3]	FY 2009: 935 (Target Not Met)	1,500	1,000	+500
Long Term Objective 2.2: Decrease the rate of HIV transmission				
2.2.1: Reduce the HIV transmission rate per 100 persons living with HIV (Outcome)[3]	FY 2006: 5% (Baseline)	N/A	4.7%	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.3.1a: Reduce the proportion of MSM who reported unprotected anal intercourse during their most recent sexual encounter with a partner of discordant or unknown HIV status (Outcome)[4,5]	FY 2008: 11% (Baseline)	10%	N/A	N/A
2.3.1c: Reduce the proportion of IDU who reported risky sexual and drug-using behaviors (Outcome)[3]	FY 2005: 72% (Baseline)	N/A	69%	N/A
Long Term Objective 2.3: Increase the percentage of people with HIV who know their serostatus.				
2.4.1: Increase the percentage of people living with HIV who know their serostatus[3]	FY 2006: 79% (Baseline)	N/A	81%	N/A
2.4.2: Increase the proportion of persons with HIV-positive results from CDC-funded counseling and testing sites who receive their test results (Outcome)	FY 2008: 92% (Exceeded)	90%	90%	Maintain
2.4.3: Increase the proportion of people with HIV diagnosed before progression to AIDS (revision under development) (Outcome)	FY 2007: 82.1% (Exceeded)	80%	82%	+2%
2.5.1: Increase the percentage of HIV-infected persons in CDC-funded counseling and testing sites who were referred to Partner Services (Outcome) [3]	FY 2008: TBD (Baseline)	N/A	TBD	N/A
2.5.3: Increase the percentage of HIV-infected persons in CDC- funded counseling and testing sites who were referred to HIV prevention services (Outcome)	FY 2008: TBD (Baseline)	N/A	TBD	N/A
Long Term Objective 2.6: Reduce the rates of viral hepatitis in the United States.				
2.6.1: Reduce the rate of new cases of hepatitis A (per 100,000 population) (Outcome)	FY 2008: 0.9 /100,000 (Exceeded)	0.9 /100,000	0.9 /100,000	Maintain
2.6.2: Reduce the rate of new cases of hepatitis B (per 100,000 population)(Outcome)	FY 2008: 1.3 /100,000 (Exceeded)	1.7 /100,000	1.5 /100,000	-0.2/100,000
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 (Outcome)	FY 2009: 9 (Baseline)	9	10	+1
2.6.5: Among minority communities experiencing health disparities, increase the portion of persons who have been tested for hepatitis B virus (Outcome)	FY 2009: 38 % (Baseline)	40 %	46 %	+6%

Long Term Objective 2.7: Reduce the rates of non-HIV sexually transmitted diseases (STDs) in the United States.				
2.7.1: Reduce pelvic inflammatory disease in the U.S. (Outcome)	FY 2009: 100,000 (Baseline)	94,000	84,709	-9,291
2.7.2: Reduce the prevalence of Chlamydia among high-risk women under age 25 (Outcome)	FY 2009: 11.3% (Target Exceeded)	12.0%	11.3%	-0.7%
2.7.4: Reduce the prevalence of gonorrhea in women aged 15 to 44 (per 100,000 population) (Outcome)	FY 2009: 255/100,000 (Target Exceeded)	288/100,000	263/100,000	-25/100,000
2.7.5: Eliminate syphilis in the U.S (per 100,000 population) (Outcome)	FY 2008: 4.6/100,000	2.2/100,000	6.4/100,000	+4.2/100,000
2.7.6: Reduce the incidence of P&S syphilis (Outcome)	See sub measures			
2.7.6a: in men (per 100,000 population) (Outcome)	FY 2009: 7.8/100,000 (Target Not Met)	9.4/100,000	10.7/100,000	+1.3/100,000
2.7.6b: in women (per 100,000 population) (Outcome)	FY 2009: 1.4/100,000 (Target Not Met but Improved)	2.0/100,000	2.1/100,000	-0.01/100,000
2.7.7: Reduce the incidence of congenital syphilis per 100,000 live births (Outcome)	FY 2009: 10/100,000 (Target Not Met)	16.2/100,000	18.5/100,000	+2.3/100,000
2.7.8: Reduce the racial disparity of P&S syphilis (reported ratio is black:white) (Outcome)	FY 2009: 9:1:1 (Target Not Met)	9:0:1	10.1	+1

Long Term Objective 2.8: Decrease the rate of cases of TB among U.S.-born persons in the United States.				
2.8.1: Decrease the rate of cases of TB among U.S.-born persons (per 100,000 population) (Outcome)	FY 2009: 2.0/100,000 (Not Met but Improved)	1.9/100,000	1.7/100,000	-0.2/100,000
2.8.2: Increase the proportion of newly diagnosed TB patients who complete treatment within 12 months (where <12 months of treatment is indicated) (Outcome)	FY 2007: 83.4% (Target Not Met)	>87.5%	>88.0%	+0.5%
2.8.3: Increase the percentage of culture-positive TB cases with initial drug susceptibility results reported (Outcome)	FY 2009: 95.7% (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 2007: 64.3%	70 %	75%	+5%

[1]This table has been amended to reflect targets for HIV incidence, transmission and knowledge of serostatus, consistent with the National HIV/AIDS Strategy. Revisions to other HIV measures have been incorporated to reflect the NHAS and improvements in systems and methods. CDC is working to develop and refine long-term measures of access to care and health disparities and will include such measures in a revised and reformatted performance plan in FY 2013.
[2]Targets do not reflect impact of funding from ACA/PPHF.
[3] Language has been revised to reflect the goals of the National HIV/AIDS Strategy and targets for this measure are consistent with targets included in the Strategy.
[4]Proposed new measure based on restructuring of HIV Performance Plan to align with CDC and National HIV/AIDS Strategy Priorities.
[5]This measure has triennial reporting. Annual data are not available for this measure

OTHER OUTPUTS[1]

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.A: Areas funded for HIV prevention	FY 2010: 65	65	65	Maintain
2.B: Number of jurisdictions funded for expanded, comprehensive HIV prevention planning activities	FY 2010: 12	Baseline	Up to 12	Maintain
2.C: Areas funded for HIV/AIDS surveillance	FY 2010: 65	65	65	Maintain
2.D: Number of areas funded to estimate HIV incidence	FY 2010: 25	22	25	+3
2.E: Number of jurisdictions funded for enhanced reporting of CD4 and viral load test results	FY 2010: 46	Baseline	Up to 65	Up to +19
2.F: Number of jurisdictions to conduct surveillance drug-resistant strains of HIV	FY 2010: 11	11	11	Maintain
2.G: Number of capacity building assistance providers	FY 2010: 31	30	31	+1
2.H: Number of CBOs funded to support community level interventions	FY 2010: 133	145	133	-12[2]
2.I: Number of jurisdictions funded with enhanced testing activities	FY 2010: 30	30	30	Maintain
2.J: Number of States or cities funded for enhanced viral hepatitis surveillance	FY 2010: 9	9	10	+1
2.K: Number of States or cities funded for adult viral hepatitis prevention coordinators	FY 2010: 55	55	55	Maintain
2.L: Number of grantees receiving technical and financial assistance to grantees for STD Prevention	65	65	65	Maintain
2.M: Syphilis Elimination Programs Funded	33	38	TBD[3]	N/A
2.N: Regional Infertility Programs Funded	10	10	10	Maintain
2.O: STD/HIV Regional Prevention Training Centers Funded	10	10	10	Maintain
2.P: Number of cities, States, and territories provided financial and technical aid to conduct TB prevention and control activities and collect TB surveillance data	68	68	68	Maintain
2.Q: Number of TB research consortia funded	2	2	2	Maintain
2.R: Number of State public health laboratories participating in the TB Genotyping Network	50	50	50	Maintain

[1]Targets do not reflect impact of funding from ACA/PPHF.
[2] The number of CBOs funded to support community level interventions remains the same in FY 2012 as in FY 2010. The difference of -12 is a result of comparing the FY 2012 target to the FY 2010 target.
[3] The number of programs funded annually for this activity is determined by a formula for which some data not yet available.

CDC-WIDE HIV/AIDS FUNDING

Fiscal Year	Domestic HIV/AIDS Prevention and Research (Infectious Disease)	Other Domestic HIV Prevention	Global AIDS Program[3]	CDC-Wide HIV Total[4]
2001	$653,462,000	$96,199,000	$104,527,000	$854,188,000
2002	$689,169,000	$96,038,000	$168,720,000	$953,927,000
2003[1]	$699,620,000	$93,977,000	$182,569,000	$976,166,000
2004[2]	$667,940,000	$70,032,000	$266,864,000	$1,004,836,000
2005[4]	$662,267,000	$69,438,000	$123,830,000	$855,535,000
2006[5]	$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[6]	$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[7]	$799,270,000	$0	$118,961,000	$918,231,000
2011 CR	$769,011,000	$0	$118,979,000	$887,990,000
2012 Request[8]	$857,608,000	$0	$118,023,000	$975,631,000

[1] Global AIDS amounts include funding for the Prevention of Mother to Child HIV Transmission initiative, which was transferred to the Department of State Office of the Global AIDS Coordinator in FY 2005.
[2] 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, STD and TB prevention budget activity.
[3] Amount for Global AIDS Program does not include PEPFAR funding.
[4] From FY 2000 to FY 2003 CDC-wide HIV/AIDS funding is comprised of specific activities within the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), and the National Center for Infectious Diseases (NCID). From FY 2004 to FY 2009, CDC-wide HIV/AIDS funding was comprised of activities conducted by NCHHSTP, NCCDPHP, and the National Center for Birth Defects and Developmental Disabilities (NCBDDD).
[5] 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, STD, and TB Prevention in FY 2006.
[6] 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
[7] FY 2010 and FY 2011 funding levels have been made comparable to the budget realignment, reflecting a transfer of $40 million 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 $30.4 million ACA/PPHF allocation.
[8] The FY 2012 Request proposes a transfer of $40 million 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, STD, 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. The FY 2012 Request for Domestic HIV/AIDS Prevention and Research also includes $30.4 million from the ACA/PPHF.

STATE TABLES

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS			TB ELIMINATION & LABORATORY PROGRAM	COMPREHENSIVE STD PREVENTION PROGRAM
	FY 2010 Prevention Projects	FY 2010 Surveillance	Total	FY 2010 Actual [4]	FY 2010 Actual [6]
Alabama [3]	$2,349,806	$1,053,264	$3,403,070	$1,081,606	$1,853,678
Alaska [3]	$1,508,586	$171,919	$1,680,505	$427,966	$427,698
Arizona [2,3,5]	$3,196,239	$992,907	$4,189,146	$1,518,684	$1,443,865
Arkansas [2,3]	$1,757,050	$332,446	$2,089,496	$637,340	$1,161,024
California [2,3,5]	$13,997,406	$2,779,036	$16,776,442	$8,291,283	$5,895,762
Colorado [2,3]	$4,307,745	$1,203,383	$5,511,128	$582,558	$1,104,144
Connecticut [2,3,5]	$6,193,020	$916,586	$7,109,606	$769,220	$762,645
Delaware [2,3]	$1,875,643	$299,358	$2,175,001	$295,141	$526,338
District of Columbia [3]	$5,919,306	$1,793,894	$7,713,200	$662,122	$1,255,482
Florida [3,5]	$19,426,251	$4,099,732	$23,525,983	$7,919,087	$4,552,817
Georgia [2,3]	$8,164,288	$815,142	$8,979,430	$2,826,414	$3,804,970
Hawaii [3]	$2,015,984	$259,389	$2,275,373	$792,877	$385,884
Idaho [2,3]	$895,714	$91,103	$986,817	$181,326	$421,855
Illinois [2,3,5]	$4,150,657	$705,529	$4,856,186	$1,562,967	$2,171,117
Indiana [2,3,5]	$2,596,252	$891,109	$3,487,361	$774,582	$1,668,062
Iowa [3]	$1,711,839	$337,258	$2,049,097	$365,943	$744,883
Kansas [5]	$1,818,538	$193,735	$2,012,273	$464,476	$841,764
Kentucky [2,3]	$2,092,356	$291,470	$2,383,826	$726,354	$955,565
Louisiana [3]	$5,288,702	$1,632,306	$6,921,008	$1,374,598	$2,260,008
Maine [3]	$1,620,343	$166,382	$1,786,725	$179,671	$304,900
Maryland [2,3]	$9,884,080	$1,481,275	$11,365,355	$1,282,245	$1,340,046
Massachusetts [2,3]	$8,814,346	$1,005,688	$9,820,034	$1,555,981	$1,497,148
Michigan [1,3,5]	$6,330,625	$1,588,768	$7,919,393	$1,055,073	$2,710,642
Minnesota [1,2,3]	$3,255,014	$478,423	$3,733,437	$1,114,255	$1,175,521
Mississippi [2,3,5]	$2,125,398	$423,627	$2,549,025	$887,208	$1,400,293
Missouri	$3,779,543	$712,468	$4,492,011	$652,240	$2,142,879
Montana	$1,427,694	$75,000	$1,502,694	$163,459	$307,581
Nebraska [3]	$1,324,012	$224,659	$1,548,671	$214,670	$457,246
Nevada [3]	$2,713,662	$615,659	$3,329,321	$595,058	$712,227
New Hampshire [2]	$1,653,610	$110,636	$1,764,246	$242,743	$265,822
New Jersey [2,3,5]	$13,334,580	$3,290,505	$16,625,085	$4,524,232	$3,092,982
New Mexico	$2,378,891	$284,998	$2,663,889	$371,368	$725,810

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS			TB ELIMINATION & LABORATORY PROGRAM	COMPREHENSIVE STD PREVENTION PROGRAM
	FY 2010 Prevention Projects	FY 2010 Surveillance	Total	FY 2010 Actual [4]	FY 2010 Actual [6]
New York [1,2,3]	$26,681,569	$2,427,989	$29,109,558	$2,264,985	$3,017,788
North Carolina [2]	$4,287,772	$992,366	$5,280,138	$1,946,003	$2,871,591
North Dakota [2,5]	$756,811	$ 55,134	$811,945	$186,662	$264,085
Ohio	$5,376,426	$755,062	$6,131,488	$1,211,074	$3,276,596
Oklahoma [2,3]	$2,512,653	$522,811	$3,035,464	$776,484	$1,167,116
Oregon [3,5]	$2,969,192	$484,009	$3,453,201	$700,081	$1,027,577
Pennsylvania [2]	$4,958,549	$507,616	$5,466,165	$900,069	$2,088,320
Rhode Island	$1,733,641	$224,293	$1,957,934	$327,519	$367,950
South Carolina [2,3]	$4,512,220	$1,120,989	$5,633,209	$1,340,770	$1,597,513
South Dakota [1,2]	$708,553	$67,989	$776,542	$206,231	$292,269
Tennessee [1,2,3,5]	$3,887,216	$862,547	$4,749,763	$1,552,963	$2,348,675
Texas [1,2,3,5]	$13,253,245	$2,264,304	$15,517,549	$8,194,501	$6,526,358
Utah [3,5]	$1,152,718	$310,507	$1,463,225	$335,094	$483,082
Vermont	$1,526,647	$100,470	$1,627,117	$153,275	$183,669
Virginia [1,2,3]	$5,006,087	$1,207,353	$6,213,440	$1,510,113	$1,899,526
Washington [2,3,5]	$3,796,574	$1,648,742	$5,445,316	$1,605,203	$2,430,722
West Virginia [1,2]	$1,668,049	$153,691	$1,821,740	$330,036	$712,960
Wisconsin [3]	$2,856,944	$528,543	$3,385,487	$466,579	$969,352
Wyoming	$873,379	$75,000	$948,379	$194,945	$262,387
Subtotal, States	***$236,425,424***	***$43,627,069***	***$280,052,493***	***$68,295,334***	***$80,158,194***

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS			TB ELIMINATION & LABORATORY PROGRAM	COMPREHENSIVE STD PREVENTION PROGRAM
	FY 2010 Prevention Projects	FY 2010 Surveillance	Total	FY 2010 Actual [4]	FY 2010 Actual [6]
Baltimore [5]	–	–	–	$499,300	$1,476,175
Chicago [1,2,3,5]	$5,509,482	$1,278,354	$6,787,836	$1,904,172	$2,014,117
Detroit	–	–	–	$483,313	–
Houston [2,3]	$5,355,683	$1,550,947	$6,906,630	$2,183,785	–
Los Angeles [2,3]	$12,984,937	$2,624,233	$15,609,170	$4,978,654	$3,729,786
New York City [3]	$21,510,033	$4,791,788	$26,301,821	$8,993,816	$6,802,077
Philadelphia [2,3]	$6,419,309	$1,130,863	$7,550,172	$918,184	$2,538,772
San Diego [5]	–	–	–	$2,119,188	–
San Francisco [2,3,5]	$9,268,980	$1,888,999	$11,157,979	$2,764,206	$1,562,385
Subtotal, Cities	***$61,048,424***	***$13,265,184***	***$74,313,608***	***$24,844,618***	***$18,123,312***
American Samoa [3]	$ 174,435	$19,797	$194,232	$96,765	$63,247
Guam [3,5]	$ 499,622	$50,000	$549,622	$483,125	$117,077
Marshall Islands [2,5]	$122,518	$13,598	$122,518	$250,442	$136,934
Micronesia [2]	$212,866	$10,552	$226,464	$184,054	$56,683
Northern Marianas [1,2]	$201,666	$16,567	$212,218	$257,216	$119,525
Palau [2]	$235,697	$681,823	$252,264	$131,835	$43,609
Puerto Rico [1,2,3]	$4,051,840	$190,121	$4,733,663	$834,362	$1,410,941
Virgin Islands [3]	$174,435	$ 13,598	$832,529	$86,938	$192,280
Subtotal, Territories	***$6,141,052***	***$982,458***	***$7,123,510***	***$2,324,737***	***$2,140,296***
Total, States, Cities, and Territories	**$303,614,900**	**$57,874,711**	**$361,489,611**	**$95,464,689**	**$100,421,802**

[1] Amount for HIV prevention projects reflects new funding only. In addition, 10 grantees received a total of $624,000 in unobligated funds to maintain level funding.
[2] Amount for HIV surveillance reflects new funding only. In addition, 37 grantees received a total of $1,973,235 in unobligated funds to maintain level funding.
[3] Amount for HIV surveillance reflects new funding only. In addition, 46 grantees received a total of $5,600,000 in supplemental ACA/PPHF for HIV laboratory reporting projects.
[4] Amounts reflect new funding and include $9,639,454 in HIV/TB co-infection funds. In addition, grantees received a total of $4,746,673 in unobligated funds.
[5] Grantee received funding from one or more of the following TB supplements: Outbreak Support ($434,051), Supplemental Funding ($2,382,169), Regional Training and Medical Consultation Centers ($5,789,540).
[6] Amounts reflect new funding and include $8,631,530 in HIV/STD co-infection funds. In addition, grantees received a total of $1,100,360 in unobligated funds.

EMERGING AND ZOONOTIC INFECTIOUS DISEASES

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$261,174	$261,215	$289,118	+$27,944
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$20,000	$51,750	$60,000	+$40,000
Total	**$281,174**	**$312,965**	**$349,118**	**+$67,944**
FTEs	1,166	1,186	1,198	+32

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $349,118,000 for Emerging and Zoonotic Infectious Diseases, including $60,000,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an overall increase of $67,944,000 above the FY 2010 level. The FY 2012 request includes the elimination of Prion activities ($5,473,000) and an increase of $1,000,000 to remain available until expended for Quarantine related medical and transportation costs. FY 2012 funds will support the prevention and control of infectious diseases through a range of activities including: surveillance, outbreak investigation and response, research, support for epidemiology and laboratory capacity, and the protection of populations through the use of quality systems and practices.

CDC is the global leader in addressing zoonotic and emerging infectious diseases. CDC protects populations around the world from the spread of infectious diseases by focusing on the following: 1) diseases occurring due to global migration and travel; 2) high-mortality diseases requiring evaluation in BSL-3 and BSL-4 laboratories; 4) diseases transmitted through contaminated food and water; 5) diseases transmitted from animals, mosquitoes, ticks, and fleas; and 4) diseases spread in health care settings. The domestic and global burden of these diseases is substantial. Foodborne, waterborne, vectorborne, and health care-transmitted pathogens affected millions of Americans last year and hundreds of millions around the globe. This funding provides core infectious disease capacity to CDC's other infectious disease programs, as well as cross-cutting investments to support state and local infectious disease capacity.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 307, 310, 311, 317, 319, 319D, 327, 352, 399G

Specific Authorities: PHSA §§ 308(d), 317P, 317R, 317S, 319E, 319F, 319G, 321, 322, 325, 353, 361-369, 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).

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……….…..…………………………………………………..Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$221,643,000
FY 2008	$217,771,000
FY 2009	$225,404,000
FY 2010*	$281,174,000
FY 2011CR	$312,965,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Food Safety

CDC's FY 2012 request of $34,486,000 for foodborne disease activities is an increase of $8,693,000 above the FY 2010 level. The increased funding will be used for improving state and local capacity to identify and stop outbreaks by expanding the network of OutbreakNet Sentinel Sites, to implement, assess, and standardize best methods and new technologies for multistate foodborne outbreak detection and response. CDC will also improve surveillance for foodborne illnesses and develop improved models and reports related to the burden and cost of foodborne illnesses and the attribution of illnesses to particular food types. CDC will also support the reduction of illness by improving outbreak detection and response with faster and more comprehensive public health laboratory and epidemiological surveillance and investigations. Improvements in outbreak detection and epidemiological practice through standardized DNA "fingerprinting" (e.g., PulseNet) have identified national outbreaks, including those from foods not previously associated with illness. These activities support the President's Food Safety Workgroup principles by: 1) prioritizing prevention; 2) strengthening surveillance and enforcement; and 3) improving outbreak response and recovery.

In FY 2012, CDC will:

- Expand on work with all state and federal partners to improve surveillance for foodborne illnesses and develop improved models and reports related to the health and economic burden of foods most associated with illness to inform consumers, industry, and regulators.
- Continue to enhance state and local capacity to investigate possible outbreaks rapidly by supporting a network of five OutbreakNet Sentinel Sites. These sites will implement, assess, and standardize best methods and new technologies for multistate foodborne outbreak detection and response, which will include tools for rapidly interviewing persons affected by foodborne illness and sharing information with key partners.
- Maintain PulseNet capacity in all states for pathogen fingerprinting, cluster identification, and cluster assessment at state and national levels for the identification and investigation of foodborne outbreaks.
- Support ongoing and up to three new Council to Improve Foodborne Outbreak Response (CIFOR) projects to improve the standardization, speed, and accuracy of foodborne disease outbreak detection and investigation, and to help local and state agencies implement the CIFOR "Guidelines for Foodborne Disease Outbreak Response."

- Share data on approximately 10 food safety events, including release of new reports and investigation of serious outbreaks, so information is available rapidly and routinely. Data will be shared through new lines of communication and approaches for health messaging, including social networking applications, with surveillance data user groups, the food industry, food scientists, educators, regulatory partners, and the public.
- Develop and conduct up to eight new foodborne disease outbreak training courses for public health partners.

Performance: CDC's activities supported the decrease of illnesses caused by pathogens commonly transmitted through foods. In 2009, FoodNet documented that *E. coli* O157:H7 reached the Healthy People 2010 target with less than one case per 100,000 population. CDC's food safety programs demonstrated a significant return on investment, as evidenced by an analysis which concluded that the Colorado PulseNet system would recover all its costs if it averted as few as five cases of *E. coli* O157:H7 annually. The analysis also estimated that prevention of a single fatal case of *E. coli* O157 infection would save an estimated seven million dollars in societal costs. In addition, *Listeria*, *Campylobacter*, and *Salmonella* infection rates also decreased. *Salmonella* infection rates have the least decrease, which specifically points to gaps in the current food safety system and the need to continue to develop and evaluate food safety practices as food moves from the farm to the table.

Investments in food safety decreases the time to detect outbreaks, increases the capacity and speed of foodborne outbreak investigation, and improves laboratory and epidemiological surveillance. In OutbreakNet Sentinel Sites, improved methods and tools reduced the time to subtype priority agents and increased the proportion of outbreaks for which food vehicle, microbial cause and contributing environmental factors were determined. The practices established in OutbreakNet Sentinel Sites can be implemented in other states as capacity allows. (Measures 3.1.1a, 3.1.1b, 3.1.1c, 3.1.1d, 3.A, and 3.B)

Program Description and Recent Accomplishments: Preventing bacterial, viral, and parasitic foodborne illnesses remains an important component of CDC's efforts to improve the health of Americans. Foodborne disease outbreaks require public health and industry resources and collaboration to investigate and control the outbreak. The cornerstone of CDC's foodborne disease prevention program is building and enhancing collaborative surveillance networks in states to detect and respond to outbreaks, which in turn provide the information to drive interventions for foodborne diseases prevention. CDC also supports international surveillance and training networks to better detect and investigate foodborne disease outbreaks globally.

Recent accomplishments include:

- Launched a new network for evaluating and innovating public health strategies for rapidly detecting and investigating foodborne outbreaks. This network, called OutbreakNet Sentinel Sites, began with five sites selected in September 2010, to adapt, evaluate and adopt a series of "best practices" to serve as models for other states. These methods include swifter laboratory methods to identify clusters of infections, more comprehensive routine interviews of ill persons, and standardized methods to make it easy to combine information from all the sites.
- Launched a new surveillance platform for gathering reports of foodborne outbreak investigations from states and counties, so they can be more rapidly analyzed, summarized, and shared. As part of this, CDC also launched the new Foodborne Outbreak Online Database, making the database of reported outbreaks accessible and searchable by the public, public health agencies, and partners. This type of surveillance information will serve to inform activities and policies by all food safety agencies and partners.

- Coordinated and led an extensive investigation with multiple states, Food and Drug Administration (FDA) and United States Department of Agriculture (USDA) of *Salmonella* Enteritidis infections due to contaminated shell eggs. Over 1,900 confirmed illnesses were reported, with many more likely involved but unreported. Investigations of 15 separate local clusters implicated shell eggs from two related egg producers as the source of infections. On-farm investigations identified numerous deficiencies, which led to a recall of 500 million eggs, the first time that such a recall has been undertaken, and further shipping of shell eggs from the farm was halted for five months. A large, but incalculable number of illnesses, hospitalizations, and deaths were averted. The outbreak illustrates the need for the new 2010 mandatory egg shell regulation, to reduce the risk of future outbreaks.

National Health Care Safety Network and Healthcare-Associated Infections

CDC's FY 2012 request of $47,452,000, including $20,000,000 from the Affordable Care Act Prevention and Public Health Fund, for the National Health Care Safety Network (NHSN) and healthcare-associated infection (HAI) activities, is an increase of $32,304,000 above the FY 2010 level. These funds will promote healthcare quality through the prevention of healthcare acquired conditions, including healthcare-associated infections caused by pathogens such as MRSA, Clostridium difficile (C. difficile), and multi-drug resistant gram-negative bacteria. It is CDC's goal to eliminate HAIs in all healthcare settings and to expand public health activities related to monitoring, response, prevention, and applied research. HAIs are a public health problem beyond the hospital, occurring in all settings where patients receive preventive services, diagnostics, and treatment for health conditions. With the increased base funding, CDC will expand NHSN from 2,500 to 6,500 healthcare settings (of which 5,500 are hospitals) in support of the Value Based Purchasing program of the Affordable Care Act Prevention and Public Health Fund. In addition, NHSN participation will be expanded to include approximately 1,000 non-hospital facilities (approximately 500 hemodialysis facilities and over 300 long-term care facilities), where increasing numbers of high-risk procedures are being performed. To ensure data accuracy, CDC will accelerate electronic reporting of HAI data from hospital commercial infection surveillance systems, create national standards for reporting laboratory data for HAIs and communicable diseases, and facilitate more widespread implementation of electronic algorithms for HAI detection. Funds from the Affordable Care Act (ACA) will build on the success of the HAI Recovery Act funding in preventing infections through the leadership and coordination of state health departments. ACA funding will support model states which have effectively implemented HAI prevention initiatives through programs and policies. The funding will help these states build on their ongoing successes and invest in sustainable programs that will work across the healthcare system locally to maximize the HAI prevention efforts by collaborating with other healthcare partners such as Centers for Medicare and Medicaid Services (CMS) quality improvement organizations, hospital associations, and consumer groups. The collaborations work to implement and ensure adherence to evidence-based HAI prevention practices to achieve the prevention goals included in HHS Action Plan.

In FY 2012, CDC will:

- Support CMS to implement HAI value-based purchasing requirements under health reform. The Affordable Care Act Prevention and Public Health Fund's value-based purchasing program requires hospitals to use HAI prevention metrics established in the Department of Health and Human Services (DHHS) HAI Action Plan. Hospitals participating in the CMS Hospital Inpatient Quality Reporting Program will join CDC's NHSN for Central line-associated bloodstream infection (CLABSI) reporting in 2011 and Surgical Site Infections (SSI) in 2012.

- Support state-based HAI programs to expand NHSN enrollment and facilitate the implementation of prevention activities to achieve DHHS goals across all health care settings.

- Enhance national surveillance of HAIs through NHSN by: expanding and improving electronic data collection and data analysis for local use of data to assess regional and national trends; supporting the development and implementation of data validation methods; and accelerating migration to electronic reporting from electronic health records systems.
- Support the Prevention Epicenters and additional research networks to address important scientific gaps in HAI prevention. Research will focus on novel strategies for detection and prevention of catheter-associated urinary tract infections, ventilator-associated pneumonia, bloodstream infections, *C. difficile* infections, infections caused by antimicrobial-resistant organisms, and inappropriate antimicrobial use.
- Respond to requests for assistance from health departments and health care facilities by: investigating outbreaks of HAIs; producing evidence-based HAI prevention guidelines; and maintaining critical core laboratory capacities, including serving as a national and international reference laboratory for new and emerging health care-associated pathogens.
- Implement a new hemovigilance module in NHSN. The module will collect, analyze, and report information on blood-transfusion related adverse events and improve patient safety through benchmarking.

Performance: CDC continued to aggressively combat HAIs across the spectrum of health care. Building upon the successes from CDC's work with states through the Recovery Act, CDC started the expansion of prevention activities to non-hospital settings and moved towards the elimination of HAIs across the spectrum of health care, as well as continued to reduce the incidence of HAIs nationally. CDC reduced HAIs, supporting progress towards the five-year targets and metrics defined in the DHHS HAI Action Plan to Prevent HAIs. (Measures 3.3.2 and 3.3.3)

Program Description and Recent Accomplishments: HAIs are a major public health problem in the United States, accounting for 99,000 unnecessary deaths and billions of additional health care costs annually. Recent research shows that implementation of CDC's HAI prevention recommendations can reduce HAIs by 70 percent and virtually eliminate some types of infections. Broad implementation of these guidelines will save lives, reduce suffering, and combat an estimated $28 to $33 billion in excess health care costs attributed to HAIs each year. CDC continues to work with state and local health departments, CMS, Agency for Health care Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), U.S. Department of Veterans Affairs, and other partners to prevent and eliminate HAIs. The work by CDC programs on HAI elimination is integral to, and supports the goals of, the DHHS Action Plan to Prevent HAIs. CDC has seen progress in preventing bloodstream infections and MRSA infections in hospital settings.

CDC also continues to strengthen its efforts in blood, organ, and tissue safety through its involvement in outbreak investigations, collaborations with federal, public, and private partners, and through surveillance activities like the hemovigilance module in the NHSN, allowing facilities to monitor blood safety and analyze data to inform interventions.

Recent accomplishments include:

- Reached a 20 percent reduction in central-line associated bloodstream infections nationally in data reported to NHSN in 2009, as measured by the standardized infection ratio. A recent *Journal of the American Medical Association* publication demonstrates a 17 percent decrease in invasive MRSA among patients with symptoms starting in the community, but had prior contact with the health care system and a 28 percent decrease among those hospital-onset diseases among CDC's EIP sites between 2003 and 2008.

- Developed state plans to achieve DHHS goals through the Recovery Act (from FY 2009 to FY 2010 for fifty states, the District of Columbia, and Puerto Rico). Forty-nine states, the District of Columbia, and Puerto Rico have begun implementation of their state plans, which outlines intended HAI Recovery Act activities. Recovery Act grantees have hired staff to work on HAI programs, identified HAI coordinators, started prevention collaboratives, and begun planning of data validation in collaborating with partners to improve HAI investigation, response, and reporting.

- Provided NHSN monitoring capacity to more than 3,900 facilities as of December 2010. There has also been increased capacity for electronic reporting through the use of clinical document architecture. These increases have resulted in the ability for CDC to measure more infections. CDC has partnered with CMS to enable health care facilities to use NHSN to report quality measure data as part of CMS's pay-for-reporting program, including posting of NHSN facility–level data at the Hospital Compare web site.

Quarantine and Migration

CDC's FY 2012 request of $27,485,000 for quarantine and migration is an increase of$971,000 above the FY 2010 level. FY 2012 funds will continue to improve and protect the health of vulnerable mobile populations and to implement regulations necessary to prevent the introduction, transmission, or spread of communicable diseases into the United States. Within this total is $1,000,000 to remain available until expended for quarantine related medical and transportation costs. Prior to FY 2012, quarantine and migration funding was part of the Public Health Preparedness and Response budget. Quarantine and Migration also receives funds through Emerging Infectious Diseases and Pandemic Influenza appropriations.

In FY 2012, CDC will:

- Fund transportation, medical care, treatment, and other related costs of persons under Title III of the Public Health Service Act who are subject to Federal or State quarantine laws.

- Provide technical and regulatory oversight of health screening and post-arrival health monitoring of immigrant and refugee populations that are undergoing U.S. resettlement to improve their health and protect the health of receiving communities including the implementation of new Tuberculosis (TB) Technical Instructions to reduce the importation of infectious TB.

- Modernize regulations to ensure swift and appropriate responses 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 (42 U.S.C. § 264).

- Continue to support state health departments receiving immigrants and refugees through notifications and guidance on health-related issues in new arrivals to ensure prompt post-arrival medical evaluation and by providing information on high risk populations.

- Enhance public health preparedness and effective action to mitigate the impact of infectious disease events by providing technical assistance and developing collaborative partnerships with state and local health departments, federal agencies, and international ministries of health and responding to infectious disease outbreaks in refugee camps around the world.

- Operate 20 quarantine stations across the United States that serve to limit the introduction and spread of infectious diseases by working with federal, state, and local partners to develop comprehensive operational plans to manage ill and/or exposed travelers and respond to public health events along the travel continuum.
- 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 through the Border Infectious Disease Surveillance project.
- Characterize risks associated with international travel to develop appropriate guidance by utilizing GeoSentinel, an international surveillance network of travel/tropical medicine clinics for all travel-related illnesses, to develop evidence-based recommendations that are shared with health-care 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.

Performance: CDC's quarantine and migration health activities work to reduce transmission and spread of infectious diseases in high-risk vulnerable populations including refugees, immigrants and travelers, which are activities that provide significant savings to States. For example, it is estimated that a case of multi-drug-resistant (MDR) TB averted can save up to $700,000[9].

In FY 2010, over 50 percent of all immigrants and the majority of refugees in 27 countries were screened according to revised TB Technical Instructions. CDC effectively diagnosed and treated approximately 1,000 cases of TB (40 MDR) among overseas immigrant applicants and U.S.-bound refugees, which saved states an estimated $45 million. In addition, CDC conducted over 95 contact investigations involving over 130 flights for travelers exposed to infectious diseases and responded to 22 state and partner requests for assistance for 219 new health-related travel restrictions. CDC ensured that the majority of cases involving TB and 50 percent of all cases placed on federal travel restrictions returned to or continued treatment.

Program Description and Recent Accomplishments: CDC’s global migration health and quarantine activities aim to reduce morbidity and mortality caused by infectious diseases among immigrants, refugees, international travelers, and other mobile populations that cross international borders. FY 2012 funds will support activities to improve and protect the health of vulnerable mobile populations and to implement regulations necessary to prevent the introduction, transmission, or spread of communicable diseases into the U.S. CDC supports these activities with resources from the Pandemic Influenza, and Emerging Infectious Diseases appropriations.

With continued technological advances, the world has experienced a dramatic increase in the volume and speed of intercontinental movement of people, animals, and cargo. More than two million people travel to or through the United States by air, sea, or land daily. About half of worldwide international travelers have some kind of health problem while traveling and approximately eight percent of them seek medical attention while abroad or after their return. In addition to the mass movement of people into and out of the United States through international travel, the U.S. Government offers U.S. resettlement to approximately 80,000 refugees and 1.2 million immigrants annually. This migration occurs across large prevalence gaps in disease burden and risk. Before resettlement, most refugees and some immigrants have resided in difficult environments with limited access to medical care and preventive health services, leaving them at a significantly increased risk of illness, death and disability from a variety of health problems. Infectious diseases among immigrants, refugees, international travelers, and other globally mobile populations pose

9Rajbhandary SS, Marks SM, Bock NN. Costs of patients hospitalized for multi-drug resistant tuberculosis. Int J Tuberc Lung Dis 2004;8(8):1012-1016.

a significant health risk to these individuals, their families, and pose a public health risk to the U.S. communities in which they visit or reside.

Recent accomplishments include:

- Reduced importation of disease and improving the health of U.S.-bound refugees by providing more than 67,000 individual notifications to state health departments of immigrants and refugees with a notifiable disease within 21 days of their arrival and responding to 22 infectious disease outbreaks in refugee camps (including 2009 H1N1 influenza, malaria, measles, cholera, and pertussis).
- Improved the ability to respond to an event of public health significance by increasing the number of international airports and land borders covered by a communicable disease preparedness plan from six to 20.
- Conducted a national communications campaign to raise awareness of preventing the spread of influenza during travel, which generated more than 131 million media impressions and was covered in more than 50 newspaper outlets, 68 television broadcasts, and 80 websites.

Emerging Infectious Diseases

In FY 2012, increased funding will continue to support on-going antimicrobial resistance (AR) activities. In addition to supporting AR and infectious disease epidemiology and laboratory activities across CDC, EID funding strengthens the national infectious disease capacity by ensuring State and local health departments can quickly recognize and respond to emerging infectious disease threats locally. CDC leads the world in identifying characterizing, and responding to emerging infectious disease threats. In addition, $40,000,000 from the Affordable Care Act Prevention and Public Health Fund will support Epidemiology and Laboratory Capacity and Emerging Infections Program cooperative agreements to increase the number of highly trained and properly equipped epidemiologists, laboratorians, and informaticians in State, local, and territorial health departments. These activities are further described in the Affordable Care Act Prevention and Public Health Fund section below.

In FY 2012, CDC will:

- Continue to work with health departments and academic institutions to conduct population-based surveillance on emerging infections and conditions not covered by routine health department surveillance, such as *Clostridium difficile* and gram negative bacteria. This surveillance documents national disease burden, improves understanding of transmission, and helps assess the impact of prevention measures.
- Support the Health Care Infection Control Practices Advisory Committee Federal Advisory Committee Act; HAI disease outbreak and epidemiological investigations; HAI disease epidemiology and laboratory programs; safety of blood, organ, and other tissues; patient safety; and injection safety.
- Develop, test, and deploy improved diagnostics for infectious diseases – especially orphan pathogens such as plague, dengue, and chikungunya. These diagnostics range from highly sensitive and specific tests for identification and discovery to rapid point-of-care diagnosis in developing counties.

- Increase support for the rapid detection of new and emerging infectious diseases through laboratory capacity at CDC. CDC's Biotechnology Core Facility provides laboratory and research support to all CDC scientists in multiple disciplines with state-of-the-art technology. The Biotechnology Core Facility is equipped with high-performance computer hardware and software to facilitate infectious disease research, data mining, and molecular biological analyses.
- Detect, study, and monitor unexplained illness and death from infectious diseases in the United States and globally and continue to provide reference laboratory services to states and other countries. CDC serves as a World Health Organization collaborator and reference laboratory for multiple infectious diseases, including high-mortality select agents and Category A bioterrorism threat agents, which require Biosafety Level 3 (BSL 3) or Biosafety Level 4 (BSL 4) laboratory conditions for safe handling.
- Strengthen infectious disease capacity at the state, local, and territorial level. The Epidemiology and Laboratory Capacity (ELC) and Emerging Infections Program (EIP) cooperative agreements allow health departments to build their infectious diseases capacity by hiring, training, and equipping staff, upgrading and maintaining laboratories, and investing in information technology to improve disease reporting and monitoring and enhance information exchange within and between public health agencies and clinical care systems.
- Prevent and control disease outbreaks across the globe. For example, CDC responded to 22 infectious disease outbreaks (including 2009 H1N1 influenza, malaria, measles, cholera, meningitis, and pertussis) in refugee camps, reducing importation of disease through these vulnerable U.S.-bound populations. Domestically, CDC also supported multiple outbreak investigations nationwide, utilizing OutbreakNet, a national network of epidemiologists and other public health officials who investigate outbreaks of foodborne, waterborne, and other enteric illness.

Performance: CDC continued to build and maintain capacity in state, local, and territorial health departments for infectious diseases. The health departments depend upon ELC support to build and maintain their infrastructure for identifying and monitoring the occurrence of infectious diseases, detecting new emerging disease threats, responding to outbreaks, and develop and evaluate public health interventions. In FY 2010, public health workforce capacity (laboratorians, epidemiologists, health information technologists, support staff, etc.) supported by ELC includes more than 500 fully or partially funded positions.

Core EIP surveillance activities generate reliable estimates of the incidence of certain infections and provide the foundation for a variety of epidemiologic studies to explore risk factors, spectrum of disease, and prevention strategies, and quickly translates surveillance and research activities into informed policy and public health practice. For example, during the 2009 H1N1 influenza response, EIP quickly developed and implemented Guillain-Barre Syndrome surveillance that was critical in monitoring and evaluating the safety of 2009 H1N1 influenza vaccine and informing the 2009 H1N1 influenza vaccination campaign. EIP is a critical program and CDC will continue to maintain funding to 10 EIP sites. (Measure 3.D)

Program Description and Recent Accomplishments: While some diseases have been conquered by modern advances such as antibiotics and vaccines, new ones are constantly emerging and others reemerge in drug-resistant forms. Although it is impossible to predict their individual emergence in time and place, changing demographics and ecologies ensure that infectious diseases will continue to evolve. Left unattended, today's emerging diseases may become the endemic diseases of tomorrow. EID funding builds a stronger, more flexible public health system prepared to respond to known disease problems, as

well the unexpected such as a pandemic, an outbreak caused by an unknown organism, or a bioterrorist attack.

Through the ELC and EIP programs, CDC has invested in a flexible and adaptable national infrastructure to identify and respond to emerging infectious diseases and other public health threats. This infrastructure creates the core capacity needed at the state, local, and territorial level to establish and maintain disease surveillance and control of emerging infectious and vaccine-preventable disease threats by building a sufficient and competent workforce, laboratory facilities and capacities, and epidemiologic, statistical, and communication skills. ELC recipients include all 50 state health departments, six large local health departments, Puerto Rico, and Palau, allowing for considerable scalability. For example, resources and technical assistance can easily be pushed to all 58 ELC grantees. ELC also facilitates development of nationwide ELC-funded surveillance systems that are likely to be more cost-effective than discrete and unconnected systems. The EIP's geographic diversity (10 states across the United States) and EID-funded flexible infrastructure allows it to respond quickly to emerging public health threats. Additionally, EIP and its partners develop and model cutting-edge surveillance and prevention approaches to build and foster specialized epidemiology and laboratory capacity that, along with ELC support of basic/core capacities, enhances local, state, and national infrastructure for addressing infectious diseases. In addition, CDC supports various information systems that facilitate rapid, secure, and accurate information exchange. The information systems serve as a foundation for many of the infectious disease activities supported by CDC, such as detecting changes in the epidemiology of diseases, emergence of new strains, and evaluating vaccine effectiveness.

Recent accomplishments include:

- Conducted, through EIP grantees, active surveillance in 2009 for Guillain-Barre Syndrome (GBS). This surveillance provided data used to make decisions about continuing the vaccine campaign. GBS has previously been associated with vaccines, including influenza vaccines, thus it was critical to monitor the 2009 H1N1 campaign to identify a possible increased risk of GBS associated with the vaccine. This real time surveillance provided reassurance during the vaccination campaign that no large increases in the number of GBS cases were occurring.
- Utilized ELC and EIP flexibility and ability to address emergent issues and to push resources out to State and local health departments to rapidly implement critical public health enhancements for HAIs, vaccine-preventable diseases, core epidemiology and laboratory capacity, and health information systems under the Recovery Act and the Affordable Care Act Prevention and Public Health Fund.
- Provided scientific and technical support for the development of the 2010 recommendations for the use of the new 13-valent pneumococcal conjugate vaccine (PCV 13) among children for prevention of invasive pneumococcal disease and ear infections. This vaccine is expected to further reduce the U.S. burden of invasive pneumococcal disease by more than 60 percent among children and 40 percent among adults through herd immunity.

Antimicrobial Resistance

The Antimicrobial (AR) program supports state-based and local surveillance systems for identifying emerging resistance and tracking infections in the community and health care settings and in animals. Various educational activities and CDC's involvement with national planning efforts are used to combat AR. AR activities, such as surveillance, technical assistance, and epidemiological and laboratory support, will continue in FY 2012.

CDC's antimicrobial resistance program is cross-sectional and serves as the foundation for the detection, prevention and control of drug-resistant emerging infections. Repeated and improper uses of antibiotics

are important factors in the increase in drug-resistant bacteria, viruses, and parasites. Preventing infections and decreasing inappropriate antibiotic use are the best strategies to control resistance.

In FY 2012, CDC will:

- Support the implementation of the U.S. Interagency Task Force on Antimicrobial Resistance action plan, *A Public Health Action Plan to Combat Antimicrobial Resistance* including extramural funding of surveillance, prevention, and research activities.
- Continue antimicrobial resistance surveillance activities for National Antimicrobial Resistance Monitoring System (NARMS) and other surveillance systems for other emerging and existing drug-resistant organisms.
- Provide technical assistance for detection and prevention activities related to health care, community, and veterinary antimicrobial resistance activities. CDC will also continue to provide epidemiology and laboratory support for outbreaks of antimicrobial resistant organisms.
- Support CDC's Emerging Infections Program's (EIP) Active Bacterial Core surveillance (ABCs) and Healthcare-Associated Infections surveillance (HAIs).
- Support state-based funding to promote appropriate antibiotic use in communities such as "Get Smart: Know When Antibiotics Work in the Community"

Performance: In one study, the attributed excess mortality of antimicrobial resistant infection in hospitals was 6.5 percent. The excess duration of a hospital stay ranged from 6.4 to 12.7 days and the direct medical cost per patient ranged from $18,588 to $29,069. CDC worked with partners to identify drug-resistant organisms, prevent and control infections, promote appropriate antibiotic use in communities, and to provide recommendations for laboratory testing and practices. (Measure 3.C)

Program Description and Recent Accomplishments: CDC implements surveillance, prevention and control, infrastructure support, training, and applied research programs to address the emerging threat of AR. AR is common in many infections of public health importance domestically and globally including *Staphylococcus aureus*, *Streptococcus pneumoniae*, malaria, tuberculosis, *Salmonella*, *Shigella*, *Neisseria gonorrhoeae*, HIV, and others. The number of bacteria resistant to antibiotics has increased in the last decade and nearly all significant bacterial infections around the world are becoming resistant to commonly prescribed antibiotic treatments, making antibiotic resistance one of the world's most pressing public health problems. AR increases patient morbidity, mortality, and health care costs.

Recent accomplishments include:

- Conducted population-based surveillance for invasive methicillin-resistant *Staphylococcus aureus* (MRSA) to study the impact of a new focus on prevention of health care-associated MRSA infections. Over the 4-year period from 2005-2008 in nine diverse metropolitan areas, rates of invasive health care-associated MRSA infection decreased 17 percent among patients with symptoms starting in the community, but who had prior contact with the health care system and 28 percent among those with hospital-onset disease. Reductions were greatest in the subset of bloodstream infections, with declines of about 34 percent in all hospital-onset MRSA BSI and about 20 percent in health care-associated BSIs occurring before hospitalization.
- Increased surveillance of foodborne bacterial pathogens resulted in the first identification of azithromycin resistance and the detection of emerging fluoroquinolone resistance. This information will be used to evaluate the appropriateness of current treatment guidelines.

- Collaborated with FDA and USDA to monitor the emergence of AR in bacterial pathogens transmitted from animals to humans. A summary report of results from over 4,000 isolates collected in 2007 show resistance in these food-borne pathogens is increasing in some instances. 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.

All Other Emerging and Zoonotic Infectious Diseases

CDC's FY 2012 request of $52,658,000 for all other emerging and zoonotic infectious disease activities is a decrease of $13,607,000 below the FY 2010 level, which includes the elimination of Prion activities ($5,473,000), a reduction for other cross-cutting infectious disease activities, and administrative savings. These funds support a range of critical emerging and zoonotic infectious disease programs such Lyme Disease, Chronic Fatigue Syndrome, and Special Pathogens, as well as other activities described below.

Mosquitoes, Ticks, and other Vector-borne Diseases

CDC supports intramural and extramural research and programs for the prevention and control of diseases spread by mosquitoes, ticks, fleas and other vectors, in the United States and abroad. These diseases cause tens of thousands of illnesses in the United States each year, millions of cases internationally, and represent one of the most critical emerging threats to health in the United States.

In FY 2012, CDC will:

- Maintain support for states and territories to use surveillance data in making effective decisions for the control of vector-borne diseases.
- Enhance surveillance and prevention for Lyme and other tick-borne diseases by establishing TickNet, a collaboration with health departments in 16 states. Using TickNet sites, CDC will initiate a multistate, community-based, placebo-controlled trial to evaluate the impact of backyard acaricide applications on Lyme disease incidence. CDC will also develop and distribute an educational toolkit for communities and clinicians on the best strategies for prevention, diagnosis, and treatment of Lyme and other tick-borne diseases.
- Work with industry to bring to market novel and highly efficacious botanical pesticides developed and tested by CDC and university collaborators. These new formulations offer promise as effective and safe alternatives to existing synthetic pesticides to protect people from mosquitoes, tick, fleas, and other disease-causing pests.
- Continue to implement strategies to reduce mortality from plague in northwest Uganda by 50%. Strategies include more effective antibiotics; inexpensive, highly accurate and rapid dipsticks for point-of-care diagnosis; incorporation of village healers in reporting plague cases; and testing new, effective methods of rat and flea control.
- Reduce mortality from dengue hemorrhagic fever by expanding CDC's award-winning training for the identification and management of dengue patients to all clinicians in Puerto Rico, as well as to clinicians in the United States, the Americas, and Asia. Over 8,000 clinicians (approximately half) in Puerto Rico have already been trained in response to the 2010 dengue epidemic on the island.
- Test human vaccines for dengue and West Nile viruses (WNV), including DNA vaccines effective against multiple viruses at once. CDC will continue to monitor the safety and evaluate the real-world efficacy of existing vaccines against yellow fever and Japanese encephalitis.

- Continue to work with tribes and communities in the southwest United States to combat the deadly epidemic of Rocky Mountain spotted fever.
- Prepare for emerging threats such as chikungunya and Rift Valley fever viruses. CDC and the Pan American Health Organization have developed, and will work with states to implement, guidelines for responding to the importation of chikungunya virus—which has already infected over two million people in the Indian Ocean region. More than 35 chikungunya cases have been imported into the United States already, highlighting the threat.

Performance: CDC acts and supports the states in a continuing effort to protect the nation from emerging vector-borne pathogens, an increasing threat as the environment changes and globalization increases. The ongoing WNV epidemic, for example, has resulted in over 30,000 reported human cases, although the true number of Americans sickened by WNV since its introduction in 1999 may be over 330,000. At an estimated taxpayer cost of $18,232 (Sacramento) to $61,216 (Louisiana) per patient, the burden is significant[10]. ArboNet, the nationwide surveillance network for mosquito-borne viruses, was developed by CDC and implemented in collaboration with the states in 2000, and has been continually expanded and improved. It has provided the United States, for the first time, with the means for rapidly identifying and using data to respond strategically to new vector-borne disease epidemics and invasions. Estimates suggest that the costs of managing a vector-borne disease outbreak can be up to 300 times greater if response is delayed, rather than using a surveillance system like ArboNet for early case detection and prompt response[11].

Program Description and Recent Accomplishments: Preventing viral and bacterial diseases transmitted by mosquitoes, ticks, and other vectors, both here and abroad, continues to be an important goal of the CDC. Americans throughout the country are at risk from vector-borne diseases, such as Lyme disease, dengue, and Rocky Mountain spotted fever. As became evident after the introduction of WNV in 1999, the United States is also increasingly at risk from invasive vector-borne pathogens. CDC's vector-borne laboratories provide the "gold standard" in diagnostics and rapid genetic identification of emerging pathogens. CDC works closely with state and local health departments, and with international partners, to implement rapid detection and response to known and novel pathogens. Furthermore, CDC works closely with industry and universities to develop better methods for preventing and combating epidemics.

Recent accomplishments include:

- Developed and implemented, with the American Red Cross and the American Association of Blood Banks, a plan to screen all blood donations in the United States for the presence of WNV. By 2010, 3,000 infected donations were removed from the blood supply, preventing 3,000-9,000 cases of transfusion-transmitted WNV.
- Developed one of the first candidate vaccines against all four species of dengue virus; it is now in human trials. As many as 100 million people worldwide are infected with dengue annually. CDC's vaccine against WNV was the first-ever licensed DNA vaccine. This novel and significant technology is also now in human clinical trial.

10 Sacramento - Emerging Infectious Diseases (2010), 16:480-486. Economic cost analysis of West Nile virus outbreak, Sacramento County, California, USA, 2005. Barber LM, Schleier JJ 3rd, Peterson RK. Montana State University, Bozeman, Montana 59717-3120, USA

11 PLoS Neglected Tropical Diseases (2010) Oct 26;4(10):e858. Unforeseen costs of cutting mosquito surveillance budgets. Vazquez-Prokopec GM, Chaves LF, Ritchie SA, Davis J, Kitron U. Department of Environmental Studies, Emory University, Atlanta, Georgia, USA. gmvazqu@emory.edu

- Responded to emergencies in states, including one of the largest epidemics of dengue ever recorded in Puerto Rico, the first epidemic of dengue in Florida in 75 years, clusters of dengue cases imported from Haiti in Nebraska and Georgia, and epidemics of WNV and Rocky Mountain spotted fever in Arizona. CDC has also responded to epidemics of yellow fever, dengue, plague and possible vector-borne pathogens in Africa, Asia and the Americas. CDC assists local authorities to diagnose cases, identify risks and respond strategically using integrated pest management, which counteracts the development of pesticide resistance.

High-Consequence Pathogens

CDC maintains Biosafety Level 3 (BSL 3) and Biosafety Level 4 (BSL 4) laboratories to support epidemiology, research, and prevention efforts to reduce the public health threat of high-consequence pathogens. This group of highly hazardous disease agents includes viruses that cause Ebola and Marburg hemorrhagic fevers, Lassa fever, Rift Valley fever, Crimean-Congo hemorrhagic fever, Machupo and Junin hemorrhagic fevers, and hantavirus pulmonary syndrome. The majority of these viruses are Select Agents and Category A bioterrorism threat agents.

In FY 2012, CDC will:

- Conduct domestic surveillance, provide technical assistance, and investigate all suspect domestic cases of viral hemorrhagic fever (including infections due to Ebola virus, Marburg virus, Lassa virus, Lujo virus, Crimean-Congo Hemorrhagic Fever virus, and South American arenaviruses), lymphocytic choriomeningitis virus (LCMV), hantavirus pulmonary syndrome (HPS), and hemorrhagic fever with renal syndrome (HFRS).
- Perform research into the pathogenic mechanisms of hantaviruses and other hemorrhagic fever viruses, and develop sensitive and specific assays for detecting approximately 35 different viruses.
- Provide global technical assistance to ministries of health and other international health organizations; participate in outbreak responses; and conduct epidemiologic studies on the detection, prevention, and control of viral special pathogens.

Performance: CDC ensured that countries have ready access to the technical assistance needed to detect and contain global disease threats and develop the expertise and capacity to fulfill their obligations to identify, report, and contain public health threats as outlined in the International Health Regulations. CDC used data gathered through surveillance systems to mount outbreak responses and to strategically target control efforts. Enhanced detection of emerging viral hemorrhagic fevers and other high-consequence viral pathogens remains a high-priority activity, as investments in these preparedness activities can result in tremendous savings related to limiting and preventing outbreaks of these diseases, many of which have a high case fatality rate.

Program Description and Recent Accomplishments: Funds support the detection and control of high-consequence viral special pathogens. CDC responds to global disease outbreaks and provides assistance for disease detection and control measures of highly infectious viruses, many of which cause hemorrhagic manifestations in humans, and other recently identified and emerging viral diseases. Almost all of these viruses are classified as Biosafety Level 4 (BSL-4) pathogens. CDC's outbreak response activities are often requested by international partners to provide diagnostic assistance, expertise for infection control, and to care for individuals in outbreaks of severe illness. In addition, CDC develops, evaluates, and improves the laboratory diagnosis, treatment, and prevention of high-consequence viral disease agents (special pathogens) and provides epidemiologic management of suspected cases.

Recent accomplishments include:

- Conducted ongoing safety and efficacy trial of live-attenuated Rift Valley fever vaccine in sheep in South Africa.
- Provided rule-out testing for possible viral hemorrhagic fevers (VHFs), including tick-borne encephalitis cases, from 10 U.S. states, Uganda, Sudan, Saudi Arabia, Peru, Nigeria, the Philippines, Bangladesh and Ukraine; developed diagnostic capacity, training and ecologic studies for VHFs in India; and assisted Saudi Arabia and Kazakhstan Ministries of Health in VHF surveillance and outbreak responses.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activities are included:

- Epidemiology and Laboratory Capacity Program – $40,000,000
- Healthcare-Associated Infections – $20,000,000

Epidemiology and Laboratory Capacity Program

The Affordable Care Act Prevention and Public Health Funds directed to ELC and EIP cooperative agreements will increase the number of highly trained and properly equipped epidemiologists, laboratorians, and informaticians in State, local, and territorial health departments. The staff responds to infectious disease threats. In addition to personnel, the Affordable Care Act Prevention and Public Health Funds will equip health departments with modern laboratories and information systems that will enable rapid communication and electronic exchange of public health information, which will allow health departments to improve their response to disease outbreaks, monitor trends, and evaluate the impact of interventions, such as the efficacy of vaccinations and infection control practices. The Affordable Care Act Prevention and Public Health Funds will allow health departments to effectively engage in an era of health information exchange evolving electronic health records.

Health Care-Associated Infections

Funds from the Affordable Care Act Prevention and Public Health Fund will build on the success of the HAI Recovery Act funding in preventing infections through the leadership and coordination of state health departments. PPHF funding will support model states that have effectively implemented HAI prevention initiatives through programs and policies. The funding will help these states build on their ongoing successes and invest in sustainable programs that will work across the healthcare system locally to maximize the HAI prevention efforts by collaborating with other healthcare partners such as Centers for Medicare and Medicaid Services (CMS) quality improvement organizations, hospital associations, and consumer groups. The collaborations work to implement and ensure adherence to evidence-based HAI prevention practices to achieve the prevention goals included in HHS Action Plan.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Emerging and Zoonotic Infectious Diseases	**$281,174**	**$312,965**	**$349,118**	**+$67,944**
- National Healthcare Safety Network (non-add)	$15,148	$15,150	$27,452	+$12,304
- Food Safety (non-add)	$25,793	$25,797	$34,486	+$8,693
- ACA/PPHF (non-add)	$20,000	$51,750	$60,000	+$40,000

MEASURES TABLE[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2010: 42,162 (Target Exceeded)	35,276	40,000	+4,724
Long Term Objective 3.1: Protect Americans from infectious diseases – foodborne illnesses.				
3.1.1a: By 2020, reduce the incidence of infection with four key foodborne pathogens: Campylobacter (Outcome)	FY 2009: 12.93 (Target Exceeded)	12.30	12.06	-0.24
3.1.1b: By 2020, reduce the incidence of infection with four key foodborne pathogens: Escherichia coli O157:H7 (Outcome)	FY 2009: 0.98 (Target Exceeded)	1	1	Maintain
3.1.1c: By 2020, reduce the incidence of infection with four key foodborne pathogens%: Listeria monocytogenes (Outcome)	FY 2009: 0.34 (Target Not Met)	0.23	0.23	Maintain
3.1.1d: By 2020, reduces the incidence of infection with four key foodborne pathogens: Salmonella species (Outcome)	FY 2009: 14.99 (Target Not Met but Improved)	6.8	6.8	Maintain
Long Term Objective 3.2: Reduce the spread of antimicrobial resistance.				
3.2.1: Decrease the number of antibiotic courses prescribed for ear infections in children under 5 years of age per 100 children (Outcome)	FY 2010: 58.5 (Target Not Met)	50	48	-2
Long Term Objective 3.3: Protect Americans from death and serious harm caused by medical errors and preventable complications of health care.				
3.3.2: Reduce the estimated number of cases of invasive MRSA infection (Outcome)[2]	FY 2008: 89,785 cases (Target Exceeded)	92,272 cases	74,740 cases	-17,532
3.3.3: Reduce the CLABSI standardized infection ratio (SIR) (Outcome)[2]	FY 2010: 0.8 (Historical Actual)	N/A	0.6	-0.2
3.3.4: Increase the number of hospitals and other selected health care settings that report into the National Health care Safety Network (NHSN)[2]	FY 2010: 2,619 (Baseline)	Baseline	6,500	N/A
Long Term Objective 3.4: Prevent the importation of infectious diseases to the U.S. in mobile human, animal and cargo populations				
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)	FY 2007: 1 of 4 (Baseline)	N/A	N/A	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2009: 49.5 % (Target Exceeded)	50 %	60 %	+10
3.4.3: Increase the likelihood of travelers seeking pre-travel medical advice for travel to Africa (Outcome)	FY 2008: 8.1 (Historical Actual)	9.0	10	+1
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 United States (Outcome)	FY 2009: 69.5% (Target Exceeded)	70%	74%	+4
3.4.5: Maintain low mortality in nonhuman primates (NHP) imported to the U.S. for science, exhibition, and education (Outcome)	FY 2010: <1% (Target Met)	<1%	<1%	Maintain
3.4.6: Increase the number of hospitals with MOAs in priority 1 cities (Output)	FY 2010: 175 (Target Not Met)	180	190	+10
3.4.7: Increase the number of illnesses in persons arriving in the United States that are reported to CDC DGMQ by conveyance operators, CBP, and others (Output)	FY 2010: 2,960 (Target Exceeded)	2,500	3,100	+600
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)	FY 2010: $490,000 (Target Exceeded)	$511,000	$490,000	-21,000

[1]In some areas, targets do not reflect impact of funding from the ACA/PPHF or the American Recovery and Reinvestment Act.

OTHER OUTPUTS[1,2]

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
3.A: Number of countries receiving training in PulseNet protocols	FY 2009: 21	10	18	+8
3.B: Cumulative number of Public Health Laboratories capable of Accessing CaliciNet to detect viral diseases	FY 2009: 16	24	28	+4
3.C: Number of state/local health departments, health care systems funded for surveillance, prevention, control of antimicrobial resistance[3]	FY 2010: 20	20	20	Maintain
3.D: Number of EIP network sites	FY 2010: 10	10	10	Maintain
3.E: Establish regional TickNet sites to collect data on underreporting of Lyme and other tickborne diseases	FY 2010: 16	16	16	Maintain

[1]In some areas, targets do not reflect impact of funding from ACA/PPHF.
[2]The outputs are not necessarily reflective of all programmatic activities funded by the appropriated amount.
[3]Measures do not reflect the impact of American Recovery and Reinvestment Act funding.

GRANTEE TABLE

CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2012 DISCRETIONARY STATE GRANTS
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

State/Territory/Grantee	FY 2010 Actual*	FY 2011 Continuing Resolution**	FY 2012 President's Budget	FY 2012+/- FY 2010
Alabama	$1,219,603	$1,203,334	$1,203,334	-$16,269
Alaska	$1,225,346	$1,260,678	$1,260,678	$35,332
Arizona	$1,942,203	$1,150,973	$1,150,973	-$791,230
Arkansas	$1,281,715	$1,211,638	$1,211,638	-$70,077
California	$3,723,040	$3,319,473	$3,319,473	-$403,567
Colorado	$1,639,878	$1,563,156	$1,563,156	-$76,722
Connecticut	$875,768	$834,476	$834,476	-$41,292
Delaware	$962,720	$925,057	$925,057	-$37,663
Florida	$1,928,890	$1,269,036	$1,269,036	-$659,854
Georgia	$965,518	$1,044,994	$1,044,994	$79,476
Hawaii	$1,280,259	$1,169,816	$1,169,816	-$110,443
Idaho	$991,209	$796,128	$796,128	-$195,081
Illinois	$1,880,347	$1,866,251	$1,866,251	-$14,096
Indiana	$1,085,213	$982,621	$982,621	-$102,592
Iowa	$2,350,082	$1,485,586	$1,485,586	-$864,496
Kansas	$976,206	$931,439	$931,439	-$44,767
Kentucky	$818,739	$759,044	$759,044	-$59,695
Louisiana	$1,831,736	$1,566,691	$1,566,691	-$265,045
Maine	$1,139,547	$866,513	$866,513	-$273,034
Maryland	$1,184,696	$1,091,427	$1,091,427	-$93,269
Massachusetts	$2,339,970	$1,700,708	$1,700,708	-$639,262
Michigan	$2,527,156	$1,969,906	$1,969,906	-$557,250
Minnesota	$1,418,738	$1,329,055	$1,329,055	-$89,683
Mississippi	$1,088,716	$970,403	$970,403	-$118,313
Missouri	$1,383,265	$1,312,673	$1,312,673	-$70,592
Montana	$1,004,481	$839,637	$839,637	-$164,844
Nebraska	$1,228,875	$1,158,615	$1,158,615	-$70,260
Nevada	$865,436	$833,564	$833,564	-$31,872
New Hampshire	$1,214,351	$1,206,979	$1,206,979	-$7,372
New Jersey	$1,347,115	$1,176,155	$1,176,155	-$170,960

CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2012 DISCRETIONARY STATE GRANTS
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

State/Territory/Grantee	FY 2010 Actual*	FY 2011 Continuing Resolution**	FY 2012 President's Budget	FY 2012+/- FY 2010
New Mexico	$1,143,759	$1,077,780	$1,077,780	-$65,979
New York	$2,345,828	$1,934,798	$1,934,798	-$411,030
North Carolina	$1,501,023	$1,237,796	$1,237,796	-$263,227
North Dakota	$916,172	$892,675	$892,675	-$23,497
Ohio	$1,791,747	$1,874,841	$1,874,841	$83,094
Oklahoma	$808,455	$805,188	$805,188	-$3,267
Oregon	$1,409,066	$1,057,271	$1,057,271	-$351,795
Pennsylvania	$1,230,769	$1,224,803	$1,224,803	-$5,966
Rhode Island	$1,576,974	$1,026,831	$1,026,831	-$550,143
South Carolina	$1,664,888	$1,637,097	$1,637,097	-$27,791
South Dakota	$692,677	$672,042	$672,042	-$20,635
Tennessee	$1,324,628	$1,289,500	$1,289,500	-$35,128
Texas	$1,921,530	$1,827,572	$1,827,572	-$93,958
Utah	$1,469,130	$1,370,884	$1,370,884	-$98,246
Vermont	$1,146,436	$1,177,697	$1,177,697	$31,261
Virginia	$1,786,976	$1,324,730	$1,324,730	-$462,246
Washington	$1,717,534	$1,471,169	$1,471,169	-$246,365
West Virginia	$982,610	$921,956	$921,956	-$60,654
Wisconsin	$1,961,801	$2,004,089	$2,004,089	$42,288
Wyoming	$1,109,030	$966,732	$966,732	-$142,298
Chicago	$688,549	$657,346	$657,346	-$31,203
Houston	$1,547,034	$840,349	$840,349	-$706,685
Los Angeles County	$1,236,215	$1,243,431	$1,243,431	$7,216
New York City	$2,606,105	$2,410,878	$2,410,878	-$195,227
Philadelphia	$1,025,891	$779,467	$779,467	-$246,424
Washington DC	$430,812	$408,563	$408,563	-$22,249
Palau	$171,487	$154,682	$154,682	-$16,805
Puerto Rico	$526,526	$527,367	$527,367	$841
Total States/Cities/Territories	**$80,454,474**	**$70,613,564**	**$70,613,564**	**-$9,840,910**

*FY 2010 Includes $16.7 million the Affordable Care Act Prevention and Public Health Fund + $5.0 million Recovery Act funding for Health Information and Technology (one-time transfer from HHS).
**FY 2011 Continuing Resolution Assumes level of the Affordable Care Act Prevention and Public Health Fund with FY 2010. No Recovery Act funding.
***FY 2012 President's Budget assumes level of the Affordable Care Act Prevention and Public Health Fund with FY 2011 CR. No Recovery Act funding.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Chronic Disease Prevention and Health Promotion - Budget Authority[1]	$865,445	$865,581	$725,207	-$140,238
Preventive Health and Health Services Block Grants – Budget Authority	$100,240	$100,255	$0	-$100,240
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA[2]	$25,000	$0	$0	-$25,000
ACA/PPHF	$58,933	$300,950	$460,301	+$401,368
Total	**$1,049,618**	**$1,266,786**	**$1,185,508**	**+$135,890**
FTEs	948	978	1,018	+70

[1] Funding levels reflect the transfer of $40,000,000 in school health activities to the Domestic HIV/AIDS budget.
[2] In FY 2010, $25 million, available for five years, was appropriated for Obesity Demonstration Projects under the Affordable Care Act.

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $1,185,508,000, including $460,301,000 from the Affordable Care Act Prevention and Public Health Fund, is $135,890,000 above the FY 2010 level. The FY 2012 program level includes an increase of $72,383,000 for the new Chronic Disease and Health Promotion Grant Program. The FY 2012 request eliminates the following programs: Healthy Communities ($22,609,000), and Racial and Ethnic Approach to Community Health ($39,274,000). The FY 2012 request also eliminates the Preventive Health and Health Services Block Grant, a decrease of $100,255,000 below the 2010 level. Through CDC's existing and expanding activities there is substantial funding to State Health Departments. Elimination of this program provides an opportunity to find savings, while maintaining core public health infrastructure at the State level.

CDC's FY 2012 budget creates a new approach to Preventing Chronic Diseases through a new Comprehensive Chronic Disease Prevention Program (CCDPP) by consolidating CDC's Heart Disease and Stroke, Diabetes, Cancer, Arthritis and other Conditions, Nutrition, Health Promotion, Prevention Centers, and select school health activities into one competitive grant program. These inter-related conditions share many common risk factors and interventions that would benefit from coordinated, collaborative implementation and oversight to foster collaboration and coordination and improve efficiency among these specific programs. The CCDPP also provides States with additional flexibility to address the top five leading chronic disease causes of death and associated risk factors, while increasing accountability and improving health outcomes. This new approach will improve overall health outcomes while also strengthening accountability of Federal resources. CDC's FY 2012 budget includes an increase of $72,383,000 for this new program, of which $20,000,000 will be dedicated for performance incentive awards for grantees that have substantially improved health outcomes.

Chronic disease prevention and health promotion activities include prevention and control of tobacco use, obesity, heart disease and stroke, diabetes and cancer; the promotion of maternal, infant, and adolescent health, healthy personal behaviors, oral and community health; and the maintenance of surveillance systems to track and monitor behavioral risk factors.

Chronic diseases are among the most prevalent, costly, and preventable of all health problems. CDC's goals for the chronic disease prevention and health promotion program are to reduce rates of morbidity, disability, and premature mortality from chronic disease by focusing on prevention, especially among populations at greatest risk of chronic illness. CDC contributes to, and bases its work on, the best available science. With a focus on the most common preventable chronic diseases and their risk factors, CDC works to coordinate the nation's efforts to prevent and control these inter-related health problems.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 307, 310, 311, 317

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

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………….……………………………………….………Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year	Amount*
FY 2007	$923,762,000
FY 2008	$931,097,000
FY 2009	$983,686,000
FY 2010**	$1,049,618,000
FY 2011CR	$1,266,786,000

*Amounts include funding for the Preventive Health and Health Services Block Grants

** Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Tobacco

CDC's FY 2012 request of $186,226,000 for Tobacco, including $79,000,000 from the Affordable Care Act Prevention and Public Health Fund, is $61,026,000 above the FY 2010 level.

In FY 2012, CDC will:

- Support 59 programs through the National Tobacco Prevention and Control (NTPC) program, (50 states, eight territories/jurisdictions, and the District of Columbia) to prevent initiation of tobacco use among youth and young adults, promote tobacco use cessation among adults and youth, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities.
- Implement a national tobacco media campaign on the health effects of tobacco use to further prevent youth from starting to use tobacco and motivate adult and young adult tobacco users to quit. This campaign will build public support for proven, population-based policies, and reinforce messages delivered by state and community media campaigns.

- Support smoking cessation services in 50 states, two territories and the District of Columbia by funding states to maintain, enhance or augment the national network of tobacco cessation quitlines to significantly increase quit attempts, access to effective cessation services, and numbers of successful quitters.
- Support states in expanding quitline services and meeting demand generated by federal efforts such as national media campaigns and warning labels on cigarette packages.
- Increase the capacity of the national network to handle surges in call volumes with variable capacity at the state level.
- Fund six national networks to reduce tobacco use among priority populations including African Americans, American Indians/Alaskan Natives (AI/AN), Asian Americans/Pacific Islanders, Hispanics/Latinos, lesbian/gay individuals, and persons with low socioeconomic status.
- Fund seven tribal support centers to support AI/AN tribes and tribal organizations to prevent and reduce the use of tobacco and exposure to secondhand smoke, and/or to conduct evaluation and implementation of competent, culturally relevant tobacco control and prevention strategies for use with broader AI/AN populations.
- Continue to provide technical assistance to the U.S. Food and Drug Administration's (FDA) Center for Tobacco Products. In collaboration with FDA, CDC will continue to provide technical assistance and laboratory support to FDA as they build capacity and will conduct surveillance to monitor the impact of new tobacco regulations.

<u>Performance</u>: Strong smoke-free policies substantially improve indoor air quality, reduce negative health outcomes among nonsmokers, decrease tobacco consumption, encourage smokers to quit, change social norms regarding the acceptability of smoking, and reduce the risk for cardiovascular disease. Communities that enact strong smoke-free policies have realized, on average, a 17 percent reduction in heart attack hospitalizations among the general public. The number of states (including DC) with comprehensive smoke-free laws in effect increased from 16 in 2008 to 26 in 2010.

Increasing the price of cigarettes discourages initiation among youths, prompts quit attempts, and reduces average cigarette consumption among those who continue to smoke. Cigarette excise taxes increase cigarette prices, thereby reducing cigarette use and smoking-related death and disease. Additionally, evidence shows that a 10 percent increase in the price of cigarettes can reduce consumption by nearly four percent among adults and can have an even greater effect among youths and other price-sensitive groups. The average state excise tax for cigarettes increased from $1.18 in 2008 to $1.44 per pack in 2010 (22 percent increase).

Through the implementation of its National Tobacco Prevention and Control program, CDC aims to decrease the burden of tobacco related death and disease through the following:

- Reducing the proportion of adults (aged 18 and over) who are current cigarette smokers. (Measure 4.2.3) Adult cigarette use has remained largely static in recent years. Between 2003 and 2007, the percentage of current smokers decreased from 23 percent to 20 percent. In 2009, the percentage of current smokers reported increased to 20.6 percent. Reducing adult smoking prevalence is a Healthy People (HP) 2010 and 2020 objective targeted at 20 percent.

- Reducing the proportion of adolescents (grades 9 through 12) who are current cigarette smokers. (Measure 4.6.3) Youth cigarette use declined sharply during 1997–2003; however, this decline has stalled over the past several years. In 2003, the percent of youth cigarette use reported was 22 percent. In 2005 it increased to 23 percent and then dropped to 20 percent in 2007 and 19.5 percent in 2009. Reducing youth smoking prevalence is a Healthy People 2010 and 2020 objective targeted at 16 percent.
- Increasing the proportion of the U.S. population that is covered by comprehensive state and/or local laws making workplaces, restaurants, and bars 100 percent smoke-free (no smoking allowed, no exceptions). The percentage of the population covered by a smoke-free law has steadily increased from 13.5 percent in 2005 to 48 percent in 2010. The target for FY 2012 of 56.9 percent is based on the Healthy People 2020 target that all states will have implemented comprehensive smoke-free laws by 2020.
- Increasing awareness of the dangers of tobacco use. A baseline will be established to measure national awareness of the dangers of tobacco use and a target will be set to significantly increase awareness during FY 2012 as the national media campaign is implemented.
- Increasing the number of tobacco users who receive assistance with quitting from a quitline. The FY 2012 target will be determined based on information collected through the quitline/cessation data warehouse which was set up for monitoring of NTCP funding announcements.

Program Description and Recent Accomplishments: Through a cooperative agreement, CDC continues to support comprehensive programs to prevent and control tobacco use in all 50 states, the District of Columbia, eight U.S. territories/jurisdictions, and seven tribal-serving organizations. In addition, CDC funds six national networks to reduce tobacco use among specific populations. CDC publishes and disseminates accepted best practices to help states plan, implement, evaluate, and sustain their own tobacco control programs. CDC provides national leadership for a comprehensive, broad-based strategy to reduce tobacco use by: 1) preventing young people from starting to smoke; 2) eliminating exposure to secondhand smoke; 3) promoting quitting among young people and adults; and 4) identifying and eliminating tobacco-related health disparities. CDC's tobacco activities align with the recently released Department of Health and Human (HHS) Services Tobacco Control Strategic Action Plan to facilitate coordination of tobacco prevention activities among all HHS operating divisions to ensure an optimal and efficient public health impact.

Recent accomplishments include:

- Demonstrated measurements of cotinine have shown how exposure to secondhand smoke has steadily decreased in the United States over time. These measurements show that cotinine levels in nonsmokers who were exposed to secondhand smoke fell by 54.5 percent from 1988 to 2008 (from 88 percent during 1988-1991 to 40 percent during 2007-2008). As of December 31, 2010, a total of 26 U.S. states (including Washington, DC) had comprehensive smoke-free laws in effect that prohibit smoking in indoor areas of workplaces, restaurants, and bars.

- Provided the evidence base to support an increase in the price of tobacco. In 2009-2010, tobacco excise taxes were increased by the federal government, 19 states, and Washington, DC. Cigarette price increases discourage initiation among youth, prompt quit attempts, and reduce cigarette consumption (e.g., a 10 percent increase in the price of cigarettes results in a four percent decrease in cigarette consumption among adults). CDC supports state efforts to use evidence-based pricing strategies to reduce tobacco use. On April 1, 2009, the largest federal tobacco excise tax increase in history went into effect, increasing the excise tax on cigarettes from 39 cents to $1.01 per pack. This tax increase brought the combined federal and average state excise tax for cigarettes to more than $2 per pack, achieving the Healthy People 2010 objective. CDC published a Morbidity and Mortality Weekly Report (MMWR) in 2009 and follow-up report in 2010 on state and federal excise tax increases that generated significant media attention.
- Demonstrated that in states with larger investments in comprehensive tobacco control programs, cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs increased.

Oral Health

CDC's FY 2012 request of $14,609,000 for Oral Health reflects a reduction of $391,000 below the FY 2010 level for administrative savings.

In FY 2012, CDC will:

- Fund up to 16 to 23 states to support capacity-building oral health prevention programs. State 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 will be measured by state-based surveys. States target schools with a high percentage of students on free and reduced cost meal programs.
- Provide technical assistance to all states for oral health surveillance, Community Water Fluoridation (CWF), dental sealant programs, coalition building, partnership development, and evaluation. CDC will also continue to provide funding to national partners that offer technical assistance to states in the areas of data collection and analysis, program review, evaluation, and policy development, including the Association of State and Territorial Dental Directors, and the Children‘s Dental Health Project.
- Support the National Oral Health Surveillance System (NOHSS), a Web-based system that enables states to collect a standardized set of oral health indicators designed to help monitor the burden of oral diseases, use of dental care services, and status of community water fluoridation.
- Conduct research in oral health to enhance the effectiveness of interventions to prevent oral diseases by reviewing scientific evidence, studying the cost-effectiveness of interventions, identifying the most efficient ways to deliver them through programs, and demonstrating their impact in terms of disease prevention and control. CDC will also help health departments collect, interpret, and share oral health data for use in targeting limited resources to people with the greatest needs and monitor progress in meeting state and national Healthy People objectives.

Performance: The Healthy People 2020 goal for oral health is for 79.6 percent of the nation to have access to fluoridated water and the current level as of 2009 is 72 percent, an increase from 62 percent in 1992. The best evidence indicates that water fluoridation reduces tooth decay by 30 to 50 percent. A multivariate analysis of Louisiana Medicaid claims data found that preschoolers living in fluoridated

communities had treatment costs that were $36.28 lower than their counterparts living in non-fluoridated communities.

In addition, there is strong evidence from the Task Force on Community Preventive Services that school sealant programs decrease dental caries in children. Children receiving dental sealants in school-based programs have 60 percent fewer new decayed pit and fissure surfaces in back teeth for up to two to five years after a single application. In addition, sealants are cost-saving. One study found that sealing a tooth reduced total dental costs over 10 years from $68.10 to $54.60.

Program Description and Recent Accomplishments: CDC's Division of Oral Health works to build and demonstrate the merits of national and state public health core infrastructure and capacity. CDC is recognized for its national leadership in helping states, territories, and other countries collect oral health data and apply new methods for oral health surveillance. CDC is well-known for monitoring the status of community water fluoridation and working to enhance the quality of fluoridation throughout the nation, as well as for training state and local fluoridation engineers and state program leaders on fluoridation theory and practice. CDC provides significant consultation and technical assistance on community fluoridation-related issues nationally and internationally, and also promotes school-based and school-linked dental sealant programs by translating the science base into practice recommendations and providing technical assistance to improve the effectiveness and efficiency of these programs.

Recent accomplishments include:

- Scheduled to publish a series of guidance papers on school-based sealant programs in the Spring of 2011 in the Journal of the American Dental Association. These papers substantively address some of the major barriers to implementing school-based sealant programs for low-income children.
- Demonstrated an increase in the number of funded state programs that report sealant program outcomes from eight to ten.
- Demonstrated an increase in the percent of the population on public water systems who received optimally fluoridated water from 69 percent in FY 2008 to 72 percent in FY 2009. The Healthy People 2020 target is 79.6 percent.

Safe Motherhood and Infant Health

CDC's FY 2012 request of $55,734,000 for Safe Motherhood reflects an increase of $10,867,000 above the FY 2010 level. A total of $6,500,000 of the increase is intended to increase support for teen pregnancy prevention activities. CDC will continue to work to prevent teen pregnancy as well as assist states with identifying and addressing reproductive and infant health issues through ongoing Safe Motherhood programs.

In FY 2012, CDC will:

- Fund up to 40 Pregnancy Risk Assessment Monitoring System (PRAMS) programs to collect data on women's behaviors and experiences before, during, and immediately after pregnancy. The data gathered helps identify groups of women at high risk for health problems, monitor changes in their health status, and measure progress in improving the health of mothers and infants.

- Issue notice of grant awards, in collaboration with the Office of Adolescent Health, to monitor the projects awarded, and implement evaluations of the funded grantees to demonstrate the effectiveness of innovative, multi-component, community-wide initiatives in preventing teen pregnancy and reducing rates of teen births in communities with the highest rates, with a focus on reaching African American and Latino youth aged 15-19. Additional Safe Motherhood funds will support a federally-sponsored contract to evaluate the impact of the local organizations community-wide initiatives to reduce teen pregnancy.
- Fund research on preterm birth and infant mortality to identify women at risk and opportunities for prevention through a broad coalition of partnerships, focusing on both the social and biological factors causing preterm birth along with racial disparities.
- Fund the Maternal and Child Health Epidemiology Program (MCH-EPI) which builds maternal and child health epidemiology and data capacity at the state, local, and tribal levels to effectively use epidemiologic research and scientific information to inform public health policy and action related to the health of women, children, and families. The MCH-EPI program design allows for expertise and assistance with priority projects such as: influenza preparedness, infant mortality and morbidity, tobacco cessation in pregnant women, and maternal mortality and morbidity.
- Fund the Assisted Reproductive Health Technology (ART) Surveillance Activity to evaluate the efficacy and safety of ART by providing surveillance and research, training, technical assistance, and consultation and collaboration with partners.
- Develop evidence-based guidelines for the safe and effective use of contraception (i.e., Medical Eligibility Criteria and Selected Practice Recommendations), and disseminate the guidelines to health care providers nationwide.
- Conduct and disseminate findings from research designed to evaluate the impact of state policies on teen birth rates, identify new interventions to provide family planning services, and encourage use of dual contraceptive method use.

Teen Pregnancy Prevention

CDC's FY 2012 request of $22,300,000 to support teen pregnancy prevention activities is an increase of $6,500,000 above the FY 2010 level.

In FY 2012, CDC will:

- Fund nine state- and community-based organizations and five national organizations to promote the use of evidence-based teen pregnancy prevention programs.
- Use funding to help local youth-serving organizations select, implement, and evaluate science-based programs to prevent teen pregnancy and related sexual risk behaviors.
- Provide assistance to create multi-component, community-wide programs that are consistent with community norms in communities with the greatest rates of teen pregnancy and births.

Program Description: Using science-based approaches for teen pregnancy prevention CDC helps ensure that programs have a greater chance of succeeding. A science-based approach includes the following:

- Uses demographic, epidemiologic, and social science research to identify populations at risk for early pregnancy or sexually transmitted diseases, and identifies the risk and protective factors for those populations.
- Uses health behavior or health education theory for selecting risk and protective factors that will be addressed by the program, and helps select intervention activities.

- Uses a logic model to link risk and protective factors with program strategies and outcomes.
- Selects, adapting if necessary, and implements rigorously evaluated programs.
- Conducts process and outcome evaluation of the implemented program, and modifies approach based on results.

Baby Friendly Hospitals

The FY 2012 request includes $2,500,000 for Baby Friendly Hospitals, funded from the ACA/PPHF.

In FY 2012, CDC will:

- Provide technical assistance to hospitals and health care providers to implement evidence-based maternity care practices that empower parents to make informed infant feeding decisions consistent with the internationally recognized Baby-Friendly hospital standards.
- Monitor and track sustained adoption of these evidence-based maternity care practices.
- Implement a targeted regional strategy through hospitals and health care providers to address disparities and ensure all populations have access to maternity care practices that support breastfeeding.

Performance: Through its Safe Motherhood and Infant Health research, surveillance and programmatic activities, CDC aims to:

- Increase the number of youth reached through evidence-based teen pregnancy prevention programs. The number of youth will not be known until the funding entities have been named and an estimate has been established. The program in the past has focused on building capacity in local coalitions, not on reaching youth directly. CDC anticipates that this shift will produce a measurable impact once data become available.
- Provide better understanding through research of the complexities of preterm births supporting the Healthy People 2020 target.
- Develop enhanced capacity for improving maternal and infant mortalities and identifying modifiable risk factors for prevention.
- Increase Maternal and Child Health state assignees from 12 in FY 2010 to 16 in FY 2012.

Program Description and Recent Accomplishments: CDC will continue to promote optimal reproductive and infant health and quality of life by informing public policy, health care practice, community practices, and individual behaviors through scientific and programmatic expertise, leadership, and support. CDC promotes safe motherhood before, during, and after pregnancy to include the physical, mental, cultural, and socioeconomic aspects that move beyond absence of disease to the well-being of the childbearing woman and her family. CDC conducts work in this area through intramural activities and extramural cooperative agreements, grants, and contracts.

Recent accomplishments include:

- Developed evidence-based guidelines for the safe and effective use of contraception (i.e., Medical Eligibility Criteria and Selected Practice Recommendations), and disseminated the guidelines to health care providers nationwide. CDC released the first MMWR on this topic entitled *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010*.

- Recognized efforts in producing guidelines on pregnant women and breastfeeding for the 2009 H1N1 influenza pandemic. Safe Motherhood scientists operating in direct coordination with CDC influenza experts, summarized cases of infection with 2009 H1N1 influenza virus in pregnant women identified in the United States during the first month of the outbreak, and deaths associated with this virus during the first two months of the outbreak. The paper, *H1N1 2009 influenza virus infection during pregnancy in the USA* was a Shepard Award finalist in 2009.
- Released CDC's PRAMS On-line Data for Epidemiologic Research (CPONDER) in 2009 which allows access to data collected Pregnancy Risk Assessment Monitoring System surveys. This new system allows users to design their own analysis by choosing from an indexed list of available categorical variables.

Community Transformation Grants

CDC's FY 2012 request of $221,061,000 from the Affordable Care Act Prevention and Public Health Fund, will support Community Transformation Grants (CTG). CTG will focus on advancing State, local, Tribal, and Territorial policies and systems to reduce the Leading Causes of Death (LCD), associated risk factors, and health disparities. The FY 2012 budget eliminates Healthy Communities ($22,609,000) and Racial and Ethnic Approach to Community Health ($39,274,000). The goals and activities of these programs will be integrated into the new CTGs.

In FY 2012, CDC will:

- Fund, through competition, state and local governmental agencies, Indian tribes or tribal organizations, territories, national networks of community based organizations and state/local non-profit organizations to implement policy, environmental, programmatic, and infrastructure changes to promote healthy living and reduce disparities.
- Provide sustained investments to reduce tobacco use, reduce obesity (BMI), increase physical activity, increase healthy nutrition (such as consumption of fruits and vegetables, increases in low-fat milk consumption, and reductions in salt consumption), and reduce the severity and impact of chronic diseases and associated risk factors.
- Fund national organizations to provide training and technical assistance to funded communities to effectively plan, develop, implement, and evaluate community-based interventions to reduce the risk factors that influence the burden of chronic disease and associated risk factors in communities.

Performance: Performance metrics for this new activity will be available after the release of the budget. These measures may include improvements in health outcomes including changes in weight, proper nutrition, physical activity, tobacco use prevalence, emotional well-being and overall mental health, and the number of policies and practices implemented in the jurisdiction. Grantees will also be expected to document the proportion of the population and population subgroups “reached” by the newly implemented policies and practices.

Program Description and Recent Accomplishments: The purpose of this program is to create healthier communities through the implementation of broad, evidence and practice-based policy, environmental, programmatic, and infrastructure changes in states, communities, tribes and territories. This program aligns with the National Prevention Strategy strategic directions and specifically addresses tobacco-free living, active living and healthful eating, high-impact quality clinical preventive services, social and emotional wellness, and healthy and safe physical environments.

CDC will build on major accomplishments from communities funded through the American Recovery and Reinvestment Act (Recovery Act) and the Affordable Care Act. These communities provide a

platform for testing wide-scale application of a focused set of evidence-based policy, environmental, and systems strategies. Best practices and lessons learned from these communities will serve to inform grantees funded through this initiative.

Coordinated Chronic Disease Prevention and Health Promotion Grant Program

CDC's FY 2012 request of $705,378,000 for the Coordinated Chronic Disease Prevention and Health Promotion Grant Program (CCDPP) includes $157,740,000 from the Affordable Care Act Prevention and Public Health Fund. This new comprehensive chronic disease program will provide CDC greater flexibility to better address the significant national burden of chronic diseases by combining the following existing programs into the new CCDPP: Heart Disease and Stroke, Diabetes, Cancer, Arthritis and other Conditions, Nutrition, Health Promotion, Prevention Centers, and non-HIV/AIDS School Health activities. The FY 2012 request creates the Chronic Disease Prevention and Health Promotion Grant Program to improve health outcomes and reduce the national burden of chronic disease. CCDPP will address the top five leading chronic disease causes of death and disability (e.g., heart disease, cancer, stroke, diabetes, and arthritis) and associated risk factors, exclusive of tobacco.

The program will consist of five main components: 1) Competitive grant awards to all State health departments, Territories, and some Tribes to establish or strengthen leadership, expertise, and coordination of overarching chronic disease prevention programming, surveillance, epidemiology and evaluation, policy, and communication; 2) Competitive grant awards to State health departments, Territories and some Tribes to establish core activities addressing: policy and environmental approaches to improve nutrition and physical activity in schools, worksites and communities; interventions to improve delivery and use of selected clinical preventive services; and community programs to support chronic disease self management to improve quality of life for people with chronic disease and to prevent diabetes, heart disease, and cancer among those at high risk; 3) Competitive Performance Incentive awards to state and territorial health departments, based on performance, to implement or expand effective programs addressing the leading chronic disease causes of death and disability; 4) Support for academic institutions and national organizations; and 5) CDC program leadership and subject matter expertise.

CDC, working with states, may continue some existing programs as currently structured, expand others, redirect resources to more effective activities, change the scope of existing activities based on effectiveness and need, and if appropriate, use existing program resources to start new activities or end some existing programs. Through CCDPP, all grantees are expected to achieve population level change in the specified outcomes and to identify populations disproportionately affected by the condition being addressed and to implement strategies to narrow gaps in health status between these special populations and the population as a whole. Grantees will also address evaluation and delivery of evidence-based interventions in their annual plan to CDC. Within the total program level, up to 20 percent is dedicated for CDC technical assistance, evaluation, oversight, and management activities.

The program will create a comprehensive overarching chronic disease prevention program to strengthen state-based coordination of categorical chronic disease activities, improve program efficiencies, provide leadership and support for cross-cutting activities and enhance the effectiveness of chronic disease prevention and risk factor reduction efforts across the included categorical programs. Finally, the program will create performance awards, to be provided to states on a competitive basis, to implement or expand proven interventions that the state has shown to be effective in advancing overall CCDPP goals.

The five components, and approximate funding levels, include:

1) Competitive grant awards to all State health departments, Territories and some Tribes to establish or strengthen leadership, expertise, and coordination of overarching chronic disease prevention

programming, surveillance, epidemiology and evaluation, policy, and communication ($115,884,000).

2) Competitive grant awards to State health departments, Territories, some Tribes and other entities to establish core activities addressing the areas below ($389,576,000).
    - Policy and environmental approaches to improve nutrition and physical activity in schools, worksites, and communities.
    - Interventions to improve delivery and use of selected clinical preventive services.
    - Community programs to support chronic disease self management to improve quality of life for people with chronic disease and to prevent diabetes, heart disease, and cancer among those at high risk.
    - Surveillance, evaluation, translational research, technical assistance and other support to funded entities to identify, implement, and assess the impact of strategies targeting the leading chronic disease causes of death and disability.
3) Competitive performance incentive awards to state and territorial health departments, based on performance, to implement or expand effective programs addressing the leading chronic disease causes of death and disability ($22,460,000).
4) Support for academic institutions and national organizations ($36,382,000).
5) Support for CDC program leadership and subject matter expertise ($141,076,000)

In FY 2012, CDC will:

- Allocate funding through a combination of core funding and competitive grants to State, Tribal, Local, and Territorial health departments to support:
    - Core funding to support CCDPP leadership and expertise in surveillance, epidemiology, evaluation, policy, and communications. Core funding will coordinate community based investments and activities in schools, worksites and health systems.
    - Competitive grants supporting evidence-based strategies and achieving measurable outcomes related to specific chronic diseases, conditions and risk factors. Grantees will focus on the most effective, impactful strategies and programs to effectively address the leading chronic disease causes of death and disability.
- Award performance-based competitive grants to states, territories, and tribes with demonstrated experience with and success in implementing effective chronic disease prevention and reduction programs, to expand the impact of these programs or implement new effective programs.
- Award funding through competitive grants to academic institutions and national organizations. Specifically, funds will:
    - Continue to support academic health centers (via cooperative agreements) associated with schools of public health or medicine throughout the country. These academic health centers will continue to develop, test, and evaluate effective interventions to reduce chronic conditions and their underlying modifiable risk factors. These interventions will then be disseminated and used throughout the public health system at the federal, state, and local levels.
    - Fund national organizations to provide technical assistance, training and support to state, local, tribal, and territorial health departments.

Performance: During the transition period to full implementation of the Chronic Disease Prevention and Health Promotion Grant Program which will generate new performance goals and measures, CDC proposes the following new performance metrics:

Chronic Disease Prevention

Reduce age-adjusted mortality due to chronic diseases:

Heart Disease –

- Reduce the age-adjusted annual rate per 100,000 population of coronary heart disease deaths (GPRA, HP-HDS2).

Cancer –

- Reduce the age-adjusted annual rate of cancer mortality per 100,000 population. (HP-C1).

Stroke –

- Reduce the age-adjusted annual rate per 100,000 population of stroke deaths (GPRA, HP-HDS3).

Diabetes –

- Reduce the age-adjusted annual rate per 100,000 population of diabetes-related deaths (HP-D3).

Reduce prevalence of disabling chronic diseases:

Arthritis –

- Reduce the proportion of adults with doctor-diagnosed arthritis who experience a limitation in activity due to arthritis or joint symptoms Reduce the proportion of adults with doctor-diagnosed arthritis who experience a limitation in activity due to arthritis or joint symptoms (HP-AOCBC2).

Obesity –

- Reduce the age-adjusted proportion of adults who are obese. (HP-NWS9)
- Reduce the proportion of children and adolescents who are considered obese (HP-NWS10.1, 10.2, 10.3, 10.4).

Health Promotion

Improve quality of life and health outcomes by promoting environmental and policy changes pertaining to:

Nutrition –

- Increase the number of states with policies to improve nutritional quality of competitive foods in schools. (GPRA).
- Increase the number of States with nutrition standards for foods and beverages provided to preschool-aged children in child care (HP-NWS1).

Physical Activity –

- Increase the proportion of the Nation's public and private elementary/middle/high schools that require daily physical education for all students (HP-PA4.1, 4.2, 4.3).

Surveillance –

- Increase the number of central, population-based registries from the 50 States and the District of Columbia that capture case information on at least 95 percent of the expected number of reportable cancers (HP-C12).

Clinical Preventive Services related to chronic disease prevention, early detection and management –

- Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines (C17)(slightly different for GPRA).
- Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines (HP-C15).
- Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines (HP-C16).
- Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least twice a year (GPRA and HP-D11).
- Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high (HP-HDS4).
- Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years (HP-HDS6).

Promote education and management skills for those diagnosed with or at risk for chronic diseases:

Nutrition and Physical Activity –

- Increase the contribution of fruits to the diets of the population aged two years and older (HP-NWS14).
- Increase the variety and contribution of vegetables to the diets of the population aged two years and older (HP-NWS15.1, 15.2) .
- Increase the contribution of whole grains to the diets of the population aged two years and older (HP-NWS16).
- Reduce the proportion of adults who engage in no leisure-time physical activity Reduce the proportion of adults who engage in no leisure-time physical activity (GPRA, HP-PA1).

Diabetes –

- Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education
- Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education (HP-D14).
- Increase prevention behaviors in persons at high risk for diabetes with pre-diabetes (HP-D16).

Heart Disease –

- Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (GPRA, HP-HDS12).
- Maintain the age-adjusted proportion of persons age 20+ with high total cholesterol (>=240mg/dL) at no higher than its current rate (HP: reduce). (GPRA, HP-HDS-7).

- Reduce consumption of sodium in the population aged 2 years and older (HP-NWS19).

This program will be created by merging the existing budget lines for Nutrition, Physical Activity and Obesity; Health Promotion; Heart Disease and Stroke; School Health, Diabetes; Cancer Prevention and Control; Prevention Centers; and Arthritis and Other Chronic Diseases. The program merges these former dedicated funding lines because these programs share the common goals of addressing similar risk factors and health behaviors related to chronic disease prevention and health promotion. Consequently, redirecting the funding from these disease-specific programs provides CDC the flexibility to support the development and implementation of coordinated strategies in funded entities to achieve a greater public health impact.

To ensure optimal implementation, CDC will work with states, tribes and territories to continue existing programs as currently structured, and expand, adjust or redirect resources to the most effective activities within the new program framework. Working with States, Tribes and Territories, CDC could also change the scope of existing activities based on effectiveness and need, and if appropriate, use resources to start new activities that address the leading causes of death and preventable disability or terminate existing programs based on performance. All grantees will be expected to achieve population level change in the specified outcomes and to identify specific "special populations" that suffer disproportionately from the condition being addressed. Furthermore grantees will be expected to implement strategies to narrow gaps in health status between these "special populations" and the population as a whole. The resultant program will provide funded entities with the opportunity to implement coordinated chronic disease prevention and health promotion strategies.

Competitive grants and cooperative agreements will support:

- Chronic disease prevention programs in state, tribal, local and territorial health departments.
- Program specific action with an emphasis on policy, systems and environmental approaches to address chronic diseases and their associated risk factors, exclusive of tobacco.
- Chronic disease self management and evidence based structured lifestyle interventions that include an emphasis on nutrition, physical activity and weight management.
- Coordinated National and State chronic disease and modifiable risk factor surveillance systems.
- Targeted translational research and evaluation to expand the scope of evidence based strategies and promising practices that State, local, Tribal and Territorial health departments can implement to lower the burden of chronic disease and diminish health disparities.
- National non-governmental organizations to provide technical assistance, training, and support.

IT INVESTMENTS

CDC Administrative Systems includes multiple systems that support funding decisions, research and contracts tracking, and other administrative services. Epidemiology and Assessment Systems 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. CDC Public Health Monitoring Systems provides electronic capabilities for gathering, storing, manipulating and disseminating valuable data for public health monitoring activities supporting Chronic Disease Prevention and Health Promotion. CDC Public Health Program Support Systems involves 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. CDC Cancer Surveillance and Application Support provides IT support for state-based cancer registries that collect, manage, and analyze data about cancer cases and cancer deaths. CDC PRAMS Data Collection System is a surveillance system for the Pregnancy Risk Assessment Monitoring System (PRAMS) project which collects state-specific, population-based data on maternal attitudes and experiences before, during, and after pregnancy. CDC 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. CDC Public Health Communication 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. (For funding information, see Exhibit 53.)

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activities are included:

- Tobacco Campaign and Quitlines – $79,000,000
- Community Transformation Grants – $221,061,000
- Chronic Disease Funding to States – $157,740,000
- Baby Friendly Hospitals – $2,500,000

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Chronic Disease Prevention and Health Promotion[1]	**$1,049,618**	**$1,266,786**	**$1,185,508**	**+$135,890**
- Tobacco	$125,200	$160,716	$186,226	-$61,026
- ACA/PPHF (non-add)	$14,500	$50,000	$79,000	+$64,500
- Oral Health	$15,000	$15,002	$14,609	-$391
- Safe Motherhood/Infant Health	$44,867	$44,873	$55,734	+$10,867
- ACA/PPHF (non-add)	$0	$0	$2,500	+$2,500
- Preventive Health and Health Services Block Grant	$100,240	$100,255	$0	-$100,240
- Community Health Activities	$61,883	$61,892	$221,061	+$159,169
- ACA/PPHF (non-add)	$0	$170,000	$221,061	+$221,061
- Chronic Diseases Prevention and Health Promotion Grants	$632,995	$633,098	$705,378	+$72,383
- ACA/PPHF (non-add)	$0	$52,200	$157,740	+$157,740
- All Other Chronic Disease Activities	$69,433	$28,750	$0	-$69,433
- ACA (non-add)[1]	$25,000	$0	$0	-$25,000
- ACA/PPHF (non-add)	$44,433	$28,750	$0	-$44,433

[1]Funding levels reflect the transfer of $40,000,000 in school health activities to the Domestic HIV/AIDS budget.
[2]In FY 2010, $25 million, available for five years, was appropriated for Obesity Demonstration Projects under the Affordable Care Act.

MEASURES TABLE[1,2]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Long Term Objective 4.6: Reduce death and disability due to tobacco use.				
4.6.2: Reduce per capita cigarette consumption in the U.S. per adult age 18+ (Outcome)	FY 2005: 1,716 (Historical Actual)	N/A	N/A	N/A
4.6.3: Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers (Intermediate Outcome)[3]	FY 2009: 21% (Historical Actual)	N/A	20%	N/A
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 2009: 41% (Historical Actual)	N/A	56.9%	N/A
4.6.5: Reduce the proportion of adolescents (grade 9 through 12) who are current cigarette smokers.(Intermediate Outcome)	FY 2009: 19.5% (Historical Actual)	N/A	18.6%	+18.6

[1]Measures and targets have not yet been adjusted for the new consolidated approach. These changes will be made in the FY 2013 President's Budget request, pending Congressional acceptance of the proposal.
[2] Targets do not reflect impact of funding from ACA/PPHF or the American Recovery and Reinvestment Act.
[3] 4.6.3 is interim measure until data becomes available for 4.6.2.

OTHER OUTPUTS[1,2]

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
4.X: Number of state tobacco prevention and control programs (includes DC and eight territories)	FY 2011: 59	59	59	Maintain
4.Y: Tobacco Cessation Quitlines – States/ Territories/ Tribes funded to maintain and enhance existing quitlines	FY 2011: 56	53	53	Maintain
4.Z: Number of cooperative agreements for tobacco prevention with key organizations with access to diverse population	FY 2011: 13	13	13	Maintain
4.A.A: Scientific, technical, and public inquiry response on tobacco use	FY 2011: 50,000	50,000	50,000	Maintain
4.A.B: Total state health departments and other organizations (e.g., local health departments) requesting advertising campaign materials through the Media Campaign Resource Center	FY 2011: 250	250	250	Maintain

[1]Measures and targets have not yet been adjusted for the new consolidated approach. These changes will be made in the FY 2013 President's Budget request, pending Congressional acceptance of the proposal.
[2] Targets do not reflect impact of funding from ACA/PPHF.

STATE TABLE

State/Local/ Territory/Tribal Grantee	FY 2010 Actual Breast and Cervical Cancer	FY 2010 Actual National Comprehensive Cancer Control Program	FY 2010 Actual Diabetes Prevention and Control Programs	FY 2010 Actual Tobacco
Alabama	$3,315,293	$300,000	$291,564	$1,326,917
Alaska	$2,386,679	$285,000	$424,661	$1,155,593
Arizona	$2,393,690	$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	$546,388	$430,000	$507,359	$1,326,312
Connecticut	$1,516,455	$227,000	$252,782	$1,079,240
Delaware	$1,126,313	$255,000	$386,912	$669,373
District of Columbia	$510,000	$202,542	$261,917	$531,753
Florida	$4,945,692	$445,000	$694,394	$1,873,958
Georgia	$4,279,648	$264,706	$369,150	$1,094,478
Hawaii	$1,176,054	$256,234	$328,887	$926,456
Idaho	$1,846,989	$255,000	$330,219	$1,141,438
Illinois	$6,608,935	$236,631	$850,153	$1,141,246
Indiana	$2,050,000	$450,000	$312,007	$1,037,550
Iowa	$2,763,748	$268,915	$229,862	$1,011,630
Kansas	$2,358,323	$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	$179,930	$173,001	$202,000	$1,101,612
Louisiana State University	$1,713,538	$284,141	$0	$0
Maine	$1,810,003	$254,999	$340,473	$944,248
Maryland	$4,965,122	$259,162	$301,588	$1,205,315
Massachusetts	$3,038,573	$475,000	$854,983	$1,558,517
Michigan	$9,031,859	$480,000	$947,905	$1,662,974
Minnesota	$4,581,042	$474,999	$913,246	$1,199,593
Mississippi	$2,134,504	$255,000	$292,533	$1,104,566
Missouri	$3,018,261	$260,387	$470,314	$1,156,691
Montana	$2,252,092	$296,957	$599,533	$961,792
Nebraska	$2,996,376	$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	$3,140,845	$250,000	$478,533	$1,274,833
New Mexico	$3,497,843	$305,000	$433,792	$1,141,221
New York	$8,620,400	$480,000	$986,305	$1,873,958
North Carolina	$3,453,909	$300,000	$887,207	$1,672,280

State/Local/ Territory/Tribal Grantee	FY 2010 Actual Breast and Cervical Cancer	FY 2010 Actual National Comprehensive Cancer Control Program	FY 2010 Actual Diabetes Prevention and Control Programs	FY 2010 Actual Tobacco
North Dakota	$1,456,233	$303,739	$244,261	$1,155,818
Ohio	$4,243,208	$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	$2,522,348	$256,235	$522,169	$1,289,693
Rhode Island	$1,606,275	$278,689	$758,986	$1,144,904
South Carolina	$3,266,027	$313,266	$666,163	$1,217,810
South Dakota	$1,061,951	$222,542	$257,525	$963,055
Tennessee	$1,210,409	$310,000	$268,653	$1,281,398
Texas	$7,004,839	$293,750	$976,813	$1,873,879
Utah	$2,734,731	$454,500	$888,327	$1,215,563
Vermont	$1,113,195	$255,000	$242,247	$1,140,226
Virginia	$2,808,820	$245,000	$372,906	$1,057,786
Washington	$4,932,039	$255,000	$974,690	$1,411,385
West Virginia	$4,208,220	$285,000	$916,152	$1,170,999
Wisconsin	$3,591,280	$277,526	$852,883	$1,191,137
Wyoming	$683,331	$269,565	$259,499	$1,037,398
Indian Tribes	$7,752,119	$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
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	$392,824	$250,000	$200,000	$206,570

State/Local/ Territory/Tribal Grantee	FY 2010 Actual Breast and Cervical Cancer	FY 2010 Actual National Comprehensive Cancer Control Program	FY 2010 Actual Diabetes Prevention and Control Programs	FY 2010 Actual Tobacco
Marshall Islands	$0	$180,000	$86,301	$100,000
Micronesia	$0	$475,000	$144,200	$211,403
Northern Mariana Islands	$3,824,784	$255,000	$72,478	$148,650
Palau	$561,725	$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	**$168,515,277**	**$19,672,802**	**$28,069,069**	**$63,556,474**

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$143,626	$143,646	$143,899	+$273
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$0	$0	$0	$0
Total	**$143,626**	**$143,646**	**$143,899**	**+$273**
FTEs	204	204	204	0

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $143,899,000 for birth defects, developmental disabilities, disabilities and health reflects an overall increase of $273,000 above the FY 2010 level. The request consolidates disease specific funding into three new budget lines: Child Health and Development, Health and Development for People with Disabilities, and Public Health Approach to Blood Disorders. These budget lines represent new comprehensive programs that refocus activities on integrated and competitive grant programs that facilitate more effective approaches. This approach gives CDC greater flexibility to address critical public health challenges and allocate resources to maximize the public health impact of its programmatic activities. The FY 2012 request also includes $23,778,000 for Autism activities within the Child Health and Development budget line.

A gradual transition to the more flexible approach will take place over the next three years to avoid disruption of current activities and grant cycles. CDC, working with external stakeholders, may continue some existing programs as currently structured, expand others, redirect resources to more effective activities, change the scope of existing activities based on effectiveness and need, and if appropriate, use existing program resources to start new activities or end some existing programs. FY 2012 funds will support CDC's goal to prevent birth defects, improve outcomes of individuals affected by birth defects and developmental disabilities, eliminate disparities associated with disabilities, and prevent death and disability associated with blood disorders.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 307, 308D, 310, 311, 317, 327, 352, 399G, 1102

Specific Authorities: PHSA §§ 317C, 317J, 317K, 317L 317Q, 399M, 399Q, 399S, 399T, 399AA, 399BB, 399CC, 1108-1115; The Prematurity Research Expansion And Education For Mothers Who Deliver Infants Early Act §§ 3,5 (42 USC 247b-4f and 42 USC 247b-4g).

* See Special Items tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization…………………………………………….…….……Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$122,242,000
FY 2008	$127,366,000
FY 2009	$138,022,000
FY 2010*	$143,626,000
FY 2011CR	$143,646,000

*Funding levels prior to FY 2010 have not been made comparable to the FY2012 budget realignment

BUDGET REQUEST

Child Health and Development

CDC will rename the Birth Defects and Developmental Disabilities budget line to *Child Health and Development*, and consolidate existing sub-lines (Birth Defects, Fetal Alcohol Syndrome, Folic Acid, and Infant Health) into a single budget line. CDC's FY 2012 request of $66,667,000 for Child Health and Development reflects an increase of $1,727,000 above the FY 2010 level. Within this level, the FY 2012 request includes $23,778,000 for Autism activities. The proposed consolidation will give the flexibility to develop and implement targeted prevention programs to focus on the most critical maternal and child health challenges. CDC's commitment to healthy infants and children starts before conception with the health of the mother. Research demonstrates that the health of the mother plays a critical role in a child's ability to grow up healthy and ready to learn. Good nutrition, healthy pregnancies, safe and nurturing parental relationships, and early interventions all have a positive impact on an infant and child's health and development. The proposed budget consolidation described unifies CDC's ongoing efforts to promote preconception care, support surveillance and research on risk factors for birth defects and developmental disabilities and other poor developmental outcomes and promote early identification and intervention efforts for children with autism and developmental disabilities.

This consolidated budget will provide CDC with the flexibility to prioritize programs that have the potential to maximize impact on the public's health through improved preconception care, positive birth outcomes, optimal child health, and infant and child development outcomes. This approach will also afford CDC the flexibility to aggressively track birth defects and developmental disabilities.

CDC plans to consolidate and expand its surveillance, research and prevention activities to reduce inefficiencies and direct resources and technical assistance to areas of greatest need and expand the agency's reach in preventing birth defects and disabilities and improving the health of all persons living with these conditions.

Funds will support surveillance and research activities to identify causes and risk factors for birth defects and developmental disabilities with the greatest public health burden, enhance prevention research and implement strategies to improve health outcomes.

Performance: Autism spectrum disorders (ASDs) affect approximately one in 110 children. The network of Autism and Developmental Disabilities Monitoring (ADDM) sites monitors the rates of ASD in various geographic regions, and six sites received supplemental funding to conduct surveillance of younger children. ADDM also monitors other developmental disabilities, such as cerebral palsy and intellectual disability. These activities provide a more complete picture of the prevalence of ASD and other developmental disabilities and better inform early intervention efforts to address the growing needs of affected families. CDC worked to improve the quality and utility of birth defects monitoring data and to increase knowledge of the role of modifiable risk factors for birth defects. While CDC used a new data linkage software tool it did not meet and complete the target to evaluate the association of childhood cancer and birth defects. To meet this target, preliminary results of the CDC study suggested a need to

further classify birth defect cases by phenotype, so all cases are undergoing a review by clinical geneticists.

In addition to surveillance activities, CDC has achieved progress in interventions. Research has shown that taking folic acid before getting pregnant and in early pregnancy lowers the risk of having major birth defects of the baby's brain and spine by 50 percent to 70 percent. Since fortification of the cereal grain supply with folic acid in 1998, a 36 percent reduction in spina bifida and anencephaly has occurred. However, CDC did not meet its target to reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly among Hispanic women. To address this target audience, CDC will focus on increasing folic acid consumption in the Hispanic community by utilizing promotoras, or lay health outreach workers, to conduct grassroots education on the importance of folic acid consumption among Hispanic women of childbearing age.

Finally, in the United States, approximately 12 percent of pregnant women report alcohol use and two percent report binge drinking in the past 30 days. CDC met its target of increasing provider based fetal alcohol syndrome screening intervention by one percent and continues to support prevention activities to reduce alcohol use prior to and during pregnancy. (Measures 5.D, 5.1.1, 5.1.4, 5.1.2, 5.C, and 5.1.3)

Program Description and Recent Accomplishments: CDC engages in public health surveillance, research, and prevention activities with the ultimate goal of preventing or reducing birth defects and developmental disabilities. One in 33 babies in the United States is born with a birth defect while 13 percent of children have a developmental disability. 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, effective prevention efforts. Funding for CDC's activities is provided through cooperative agreements to support epidemiologic research efforts and birth defects surveillance. Grantees include state health departments and academic research centers. CDC also provides technical assistance to states on surveillance for birth defects and developmental disabilities.

CDC will begin a gradual transition to a more flexible program for funding and managing activities in the Child Health and Development budget line with the goal of building upon the successful collaboration CDC has with state and local health departments, national and community organizations, universities, and other partners. To the extent feasible, CDC plans to expand the scope of the program to reach a greater proportion of the population with birth defects and disabilities.

The new Child Health and Development program will enhance CDC's ability to address the following objectives/intended outcomes:

- Expand and enhance surveillance and tracking systems for birth defects and developmental disabilities, including follow up for longer term outcomes (e.g., survival, use of special education services, health care utilization).
- Identify and understand the preventable risk factors (e.g., smoking, alcohol use) for birth defects and developmental disabilities.
- Develop, evaluate, and disseminate effective prevention strategies aimed at preventing the occurrence of birth defects and developmental disabilities.
- Develop, evaluate, and disseminate programs and strategies aimed at maximizing the quality of life for individuals with birth defects and developmental disabilities.

Beginning in FY 2012, CDC will begin to consolidate funding opportunity announcements for Child Health and Development under three main umbrella activities:

- **Public health surveillance** to characterize the problem, prevalence, incidence and distribution of birth defects to inform public health research, priority setting and program monitoring.
- **Epidemiological research** to understand the major modifiable risk factors in order to develop intervention/prevention programs and policies.
- Effective **prevention/health promotion programs and policies** developed, evaluated, and disseminated for adoption by global, national, state and local organizations.

Recent accomplishments include:

- Continued development of CDC's birth defects and developmental prevention capacity by publishing key findings on risk factors on pre-pregnancy obesity and the risk of congenital heart defects; maternal occupation and the risk of birth defects; use of antibacterial medications during pregnancy and risk of birth defects; fertility treatments (assisted reproductive technologies) and the association with major birth defects.
- Worked to reduce the disparity NTD rates for Hispanic women of childbearing age by conducting analysis suggesting that corn masa flour fortification will effectively target Mexican American women without substantially increasing folic acid intake among other populations.
- Improved screening, early diagnosis, and referral to early intervention for children with an ASD by providing prevalence of ASDs among eight-year-old children. At a state level, these data have been used to support health care reform including legislation to mandate insurance coverage for autism support services. At a national level, these data continue to inform the efforts of the federal Interagency Autism Coordinating Committee in the development of the strategic research agenda for autism.

Health and Development for People with Disabilities

CDC will rename the Human Development and Disability budget line to *Health and Development for People with Disabilities*, and consolidate existing sub-lines (Disability and Health, Early Hearing Detection and Intervention, Charcot Marie Tooth Disorders, Limb Loss, Muscular Dystrophy, Special Olympics Healthy Athletes, Paralysis Resource Center, Fragile X, Attention Deficit Hyperactivity Disorder, Tourette Syndrome, and Spina Bifida) into a single line. CDC's FY 2012 request of $57,067,000 for Health and Development for People with Disabilities reflects a decrease of $1,709,000 below the FY 2010 level. The consolidation will allow CDC the flexibility to dedicate resources to support enhanced surveillance, expanded research, and broader state-based prevention efforts on the most critical public health challenges facing people with disabilities.

This consolidated budget will provide CDC with the ability to focus on the critical issues facing the population of persons with disabilities across the lifespan. CDC will be able to dedicate its resources to:

- Support and expand State-based disability and health programs and early detection and intervention programs.
- Develop and maintain health surveillance repositories that effectively track key health indicators for people with intellectual disabilities and complex disabling conditions over time.
- Engage in prevention research that reduces disparities in obesity and other health indicators and addresses the policy and knowledge gaps in existing public health programs related to persons with disabilities.
- Support public health practice and resource centers on key topics.

CDC anticipates that this consolidation would provide CDC the flexibility to dedicate existing resources to support enhanced surveillance, expanded research and broader State-based prevention efforts on the most critical public health challenges facing people with disabilities today. CDC's goals under this proposed consolidation are to improve health and health care access for people with disabilities; improve existing surveillance data on the health status of people with disabilities; and, based on this research, develop intervention programs that prevent secondary conditions from negatively impacting the lives of people with disabilities with a variety of disabilities across the lifespan.

Funds will support activities, in collaboration with national, state, and local partners to address the public health issues related to human development, eliminate health disparities associated with disability, and promote the health and well-being of all people with disabilities.

Performance: Through public health efforts, such as surveillance, research, and health promotion, CDC can positively impact the health and quality of life among people with disabilities by reducing health disparities and the incidence and severity of secondary conditions and chronic diseases, such as obesity and smoking, in those with disabilities. Performance goals for assessing the decrease of health disparities in people with disabilities include the following measures noted below.

Investments in promoting optimal child development, especially in low-income families, can reduce social costs, such as special education, foster care, welfare, medical care, law enforcement, social security, and social services. Preliminary analysis of CDC's Legacy for Children™ in two sites indicates that the parenting intervention resulted in 17 percent fewer children at age two meeting early intervention referral eligibility, and 20 percent fewer children at age three demonstrating intellectual functioning below normal range.

Early identification and intervention programs can be cost effective for people with disabilities and their families. Working with states, CDC has successfully screened for hearing loss more than 95 percent of babies born in the United States through the Early Hearing Detection and Intervention Program. Estimates show that early hearing screening and intervention can save approximately $200 million in additional education costs each year. (Measures 5.2.2, 5.F, and 5.2.3. 5.2.3)

Program Description and Recent Accomplishments: CDC promotes optimal development among at-risk children and overall health for people with disabilities. Activities include: 1) early identification and interventions for children at-risk for developmental problems; 2) newborn screening to identify children with hearing loss; 3) research on risk factors and measures of health, functioning, and disability; and 4) implementation of state disability and health programs to support program infrastructure and health promotion for individuals with a disability.

CDC will gradually begin transitioning the eleven current condition-specific budget lines within Health and Development for People with Disabilities line into a single funding line in FY 2012 over three years that would allow a more flexible program for funding and managing activities. Building upon the successful collaboration CDC has 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 nationally and internationally of people of all ages living with disabilities. The broader approach will focus most immediately on the areas of greatest burden and unmet need.

The new Health and Development for People with Disabilities program will enhance CDC's ability to address the following objectives/intended outcomes:

- Ensure that all newborns are screened and assessed for hearing loss and receive appropriate intervention according to established guidelines.
- Reduce disparity in obesity and other health indicators in children, youth, and adults with disabilities.

- Identify and reduce disparities in health care access for persons with disabilities.
- Incorporate disability status as a demographic variable into all relevant CDC surveys, programs, and policies.
- Improve developmental outcomes of at-risk children and children with disabilities

Beginning in FY 2012, CDC will aim to consolidate extramural funding strategies and reduce the number of funding mechanisms. More targeted initiatives may remain under separate funding opportunity announcements to ensure CDC has the flexibility necessary to redirect funds toward newly identified issues affecting these populations.

Recent accomplishments include:

- Collaborated on emergency response efforts during the aftermath of the Haiti earthquake with federal agencies and partners, such as the Amputee Coalition of America (ACA) and the Christopher and Dana Reeve Foundation, to provide important information for both clinicians and amputees. CDC continues to work with ACA to address the care for the estimated 2,000 to 4,000 patients who are now amputees and face continuing care needs in a country with few resources for individuals with disabilities.
- Established the prevalence of ADHD (9.5 in 100 aged 4-17 years, with demographic variances), Duchenne/Becker Muscular Dystrophy (1.3 to 1.8 per 10,000 males aged 5-24 years), and Tourette Syndrome (3 per 1,000 over lifetime) which states will use to inform services needs and decisions.
- Improved hearing screening, follow-up, and early intervention services by developing and implementing Early Hearing Detection and Intervention (EDHI) tracking and surveillance systems. CDC invested in infrastructure by supporting 53 states and territories to help state EHDI programs ensure babies receive the hearing services they need.

Public Health Approach to Blood Disorders

CDC's FY 2012 request of $20,165,000 for Public Health Approach to Blood Disorders reflects an increase of $255,000 over the FY 2010 level. The FY 2012 request consolidates existing budget sub-lines into one line called Public Health Approach to Blood Disorders. The consolidated line allows CDC to transition to a more comprehensive approach that will reach a larger proportion of the population with blood disorders. This will be achieved by expanding surveillance systems, prevention research, and health promotion to develop and evaluate prevention strategies needed to improve the health of populations affected by blood disorders-bleeding and clotting disorders, and hemoglobinopothies. CDC also plans to direct funding currently used for activities that are duplicative in nature or performed by other parts of the healthcare system to other blood disorder activities.

Performance: CDC's Universal Data Collection System (UDC) project provides population level information that is used to inform research and decision-making to improve the health and quality of life for Americans with blood disorders. For this reporting period, CDC has met or exceeded its target by increasing the number of people who participate in the UDC. Collection of new data elements and analysis in 2012 will include assessing the use of routine screening for inhibitors in people with hemophilia.

Deep Vein Thrombosis and Pulmonary Embolism (DVT/PE) is one of the leading causes of death and disabilities affecting 350,000 to 600,000 people each year, up to 100,000 of whom die, imposing costs of up to $10 billion annually. CDC funded two pilot surveillance systems that will help define best practices for a national surveillance system that can provide a baseline for measuring the effectiveness of activities

and programs in identifying research on associated risk factors, and measuring the effectiveness of future prevention efforts. CDC met its target for establishing pilot surveillance projects for DVT/PE. (Measures 5.2.1 and 5.J)

Program and Recent Accomplishments: CDC's blood disorders program activities include determining the causes of and risk factors for blood disorders; minimizing occurrences and complications of blood disorders; developing, evaluating, and facilitating widespread adoption of effective prevention strategies; and ensuring people with or at risk for blood disorders have access to credible health information. Funds are distributed to CDC partners through cooperative agreements (research and non-research) and contracts. Cooperative agreements are awarded to 12 regional coordinating centers that oversee a network of 135 hemophilia treatment centers (HTCs) with the average award for each region equaling $500,000, seven thalassemia treatment centers (TTCs), and five thrombosis/hemostasis centers across the United States. Key strategies for improving health outcomes and preventing complications for those with or at risk for blood disorders include transforming HTCs, TTCs and thrombosis/hemostasis centers into Blood Disorder Treatment Centers providing comprehensive care for blood disorders and merging and redesigning data collection systems from those that focus on a single disorder to a single system that collects data for several disorders. The program worked with the National Institutes of Health (NIH) and other federal partners to establish a new Healthy People 2020 priority area for blood disorders that will track 22 objectives.

Beginning in FY 2012, CDC will gradually transition its four disease-specific blood disorder activities into one consolidated approach. The consolidated approach will broaden the work already being done through CDC's successful collaborations with a CDC-funded national network of 135 HTCs, national and community organizations, universities and other partners by providing flexibility to expand activities to include all non-malignant blood disorders with an immediate focus on disorders with the greatest burden and unmet need: DVT/PE, Sickle Cell Disease (SCD), and von Willebrand Disease. This broad public health approach to blood disorders will extend CDC's reach from approximately 20,000 people seen at HTCs to other patients with bleeding disorders currently treated outside the HTCs and the roughly four million people with one of the targeted blood disorders. By 2014, the public health approach to blood disorders is expected to:

- Reduce the number of DVT/PE, deaths, and disability.
- Reduce the number of emergency department visits and hospital admissions among people with SCD.
- Reduce the number of unnecessary hysterectomies due to bleeding disorders.
- Reduce the number of maternal deaths due to hemorrhage or pulmonary embolism.
- Reduce the proportion of persons with hemophilia who develop decreased joint mobility due to bleeding into joints.

Recent accomplishments include:

- Promoted the health of and improved outcomes among people at risk for or affected by a blood disorder by convening the first National Conference on Blood Disorders in Public Health. The meeting, co-sponsored by Health Resources and Services Administration (HRSA), NIH's National Heart, Lung, and Blood Institute (NHLBI), the American Society of Hematology and Hemophilia of Georgia. The forum was informed by the program's publication of a supplement to the *American Journal of Preventive Medicine* with 18 articles describing public health research findings in blood disorders. The forum served as a catalyst for collaboration and the development of a nationally recognized public health framework, and resulted in an opportunity to share lessons learned and evidence based practice in blood disorders.
- Improved care and services by collaborating with Agency for Health Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), HRSA, and the NIH to form an HHS Hemoglobinopathy Program Initiative, a high impact multi-agency approach that will offer more effective care and lower societal and medical costs for individuals affected by blood disorders such as sickle cell disease and thalassemia.
- Initiated collection of data to describe epidemiologic and clinical characteristics of people with hemoglobinopathies through public health surveillance pilots on sickle cell disease and thalassemia. Funds were awarded, through an interagency agreement with NIH, to seven state health departments (California, Florida, Georgia, Michigan, New York, North Carolina, and Pennsylvania).

IT INVESTMENTS

CDC Centers for Autism and Developmental Disabilities Research and Epidemiology: This is an extramural Cooperative Agreement with Michigan State University to develop and maintain various data capture systems for the Study to Explore Early Development (SEED), a multi site case-cohort study that aims to gain information as to the natural history and causes of autism. The Data Coordinating Center at Michigan State also maintains all of the electronic data entered for this study and will produce analytic datasets for study researchers and eventually for the public. It supports the program goal and Congressional mandate for CDC to conduct autism research. CDC Public Health Monitoring for Birth Defects, Development Disabilities, Disabilities and Health: This investment is a rollup of several information technology systems for Capital Planning and Investment Control purposes. Each system comprising this rollup is described individually below. The Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP) is an ongoing multiple source population based surveillance system for five developmental disabilities in the five county metropolitan Atlanta area: autism, intellectual disability, cerebral palsy, and sensorineural hearing and vision loss; the database instrument used to capture the data is a Microsoft Access based system; CDC is currently developing a web based version of this system. CDC has exported this methodology to eleven states in the U.S. as part of the Autism and Developmental Disabilities Monitoring Network (ADDM). The Metropolitan Atlanta Congenital Defects Program (MACDP) is an ongoing multiple source population based surveillance system for major structural birth defects in infants and children ascertained up to age six who resided in the five county metropolitan Atlanta areas. The data collection instrument for MACDP is a client server based system that can be converted to a web based application. Currently this electronic system is still in the testing phase and the data are collected on paper. This methodology has been exported to several states as well. The Universal Data Collection System (UDC) is an ongoing clinical data management system that combines clinical data from 135 hemophilia treatment centers and seven thalassemia treatment centers across the US. These data are used in surveillance to produce point estimates of the prevalence, risk factors and co-morbidities of certain blood disorders and hemoglobinopathies in the

United States. Currently this is a PC- based application hosted at each collaborator's site. The application is being rewritten as a web-based application using the SPSS Dimensions software.

The Fetal Alcohol Syndrome (FAS) Surveillance System is a surveillance system designed to capture data on FAS prevalence in the five county areas. The instrument used to collect this data is a grantee developed Microsoft Access database, with no current plans for a significant rewrite. (For funding information, see Exhibit 53.)

CDC's Early Hearing Detection and Intervention (EHDI) program provides support for the development of newborn hearing screening standards to enable interoperable electronic data exchanges among Electronic Health Record (EHR) systems, EHDI data systems, and potentially other public information systems. Through a cooperative agreement with the Public Health Data Standards Consortium (PHDSC), newborn hearing screening is being proposed as the foundation for the public health role in EHR information exchanges and to develop the methodology for public health participation in HIT product testing and certification. PHDSC will develop tools for testing interoperability standards identified in the Healthcare Information Technology Standards Panel (HITSP) Newborn Screening Interoperability Specification (IS 92) and the Integrating the Healthcare Enterprise® (IHE) EHDI Content Profile. PHDSC has agreed to participate with national certification entities that may be formed to present EHDI certification criteria for inclusion in the HIT certification rules.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

There are no activities included.

PROGRAM ACTIVITY TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Birth Defects, Developmental Disabilities, Disabilities and Health	**$143,626**	**$143,646**	**$143,899**	**+$273**
- Child Health and Development	$64,940	$64,950	$66,667	+$1,727
- *Autism (non-add)*	*$22,058*	*$22,061*	*$23,778*	*+$1,720*
- Health and Development for People with Disabilities	$58,776	$58,784	$57,067	-$1,709
- Public Health Approach to Blood Disorders	$19,910	$19,912	$20,165	+$255

MEASURES TABLE[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Long Term Objective 5.1: Prevent birth defects and developmental disabilities.				
5.1.1: Identify and evaluate the role of at least five new risk factors for birth defects and developmental disabilities (Output)	FY 2010: Yes (Target Met)	Establish large statistically powerful sample for developmental disabilities research	Evaluate association between pregestational diabetes, prepregnancy obesity and major birth defects	N/A
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 2007: 5.7 (Target Not Met)	4.6	4.4	-0.2
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)	FY 2010: Yes (Target Met)	Increase provider-based screening and intervention by 2% from baseline	Increase provider-based screening and intervention by 3% from baseline.	N/A
5.1.4: Improve the quality and usability of birth defects surveillance data (Outcome)	FY 2010: No (Target Not Met) FY 2010: No (Target Not Met)	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.	Develop and promote the use of minimal standards for surveillance in 10 state-based birth defects programs	N/A
Long Term Objective 5.2: Improve the health and quality of life of Americans with disabilities.				
5.2.1: Increase the number of people with blood disorders who participate in the monitoring system by 10% (Outcome)	FY 2010: 26,335 (Target Exceeded)	25,607	27,339	+1,732
5.2.2: Identify an effective public health intervention to ameliorate the effects of poverty on the health and well-being of children (Outcome)	FY 2010: Yes (Target Met)	Data collection and analysis for age 5 year	Data collection and analysis for age 8 year	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5.2.4: Increase the mean lifespan of patients with Duchenne and Becker Muscular Dystrophy (DBMD) and carriers by 10% as measured by the Muscular Dystrophy Surveillance, Tracking and Research Network (Outcome)	FY 2009: Yes (Target Met)	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	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).	N/A
5.2.5: Reduce the number of infants not passing the hearing screening that are lost to follow up (Outcome)	FY 2008: 43.0 (Target Met)	37.0	31.0	-6

[1]Measures and targets have not yet been adjusted for the new consolidated approach. These changes will be made in the FY 2013 President's Budget request, pending Congressional acceptance of the proposal.

OTHER OUTPUTS[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5.A: Number of state-based birth defects surveillance programs	FY 2010: 14	14	14	Maintain
5.B: Number of Centers for Birth Defects Research and Prevention	FY 2009: 8	8	8	Maintain
5.C: Number of model state-based FASD surveillance systems and regional training centers	FY 2009: 8	8	8	Maintain
5.D: Number of states participating in monitoring for Autism and other Developmental Disabilities (ADDM)	FY 2010: 12	12	12	Maintain
5.E: Number of states participating in research the Study to Explore Early Development	FY 2009: 6	6	6	Maintain
5.F: State Tracking/Research projects on Early Hearing Detection and Intervention	FY 2010: 53	53	53	Maintain
5.G: Disability and Health State Programs	FY 2009: 16	16	16	Maintain
5.H: Projects addressing disabling rare disorders (Fragile X, Muscular Dystrophy)	FY 2010: 25	25	25	Maintain
5.J: Establish pilot surveillance projects for DVT/PE.	N/A	2	<1	<1

[1]Measures and targets have not yet been adjusted for the new consolidated approach. These changes will be made in the FY 2013 President's Budget request, pending Congressional acceptance of the proposal

ENVIRONMENTAL HEALTH

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Request	FY 2012 +/- FY 2010
Environmental Health - BA	$181,004	$181,030	$128,715	-$52,289
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$0	$35,000	$9,000	+$9,000
Total	**$181,004**	**$216,030**	**$137,715**	**-$43,289**
FTEs	305	307	307	+2

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $137,715,000, including $9,000,000 from the Affordable Care Act Prevention and Public Health Fund, is $43,289,000 below the FY 2010 level. The FY 2012 program level reflects an elimination of the Built Environment activities ($2,683,000), reduction to climate change ($972,000), reduction to Asthma and Childhood Lead Poisoning/Healthy Homes ($33,045,000), and the creation of a new, multi-faceted approach to "Healthy Home 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.

FY 2012 funds will support program activities in capacity building, evaluation, research, public health surveillance, education, training, financial and technical assistance, and building national and global partnerships.

CDC's environmental health activities focus on preventing illness, disabilities, and premature death caused by non-infectious, non-occupational environmental-related factors. CDC is committed to protecting the health of populations who are particularly vulnerable to certain environmental hazards such as children, older adults, and people with disabilities. CDC's environmental health activities include: environmental health tracking, climate change, radiation studies and preparedness, outbreak response, environmental exposure assessments, as well as programs to reduce asthma, prevent childhood lead poisoning, ensure safe drinking water, and strengthen core environmental health services.

AUTHORIZING LEGISLATION

General Authorities: PHSA §§ 301, 307, 310, 311, 317, 327, 352, 1102

Specific Authorities: PHSA §§ 317A, 317B, 317I, 361, 366; Housing and Community Development Act, § 1021 (15 U.S.C. 2685): Chemical Weapons Elimination Activities (50 USC 1512, 50 USC 1521); Housing and Community Development (Lead Abatement) Act of 1992 (42 USC 4851 et seq.); Housing and Community Development (Lead Abatement) Act of 1992 (42 USC Sec. 4851 et seq.).

* See Special Items tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

Allocation Methods: Direct Federal/Intramural; Competitive Grants/Cooperative Agreements; Direct Contracts; Interagency Agreements

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$146,634,000
FY 2008	$154,486,000
FY 2009	$185,415,000
FY 2010*	$181,004,000
FY 2011CR	$216,030,000

*Funding levels prior to FY 2010 have not been made comparable to the FY2012 budget realignment

BUDGET REQUEST

Environmental Health Laboratory

CDC's FY 2012 request of $43,425,000 for the Environmental Health Laboratory is $6,000 above the FY 2010 level. The increase will support increased development and application of advanced laboratory technology to improve the diagnosis, treatment, and prevention of disease resulting from exposure to toxic substances. The Environmental Health Laboratory is globally recognized as a state-of-the-art institution. Other Environmental Health Laboratory program areas include cardiovascular disease, diabetes, and newborn screening for treatable newborn diseases.

In FY 2012, CDC will:

- Continue to fund California, New York, and Washington's biomonitoring programs to enhance state-based laboratory biomonitoring programs. This funding will enhance states' capacity to measure human exposure to environmental chemicals within their jurisdictions.
- Provide laboratory measurements for 52 studies that examine exposure of vulnerable population groups to environmental chemicals, or, that investigate the relationship between exposure levels and adverse health effects, in order to advance our understanding of the potential health impact of human exposure to chemicals in our environment.
- Continue to measure and report on the U.S. population's exposure to environmental chemicals and begin measurement of chemicals of interest to other agencies such as strontium and manganese, in order to further the science base for measuring and tracking over time which environmental chemicals are present in humans and at what levels.
- Complete newborn screening proficiency testing coverage for the detection of 29 congenital disorders, identified on the American College of Medical Genetics recommended National Uniform Newborn Screening Panel, to ensure the accuracy of testing in state newborn screening programs.

Performance: CDC's Environmental Health Laboratory assesses population exposure to environmental chemicals; provides quality assurance and standardization for laboratory programs; improves and develops laboratory methods to diagnose and prevent disease; contributes to studies of populations exposed to environmental chemicals; and assists states with newborn screening. (Measures 6.1.1, 6.1.2, 6A, 6B, 6F)

Since 2006, CDC has met or exceeded performance measure targets that track the number of environmental chemicals, including nutritional indicators, measured in the U.S. population. In FY 2010, CDC met their target of 323 chemicals measured. These assessments provide critical exposure data to scientists, physicians, and health officials who use the data to: 1) determine which chemicals and indicators are in people's bodies and at what levels; 2) establish national references ranges and trends

against which physicians and health officials can determine which groups may have an unusually high exposure; and 3) assess the effectiveness of public health actions.

CDC's Environmental Health Laboratory implements quality assurance and standardization programs that relate to chronic diseases, newborn screening disorders, nutritional status and environmental exposures. While participation in these programs is voluntary, CDC has steadily increased the number of labs participating. In FY 2010, CDC met the target of 974 laboratories voluntarily participating in the standardization and quality assurance programs, an increase of seven laboratories above the FY 2009 target. (Measure 6.1.3)

Program Description and Recent Accomplishments: By preventing disease from exposure to toxic chemicals in the environment, responding to threats and public health emergencies involving chemicals, and improving laboratory methods to diagnose and prevent disease, CDC's Environmental Health Laboratory has been in the vanguard of efforts to improve people's health across the nation and around the world.

Recent accomplishments include:

- Published the *Fourth National Report on Human Exposure to Environmental Chemicals* and the *National Report on Biochemical Indicators of Diet and Nutrition*. The Exposure Report included first-time exposure data on the U.S. population's exposure to parabens, which are widely used as antimicrobial preservatives in cosmetics, pharmaceuticals and in food and beverage processing. This data on the U.S. population is an important factor in directing priorities for research on human health effects from exposure to chemicals, and can help identify exposure trends that may be due to regulatory changes.
- Funded Wisconsin and Massachusetts to support continued implementation of population-based pilot newborn screening studies for Severe Combined Immune Deficiency (SCID). As a result of implementation of this new screening technique, Wisconsin and Massachusetts successfully identified six babies with classic SCID and more than 40 with other immune deficiencies in FY 2010.
- Developed a method for measuring 27 metabolites of volatile organic compounds (VOCs) in human urine. As a result, CDC can quantify VOC exposure from a variety of sources, such as tobacco smoke, industrial emissions, and vehicular exhaust, and evaluate the potential adverse health impact of these exposures.

Environmental Health Activities

CDC's FY 2012 request of $61,616,000 for Environmental Health Activities, including $9,000,000 from the Affordable Care Act Prevention and Public Health Fund, is $10,250,000 below the FY 2010 level for administrative savings as well as a programmatic savings to Climate Change activities ($972,000) and the elimination of the Built Environment program ($2,683,000). CDC will aim to incorporate the Built Environment into the new Community Transformation Grant program. Examples of activities currently supported by Environmental Health funding include, but are not limited to: focusing on exposure to ionizing radiation, addressing the public health consequences of climate change, and researching environmental causes of foodborne and waterborne diseases. The funding also supports the National Environmental Health Tracking Network, which is detailed in the subsection below.

In FY 2012, CDC will:

- Advance the identification of potentially harmful human exposures and/or contamination related to ionizing radiation; conduct research on communicating information about radiation exposures and/or contamination to the public, responders, and clinicians; and protect the public's health in the event of a radiological emergency.
- Train 250 public health professionals and clinicians to identify and treat radiation-related exposures in order to produce more scientifically based and appropriate public health responses to radiation emergencies.
- Continue funding for eight state health departments and two local health departments through a cooperative agreement to address the public health consequences of climate change and its implications on human health, with an emphasis on vulnerable populations.
- Fund up to ten states through a cooperative agreement to contribute to the private well water surveillance initiative to identify exposures, assess well monitoring coverage, evaluate regional water issues, and identify and prioritize areas for research.
- Continue to fund research on the environmental causes of foodborne and waterborne diseases via the Environmental Health Specialist Network (EHS-Net) grant program to reduce morbidity and mortality from environmentally-related illnesses, as well as build capacity in state public health agencies that improves the practice of environmental health through evidence-based interventions.

Performance: CDC investigates the human health effects of hazards in the environment such as water and air pollutants, radiation, and hazards related to natural and other disasters. CDC's performance measure 6.1.2, tracks the number of completed studies that examine the health effects from environmental health hazards. The results of these studies help CDC develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their health consequences. Since 2005, CDC has met or exceeded their performance targets for this measure.

CDC distributes emergency radiation preparedness toolkits to clinicians and public health workers to improve their ability to identify and respond to a radiological event. From FY 2005 to FY 2009, CDC distributed 10,000 of these toolkits to clinicians and/or healthcare providers. (Measure 6.H)

Program Description and Recent Accomplishments: CDC’s environmental health activities include climate change, radiation studies and preparedness, as well as programs to ensure that drinking water is safe and to strengthen the nation’s core environmental health services.

Recent accomplishments include:

- Enhanced emergency response capacity and local public health climate policies in Austin, TX through collaboration with Travis County Health Department and other partners to integrate environmental public health indicators associated with climate change into local climate mitigation plans.
- Awarded approximately $1,700,000 in FY 2010 to the Environmental Health Specialist Network (EHS-Net) for research and interventions to address environmentally-related foodborne and waterborne illnesses. The awards were provided through seven research awards ($175,000 average award) and four practice awards ($135,000 average award). In addition, a comprehensive five-year evaluation plan for the EHS-Net was developed to assess the baseline infrastructure, implementation process, performance, and impact of the EHS-Net program in each participating state.

National Environmental Public Health Tracking Network

The FY 2012 request of $32,141,000 for the National Environmental Public Health Tracking Program, including $9,000,000 from the Affordable Care Act Public Health and Prevention Fund, is $1,027,000 below the FY 2010 level. These combined funds to states and cities will continue to build local tracking networks and works to develop and expand the National Environmental Health Tracking Network.

In FY 2012, CDC will:

- Expand and maintain local surveillance systems in 23 states and New York City for non-infectious health conditions and environmental hazards with new content areas, additional years of data for existing content areas, and new training tools and resources for all users. CDC will support state and local health departments through a five-year cooperative agreement.
- Continue implementing the Tracking Network Secure Portal to support collaboration among grantees and other partners; integrate health, exposure, hazard, and other data; share tools and best practices; and develop content for the Tracking Network Public Portal. Specifically, CDC 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.
- Provide and facilitate the use of modeled air quality [ozone and particulate matter] developed by CDC and EPA for counties without air quality monitors on at least 15 state/local tracking networks in order to provide measures of potential population exposure.

Performance: Measuring amounts of hazardous substances in our environment, assessing changes over time and geography, and understanding how they may cause illness are critical functions to environmental public health. Environmental public health tracking systems that capture accurate exposure and outcome data can facilitate public health efforts to prevent and control disease and disability linked to environmental exposures. CDC has made progress in meeting the performance measure that monitors public health actions undertaken (using environmental public health tracking data) to prevent or control potential adverse health effects from environmental exposures. Since FY 2002, state and local public health officials have used this surveillance system to implement almost 98 data-driven public health actions to prevent adverse health effects from environmental exposures. Specific health actions include analyzing area cancer rates at the request of a concerned citizen, providing data and testimony to inform carbon monoxide detector legislation, and identifying trends of increasing pre-term births in a particular county and notifying county health officials. (Measure 6.C)

Program Description and Recent Accomplishments: The National Environmental Public Health Tracking Program funds states and cities to build local tracking networks and works to develop and expand the National Environmental Health Tracking Network. The national and state tracking networks provide information about health effects, environmental hazards, exposures, and data on other factors that help put the relationships between exposures and health effects in context. The program provides over 75 percent of its budget to fund state and local health departments, university public health programs, and nongovernmental organizations.

Recent accomplishments include:

- Expanded the scope of the National Environmental Health Tracking Network to include four new content areas: modeled air data for ozone and particulate matter ($PM^{2.5}$) carbon monoxide mortality, reproductive health outcomes, and birth defects. The modeled air data are unique to the National Environmental Health Tracking Network and provide information that has never been available to the public in this format.

- Funded the Iowa Department of Public Health to join the National Environmental Health Tracking Network for five years.
- Established four collaborative projects to examine the link between air quality and birth outcomes such as low birth weight; heat and hospitalization and deaths from 12 health outcomes; lead in air and childhood blood lead levels; and, air quality and hospitalization from asthma and heart attacks.

Healthy Home and Community Environments

CDC's FY 2012 request of $32,674,000 for Asthma and Healthy Homes/Childhood Lead Poisoning is $33,045,000 below the FY 2010 level for administrative savings and programmatic savings through the new consolidated approach. Prior to FY 2012, CDC maintained separate budget lines for the National Asthma Control Program (NACP) and the Healthy Homes/Childhood Lead Poisoning Prevention Program. In FY 2012, CDC will begin to develop a strategy to integrate these two programs into the "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 transition to this new, coordinated 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, mold, safe drinking water, and the absence of smoke and carbon monoxide detectors.

Although home-based interventions address a multitude of diseases, such as asthma, reducing the burden of asthma requires comprehensive asthma control. Effective comprehensive asthma control includes assessment and monitoring asthma severity and control, proper medications, educating patient in self-management skills, and controlling exposure to other indoor and outdoor environmental factors that can worsen asthma. This is consistent with the National Institute of Health's Guidelines for the Diagnosis and Management of Asthma. The key intervention is to increase use of inhaled corticosteroids, something that will be facilitated through expansion of coverage through the Affordable Care Act.

In FY 2012, CDC will:

- Reduce NACP funded states from 36 to 15 or fewer for comprehensive asthma control programs that implement effective interventions that reduce asthma-related morbidity and mortality, and support state-based surveillance systems to monitor progress.
- Maintain collection and analysis of asthma surveillance through efforts to:
- Produce state-level adult asthma prevalence rates for detailed subgroups in 50 states, three territories (Puerto Rico, Guam, and the Virgin Islands), and the District of Columbia, through funding the Behavioral Risk Factor Surveillance System. Coverage will be expanded for asthma treatment through the Affordable Care Act.
    - Generate national-level data on asthma attacks, asthma management, days of work or school lost, emergency room visits, and hospitalizations due to asthma using existing data available from the National Center for Health Statistics.
    - Produce detailed state and local data about the health and experiences of persons with asthma through funding the Asthma Call-back Survey.

- Reduce funded recipients from 40 to 34 to implement Healthy Homes programs.
- Achieve savings by 42 percent among the 34 Healthy Homes programs.
- Provide software and technical assistance to deploy the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS), which gathers information related to health hazards in homes, to an additional nine states. However, CDC will no longer provide funding to support and maintain HHLPSS. States which adopt the system will be required to support it.

Performance: CDC is revising measures to develop a more consolidated approach. CDC estimates the total direct cost of asthma at $2,489 per person per year for the period 2002-2007 (calculated in 2009 dollars).[12] For the most recent year available, 2007, the total direct cost of asthma to society was $41 billion.[13] NIH's Guidelines for the Diagnosis and Management of Asthma highlight four components of quality asthma care: assessment and monitoring asthma severity and control, medications, educating patient in self-management skills, and control of environmental factors and conditions that can worsen asthma. CDC works to implement these NIH guidelines to improve health outcomes and reduce costs associated with asthma exacerbation. Asthma self-management education, delivered to high-risk adult asthma patients in the clinic, by phone and at home, as needed, has resulted in 54 percent fewer hospital readmissions and 34 percent fewer ED visits, saving $36 in health care costs and lost work days for every $1 spent.3 (Measure 6.2.4, 6E)

Most people spend over 90 percent of their time indoors and about half of every day inside their homes. CDC works to increase the number of state and local lead and health healthy homes programs working to mitigate health hazards in homes such as lead poisoning hazards, secondhand smoke, asthma triggers, radon, mold, drinking water, and the absence of smoke detectors (Measures 6.2.2, 6 D). In FY 2009, CDC funded 40 state and local lead and healthy homes programs to reduce exposures to lead and other health hazards in homes (Measure 6D). CDC continues to be strongly committed to eliminating childhood lead poisoning as a public health issue. In FY 2006, CDC exceeded the target and will continue to reduce these numbers until childhood lead poisoning is eliminated (Measures 6.2.2, 6D). The Agency proposes to revise PART Measure 6.2.2 in the FY 2013 President's budget request.

Program Description and Recent Accomplishments: In FY 2010, over 80 percent of CDC's National Asthma Control Program (NACP) funding supported 34 states, Washington D.C., Puerto Rico, and six asthma partner organizations to identify and track those affected by asthma; build partnerships; and develop and implement science-based interventions and best practices to reduce asthma-related morbidity and mortality and address the impact of indoor and outdoor air pollution on people with asthma. NACP funding has lead to a variety of successful interventions.

Recent accomplishments include:

- Provided assistance in the development of an Illinois Green Construction Executive Order requiring all state-funded road construction projects in non-attainment areas to use clean construction practices, such as cleaner fuels in and pollution controls on their diesel vehicles and equipment.

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[12] Link, S., Nurmagambetov, T. The Current Costs of Asthma in the US. Published January 2011 *Issue of J of Allergy and Clinical Immunology*.
[13] Castro M, et al. "Asthma Intervention Program Prevents Readmissions in High Health Care Users," *American Journal of Respiratory Critical Care*. 2003;168:1095-1099.

- Developed a training curriculum to integrate environmental asthma management into pediatric health care by the Hawaii Community Rural Asthma Control Program. Community health centers use this curriculum to train providers and community health workers to educate patients and their families about asthma triggers and how to assess their environment for those triggers.
- 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, indoor air assessments for persons with asthma, and assistance to schools and daycares to improve building air quality.
- Improved primary care for asthma and other chronic health conditions in Rhode Island using a team approach, quality improvement methods, and electronic patient tracking.
- Implemented policies to prevent idling of motor vehicles on school property in New Hampshire and requiring annual school indoor air quality assessments.

The Healthy Homes program uses a holistic approach to address multiple health hazards in homes, which can include secondhand smoke, asthma triggers, radon, mold, and vector-borne diseases. This approach provides a more efficient system, compared with addressing a single disease or condition in the home. The Healthy Homes program focuses on the goal of eliminating lead poisoning as a public health issue. CDC provides state and local public health professionals with the training and tools necessary to address a broad range of housing deficiencies and hazards associated with unhealthy and unsafe homes. Implementation of a new cooperative agreement will support trained staff at the state and local levels to identify and systematically mitigate and eliminate health and safety hazards in the home environment. In FY 2010, the program provided approximately 85 percent of its budget to fund state and local health departments, university public health programs, and nongovernmental organizations.

Recent accomplishments include:

- Trained nearly 8,000 public health workers in the principles of Healthy Homes. This includes identifying and implementing low-cost, reliable methods to reduce health and safety risks in substandard housing.
- Deployed a new data surveillance system, the Healthy Homes and Lead Poisoning Surveillance System, to gather information related to health hazards in homes. The system was deployed in 15 states in 2010 and will be deployed to 10 additional states in 2011.
- Funded six state and local Healthy Homes pilot projects through the Building Strategic Alliance for Healthy Housing cooperative agreement. Grantees funded under this announcement are developing a comprehensive healthy housing plan or enhancing an existing plan. In the first year, grantees developed strategic plans for addressing health-related housing problems within their jurisdictions and are working to implement these plans.

IT INVESTMENTS

CDC invests in numerous Information Technology (IT) systems that support strategic and performance outcomes. The 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. The National Environmental Public Health Tracking Network is a tracking system that integrates data about environmental hazards and exposures with data about diseases that are possibly linked to the environment. This system allows 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 regulatory and public health actions to prevent or control environment-related diseases. Another

IT investment, Project Profile, is a centralized database management tool and reporting mechanism that captures all ATSDR projects and activities. The database is a tool that captures strategic planning and performance, current project status, and final agency expenditures. (For funding information, see Exhibit 53)

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activity is included:

- Environmental Public Health Tracking Network – $9,000,000

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Environmental Health	**$181,004**	**$216,030**	**$137,715**	**-$43,289**
- Environmental Health Laboratory	$43,419	$43,425	$43,425	+$6
- Environmental Health Activities	$71,866	$106,876	$61,616	-$10,250
- ACA/PPHF (non-add)	$0	$35,000	$9,000	+$9,000
- Asthma/Healthy Homes/Lead	$65,719	$65,729	$0	-$65,719
- Healthy Homes and Community Environment	$0	$0	$32,674	+$32,674

MEASURES TABLE[1,2]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 (Efficiency)[3]	FY 2010: 42% (Target Exceeded)	29%	N/A	N/A
Long Term Objective 6.1: Determine human health effects associated with environmental exposures.				
6.1.1: Number of environmental chemicals, including nutritional indicators that are assessed for exposure of the U.S. population (Output)	FY 2010: 323 (Target Met)	323	323	Maintain
6.1.2: Complete studies to determine the harmful health effects from environmental hazards (Output)	FY 2010: 25 (Target Met)	25	25	Maintain
6.1.3: Number of laboratories participating in DLS Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements (i.e., newborn screening, chronic diseases [diabetes, cholesterol], environmental health [blood lead, cadmium and mercury], and nutritional indicators) (Output)	FY 2010: 974 (Target Met)	974	974	Maintain
Long Term Objective 6.2: Prevent or reduce illnesses, injury, and death related to environmental risk factors.				
6.2.2: Number of children under age 6 with elevated blood lead levels (Outcome)	FY 2008: 255,000 (Target Not Met)	79,000	67,000	-12,000
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 2008: 43% (Target Not Met)	49%	51%	+2

[1]Measures and targets have not yet been adjusted for the new consolidated approach. These changes will be made in the FY 2013 President's Budget request.
[2] Targets reflect impact of funding from ACA/PPHF.
[3] Cost savings reported for 2010 is reflective of cost factors that have been adjusted to align with the cost factors used to establish the original baselines that were developed under the previous CDC Coordinating Center structure.

OTHER OUTPUTS[1, 2]

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
6.A: New or improved methods developed for measuring environmental chemicals in people	FY 2010: 9	9	9	Maintain
6.B: Laboratory studies conducted to measure levels of environmental chemicals in exposed populations	FY 2010: 52	52	52	Maintain
6.C: Public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures	FY 2009: 14	15	15	Maintain
6.D: Funded state and local lead and healthy homes programs to reduce exposures to lead and other health hazards in homes	FY 2009: 40	46	34	-12 (26%)
6.E: State, local, and territorial programs funded to develop or implement asthma control plans	FY 2009: 36	36	15	-21 (58%)
6.F: States assisted with screening newborns for preventable diseases	FY 2010: 50	50	50	Maintain
6.G: State and local health departments with comprehensive strategic plans that identify and address the health impacts of climate change	FY 2009: 11	10	10	Maintain
6.H: Emergency radiation preparedness toolkits provided to clinicians/ public health workers	FY 2005 – FY 2009: 10,000	1,000	1,000	Maintain
6.I: State or local health departments supported to integrate prospective Health Impact Assessments (HIAs) into transportation and community design and or planning	FY 2010: 4	8	8	Maintain

[1]Measures and targets have not yet been adjusted for the new consolidated approach. These changes will be made in the FY 2013 President's Budget request, pending Congressional acceptance of the proposal.
[2]Targets reflect impact of funding from ACA/PPHF.

INJURY PREVENTION AND CONTROL

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$148,790	$148,812	147,501	-$1,289
PHS Evaluation Transfers	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$0	$0	$20,000	+$20,000
Total	**$148,790**	**$148,812**	**$167,501**	**+$18,711**
FTEs	184	185	185	+1

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $167,501,000 for injury prevention and control, including $20,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of $18,711,000 above the FY 2010 level for unintentional injury prevention activities. Injuries can occur throughout the lifespan and their consequences may prevent individuals from living their life to the fullest potential. In the area of unintentional injury prevention, CDC works to ensure that all people have safe and healthy homes, places to play, and transportation options to address injuries, including those resulting from motor vehicle crashes, older adult falls, prescription drug overdoses, childhood drowning and traumatic brain injuries, and responding to blast injuries and other traumatic events. CDC also works to promote safe homes, communities, and relationships by addressing the prevention of intentional injuries from intimate partner violence, child maltreatment, youth violence, suicide, and sexual violence.

CDC documents the burden, identifies ways to prevent injuries from occurring, and disseminates interventions grounded in a rigorous science base. CDC also builds state-based injury prevention capacity; tracks and monitors injury trends at the national, state, and local levels; identifies and addresses emerging issues; and collaborates with partners to develop programmatic interventions and publicize key research findings. These prevention efforts aim to reduce the $406 billion that injuries cost the United States in medical costs and lost productivity each year.

AUTHORIZING LEGISLATION

General Authorities[*]: PHSA §§ 214, 215, 301, 304, 307, 308D, 310, 311, 317, 319, 319D, 327, 352, 399G, 1102, Bayh-Dole Act of 1980 (P.L. 96-517)

Specific Authorities: PHSA §§ 391, 392, 393, 393A, 393B, 393C, 393D, 394, 394A, 399P, Traumatic Brain Injury Act of 2008 (P.L. 110-206), Safety of Seniors Act of 2007 (P.L. 110-202), Family Violence Prevention and Services Act § 413 (42 USC Sec. 10418)

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$136,118,000
FY 2008	$134,837,000
FY 2009	$145,242,000
FY 2010*	$148,790,000
FY 2011CR	$148,812,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Intentional Injury Prevention

CDC's FY 2012 request of $105,796,000 for intentional injury prevention is $380,000 below the FY 2010 level for administrative savings. The request includes $41,850,000 for Rape Prevention Education (RPE) activities. CDC works to advance the science base and prevent injuries by better understanding risk factors for violent acts, building capacity at the state and local level to address prevention, and identifying effective interventions to prevent instances of violence before they occur. Funding for intentional injury prevention, also known as violence prevention, supports multiple areas of prevention including the prevention of intimate partner violence (IPV), sexual violence (SV), teen dating violence (TDV), youth violence and child maltreatment.

In FY 2012, CDC will:

- Continue to fund 14 Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) grantees. DELTA grantees provide technical assistance, training, and resources to communities to build IPV prevention capacity and increase local access to prevention programs.
- Provide support to Rape Prevention Education (RPE) grantees to implement interventions that target risk factors for SV and provide technical assistance to grantees. RPE awards formula grants to all states and territories for sexual violence prevention programs conducted by rape crisis centers, state sexual assault coalitions, and other public and private nonprofit entities.
- Fund an initiative to prevent teen dating violence and promote respectful, nonviolent dating relationships among adolescents living in high-risk, inner-city communities. The initiative, Dating Matters: Strategies to Promote Healthy Relationships, will develop, implement, and evaluate a comprehensive approach to promoting respectful, nonviolent teen dating relationships by utilizing evidence-based practices and experiences.
- Implement Striving To Reduce Youth Violence Everywhere (STRYVE), a national public health strategy to prevent youth violence. STRYVE systematically addresses youth violence by coordinating and implementing comprehensive, evidenced-informed youth violence prevention strategies, programs, and policies within communities.

Performance: CDC's leadership in violence prevention programming has increased the recognition that violence is a preventable public health problem. Preventing violence before it starts not only reduces physical and emotional injuries, but may also reduce the risk of involvement in other high-risk behaviors such as smoking, alcohol abuse, drug use, and risky sexual activity. Multiple interventions have demonstrated a reduction in rates of intimate partner violence and sexual violence. For example, an evaluation of the Safe Dates Program reported 56 to 92 percent less dating violence in the time period following participation than individuals in the control group.

Additionally, models like Triple P (Positive Parenting Program) have been documented to reduce rates of substantiated abuse cases, child out-of-home placements, and child injuries. An evaluation of Triple P, in nine counties in South Carolina, estimated that Triple P could translate annually into nearly 700 fewer cases of child maltreatment, 240 fewer out-of-home placements, and 60 fewer children with injuries requiring hospitalization or emergency room treatment for every 100,000 children under age eight. If implemented statewide in South Carolina alone, Triple P could prevent nearly 1,000 cases of sustained child maltreatment. (Measures 7.B and 7.1.2a)

Program Description and Recent Accomplishments: CDC focuses on preventing violence before it occurs by: gathering population data and identifying risk and protective factors; evaluating prevention strategies to identify effective approaches; and encouraging adoption of prevention strategies based upon the best available science. CDC supports the development of comprehensive approaches that address violence at the individual, relationship, community and societal levels.

Recent accomplishments include:

- Developed an intimate partner violence prevention plan for each DELTA state. Each grantee drafted their prevention plan, identifying the state's unique needs, resources, and progress moving forward. Through CDC's support, DELTA program grantees are currently implementing these plans to establish data systems, implement evidence-based programs, and build key partners' primary prevention capacity.
- Implemented a statewide roll out and began evaluation of Green Dot. Green Dot is a model for identifying approaches in the SV prevention field that are ready for evaluation and broader implementation. The RPE program in Kentucky led the adaptation and implementation of Green Dot for high schools, a promising approach to sexual violence prevention that capitalizes on peer and cultural influence. High school students from a wide variety of peer groups participate in a program that equips them to integrate bystander prevention approaches into existing relationships and daily activities. Based on promising results, the Kentucky RPE program is now implementing a statewide roll out of the Green Dot approach for all high schools in the state. A more rigorous evaluation is also underway.
- Developed Uniform Definitions of Child Maltreatment and Recommended Data Elements to inform data collection and analysis efforts. Consistent definitions were needed to monitor the incidence of child maltreatment, examine trends over time and compare jurisdictional differences. Uniform definitions ensure the ability to compare data across states and enable an effective response to the problem of child maltreatment.

National Violent Death Reporting System

The FY 2012 request of $5,008,000 for the National Violent Death Reporting System (NVDRS) reflects an increase of $1,465,000 above the FY 2010 level. NVDRS gathers and links state-level data from state and local agencies, medical examiners, coroners, police, crime labs, and death certificates to answer questions about trends and patterns of violence.

In FY 2012, CDC will:

- Provide increased funding and technical assistance for up to 24 states participating in NVDRS to ensure the collection of high-quality and timely data on violent deaths.

Performance: In FY 2010, CDC supported 18 states to ensure collection of accurate and comprehensive data on violent deaths. NVDRS built upon other investments by linking existing data systems to create a more robust understanding of the circumstances surrounding violent deaths and how they can be prevented. Participating states used NVDRS data to prioritize program and policy interventions and

leverage additional funding to implement programs. For example, the Wisconsin Burden of Suicide report outlining the Wisconsin NVDRS findings served as a call to action for the Safe Communities of Madison/Dane County. The suicide data encouraged stronger support of suicide prevention and led to a public education campaign during Suicide Prevention Week. (Measure 7.A)

Program Description and Recent Accomplishments: NVDRS is a state-based surveillance system that pools information about the "who, when, where and how" of data on violent deaths, unintentional firearm injury deaths, and deaths of undetermined intent to better understand the "why." Capturing data is critical to: link records on violent deaths that occurred in the same incident, to help identify risk factors for multiple homicides or homicides-suicides; provide timely preliminary information on violent deaths; describe in detail the circumstances that may contribute to a violent death; and better characterize perpetrators, including their relationships to victim(s). This provides an opportunity to link detailed information – from death certificates, police reports and coroner or medical examiner reports – into a usable, anonymous database. NVDRS pulls together data on child maltreatment fatalities, intimate partner homicides, homicides, and suicides that are critical to inform decision makers and program planners about the magnitude, trends, and characteristics of violent deaths so that appropriate prevention efforts can be put into place. It also facilitates the evaluation of state-based prevention programs and strategies.

NVDRS data is publicly available through CDC's WISQARS NVDRS module, which provides customizable searches based on factors including demographics, victim/suspect relationship, and method of injury.

Recent accomplishments include:

- Released a report on poison-related suicides in Virginia using NVDRS data. This report was designed to raise awareness about poison-related suicidal behavior in Virginia and to provide information to prevent future deaths. For example, the report found that groups at-risk for non-fatal poisoning suicide attempts may not be the same groups at risk to die by poison-related suicide.
- Brought together a group of public health professionals in South Carolina to form the Suicide Prevention Task Force. Using data provided by South Carolina's National Violent Death Reporting System and the framework from CDC's National Strategy to Prevent Suicide, the task force crafted a plan to provide a unified strategy for suicide prevention efforts at all levels. Fueled by data from NVDRS, the plan gained momentum and was ultimately signed by the governor.
- Utilized NVDRS data in New Jersey to create maps of crime and violent death statistics. Building on the state GIS program already in use, New Jersey currently uses the comprehensive data provided by NVDRS to create a number of different informative maps, which geographically illustrate violent death prevalence and type. The system creates a map for a variety of different factors — intimate partner deaths where there was prior knowledge of abuse by county, or suicides by school district — which improves our understanding of violence and improves prevention efforts.

Unintentional Injury Prevention

CDC's FY 2012 request of $50,986,000 for Unintentional Injury Prevention activities, including $20,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an increase of $19,089,000 above the FY 2010 level. Using existing mechanisms including the Core program, $20,000,000 from the Affordable Care Act Prevention and Public Health Fund will further enhance current unintentional injury prevention activities, and include the implementation and evaluation of evidence-based interventions in areas such as motor vehicle safety, older adult falls, unintentional drug overdoses and drowning among states and tribes.

In FY 2012, CDC will:

- Fund and provide technical assistance for up to 30 states through the Core program to augment existing injury and violence prevention activities and data collection, in addition to building state level capacity for injury and violence prevention.
- Fund a subset of Core states to implement evidence-based programs and strategies and conduct policy activities in the areas of motor vehicle safety, older adult falls and injury surveillance. One program to be funded will work to integrate evidence-based older adult fall prevention practices and interventions with the community and clinical care practice. Through these programs, CDC plans to identify the most cost-effective interventions to replicate widely. (Funding may also be provided from the intentional injury prevention line to support the implementation of violence prevention activities through this program).
- Continue piloting a graduated driver licensing (GDL) planning guide in eight states. CDC developed the GDL Planning Guide to assist states in implementing, improving, and enforcing their state's GDL policy. Based on the outcome of the pilot, planning guides for other topics will be developed and used to strengthen state motor vehicle policies.
- Fund eight American Indian/Alaska Native tribal organizations to tailor, implement, and evaluate evidence-based interventions to reduce motor vehicle related injuries in their communities.
- Coordinate with partner organizations to develop and distribute tools to practitioners, decision-makers, and the public on program and policy strategies to improve motor vehicle safety and support older adult falls and TBI prevention efforts.

Performance: Unintentional injury prevention is cost effective. The average $52 child safety seat saves $2,200 in injury costs. GDL systems have been shown to save $500 per young driver. Adherence to treatment guidelines for severely-injured TBI patients costs $2,618 per person but saves $11,280 in medical costs. Furthermore, three falls prevention programs have demonstrated positive returns on investments: $1.80 per dollar invested for Tai Chi: Moving for Better Balance; $1.10 for Stepping On; and $0.80 for the Otago Exercise Program when delivered to individuals 80 years and older. (Measure 7.D)

Strategies and tools developed and implemented as part of the unintentional injury program decrease the risk of being involved in a motor vehicle crash, suffering an unintentional injury and can reduce severity of the impact of injuries. For example, raising seat belt use to 100 percent nationally would save 4,000 lives and increasing the proper use of child safety seats would reduce the risk of death in passenger cars by 71 percent for infants and by 54 percent for toddlers aged one to four years. These interventions are also recommended by the Guide to Community Preventive Services.

CDC's unintentional injury prevention efforts have contributed to increased availability of accurate and timely surveillance data to help identify injury priorities, strong partnerships, and the availability of evidence-based interventions and policies. CDC's Core-funded states are more likely to have an established state injury prevention program with these elements and have access to essential injury-focused data sets than non-Core funded states. CDC's Core-funded states have used the increased focus on injury prevention that they have garnered at the state level to leverage substantial additional resources for injury prevention. Additionally, the comprehensive injury data reporting supported by the Core program provides states with critical information needed to quantify the burden of injury, prioritize activities and allocate resources to the leading causes of injury in their state, and understand the impact of interventions on the burden of injuries and deaths. (Measure 7.C)

Program Description and Recent Accomplishments: Since 2005, CDC's Core program has assisted states in building capacity for injury prevention; in collecting, analyzing, and using injury data to inform planning and policy; and implementing and evaluating injury and violence prevention interventions. Strong, comprehensive injury and violence prevention programs ensure that states have the capacity to implement and evaluate interventions, that state data are available to guide programmatic and policy interventions, that efforts are coordinated among partner organizations focused on injury and violence prevention, and that state and local policy changes are identified to support injury prevention. Funded Core states also form advisory committees to develop and prioritize injury plans and collaborate with partner groups to advance injury prevention. As a result, several funded states have been able to increase statewide support for injury prevention policies and have data systems that are able to monitor the impact of injury prevention policies. In 2009, the Core program expanded to provide additional funding to several Core program states to implement select evidence-based injury and violence prevention activities. For example, in FY 2009 and FY 2010 a subset of Core states received additional funding to develop child injury plans and others to address older adult falls prevention by increasing access to effective falls prevention programs, which are often limited due to scarce resources at the state and local level.

In addition to Core, CDC's unintentional injury prevention funding supports the development and dissemination of effective evidence-based interventions to prevent unintentional injuries before they occur, thus promoting safe and healthy homes, places to play and transportation options. Unintentional injuries, such as drowning, falls, unintentional drug overdoses, and motor-vehicle crash-related injuries, account for more than 120,000 deaths, over 27 million non-fatal injuries and over one-third of all emergency department (ED) visits each year. Motor vehicle crash-related injuries alone are the leading cause of death for people ages one to 34, four million people sustain injuries that require an emergency department visit each year. CDC uses a science-based, public health approach to promote safe recreation and travel and develop recommendations for effective programs and policies in such areas as booster seat and seatbelt use, older adult falls prevention, GDL, preventing bicyclist and pedestrian injuries, traumatic brain injuries and reducing risk levels for American Indian/Alaska Native and other high risk populations.

Recent accomplishments include:

- Provided additional funding to five states to increase their capacity and ability to contribute to policy change, dissemination, adoption and implementation. For example, the New York State Injury Program developed a series of topic specific policy materials for local health departments to strengthen prevention efforts across the state, the first of which focused on falls prevention.
- Funded a tribal motor vehicle safety program in Arizona with the San Carlos Apache Tribe. The program led to a 46 percent increase in seat belt use, a 52 percent increase in total DUI arrests and a 29 percent overall decrease in motor vehicle crashes.
- Supported the Massachusetts injury prevention planning group (PINN), in partnership with the Sports Legacy Institute, to raise awareness of the dangers of sports-related concussions and other head injuries among youth. Using existing CDC "Heads Up" concussion kits, grantee enlisted the resources of their PINN members from hospitals to distribute kits to ER and trauma staff, host in-service trainings for medical personnel, and to sponsor coaches' clinics for youth and high school coaches and parent volunteers in their host communities.

Injury Control Research Centers

CDC's FY 2012 request of $10,719,000 for the Injury Control Research Centers (ICRCs) is $2,000 above the FY 2010 level. The ICRCs conduct research and identify critical gaps in knowledge of injury risk and protective factors to inform the development of effective programs and interventions.

In FY 2012, CDC will:

- Fund 11 ICRCs across the U.S. to conduct injury and violence prevention research.
- Coordinate with ICRCs to identify gaps in injury and violence prevention research, advance injury prevention research projects and translate findings into policy and programmatic interventions that can be implemented at the state and community level.

Performance: ICRCs play important roles in the area of injury and violence prevention by conducting research to build the science base and by supporting the implementation of injury and violence prevention programmatic, communication, and policy work. For example, researchers from the Johns Hopkins Bloomberg School of Public Health, Center for Injury Research and Policy conducted a nationwide review of Graduated Driver Licensing (GDL). The results of their study demonstrated that the most restrictive GDL programs were associated with a 38 percent reduction for fatal crashes and a 40 percent reduction for injury crashes among 16 year olds. These results have been successfully used by scientists and advocates in several states to educate lawmakers about the importance of strengthening state GDL systems.

Program Description and Accomplishments: CDC-funded ICRCs are located in universities and medical centers across the United States and conduct research in all three core phases of injury control (prevention, acute care, and rehabilitation). ICRCs also serve as training and technical assistance centers as well as information centers for the public. Many ICRCs have strong relationships with state and local health departments, and their work has informed program and policy interventions at the state and local level.

Recent Accomplishments include:

- Demonstrated, through a grant with the University of North Carolina Injury Prevention Research Center, that rental units and non-working smoke alarms were the two leading factors in residential fire fatalities. Partnering with the State Fire Service and other organizations to increase smoke alarm distribution and use resulted in a 25 percent decrease in fire fatalities in North Carolina over a five year period.
- Developed a database for case data for domestic abuse homicide and suicides in Iowa gathered by the Iowa Domestic Abuse Death Review Team. Data had previously been gathered and analyzed by hand, which was very time-consuming. This project also forged the beginning of a public health preceptorship for students from the College of Public Health who are interested in violence prevention. The data collected as part of this project will also help to inform future programmatic and policy efforts.

IT INVESTMENTS

CDC invests in information technology to improve its tracking and monitoring of both injury trends and funding expenditures. NEXT, a budget tracking tool, tracks and monitors the planning and execution of injury center projects. WISQARS, a web-based data query system, provides customizable information on injury burden to the public via data tables and maps. This system was expanded to include cost modules in FY 2010. (See Exhibit 53)

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activity is included:

- Unintentional Injury Prevention – $20,000,000

Using existing mechanisms including the Core program, $20,000,000 from the Affordable Care Act Prevention and Public Health Fund will further enhance current unintentional injury prevention activities, and include the implementation and evaluation of evidence-based interventions in areas such as motor vehicle safety, older adult falls, unintentional drug overdoses and drowning among states and tribes.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Injury Prevention and Control	**$148,790**	**$148,812**	**$167,501**	**+$18,711**
- Intentional Injury	$106,176	$106,192	$105,796	-$380
- Unintentional Injury	$31,897	$31,901	$30,986	+$19,089
- ACA/PPHF (non-add)	$0	$0	$20,000	+$20,000
- Injury Control Research Centers	$10,717	$10,719	$10,719	+$2

MEASURES TABLE[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Long Term Objective 7.1: Achieve reductions in the burden of injuries, disability, or death from intentional injuries for people at all life stages.				
7.1.1: Reduce youth homicide rate by 0.1 per 100,000 annually (Outcome)	FY 2008: 7.4 / 100,000 (Target Exceeded)	8.7 / 100,000	8.6 / 100,000	-0.1 / 100,000
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) [2]	FY 2009: 7.4% (Target Not Met but Improved)	N/A	N/A	N/A
7.1.2b: Reduce victimization of youth enrolled in grades 9-12 as measured by: the 12-month incidence of dating violence (Outcome) [2]	FY 2009: 9.8% (Target Not Met but Improved)	N/A	N/A	N/A
7.1.2c: Reduce victimization of youth enrolled in grades 9-12 as measured by: the 12-month incidence of physical fighting (Outcome) [2]	FY 2009: 31.5% (Target Not Met but Improved)	N/A	N/A	N/A
Long Term Objective 7.2: Achieve reductions in the burden of injuries, disability or death from unintentional injuries for people at all life stages.				
7.2.2: Achieve an age-adjusted fall fatality rate among persons age 65+ of no more than 69.6 per 100,000 (Outcome)	FY 2007: 47.1 (Target Not Met)	52.1	56.5	+4.4
7.2.3: Decrease the estimated percent increase of age-adjusted fall fatality rates among persons age 65+ years (Outcome)	FY 2007: -1.05% reduction (Target Not Met)	9.56% reduction	9.73% reduction	+0.17

[1]Targets do not reflect impact of funding from ACA/PPHF.
[2] YRBS is data source for 7.1.2 measures and reports biennially. The next target due for reporting will be 2011.

OTHER OUTPUTS[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
7.A: National Violent Death Reporting System	18	18	≤ 24	≤ 6
7.B: Rape Prevention and Education Grants	57	57	57	Maintain
7.C: Core State Injury Program	30	30	≤30	Maintain
7.D: Graduated Drivers License Policy Pilot Project	4	4	8	+4

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

STATE TABLE

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DISCRETIONARY STATE/FORMULA GRANTS			
	Core State Injury Program	National Violent Death Reporting System	Rape Prevention and Education
STATE/TERRITORY	FY 2010 Actual	FY 2010 Actual	FY 2010 Actual
Alabama	$0	$0	$598,939
Alaska	$0	$160,578	$86,224
Arizona	$125,185	$0	$690,682
Arkansas	$0	$0	$360,876
California	$125,185	$0	$4,548,094
Colorado	$253,012	$216,027	$579,341
Connecticut	$125,185	$0	$459,139
Delaware	$0	$0	$107,241
District of Columbia	$0	$0	$78,860
Florida	$125,185	$0	$2,147,097
Georgia	$125,185	$257,561	$1,100,801
Hawaii	$125,185	$0	$164,696
Idaho	$0	$0	$175,742
Illinois	$0	$0	$1,668,900
Indiana	$0	$0	$818,171
Iowa	$0	$0	$394,820
Kansas	$125,185	$0	$362,909
Kentucky	$125,185	$219,561	$544,515
Louisiana	$125,185	$0	$601,854
Maine	$125,185	$0	$173,172
Maryland	$125,185	$251,999	$712,927
Massachusetts	$125,185	$239,398	$854,224
Michigan	$0	$264,182	$1,335,949
Minnesota	$360,670	$0	$662,339
Mississippi	$0	$0	$383,850
Missouri	$0	$0	$753,007
Montana	$0	$0	$123,158
Nebraska	$125,185	$0	$231,739
Nevada	$125,185	$0	$270,284
New Hampshire	$0	$0	$167,918
New Jersey	$0	$200,968	$1,131,369
New Mexico	$125,185	$186,070	$246,198

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DISCRETIONARY STATE/FORMULA GRANTS			
	Core State Injury Program	National Violent Death Reporting System	Rape Prevention and Education
STATE/TERRITORY	**FY 2010 Actual**	**FY 2010 Actual**	**FY 2010 Actual**
New York	$125,185	$0	$2,548,970
North Carolina	$0	$257,593	$1,082,391
North Dakota	$0	$0	$88,256
Ohio	$125,185	$273, 727	$1,525,802
Oklahoma	$250,839	$207,720	$465,236
Oregon	$125,185	$199,322	$461,287
Pennsylvania	$125,185	$0	$1,650,337
Rhode Island	$163,012	$130,966	$142,757
South Carolina	$275,005	$215,930	$540,526
South Dakota	$0	$0	$103,368
Tennessee	$125,185	$0	$765,664
Texas	$0	$0	$2,800,649
Utah	$213,022	$206,786	$301,811
Vermont	$125,185	$0	$83,769
Virginia	$125,185	$242,684	$952,103
Washington	$125,185	$0	$793,126
West Virginia	$0	$0	$244,779
Wisconsin	$125,185	$218,686	$721,941
Wyoming	$0	$0	$68,356
State Sub-Total	**$4,520,000**	**$3,676,031**	**$37,876,163**
America Samoa	$0	$0	$0
Guam	$0	$0	$22,827
Marshall Islands	$0	$0	$11,238
Micronesia	$0	$0	$18,682
Northern Marianas	$0	$0	$11,740
Puerto Rico	$0	$0	$513,291
Palau	$0	$0	$0
Virgin Islands	$0	$0	$18,299
Territory Sub-Total	**$0**	**$0**	**$596,077**

OCCUPATIONAL SAFETY AND HEALTH

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$282,883	$282,925	$0	-$282,883
PHS Evaluation Transfers	*$91,724*	*$91,724*	*$259,934*	*+$168,210*
ACA/PPHF	$0	$0	$0	$0
EEOICPA – Mandatory	$55,358	$55,358	$55,358	$0
Total	**$429,965**	**$430,007**	**$315,292**	**-$114,673**
FTEs	865	857	450	-415

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $315,292,000 for Occupational Safety and Health, including $55,358,000 in mandatory funding for the Energy Employees Occupational Illness Compensation Program, is an overall decrease of $114,673,000 below the FY 2010 level for administrative savings, and reflects the elimination of the Education and Research Centers program ($24,370,000) and the Agricultural, Forestry and Fishing sector of the National Occupation Research Agenda ($23,000,000). The request also reflects the elimination of World Trade Center discretionary budget authority ($70,712,000) as a result of the passage of the James Zadroga 9/11 Health and Compensation Act of 2010. In the FY 2012 request, all Occupational Safety and Health resources will come from the PHS Evaluation fund and used to support Occupational Safety and Health activities such as nanotechnology, mining, and personal protective technology.

Despite improvements in workplace safety and health, 14 workers in the United States die each day from injuries sustained at work and 134 die from work-related diseases. 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 for the prevention of 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, education, and training in the field of occupational safety and health (OSH). CDC also works with partners to focus research on developing effective products, translating research findings into practice, targeting dissemination efforts, and evaluating and demonstrating the effectiveness of these efforts in improving worker safety and health. Funding supports both intramural and extramural research to prevent or reduce work-related injury and illness, provides guidance to and builds capacity in the OSH community, and supports activities required in the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

EEOICPA is a mandatory federal program that provides compensation to employees or survivors of employees of Department of Energy 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 also estimates occupational radiation exposure for certain cancer cases, considers and issues determinations on petitions for adding classes of workers to the Special Exposure Cohort and provides administrative support to the Advisory Board on Radiation and Worker Health. CDC conducts dose reconstructions to estimate an employee's occupational exposure to radiation, and the Department of Labor uses these estimates in making compensation determinations.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 306, 307, 308d, 310, 311, 317, 319, 327, 352, 399G, 1102, Bayh-Dole Act of 1980 (P.L. 96-517)

Specific Authorities: PHSA §§ 317A, 317B, 399M, 2695; Occupational Safety and Health Act of 1970 §§20-22, P.L. 91-596 as amended by PL 107-188 and 109-236 (29 USC 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 USC 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 USC 902); Bureau of Mine Act, as amended by P.L. 104-208 (30 USC 1 note, 3, 5); Workers' Family Protection Act § 209, P.L. 102-522 (29U.S.C.671(a)); 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 USC 2682, 2685); Prohibition of Age Discrimination Act (29 USC 623 note and 29 USC 657); Ryan White HIV/AIDS Treatment Extension Act of 2009 § 2695, P.L. 111-87 (42 USC 300ff-131), James Zadroga 9/11 Health and Compensation Act (2010), P.L. 111-347.

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization………………………………………………………………. Expired/Indefinite

Allocation Methods: Direct Federal/Intramural; Competitive Grant/Cooperative Agreements; Contracts; Other

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$315,100,000
FY 2008	$381,954,000
FY 2009	$360,059,000
FY 2010*	$429,965,000
FY 2011CR	$430,007,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment, and do not include EEOICPA.

BUDGET REQUEST

National Occupational Research Agenda

CDC's FY 2012 request of $101,528,000 for the National Occupation Research Agenda is $15,878,000 below the FY 2010 level, reflecting an elimination of the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupation Research Agenda (NORA) ($23,000,000) and for administrative savings. The request includes an increase of $7,044,000 for Nanotechnology, compared to the FY 2010 level. The FY 2012 request reflects the elimination of budget authority for all Occupational Safety and Health programs. NORA is funded entirely through PHS Evaluation transfer.

The National Academy of Sciences (NAS) conducted a systematic review of the AgFF program from 2006-2007 and found that issues within the AgFF program significantly affect the ability of the program to conduct relevant and effective research that will impact the safety and health of workers in the agricultural, forestry and fishing industries. For example, the NAS stated that the program lacked a single cohesive vision to drive the research agenda and that the lack of consistent leadership, long-term strategic planning, and periodic review of that course led to a piecemeal approach to the research that appeared

disjointed.[14] The NAS also stated that the AgFF program has not always focused on the most appropriate cases and that workers have not always accepted the majority of research contributions. Furthermore, the study also found that "there was little evidence that the research activities, outputs, and intermediate outcomes contributed to the stated end outcomes of reducing workplace injury and illness." CDC does not have authority to regulate Agriculture, Forestry and Fishing hazards, which has in some part led to the difficulty of third parties implementing CDC recommendations and this research is more aligned with the missions' of the Department of Labor (DOL) and/or Agriculture (USDA). DOL and USDA have more direct programs that address these issues and could be in a better place to achieve intended outcomes. For example, the DOL's website contains extensive information on how to improve farm safety and the Occupational Safety and Health Administration has approved more than twenty-five state and U.S. territory plans to adopt standards and enforcement policies related to agricultural farming.

NORA provides guidance to the entire occupational safety and health community on research priorities and moving research findings, technologies, and information into highly effective prevention practices and products adopted in the workplace to reduce work-related injury, illness, and fatalities. NORA research serves ten industry sectors: Construction; Healthcare and Social Assistance; Manufacturing; Mining; Oil and Gas; Services; Public Safety; Wholesale and Retail Trade; and Transportation, Warehousing and Utilities. NORA research also addresses the occupational health implications of nanotechnology.

Nanotechnology

The FY 2012 request of $16,544,000 for Nanotechnology is $7,044,000 above the FY 2010 level. The increased resources will enable CDC to pursue strategic, collaborative research to fill knowledge gaps about the hazards and risks related to occupational exposure to carbon nanotubes and other engineered nanoparticles utilized within various industries.

In FY 2012, CDC will:

- Continue to conduct research to reduce uncertainty about the health effects of nanotechnology. This research includes laboratory-based toxicological studies to evaluate adverse pulmonary, cardiovascular, central nervous system and dermal effects of exposure to nanoparticles.
- Continue to develop 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.
- Continue to develop and assess the use and impact of guidance materials for businesses and government agencies to develop effective risk management programs.

Performance: Nanoparticles have numerous applications to areas ranging from medicine to manufacturing. Based on an inventory of manufacturer-identified nanotechnology goods, an independent research firm has projected that by 2014, nearly $2.6 trillion worth of manufactured goods will incorporate nanotechnology and involve millions of workers. Engineered nanoparticles, because of their size and surface area, have the potential to be more toxic than larger particles of the same composition, potentially leading to respiratory and cardiovascular disease, as well as impacting the brain and other organs. While adverse effects from engineered nanoparticles have not occurred in people, CDC laboratory research has recently shown that some nanoparticles, including certain types of nanotubes and metal oxides, can be toxic to the heart and lungs in mice and rats. CDC is working to disseminate its nanotechnology research knowledge through guidance documents that provide scientific recommendations for the safe handling of nanomaterials.

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14 Agricultural, Forestry and Fishing Research at NIOSH, Reviews of Research Programs, National Academies (2008)

Program Description and Recent Accomplishments: CDC's Nanotechnology program mission is to provide national and international leadership in investigating the implications of nanoparticles and nanomaterials for work-related injury and illness and to explore their potential applications in occupational safety and health. CDC works with a variety of partners in academia, safety and health, and government to conduct research and make recommendations on nanotechnology and occupational health 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 include:

- Demonstrated that inhaled carbon nanotubes can penetrate the pleural cavity of mice and have potential for causing mesothelioma and lung cancer.
- Provided guidance to the nanotechnology community by publishing the widely cited Approaches to Safe Nanotechnology, an information exchange document which reviews current knowledge about nanoparticle toxicity, process emissions and exposure assessment, engineering controls, and personal protective equipment.
- Led the first National Nanotechnology Initiative workshop on exposure assessment.

Other Occupational Safety and Health

CDC's FY 2012 request of $158,406,000 for Other Occupational Safety and Health is $28,083,000 below the FY 2010 level for administrative savings, and reflects the elimination of the Education and Research Centers program ($24,370,000).

The Education and Research Centers (ERCs) were developed to carryout Section 21 of the Occupational Safety and Health Act to create "education programs to provide an adequate supply of qualified personnel to carryout the purposes of the Act." These activities were created in the mid-1970s to provide seed money for academic institutions to develop or expand occupational health and safety training programs for specialists currently practicing in the field. The original programmatic plan was to provide money for five years for institutions to develop and/or expand existing occupational health and safety training programs and for the grantees to become self-sustaining over time. This original goal has been met. In addition, CDC does not have a means for tracking the location and employment of ERC graduates or the percentage of graduates who work at health departments and there is no data on the number of graduates that have entered the field. The ERCs overlap activities offered by the Department of Labor's Occupational Safety and Health Bureau through their Outreach Training Program, Resource Center Loan Program, and Training Institute Education Centers. All of the ERC grants are jointly funded by CDC and the Academic Center grantee. CDC contributions cannot exceed 50 percent of individual faculty and professional staff total salaries and fringe benefits. The budget request only eliminates the CDC portion. The non-federal portion of the ERCs could still be continued and the private sector could also increase funds for these activities. In FY 2012, Other Occupational Safety and Health is funded entirely through the PHS Evaluation Transfer. CDC's other occupational safety and health activities include mine research, surveillance, exposure assessment and outreach, as well as other critical areas such as personal protective technology. CDC's personal protective technology program focuses on research, standards, development, respirator certification, surveillance and outreach.

Mine Research

CDC's FY 2012 request of $53,144,000 for Mining Research, which is level with FY 2010, will continue to help eliminate mining fatalities, injuries, and illnesses through research and prevention.

In FY 2012, CDC will:

- Continue to target high-priority issues affecting mineworkers, such as respiratory diseases, noise-induced hearing loss, and traumatic injuries as defined by stakeholder and surveillance data. The Mining Research Program operates by a goal-driven strategic plan with performance measures and addresses a range of safety and health issues in addition to disaster prevention and response.
- Continue the research and development of enhanced communication and tracking systems for underground mining operations including the design, construction and testing of these systems at a specialized underground laboratory.

Performance: CDC Mining funds target a 50 percent reduction in reducing occupational illnesses due to respirable coal dust overexposure by 2014. Recent trend data from 2009 indicates a 30 percent reduction in coal dust exposure, which is more than double the 13.7 percent reduction rate achieved in 2003, the first year these data were tracked. (Measure 9.2.2c)

Program Description and Recent Accomplishments: The goal of CDC's Mine Safety and Health Research program is to eliminate mining fatalities, injuries, and illnesses through research and prevention. Collaborations with stakeholders, which encompass industry, labor, and government, provide 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 communication and tracking, oxygen supply, and refuge alternatives.

Recent accomplishments include:

- Published a report of mine investigations entitled, Recommendations for a New Rock Dusting Standard to Prevent Coal Dust Explosions in Intake Airways, which details the extensive testing and experimentation which have resulted in CDC's new recommendation for 80 percent total incombustible content inside of intake airways. As a result, the Mine Safety and Health Administration will implement new safety standards.
- Developed new and innovative monitoring and instrument technology for the underground coal mining industry to address high-priority areas for miner safety and health. The two most notable developments are the Coal Dust Explosibility Meter (CDEM) and the Personal Dust Monitor (PDM). The mining community adopted both technologies, which will diffuse within the underground coal mining industry within a few years. In addition, the international mining community also plans to adopt both technologies.
- Completed and published several best practices and guidelines for improved mineworker safety and health. Most notable include handbooks entitled Best Practices for Dust Control in Metal/Nonmetal Mining (2010), and Best Practices for Dust Control in Coal Mining (2010) as well as an information document entitled the Control and Monitoring of Methane Gas on Continuous Mining Operations (2010).

Personal Protective Technology

CDC's FY 2012 requests $16,828,000 for Personal Protective Technology is level with FY 2010. The mission of CDC's Personal Protective Technology (PPT) program is to prevent work-related injury, illness, and death by advancing the state of knowledge and application of PPT.

In FY 2012, CDC will:

- Continue to 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 personal protective equipment (PPE), with an emphasis on fire fighter PPE ensembles, PPE for health care workers, escape technology for miners, and expanding intervention initiatives in agriculture.
- Continue to develop PPT standards and test methods, including a standard to improve combination self-contained/air-purifying respirators, and a standard on inward linkage requirements for half-mask filter face-piece respirators to provide increased assurance that these respirators can be expected to protect the user against inhalation exposures when properly donned and used.
- Enhance 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 identification of factors contributing to the misuse of the NIOSH certification label.

Performance: CDC's PPT program funds target research, standards development, respirator certification, surveillance, and outreach. An estimated 20 million workers use PPE on a regular basis to protect themselves from job hazards. PPE protects workers 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. Improvements and changes in PPT are realized in the form of new standards and regulations, revisions and alterations to existing standards, the subsequent availability of PPE that complies with the standards and regulations, and demonstrations of PPE use.

Program Description and Recent Accomplishments: The mission of CDC's PPT program is to prevent work-related injury, illness, and death by advancing the state of knowledge and application of PPT. CDC conducts the only federal program responsible for conducting occupational PPT research and certification of respiratory protection and evaluating product performance. CDC promotes improvements in PPT through research, surveillance, standard development and certification activities as well as worker training programs and the development of guidance documents on the selection, maintenance, and use of PPT. Funding for CDC's PPT efforts is both intramural and extramural.

Recent accomplishments include:

- 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.
- Developed and revised evidence-based consensus standards. In FY 2010, CDC's research on the scientific phenomenon of stored thermal energy in fire fighter protective clothing ensembles led to the adoption of an American Society for Testing and Materials International (ASTM) consensus standard and recommendation to incorporate the ASTM standard into a National Fire Protection Association standard.

World Trade Center

CDC's FY 2102 request for Occupational Safety and Health reflects a decrease of $70,712,000 below the FY 2010 level in discretionary budget authority for the World Trade Center (WTC) Program. This decrease is a result of the passage of the James Zadroga 9/11 Health and Compensation Act of 2010. In FY 2012, $313,000,000 in mandatory funding, which is reflected in the HHS' budget for the Office of the Secretary, will be provided for the WTC program. HHS, along with NIOSH will implement the provisions of the statute to provide monitoring and treatment benefits. The program supports a health registry to assess the extent and persistence of physical and/or mental health conditions. In addition, the program will conduct and/or support epidemiologic and other research studies on physical and mental health conditions that may be related to the September 11, 2011 terrorist attacks.

IT INVESTMENTS

CDC invests in several information technology systems that support Occupational Safety and Health Research. These technologies include surveillance systems, radiation dose construction systems, and systems that track project-related administrative activities. 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. OSH systems include: Data Mart (Division of Safety Research's Online Injury Surveillance Data Systems), Information Systems Development, 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, Respiratory Disease Surveillance System, and the Underground Coal Mining System. (For funding information, see Exhibit 53.)

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

There are no activities included.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Occupational Safety and Health	**$429,965**	**$430,007**	**$315,292**	**-$114,673**
- NORA	$117,406	$117,406	$101,528	-$15,878
- World Trade Center	$70,712	$70,723	$0	-$70,712
- All Other Occupational Safety and Health Research	$186,489	$186,520	$158,406	-$28,083
- Mining Research (non-add)	$53,705	$53,705	$53,144	-$561
- Healthier Workforce Center (non-add)	$5,036	$5,036	$5,036	$0
- EEOICPA – Mandatory	$55,358	$55,358	$55,358	$0

MEASURES TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
9.E.2: Reduce consumption of utilities (e.g., gas, electric, water) (Efficiency)	FY 2009: $2.79 / sq. ft. (Target Exceeded)	$3.16 / sq. ft.	$3.11 / sq. ft.	$-0.05 / sq. ft.
Long Term Objective 9.1: Conduct research to reduce work-related illnesses and injuries.				
9.1.1: Progress in implementing activities in areas of occupational safety and health most relevant to future improvements in workplace protection (Outcome)	FY 2010: Develop implementation plans in response to National Academies recommendations. (Target Met)	Develop implementation plans in response to National Academies recommendations	100% 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
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 2009: A) 189 research and intervention projects were based on tracking information (Target Met)	A) Evaluate the role that tracking information had in designing research and intervention projects.	A) Evaluate the role that tracking information had in designing research and intervention projects.	Maintain
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 2009: B) 51 intervention projects used tracking information to demonstrate the success of intervention strategy (Target Met)	B) Identify the role that follow-up tracking information can have in assessing the success of interventions.	B) Identify the role that follow-up tracking information can have in assessing the success of interventions.	Maintain

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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)	2009: C) 6.3 adults per 100,000 with elevated blood lead levels (Target Met)	C) Heighten use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%	C) Reduce the prevalence rate of elevated blood lead levels in adults by 3% (from the previous year value)	Maintain
9.1.3: Percentage of NIOSH programs that will have completed program-specific outcome measures and targets in conjunction with stakeholders and customers (Output)	FY 2010: 90% (Target Met)	90%	100%	+10
Long Term Objective 9.2: Promote safe and healthy workplaces through interventions, recommendations and capacity building.				
9.2.1: Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation (Output)	FY 2010: 85% (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 15to 17 (Outcome)	FY 2010: 3.8 / 100 FTE (Target Exceeded)	4.2 / 100 FTE	4.1 / 100 FTE	-0.1 / 100 FTE
9.2.2b: Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors: Reduction of fatal injuries among youth 15 to 17 (Outcome)	FY 2010: 2.7 / 100,000 FTE (Target Not Met)	2.5 / 100,000 FTE	2.6 / 100,000 FTE	+.1 / 100,000 FTE
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 2010: 98% (Target Exceeded)	90%	90%	Maintain
9.2.3a: Reduce occupational illness and injury as measured by: Percent reductions in respirable coal dust overexposure (Outcome)	N/A	N/A	N/A	N/A
9.2.3b: Reduce occupational illness and injury as measured by: Percent reduction in fatalities and injuries in roadway construction (Outcome)	FY 2003: 154% (Target Met)	N/A	N/A	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
9.2.3c: Reduce occupational illness and injury as measured by: Percent of firefighters and first responders' access to chemical, biological, radiological, and nuclear respirators (Outcome)	FY 2003: >7% (Target Met)	N/A	N/A	N/A

OTHER OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
9.A: Safety and Health Patent Filings	FY 2010: 5	5	5	Maintain
9.B: Certification Decisions Issued for Personal Protective Evaluated for Certification	FY 2010: 588	300	300	Maintain
9.C: Estimated Academic Graduates	FY 2010: 544	460	205	-255
9.D: Health Hazard Evaluations/Fatality Assessment and Control Evaluations	FY 2010: 278	350	350	Maintain
9.E: Number of Research Articles Published in Peer-Review Publications	FY 2010: 325	250	250	Maintain
9.F: Agricultural Centers	FY 2010: 8	9	0	-9
9.G: Research Grants	FY 2010: 166	170	135	-35
9.H: Training Grants	FY 2010: 48	50	20	-30
9.I: Number of States Receiving Public Assistance[1]	FY 2010: 37	35	35	Maintain

[1]This number does NOT include awards CDC/NIOSH made to Washington, D.C, Puerto Rico, and Canada

PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$160,582	$160,601	$205,942	+$45,360
PHS Evaluation Transfer	*$247,769*	*$247,769*	*$217,674*	*-$30,095*
ACA/PPHF	$32,358	$82,000	$70,000	+$37,642
Total	**$440,709**	**$490,370**	**$493,616**	**+$52,907**
FTEs	798	835	857	+59

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $493,616,000 for public health scientific services (PHSS), including $70,000,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an overall increase of $52,907,000 above the FY 2010 level. The FY 2012 request includes a reduction of $11,558,000 for CDC's genomics program and an increase of $23,200,000 over the FY 2010 level for health statistics. The FY 2012 request dedicates $5,000,000 within existing PHS Evaluation resources for activities authorized under Section 4301 of the Affordable Care Act.

The FY 2012 request includes $161,883,000 from PHS Evaluation resources to fully fund the National Center for Health Statistics surveys. Funds will increase sample sizes for some surveys 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. The FY 2012 request includes funding to fully support electronic birth records in all 50 states.

In FY 2012, PHSS funds will support scientific service, expertise, skills, and tools within CDC and with external stakeholders in support of the Agency's efforts to promote health; prevent disease, injury and disability; and prepare for emerging health threats. PHSS leads the development, adoption, and integration of sound public health surveillance and epidemiological practices at CDC based on advances in health statistics, epidemiology, informatics, laboratory science, scientific education and professional development and genomics. Investment in these areas at the local, state and national levels is essential to creating a public health system in which limited resources can be used most effectively; targeted interventions can be applied to those most in need; and, public health programs can be designed to identify the health, health risks, and health problems within and among populations.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 307, 317, 319, 1102

Specific Authorities: PHSA §§ 241, 306, 308, 317G, 318, 319A, 353, 391, 399V, 778, 2315, 2341, 2521; P.L. 107-347, Title V (44 USC 3501 note); Intelligence Reform and Terrorism Prevention Act of 2004 § 7211 (P.L. 108-458); Food, Conservation, And Energy Act of 2008 § 4403 (7 USC 5311a); P.L. 101-445 § 5341 (7 USC 5341); The Affordable Care Act of 2010 (P.L. 111-148)

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization…………...…………………………………………………...Expired/Indefinite

Allocation Method: Direct Federal/Intramural; Competitive Grants/Cooperative Agreements; Contracts

FUNDING HISTORY

Fiscal Year	Amount*
FY 2007	N/A
FY 2008	N/A
FY 2009	N/A
FY 2010*	$440,709,000
FY 2011CR	$490,370,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Health Statistics

CDC's FY 2012 request of $161,883,000 for Health Statistics reflects an increase of $23,200,000 above the FY 2010 level. As one of the designated Federal Statistics Agencies and the principal health statistics agency, the National Center for Health Statistics (NCHS) supports the evaluation of HHS' policies and programs through collection of data on births and deaths, health status and health care. Funds will be used to increase sample sizes for some surveys and to 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. The FY 2012 request includes funding to fully support electronic birth records in all 50 states.

In FY 2012, CDC will:

- Continue to support surveys and data collection systems, which provide critical data that represent the society's health in various areas, by:
  - Conducting the National Health Interview Survey (NHIS). The NHIS provides information annually on the health status and health care utilization of the U.S. civilian, non-institutionalized population through confidential household interviews. The NHIS is the core of HHS' data collection and is the nation's largest household health survey providing data for the analysis of a broad range of health and health care topics across racial and ethnic populations.
  - Conducting the National Health Care Surveys, a family of nationally representative health care surveys providing objective, reliable information obtained from providers in physician offices and community health centers, hospital outpatient and emergency departments, and other settings such as long term care facilities and hospitals, about the organizations and providers that supply health care, the services rendered, and the patients they serve.
  - Collecting at least a full 12 months of all public health information on births and deaths from the 57 vital registration jurisdictions (all 50 states, two cities (D.C. and New York), and five territories) through the National Vital Statistics System (NVSS) to provide the nation's official statistics. This information is needed for critical public health purposes. The NVSS provides the most complete and continuous data available to public health officials at the national, state and local levels, and to the private sector.

- Conducting the National Health and Nutrition Examination Survey (NHANES) on a nationally representative sample of 5,000 individuals at 15 U.S. sites. 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. Data are collected using a combination of personal interviews, standardized physical examinations, diagnostic procedures, and lab tests. The program uses Mobile Examination Centers to travel throughout the country to collect this data annually.

- Continue to support data access and dissemination, which provides information to a wide range of users in formats to meet their needs by:
  - Improving data access and dissemination by ensuring data are available in more easily accessible forms through published reports (print and website), pre-tabulated tables with national and state-level data, and interactive data warehouses.
  - Providing detailed charts and tables on health status and its determinants, health care resources, health care utilization, and health insurance and expenditures through publication of Health, United States.
  - Providing mechanisms for researchers to access the full range of data collected by NCHS, while protecting the confidentiality of the respondents and records through the Research Data Center.

- Continue to support data collection methodology research and dissemination in order to provide accurate data in a timely fashion to meet increasing data requirements by:
  - Improving data collection methodologies 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.

Performance: The success of CDC's health statistics activities has been demonstrated by the ability to meet various performance measures. The following indicators help the program measure its ability to provide data that is useful, timely and of high quality:

- Producing data on the Internet in easily accessible forms improves the speed and efficiency with which people access the information. CDC has met its goal of developing at least five new tools, technologies, or web enhancements per year from FY 2003 through FY 2010 and has exceeded the goal for the number of visits to the website. (Measure 8.A.1.3b)

- Assessing the satisfaction of key data users and policy makers drives program improvements. In 2010, CDC conducted a series of informational interviews with Federal Power Users 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. The target of 100 percent Good or Excellent was met. (Measure 8.A.1.1b)

Program Description and Recent Accomplishments: CDC's Health Statistics program is a unique resource for health information and plays a critical role in documenting public health challenges, supporting epidemiologic and biomedical research, and developing health policy. Data from NCHS systems and surveys are used to track changes in health and health care, including CDC, HHS and Healthy People 2010 goals, and help ensure that program interventions achieve the greatest health impact. Furthermore, these data are readily accessible, via the internet, to policymakers, researchers, private industry and the

public to inform stakeholders on health issues including health reform priorities. Funds are distributed through contracts, interagency agreements and cooperative agreements.

Recent accomplishments include:

- Provided data, through the National Health Care Surveys, on the use of electronic medical records (EMR)/electronic health records (EHR) among office-based physicians. Combined data from the 2009 surveys (mail and in-person surveys) showed that 48.3 percent of physicians reported using all or partial EMR/EHR systems in their office-based practices; about 21.8 percent of physicians reported having systems that met the criteria of a basic system; and about 6.9 percent reported having systems that met the criteria of a fully functional system, a subset of a basic system. Comparing preliminary estimates for 2010 (based on mail survey data only) with these 2009 estimates, the percentage of physicians reporting having systems that met the criteria of a basic or fully functional system increased by 14.2 percent and 46.4 percent respectively.
- Provided the first analysis of state variations in teen birth rates by race and Hispanic origin this year from the National Vital Statistics System. The analysis showed that: 1) the highest rates for non-Hispanic black teenagers were reported in the upper Midwest and in the Southeast, 2) rates for non-Hispanic white and Hispanic teenagers were uniformly higher in the Southeast and lower in the Northeast and California, and 3) the state variation in overall teen birth rates is due to variation in both race and Hispanic origin-specific birth rates and in the population composition for each state.
- Demonstrated, through data from the National Health and Nutrition Examination Survey, the percentage of obese Americans at greater risk of a variety of health problems. In addition, NHANES recently published data on obesity and socioeconomic status in adults, children and adolescents. Results show that: among men, obesity prevalence is generally similar at all income levels, however, higher income non-Hispanic black and Mexican American men are more likely to be obese than low-income men; higher income women are less likely to be obese than low-income women, but most obese women are not low-income; low-income children and adolescents are more likely to be obese than their higher income counterparts, but the relation is not consistent across race and ethnicity groups; and between 1988-1994 and 2007-2008 the prevalence of childhood obesity increased at all income levels and education levels.

Surveillance, Epidemiology, Informatics, and Laboratory Science

CDC's FY 2012 request of $213,794,000, including budget authority and PHS Evaluation transfer funds, for Surveillance, Epidemiology, Informatics, and Laboratory Science is a decrease of $18,054,000 below the FY 2010 level for administrative savings. The FY 2012 request also reflects a significant reduction to the genomics budget. An additional $35,000,000 will be provided from the Affordable Care Act Prevention and Public Health Fund for Healthcare Statistics. CDC's FY 2012 request also includes $15,000,000 for Community Preventive Services Task Force/Community Guide, of which $10,000,000 is from the Affordable Care Act Prevention and Public Health Fund. A description of these activities can be found in the Affordable Care Act Prevention and Public Health Fund section below.

CDC's Surveillance, Epidemiology, Informatics, and Laboratory Science activities strengthen and support the detection, alerting, response, monitoring and analysis of key public health information, which is translated and shared among public health entities across the United States.

Behavioral Risk Factor Surveillance System

CDC's FY 2012 request of $15,190,000 for the Behavioral Risk Factor Surveillance System (BRFSS) is a decrease of $148,000 below the FY 2010 level for administrative savings. BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Prior to FY 2012, funding for this activity was provided through the Chronic Disease and Health Promotion budget.

In FY 2012, CDC will:

- Move from random digit dialing (RDD) Telephone Format to Mixed Mode Survey Protocols by increasing the proportion of completed cell phone interviews to an appropriate representation relative to cell phone coverage within each state.
- Use information gathered from an initial pilot of mail follow-up surveys to institutionalize the use of mail surveys in all 50 states and territories. This will allow surveys to reach non-respondents of the landline telephone survey.
- Develop an integrated small area estimation system that will allow the production of survey risk factor and health condition estimates for a more comprehensive area than those available in the Selected Metropolitan/Micropolitan Area Risk Trends from the Behavioral Risk Factor Surveillance System (SMART BRFSS).
- Leverage existing mental health surveillance data and establish a CDC-wide mental health surveillance group.

Performance: In FY 2010, CDC funded all 50 states, the District of Columbia (DC), Puerto Rico, the Virgin Islands, Guam, and Palau to conduct surveillance through BRFSS whose data is used by all levels of public health to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. BRFSS was able to meet emergent surveillance needs to monitor behavioral aspects of disparate public health events such as the 2009 H1N1 pandemic and mental health effects associated with the Deepwater Horizon oil spill emergency.

Program Description and Recent Accomplishments: CDC's Behavioral Risk Factor Surveillance System, established in 1984, is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. It is the largest continuously conducted telephone survey in the world, with more than 400,000 interviews annually. States are funded through cooperative agreements to collect ongoing information on behaviors that place health at risk, medical conditions, access to health care, and use of health care services. For many states, it is the only available source of timely, accurate data on health-related behaviors. A wide range of public health officials, researchers, and key decision makers at all levels rely on BRFSS data, which are a critical part of the public health response to local, state and national health problems.

CDC will continue to design and conduct innovative pilot studies to advance the current BRFSS methodology, provide a foundation for the implementation of future methodologies (i.e., use of cell phone and address-based sampling and multilingual surveillance), and maintain this increasingly complex surveillance system that serves the needs of multiple programs while adapting to changes in communications technology, societal behaviors, and population diversity.

Recent accomplishments include:

- Provided 2009/2010 H1N1 vaccination coverage estimates and racial/ethnic differences for key target groups (high-risk adults, health care personnel, pregnant women). State-specific data provided by CDC was used by states to evaluate their progress towards achieving 2009/2010 H1N1 vaccination objectives and to design targeted communications campaigns regarding availability of the vaccine. Data from the BRFSS was used by state health officials to compare local and city health districts' H1N1 vaccination rates to estimates of nationwide and regional H1N1 vaccination rates.
- Provided rapid response to the Deepwater Horizon oil-spill emergency through the implementation of a stand-alone BRFSS-like survey to monitor the mental and behavioral health variables in the adult population in Gulf coast counties affected by the Gulf oil spill. The survey includes questions taken from the ongoing BRFSS as well as additional questions from standardized, validated instruments designed to measure anxiety, depression, and potential stress-associated physical health effects.
- Collected over 400,000 completed BRFSS interviews which provided necessary sample size for the derivation of local level estimates of the prevalence of behavioral risk factors for 283 metropolitan/micropolitan statistical areas. Resultant state and local level data were made publicly available for use by public health stakeholders, agencies, researchers, and the media.

Other Surveillance Activities

CDC's Public Health Surveillance Program assures that timely, accurate and reliable public heath surveillance information is integrated and accessible for decision making. Because of their cross-CDC utility, the BRFSS and several other surveillance systems and activities such as the National Electronic Disease Surveillance System (NEDSS), Biosurveillance Coordination and BioSense are managed within the Public Health Surveillance Program. This allows for leveraging of data sources expertise and new opportunities from increasing automation of healthcare records.

Biosurveillance Coordination and BioSense are funded through the Public Health Preparedness and Response (PHPR) budget line. A description of these programs, their activities and accomplishments is included within the PHPR narrative. NEDSS is funded through the PHSS budget line.

In FY 2012 CDC will:

- Provide leadership in the adoption of standards-based interoperable systems, which are critical for an efficient national strategy.
- Provide resources to state and local health departments for required personnel, training and equipment.
- Use electronic laboratory reporting (ELR) infrastructure to integrate public health laboratory and epidemiologic investigations.

Performance: CDC's work in public health surveillance focuses on establishing public health networks at the state, local and regional levels that have the capability to measure the burden of disease; identify populations at high-risk; identify new or emerging health concerns; monitor trends in the burden of diseases; provide a basis for epidemiologic research; and serve as a guide to the planning, implementation, and evaluation of programs to prevent and control disease, injury or death at the state and local level.

NEDSS continues to make progress in assisting public health reporting jurisdictions (i.e, states, D.C., territories, large metropolitan areas) to share information for routine surveillance and outbreak response.

Publication of case notification message specifications enables public health reporting jurisdictions to generate messages using a common set of standards and specifications. By December 2010, there were four case notification message specifications published. Guides were available for tuberculosis (TB), varicella, arboviral conditions, and generic conditions. Currently, 53 of 60 TB reporting jurisdictions are in production with the TB case notification message (increased from five in 2009); 26 of 40 for the varicella case notification message; five for the generic message; and, one state in production for the arboviral message.

Program Description and Recent Accomplishments: CDC's Public Health Surveillance Program advances the science and practice of surveillance by managing various surveillance systems with cross-CDC utility and developing new information sources, analytic methods, and tools for addressing common and emerging public health challenges while contributing to emergency preparedness and response. The program aims to provide an essential service to CDC programs and health departments that rely on data from surveillance systems and serve as a focal point for answering common questions on addressing challenges in coordinating surveillance.

NEDSS improves the nation's ability to identify, monitor, and investigate diseases and conditions of public health importance, by enabling public health agencies to use information technology more effectively. NEDSS works by: 1) providing leadership in the adoption of standards-based interoperable systems, which are critical for an efficient national strategy; 2) developing and supporting key tools for collecting, exchanging and analyzing information; 3) providing resources to state and local health departments for the required personnel, training and equipment; and 4) using electronic laboratory reporting (ELR) infrastructure to integrate public health laboratory and epidemiologic investigations.

CDC has deployed the NEDSS Base System (NBS) application in 16 states. NBS is an integrated electronic disease surveillance system, which has the capability to receive standards-based ELR. Two states and one jurisdiction are expected to go in to production in FY 2011. The NBS provides public health jurisdictions with a reference implementation of NEDSS policy and standards.

Epidemiology

CDC's efforts within the Epidemiology and Analysis Program Office ensure the targeted application of public health sciences to improve population health through research, methods development, consultation, practice, training, education, and technical assistance. The office focuses on several critical areas including contributing to Health through Prevention by providing expertise in the development of scientific content for the Guide for Community Preventive Services; disseminating timely, useful health information; and, developing innovative methods for the collection, analysis and communication of public health surveillance information.

In FY 2012, CDC will:

- Increase the number of Guide to Community Preventive Services (Community Guide) systematic reviews from an average of six per year to 15 per year. The reviews will strengthen the evidence base and practice of prevention and contribute to health improvements through improved knowledge and informed decision making about what works in preventing disease, disability, injury and death.
- Extend the reach of the Morbidity and Mortality Weekly Report (MMWR), CDC's premier scientific publication, by building bridges to partners and constituents in state and local health departments; enhancing global partnerships with colleagues overseas; bridging the gap between public health and clinical medicine; and reaching out to colleagues at CDC. The MMWR will expand publications and products, for example, incorporating the Community Guide by linking to their website on podcast scripts and identifying new options for death tables.

- Bring focus to an important public health topic through the CDC Vital Signs Program, a monthly call to action on an important public health topic. CDC fosters collaboration among science, policy and communication experts across the Agency and uses multiple media devices to help public health partners in states and communities better identify and address health problems to improve health in their jurisdiction. Topics include colorectal and breast cancer screening, obesity, alcohol and tobacco use, access to health care, HIV testing, seat belt use, cardiovascular disease, teen pregnancy and infant mortality, healthcare-associated infections, asthma, and food borne disease.
- Inform public health policy development and decision making by enhancing the widely distributed analytic methods capacity currently in existence at CDC with expertise in under-represented disciplines such as econometrics, geospatial analysis and advance statistical and mathematical modeling of disease burden and health impact of natural and manmade risks.
- Connect epidemiology and technology to support scientists throughout CDC, across the nation, and around the world with tools for investigating disease outbreaks and adverse health conditions. Epi Info™ Version 7, a suite of software tools planned for release in September 2011, will include enhancements such as flexible data storage, the ability to import data from external sources such as U.S. Census Bureau and NCHS, self contained data analysis capabilities, and the capacity to create questionnaires to improve the speed and accuracy of data collection.
- Develop a National Public Health Library (NPHL), a world class library and information system allowing for advancements in library science and information management directly enhancing CDC's mission. The NPHL will be based on a state-of-the-art IT infrastructure allowing for streamlined information retrieval and improved access to a broader array of materials such as grey literature and other information repositories. Together with the National Library of Medicine, CDC will take advantage of opportunities to improve access to information for state and local health departments, many with little or no access to public health research and literature to inform public health practice.

Performance: This investment allowed CDC to continue as a world leader in the targeted application of public health sciences to improve population health, including epidemiology, geospatial analysis, computer simulation and mathematical modeling, statistical sciences, health economics, and health policy research. CDC ensured the application of these sciences through consultation, practice, training, education, and the provision of technical assistance to public health partners at the state and local levels and health care and public health practitioners working internationally. In addition, CDC enhanced the dissemination of scientific and public health information to ensure that partners in public health and health care received information about evidence-based public health practices in a timely manner and had the tools necessary to inform decision-making and improve practice at a population level. (Measure 8.B.2)

Program Description and Recent Accomplishments: CDC's Epidemiology and Analysis Program Office develops innovative methods for the collection, analysis and communication of public health surveillance information; provides expertise in the development of scientific content for the Guide to Community Preventive Services (Community Guide); provides statistical, modeling, epidemiologic, and econometric expertise within CDC and to external partners; supports County Health Rankings–Mobilizing Action Toward Community Health (MATCH); and delivers credible, timely information from public health literature to the CDC community and externally to partners through the CDC Public Health Library and Information Center.

Recent accomplishments include:

- Demonstrated that Community Guide reviews are being used to inform decision-making at the national level. The National President of Mothers Against Drunk Driving cited a recent Community Guide review on the effectiveness of ignition interlocks in reducing recidivism among alcohol-impaired drivers during an April 2010 Senate Environment and Public Works Committee hearing on opportunities to improve transportation safety; and the executive committee of the American Automobile Association (AAA) considered the same review during a March 2010 meeting in which they deliberated about whether AAA should officially endorse the expanded use of ignition interlocks.
- Launched CDC Vital Signs in July 2010, publishing a total of three issues during the fiscal year. Each issue received considerable media attention, which facilitated nationwide distribution of the information to key stakeholder groups. CDC also collaborated with the Robert Wood Johnson Foundation to release the first annual County Health Rankings, which ranked the population health of every county of each state in the United States, and provided over 50 percent of the health data and indicators used to determine the rankings.

Informatics

CDC's work in the area of public health informatics and technology supports health and public health practice by advancing better management and use of information and knowledge. The goals of the Public Health Informatics and Technology Program Office are to maximize prevention using health information technology and health information exchange; increase the effectiveness and efficiency of public health agencies by improving their capacity to manage information and knowledge; and, advance and share new knowledge in public health informatics

In FY 2012, CDC will:

- Maximize prevention using Health Information Technology and Health Information Exchange (HITECH) to support outcomes such as improved immunization rates and chronic disease management.
- Increase public health's capability to manage information for more effective and efficient programs, through informatics planning, consultation and technical assistance; standards development and promotion; and services shared by multiple health information systems.
- Advance and share knowledge about how information technology can improve health outcomes.

Performance: One key to better effectiveness and efficiency is that critical information can move between information systems ("interoperability") to be available when and where needed. This requires standardization of data and systems. In FY 2010, 28 states (18 above target) transmitted electronic disease reports according to national standards. (Measure 8.B.1.1) This movement toward interoperable public health systems will be further accelerated by the HITECH Act. CDC worked closely with the Office of the National Coordinator for HIT and CMS to ensure that medicine and public health both use new Federal standards to improve the prevention and management of communicable diseases, chronic disease, disability and injury. For example, CDC funded and provided technical support to 10 state and local jurisdictions to receive electronic lab reports about communicable diseases and 20 jurisdictions to import immunization records from electronic health records (using HITECH funding).

Program Description and Recent Accomplishments: CDC's Informatics Program uses information science and technology to improve the effectiveness and efficiency of programs to prevent disease, disability and death. This is accomplished through the use of electronic information systems to get critical information to those making health decisions or taking action to protect lives. CDC develops policies and

standards for information exchange between healthcare providers, public health agencies and emergency response officials. The Program provides funding and technical support to information management systems across several National Centers and operates critical alerting, messaging, directory, storage and routing systems used across the nation's public health system. The Informatics Program uses regional health information exchanges for surveillance and communication and works with electronic health record systems to provide prevention-oriented decision support for doctors and nurses while they treat patients. The Program also advances the knowledge of public health informatics via cooperative agreements with several university Centers of Excellence and provides information on best practices to the local, state, Federal and global public health workforce via distance learning, publications and conferences.

Recent accomplishments include:

- Received real-time H1N1 influenza intelligence from three multi-state health information exchanges and automated reporting of communicable disease information from Ohio and Utah health systems to public health authorities by CDC-supported systems.
- Improved efficiency in information management including a 50 percent time reduction for the validation of standardized messages and nearly halving contractor labor needs through data warehouse consolidation.
- Certified 43 Public Health Emergency Preparedness Cooperative Agreement awardees for their capability to securely exchange information across jurisdictions (federal, state, territorial, tribal, and local) and to quickly identify health threats, analyze data, communicate alerts, and track the results of public health actions.

Laboratory Science

CDC's Laboratory Science Policy and Practice Program Office provides leadership, coordination, and services to strengthen laboratory science, policy and practice in order to improve laboratory quality and healthcare outcomes. The efforts of this office target CDC and all levels of the national and global healthcare systems.

In FY 2012, CDC will:

- Continue newly planned laboratory informatics activities from FY 2011, including working with internal and external partners to improve electronic transfer and sharing of laboratory data and interoperability of systems.
- Create laboratory-specific training modules for national and international audiences as part of CDC's overall e-learning effort.
- Conduct and evaluate preparedness/response laboratory trainings given by CDC's National Laboratory Training Network (NLTN).
- Develop a plan to maximize cost-benefit and assure scientific integrity for CDC's collection of historical and scientifically valuable biological specimens, known as the CDC and ATSDR Specimen Packaging, Inventory and Repository (CASPIR).
- Manage CDC's Select Agents/Toxins Compliance program and ensure adherence to established security plan and training requirements, biosecurity plan precautions, and maintenance of required secure inventory records in all CDC laboratories.

- Extend the reach and use of CDC's Technology Transfer program by educating CDC scientists, about the importance of making valuable government inventions available to a wide range of users. Increase the number of these inventions that are transferred to the private sector for broader use.

Performance: The newly formed Laboratory Science, Policy, and Practice Program Office brings together several groups from across CDC that have worked extensively to improve laboratory quality and practices. In addition, it creates new and expanded programs targeted on the same goal. The development of quality laboratory standards, both voluntary and regulatory (e.g. CLIA), has made important contributions to the improvement of laboratory practice in the United States. Extensive training for laboratorians has covered a wide range of topics all aimed at improved performance of laboratories. Other efforts have contributed to internal CDC laboratories to ensure that quality and safety practices are followed.

Program Description and Recent Accomplishments: CDC's Laboratory Science Policy and Practice Program Office provides leadership, policy development, technical expertise, and training in quality management systems and practices, and works with public health and private health care partners in improving laboratory practice both nationally and globally. The program conducts practice research on laboratory best practices and develops guidelines and standards to assist laboratories in improving performance. In addition, the program provides direct assistance to CDC laboratories by providing specimen management and repository support, conducting the Select Agent Compliance Program, and managing and stimulating technology transfer.

Recent accomplishments include:

- Reported, through the first nine months of FY 2010, that 70 percent of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses would add these new practices or modify their current practices as a result of the training. Reported that 93 percent of the trained professionals are able to successfully transfer the methodology to their LRN Reference Laboratories and make accurate identifications of the biologic threat agents.
- Licensed the CDC-discovered Novel H1N1 Influenza Virus Test to a commercial entity such that laboratories around the world can acquire the H1N1 laboratory test materials for their communities.

Public Health Workforce and Career Development

CDC's FY 2012 request of $47,939,000 for Public Health Workforce and Career Development reflects an increase of $10,119,000 above the FY 2010 level. The increase will support the CDC Prevention Corps training program. 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. An additional $25,000,000 from the Affordable Care Act Prevention and Public Health Fund will support Public Health Workforce activities. A description of these activities can be found in the Affordable Care Act Prevention and Public Health Fund section below. In FY 2012, CDC will:

- Provide fellowship programs to develop public health skills through service and experiential learning.
- Expand the use of technology to improve access to high-quality public health content for training the health professional workforce.
- Provide instructional design services for innovative e-learning programs and accredit educational activities for continuing education credit for a range of health professions.

- Support the CDC Prevention Corps, a workforce program to recruit and train new talent for assignments in state and local health departments. This new program will also address retention by requiring professional to commit to a designated timeframe in state and local health departments as a condition of the fellowship.

Performance: This investment has allowed CDC to improve public health workforce capabilities for an effective, prepared, and sustainable health workforce to meet emerging public health challenges. Each year, CDC recruits, selects, and trains fellows in critical disciplines of epidemiology, informatics, laboratory, management, prevention effectiveness, preventive medicine, and other emerging areas. These fellows work closely with staff in federal, state and local public health agencies to respond to disease outbreaks and other health threats.

In 2010, CDC achieved the target for Measure 8.B.4.1 with 200 core-funded fellows joining public health programs in local, state, and federal health departments to participate in training in epidemiology or public health leadership management. In 2010, CDC initiated a new measure (Measure 8.B.4.2) to increase the number of CDC trainees in State, Tribal, and Territorial public health agencies and made significant progress with 182 trainees in 2010 in contrast to the 2009 baseline of 119 trainees.

CDC also maintains a Continuing Education (CE) Program which, in 2010, accredited 425 CDC-sponsored offerings and awarded CE credit to physicians, nurses, pharmacists, health educators, veterinarians, and others in over 65,000 course registrations.

Program Description and Recent Accomplishments: CDC's Scientific Education and Professional Development programs ensure the use of best practices for workforce and career-development programs and promote an environment of continuous learning. CDC's fellowship programs provide opportunities to develop public health skills while providing service to state/local health departments and filling critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventive medicine, and management. The fellowships include the Epidemic Intelligence Service (EIS), the Prevention Effectiveness Fellowship Program (PEFP), the Public Health Informatics Fellowship Program, (PHIFP), Preventive Medicine Residency and Fellowship (PMR/F), and the Public Health Prevention Service (PHPS).

CDC's workforce programs operate nationally. Training and continuing education programs leverage use of technology to ensure access to high-quality public health content for all health professionals wherever they are located. Fellows are stationed at CDC or in the field and regardless of where stationed, provide front-line advice and technical assistance in epidemiology, informatics, economics, program management, and policy analysis which strengthens the ability of state and local health departments to respond to public health problems and emergencies and to build connections with the health care system. Funding is currently spent intramurally for salaries and benefits for fellows and program administration. Extramurally, funding is provided through cooperative agreements and contracts to support research, education, academic partnerships, and collaborative activities necessary to meet the program's goal of providing high-quality workforce program.

Recent accomplishments include:

- Responded to 102 requests for epidemiologic assistance from local, state, and international health agencies. EIS officers assigned to state and local health departments conducted over 225 epidemic investigations in their assignment locations.

- Responded to 13 requests from health departments for informatics assistance from PHIFP fellows to develop, evaluate, and implement strategies to manage information systems effectively and efficiently.

- Launched the Learning Connection website to maximize use of technology for access to quality public health learning products for health professionals.

Public Health Genomics

CDC's FY 2012 request of $749,000 for Genomics reflects a decrease of $11,558,000 below the FY 2010 level. CDC recognizes overlap in this area with other Federal agencies and will focus the remaining resources on the implementation of proven applications of genomics to areas of public health importance. In FY 2012, CDC will maintain a core staff to advise CDC leadership, programs and public health partners on emerging genomic applications and issues relevant to public health; helping to ensure that CDC is able to continue to contribute to the public discourse regarding the population health perspective on emerging genomic applications and issues, and that CDC leadership remains aware of genomic applications and issues with the potential to impact public health. Funds could also support convening internal and external stakeholders to identify public health opportunities in genomics.

Performance: Through investment in public health genomics, CDC has provided leadership in identifying and implementing evidence-based practices for genetic tests and family health history tools to improve health and prevent harms through valid and useful genomics clinical and public health practices. CDC's Public Health Genomics program has also expanded the knowledge base supporting evidence-based practices for genetic tests and family health history tools, through the development and dissemination of new EGAPP-sponsored evidence-based reviews and recommendations. (Output 8.C) In FY 2010, CDC funded four cooperative agreements, including two state health departments, to conduct genomics surveillance, education or policy to implement and evaluate evidence-based practices for genetic tests and family health history tools to improve health outcomes. (Output 8.B)

Program Description and Recent Accomplishments: Genomics plays a part in nine of the ten leading causes of death in the United States, including heart disease, cancer, stroke, chronic lower respiratory diseases, diabetes, and Alzheimer's disease. The study of genomics can help us learn why some people get sick from certain infections, environmental factors, and behaviors, while others do not. CDC's Office of Public Health Genomics, established in 1997, will continue to provide public health genomics expertise across the agency and inform agency leadership on genomic applications and issues relevant to CDC's mission; identify and assess genomic applications with the potential for population health impact; and provide public health science expertise to and work with CDC programs, other agencies, and external partners to facilitate the implementation of genomic applications with potential to improve population health.

Recent accomplishments include:

- Funded the Michigan Department of Community Health to increase the number of health plans that have policies consistent with U.S. Preventive Services Task Force recommendations for genetic risk assessment for hereditary breast and ovarian cancer. The number of health plans in Michigan increased from four to nine out of 24, which extended coverage to over 6.3 million Michigan residents.
- Launched the Genomic Applications in Practice and Prevention Knowledge Base (GAPP-KB), an online, centralized resource for information on the validity and utility of genomic applications, including genetic tests and family history, for use in public health and health care. GAPP-KB features the GAPP Finder, a continuously updated, searchable database of genetic tests in transition to practice; PloS Currents Evidence on Genomic Tests, an online, open-access journal for publishing knowledge summaries; and links to published evidence reviews and recommendations.

- Published an analysis of NHANES data finding that incorporating family health history with traditional diabetes risk factors could identify an additional 620,000 individuals in the U.S. population with undiagnosed diabetes without a significant change in the false positive fraction.

IT INVESTMENTS

Due to investments in health information technology (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 Health IT support multiple programs within CDC, and state, local and tribal health departments across the country. Health IT investments create the framework and systems necessary to monitor and track outbreaks, epidemics, and pandemics, such as 2009 H1N1 pandemic influenza, for case counts, distribution and geospatial visualization in near real-time. 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 BioSense, which is an emergency preparedness system to detect disease and provide near real-time situational awareness to all levels of public health, the National Electronic Disease Surveillance System, which is tying together the current myriad, separate disease surveillance systems into a comprehensive solution that facilitates the efficient collection, analysis, and use of data and the sharing of computer software solutions across disease-specific program areas, and the Archival Specimen Tracking and Retrieval Operations system that is used to assure accurate and timely receipt, tracking, shipping, inventory maintenance and provision of ad hoc reporting of the laboratory specimen collections at CDC. IT investments also include the National Vital Statistics System that 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.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activities are included:

- Healthcare Statistics/Surveillance – $35,000,000
- Public Health Workforce – $25,000,000
- Community Preventive Services Task Force/ Community Guide – $10,000,000

Healthcare Statistics/Surveillance

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 Affordable Care Act.

The NHIS will include questions to track the ACA impact on access and utilization of care. The impact on health and health care disparities, including utilization of services such as screening tests and diagnostic and therapeutic procedures, will also be monitored. The increase in the NHIS sample will provide stable estimates for targeted populations. The NAMCS sample of physicians in offices will be expanding to permit greater precision for estimates related to care received for different population groups and with different conditions. Collectively, 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 the National Ambulatory Medical Care Survey and to hospital outpatient departments through the National Hospital Ambulatory Medical Care Survey will be expanding

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. Along with data already collected on intermediate outcomes, these data and resulting analysis will permit monitoring and evaluating goals to increase prevention through health care programs and expanded insurance coverage.

Funding in FY 2012 will also be used to fund the BRFSS to track the impact of the ACA on access to and utilization of health care resources and to evaluate the impact of ACA on prevalence estimates for diseases, health conditions, and risk behaviors for the leading causes of death and disability. The requested funds would cover the cost to: (1) add approximately six questions to the BRFSS yearly cycle to address components of the ACA as they are implemented, (2) apply small area estimation to produce estimates for all U.S. counties, and (3) increase population coverage of the BRFSS by expanding multimode protocol implementation to reach populations currently underrepresented in the landline BRFSS and to produce estimates at state level. The new data in combination with the other information routinely collected by the survey will help establish a timely baseline for the initial ACA provisions and assist in evaluating the effects on a yearly basis. FY 2012 funds will be used to develop, program, and implement this data collection in calendar year 2013.

Public Health Workforce

This investment aims to increase the number and types of competency trained public health professionals and place them in areas of great need, such as state and local health agencies. Funds will be used to develop the capacity of the public health workforce in critical fellowships and other training and education programs; ensure access to high-quality public health learning resources, including e-learning; and increase short-term technical assistance to state and local health agencies in epidemiology, informatics, economics, and policy analysis. This activity will support section 5314, "Fellowship training in public health" of the ACA.

Community Preventive Services Task Force/ Community Guide

The Task Force/Community Guide will focus on working with official Liaison Organizations to the Task Force on the dissemination, adoption, and utilization of Task Force recommendations and findings to inform decision making to improve health through the use of evidence-based interventions. There are more than 28 official Liaison Organizations to the Task Force, which represent various federal agencies, non-governmental organizations, and professional agencies. Dissemination efforts would target agencies and organizations that are working to provide assistance to decision makers in dissemination, adoption, and implementation of Community Guide recommendations in their communities. These Liaison Organizations would work directly with State and Local Health Departments with the intent to begin expanding these activities to Territorial and Tribal health organizations as additional funds are available.

The Task Force/Community Guide will enhance dissemination, adoption and utilization of Task Force recommendations and findings to inform decision making to improve health thorough the use of evidence-based interventions beyond the 28 Official Liaison Organizations, through engagement with the Department of Energy (DOE)/Oak Ridge Institute for Science and Education, CDC Foundation, National Commission on Prevention Priorities (NCPP), Public Health Foundation (PHF), National Public Health Information Coalition (NPHIC), Evidence-Based Practice Centers (EPCs), and Agency for Health Research and Quality (AHRQ). Direct support would also be provided to state and local health departments for targeted dissemination efforts.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Public Health Scientific Support	**$440,709**	**$490,370**	**$493,616**	**+$52,907**
- Health Statistics	$158,541	$168,683	$196,883	+$38,342
- ACA/PPHF (non-add)	$19,858	30,000	$35,000	+$15,142
- Offices of Surveillance, Epidemiology, and Public Health Informatics	$236,848	$258,861	$223,794	-$13,054
- ACA/PPHF (non-add)	$5,000	$27,000	$10,000	+$5,000
- Public Health Workforce and Career Development	$45,320	$62,826	$72,939	+$27,619
- ACA/PPHF (non-add)	$7,500	$25,000	$25,000	+$17,500

MEASURES TABLE[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Health Statistics				
Long Term Objective 8.A.1: Monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers.				
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	FY 2007: 10.8 (Target Unmet)	9.6 months	9.4 months	- 0.2 months
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 2010: 71.3% (Target Not Met but Improved)	Increase satisfied from 67.2% to 72.2% (agree or strongly agree)	Maintain 75.2%	N/A
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 2010: 100% Good or Excellent (Target Met) (Target Met)	Maintain 100% Satisfaction	Maintain 100% Good or Excellent	N/A
8.A.1.1c: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: reimbursable customers (Outcome) [2]	FY 2007: 91% (35% good, 56% Excellent) (Baseline)	N/A	N/A: will not be conducted again until 2016	N/A
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)	FY 2007: 91% (53% Good, 38% Excellent) (Baseline)	Conduct survey/increase Excellent from 38% to 43%	Increase Excellent from 43% to 45%	N/A
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)	FY 2009: 23 (Target Exceeded)	15	20	+5
8.A.1.3a: Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data: Number of improved user tools and technologies (Output)	FY 2010: 7 (Target Exceeded)	5	5	Maintain
8.A.1.3b: Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data: Number of web visits (Output)	FY 2010: 8.7 million (Target Exceeded)	7.5 million	8.5 million	+1.0 million

Surveillance, Epidemiology, and Laboratory Services				
Long Term Objective 8.B.1: Lower barriers to data exchange across jurisdictions for public health surveillance and response.				
8.B.1.1: Increase the number of States that can send electronic messages to CDC in compliance with published standards (Output)	FY 2010: 28 states (Target Exceeded)	10 states	42 states	+32 states
Long Term Objective 8.B.2: Improve access to and reach CDC's scientific health information among key audiences to maximize health impact				
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. Number of subscribers to the Morbidity and Mortality Weekly Report (MMWR) (Outcome)	FY 2010: 130,357 (Target Exceeded)	130,322	135,322	+5,000
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 2010: 256,243 (Historical Actual)	N/A	420,000	N/A
8.B.2.3: Increase the number of annual Community Guide reviews (Output)	FY 2010: 18 (Target Exceeded)	9	15	+6
8.B.2.4: Increase the number of counties/communities that implement evidence-based policies/interventions as a result of their county health ranking (MATCH County Rankings program) (Intermediate Outcome)	FY 2010: 5 (Baseline)	N/A	20	N/A

Long Term Objective 8.B.3: 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.				
8.B.3.1: Evaluate the impact of training programs conducted by the NLTN on laboratory practices (Outcome)	FY 2010: 70% (Target Met)	More than 65% of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses who reported lacking practices for protection of individuals, security of assets and information, or training/practice drills added these practices or modified current practices as a result of the course.	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 course.	N/A
Scientific and Educational Development				
Long Term Objective 8.B.4: CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.				
8.B.4.1: Maintain the number of recruits who join public health programs in local, state, and federal health departments to participate in training in epidemiology or public health leadership management (Output)	FY 2010: 200 (Target Met)	200	200	Maintain
8.B.4.2: Increase the number of CDC trainees in State, Tribal, Local, and Territorial public health agencies (Output)	FY 2010: 182 (Historical Actual)	N/A	237	N/A

[1]Some targets reflect impact of funding from ACA/PPHF
[2]2010 results will not be available until December 2011

OUTPUT TABLE[1]

Other Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
8.A: States and territories funded for conducting surveillance	FY 2009: 55	55	55	Maintain
8.B: States funded to implement and evaluate genomics interventions	FY 2010: 2	2	0	-2
8.C: EGAPP-sponsored evidence reviews or recommendation statements published	FY 2009: 6	6	0	-6
8.E: Number of key elements of the health care system for which data are collected	FY 2009: 3	3	3	Maintain
8.F: Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey	FY 2009: 15	15	15	Maintain
8.G: Number of households interviewed in the National Health Interview Survey[2,3]	FY 2010: 39,000	35,000	46,500	+11,500
8.H: Number of physicians and visit records surveyed in the National Ambulatory Medical Care Survey[3]	FY 2010: 3,662 physicians; 30,600 visit records	3,400 physicians; 30,000 visit records	10,200 physicians; 90,000 patient records	+6,800 physicians; +60,000 visit records
8.I: Number of states funded to provide electronic birth records (either completely or in part)	FY 2009: 0	0	10	+10
8. J: States actively engaged in ongoing NEDSS/PHIN-compatible systems integration	FY 2008: 42 (Target Exceeded)	45	50	+5
8.K: States developing NEDSS-compatible systems, in deployment, or lie with the NEDSS Base System	FY 2009: 50 (Target met)	50	50	Maintain

[1]Some targets reflect impact of funding from ACA/PPHF.
[2]The target was exceeded - there was an increase in sample size during the first quarter of FY 2010 to reinstate a sample cut made in January - March 2009.
[3]The increase in sample size for NHIS and NAMCS will vary depending on when funds are received.

STATE TABLE[1]

FY 2012 DISCRETIONARY STATE/FORMULA GRANTS BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2010 Actual**	**FY 2011 CR**	**FY 2012 Estimate**	**FY 2012 +/- FY 2010**
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
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

FY 2012 DISCRETIONARY STATE/FORMULA GRANTS BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2010 Actual**	**FY 2011 CR**	**FY 2012 Estimate**	**FY 2012 +/- FY 2010**
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
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 funding from ACA/PPHF.

GLOBAL HEALTH

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$354,403	$354,453	$381,245	+$26,842
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$0	$0	$0	$0
Total	**$354,403**	**$354,453**	**$381,245**	**+$26,842**
FTEs	248	260	280	+32

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $381,245,000 for Global Health reflects an overall increase of $26,842,000 above the FY 2010 level. The FY 2012 request reflects an increase of $10,656,000 for polio eradication activities. Working in partnership with others, CDC has come to the forefront of United States Government (USG) global health efforts in recent years. CDC works in partnership with ministries of health (MOH) to effectively plan, manage, and evaluate health programs; achieve USG and international goals to improve health; and expand programs that focus on the leading causes of mortality, morbidity and disability, including both infectious and non-infectious diseases.

CDC is proud to be a lead partner in the Administration's Global Health Initiative (GHI), which will invest $63 billion in USG global health activities over six years. Building on the success of the President's Emergency Plan for AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), and other platforms, GHI 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. CDC will bring its technical expertise and established partnerships with ministries of health to bear 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. Building on the agency's long history of engagement in global health, CDC is well-positioned to contribute to the success of this initiative and to carry forward its core global health programs in FY 2012.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 307, 310, 319, 327

Specific Authorities: PHSA §§ 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); P.L. 107-116 § 215; P.L. 106-554 § 220; P.L. 111-117 § 213

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………………Expired/Indefinite

Allocation Methods: Direct Federal/Intramural; Competitive Grants/Cooperative Agreements; Direct Contracts; Interagency Agreements

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$307,497,000
FY 2008	$302,371,000
FY 2009*	$319,113,000
FY 2010**	$354,403,000
FY 2011CR	$354,453,000

*The FY 2009 and FY 2010 amounts have been made comparable to reflect the proposed transfer of Afghanistan Initiative and Health Diplomacy programs to CDC.

**Funding levels prior to FY 2010 have not been made comparable to the FY2012 budget realignment.

BUDGET REQUEST

Global HIV/AIDS

CDC's FY 2012 request of $118,023,000 for Global AIDS reflects a decrease of $938,000 below the FY 2010 level for administrative savings. In addition to funding requested through the base appropriation, CDC receives interagency funding to implement PEPFAR through the Global Health and Child Survival (GHCS) appropriations account. Despite tremendous progress in the fight against HIV/AIDS, it is still among the leading causes of death globally, with an estimated 2.6 million new HIV infections every year and more than 7,000 deaths every day. CDC plays a critical role in the President's Emergency Plan for AIDS Relief (PEPFAR) initiative, and with the combined efforts of all the implementing agencies, has made a significant contribution to the fight against global HIV/AIDS. CDC provides scientific and technical support to ministries of health, partner organizations, and other USG agencies and leverages its efforts with international organizations such as the Global Fund to Fight AIDS, TB, and Malaria; UNAIDS; World Health Organization (WHO); World Bank; and many others.

In FY 2012, 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's Division of Global HIV/AIDS (DGHA) provides technical assistance.
- Utilize established global platforms and domestic and international technical expertise in order to promote evidence-based, cost-effective HIV/AIDS services.
- Expand quality HIV/AIDS prevention, care and treatment, while transitioning these services to country ownership.
- Conduct research on program impact and cost effectiveness, including leading 80 single-country and five multi-country protocols and concepts, in accordance with a multi-agency review process that has refocused these efforts to better align with current PEPFAR priorities, the results of which will directly improve the quality and cost effectiveness of programs and policies.

Performance: PEPFAR has made significant progress. In 2003, when PEPFAR was launched, only 66,911 individuals were receiving HIV/AIDS treatment. As of the end of FY 2010, PEPFAR has directly supported treatment for more than 3.2 million people. CDC is an essential contributor to this success as well as to other program areas including HIV prevention, counseling and testing; workforce capacity; maternal and child health; surveillance, epidemiology, laboratory and health information systems; program monitoring and evaluation; and operations research. Another major PEPFAR success in which CDC has played a fundamental role is the expansion of prevention of mother to child transmission of HIV (PMTCT) activities, which allowed over 114,000 infants to be born HIV-free in FY 2010 alone. CDC is

also a key contributor to ensuring cost-effective and efficient programming in PEPFAR following the program's reauthorization in 2008.

Working in conjunction with other USG PEPFAR implementing agencies, CDC will support HIV/AIDS efforts in partner countries to move toward PEPFAR's multiyear goals, which include preventing 12 million new HIV infections, treating four million HIV-infected people, caring for 12 million people infected with or affected by HIV/AIDS, and ensuring that at least 80 percent of pregnant women receive PMTCT services, including antiretroviral prophylaxis. Cost-effective care and treatment services and interventions such as PMTCT, peer education, and HIV counseling and testing are at the heart of CDC's approach to service delivery, research, and policy reform. (Measures 10.A.1.1 through 10.A.1.4)

Program Description and Recent Accomplishments: CDC provides technical leadership and direct assistance to ministries of health and other partners in over 75 PEPFAR-supported countries through its headquarters office in Atlanta and its 41 field offices around the world. Field offices include regional offices in the Caribbean, Central America, Central Asia, and Southeast Asia. CDC's highly trained clinicians, epidemiologists, public health advisors, behavioral scientists, health economists, and laboratory scientists implement and support program activities in accordance with the following strategies:

- Strengthen health systems and capacity of partner governments, particularly ministries of health, to lead the response to this epidemic;
- Scale up and integrate evidence-based prevention, care, and treatment programs and service delivery;
- Strengthen quality laboratory, surveillance, and health information systems for data-driven programming;
- Monitor and evaluate PEPFAR-supported programs to assess impact, improve service delivery, and maximize outcomes; and
- Invest in innovation and operations research with an emphasis on program impact, cost effectiveness, and program efficiencies.

These strategies accelerate program accomplishments as well as facilitate the transference of program ownership and management to host country governments. In addition to direct technical assistance, financial assistance is provided to ministries of health and other PEPFAR implementing partners to perform program activities in accordance with approved Country Operational Plans.

Recent accomplishments include:

- Accelerated country ownership through direct government-to-government assistance and capacity building for HIV/AIDS prevention, care, and treatment services and strengthening of health systems. In order to transition to greater country ownership, in FY 2010, approximately half of CDC funding was implemented through cooperative agreements with local, in-country partners, including a strong focus on ministries of health. CDC is also providing programmatic, administrative, and fiscal oversight and leadership for the transition of Track 1.0 antiretroviral therapy (ART) treatment programs in 13 countries from U.S.-based partners to indigenous organizations.
- Collaborated with WHO to develop a wide range of HIV international guidelines, including guidance for adult HIV treatment; pediatric HIV treatment; HIV treatment for pregnant women, including to prevent mother to child transmission; HIV and infant feeding; male circumcision; and intensified TB/HIV case finding and therapy for people with HIV.

- Provided leadership and technical assistance to WHO and other partners in the development and launch of a tiered International Laboratory Accreditation program. Launched in the fall of 2009, this is the first program of its kind and will include participation of WHO and the newly established African Society of Laboratory Medicine in collaboration with CDC to ensure post-assessment improvement and follow up.

Global Immunization

CDC's FY 2012 request of $163,602,000 for Global Immunization reflects an increase of $9,949,000 above the FY 2010 level. Within this level, there is an increase of $10,656,000 for Polio Eradication to provide increased support the USG endorsed Global Polio Eradication Strategic Plan to eradicate polio in remaining endemic countries by the end of FY 2012.

In FY 2012, CDC will:

- Purchase 254 million doses of oral polio vaccine for use in mass immunization campaigns in Southeast Asia, Africa, and Europe, as CDC works toward its target of zero polio-endemic countries by the end of 2012.
- Provide leadership in the Global Polio Eradication Strategic Plan for 2010-2012 as the lead partner responsible for monitoring the execution and verification of plan activities.
- Expand 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 of supplementary immunization activities (SIAs). Expand the provision of short-term technical assistance support, through an estimated 75-150 additional temporary assignments of CDC scientific experts, based on needs in the field.
- Provide greater support for new laboratory procedures now in place 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 will enable more rapid detection of wild poliovirus (WPV) and allow for faster response to importations and/or spread of virus.
- Enhance support for experienced Stop Transmission of Polio (STOP) immunization teams in Nigeria, South Sudan, Angola, Chad, and Democratic Republic of Congo along with specialized National STOP (N-STOP) teams in Pakistan to reach additional areas. Currently STOP has 70 participants placed in 28 countries worldwide. Further investments will provide added staff to reach local districts which are not currently serviced by this program, based on the results of technical needs assessments conducted in the field. The N-STOP program in Pakistan will be placed in approximately 15-33 high-risk local health districts (with the potential for more districts to be added as events on the ground dictate) and will be run in conjunction with CDC's Field Epidemiology and Laboratory Training Program (FELTP), providing a capacity-building model for other countries.
- Continue to ensure a sustainable supply and pricing of the most effective vaccines (currently $0.14/dose) in partnership with UNICEF and industry partners to appropriately target national SIAs and routine immunization programs to achieve global polio eradication. Expand measles vaccination campaigns into high burden countries of South Asia to help reduce the number of global measles-related deaths to less than 75,000 (down from an estimated 750,000 in FY 2000).

- Continue to build in-country capacity in over 20 countries for effective immunization program management and evaluation through training and development of information systems to ensure the quality of vaccine-preventable disease surveillance.
- Strengthen routine immunization programs through multilateral partnerships to increase capacity of health systems to improve immunization coverage with the "traditional" EPI (Expanded Program on Immunization) vaccines, including measles and polio, and to provide access to new and underutilized vaccinations for target populations.
- Provide epidemiologic, laboratory, and programmatic support to the WHO and the United Nations Children's Fund (UNICEF) and provide expertise in virology, diagnostics, and laboratory procedures, serving as a global reference lab for polio, measles, and rubella.
- Participate in the plan of action for documenting verification of the elimination of measles, rubella, and congenital rubella syndrome (CRS) in the Americas with the Pan American Health Organization (PAHO).

Performance: FY 2012 funds for global immunization will support ongoing activities to make progress toward achieving the goals of global polio eradication and 90 percent reduction in cumulative global measles-related mortality compared with 2000 estimates. Investments in global immunization are highly cost-effective. The primary mechanism of support is through cooperative agreements with WHO, UNICEF, UNF, and PAHO. Findings from a 2005 study[15] of the broader economic impact of vaccination show that investment in vaccine-preventable disease mortality reduction can be expected to yield an economic rate of return of 10-20 percent or more, similar to that of primary education. (Measures 10.B.1.1 through 10.B.1.3, 10.B.2.1, 10.B.2.2, and 10.B.E.1)

Program Description and Recent Accomplishments: 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). CDC supports global immunization initiatives to improve child survival and reduce suffering and deaths associated with VPDs in resource-limited countries. Activities also aim to protect children in the United States from VPDs imported into this country or acquired abroad, and to reduce domestic medical costs of morbidity and mortality associated with imported VPDs.

Recent accomplishments include:

- Demonstrated a decline in global polio incidence by more than 99 percent, from more than 350,000 cases annually in 1988 to 1,606 cases in 2009. As of December 2010, there were 897 polio cases reported globally, representing significant progress over the previous year.
- Led the assessment of the risks of failing to detect and interrupt wild poliovirus transmission for GPEI, and has published two quarterly risk assessments as of the end of 2010 to help guide eradication efforts. Impressive progress toward controlling virus transmission was noted in all importation countries, in the re-established transmission countries of Sudan and Chad, and in the endemic countries of India and Nigeria. Continuing areas of concern are: Pakistan, Afghanistan, Angola, Democratic Republic of the Congo, parts of the Russian Federation, and the Uganda/Kenya region.

[15] Bloom DE, Canning D, Weston M. The Value of Vaccination. World Economics 2005; 6(3):15-39.

- Contributed to a reduction of global measles mortality in all ages by 78 percent, from an estimated 733,000 deaths in 2000 to an estimated 164,000 deaths in 2008.[16]

Global Disease Detection and Emergency Response

CDC's FY 2012 request of $44,191,000 for Global Disease Detection (GDD) and Emergency Response reflects a decrease of $5,000 below the FY 2010 level for administrative savings. This funding also supports CDC's global emergency response and humanitarian health activities through the transfer of the International Emergency and Refugee Health program from CDC's National Center for Environmental Health ($6,261,000). Global Disease Detection and Emergency Response funds will continue to provide support and technical assistance needed to detect and contain disease threats, build public health capacity, and provide support for humanitarian emergencies.

In FY 2012, CDC will:

- Continue to build scientific capacity and expertise, through eight GDD Regional Centers (Kenya, Thailand, China, Guatemala, Egypt, Kazakhstan, India, and South Africa), to rapidly detect, identify, and contain outbreaks of emerging infectious disease, new pathogens, and bioterrorist threats. This includes expanding and enhancing critical core public health capacities in rapid outbreak response, strong surveillance and national laboratory systems, and fully trained human resources.
- Promote global health security by strengthening interagency partnerships with Department of Defense, Department of State, USAID, and National Security Staff, and expanding involvement with new USG and nongovernmental partners to promote policy coherence, coordinated implementation and effective use of global health security resources.
- Provide technical assistance, including rapid health and nutrition assessments, public health surveillance, epidemic investigations, disease prevention and control, program evaluation, and emergency preparedness to partner governments.
- Plan and maintain partnerships with strategic international, bilateral, and non-governmental relief organizations that encourage data driven public health programming in emergencies.
- Continue five and complete five operation research projects which expand the U.S. Government's ability to effectively program and monitor U.S. humanitarian aid.

Performance: In 2006, CDC developed and implemented a GDD monitoring and evaluation (M&E) framework that captured a baseline in each of the five key activity areas from which the impact of the seven GDD Regional Centers are assessed over time. CDC collects GDD data on a quarterly basis as part of ongoing efforts to measure progress and assess program impact, and continues to enhance the GDD M&E framework on an ongoing basis. New indicators have been developed to measure GDD's contribution to building host country capacity to meet International Health Regulation (IHR) requirements and will be rolled out and implemented in 2011. GDD 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 capacity to fulfill their obligations to identify, report, and contain public health threats as outlined in the International Health Regulations. (Measure 10.E.1.1)

Program Description and Recent Accomplishments: CDC's GDD activities protect the health of the U.S. population and the global community by strengthening global, regional, and local public health capacity to rapidly detect and respond to infectious disease outbreaks and threats. The GDD program is comprised

[16] Recent measles outbreaks in Africa have delayed the completion of WHO country consultations to validate global measles mortality data for 2009; these data are expected to be released by WHO in March 2011.

of strategically positioned GDD Regional Centers in eight 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. Global Health Security activities involve partnerships with other U.S. Government agencies on global health diplomacy and bio-security issues. CDC's portfolio of global health security activities includes building 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. Activities and investments in global disease detection and humanitarian health over the last several years have produced substantial results.

Recent accomplishments include:

- Increased capacity to detect dangerous pathogens, using population-based surveillance covering more than 103 million persons since 2006.
- Provided rapid response to 122 disease outbreaks and public health emergencies (627 total since 2006), including Rift Valley fever, viral hemorrhagic fever, and dengue fever.
- Provided emergency technical assistance in over 80 humanitarian assistance missions in 2009-2010, including stabilizing the public health system and responding to the ongoing cholera outbreak in post-earthquake Haiti.

Parasitic Diseases and Malaria

CDC's FY 2012 request of $19,643,000 for Parasitic Diseases and Malaria reflects a reduction of $237,000 below the FY 2010 level for administrative savings. CDC works to prevent and control malaria and other parasitic diseases throughout the world.

In FY 2012, CDC will:

- Support implementation, monitoring, and evaluation activities in 17 African countries as part of the President's Malaria Initiative (PMI).
- Provide technical assistance annually to approximately 15 malaria-endemic, non-PMI countries.
- Conduct research on long-lasting insecticide-treated nets (LLINs), indoor residual spraying (IRS), malaria in pregnancy (MIP), and case management including diagnosis, treatment, and antimalarial drug resistance to inform new strategies and prevention approaches.
- Assess new monitoring, evaluation, and surveillance strategies, and conduct additional research, including field evaluations of malaria vaccines.
- Accelerate control and elimination of several Neglected Tropical Diseases (NTDs) -- particularly lymphatic filariais, river blindness, trachoma, schistosomiasis, and the soil-transmitted helminthes, as well as support WHO and other partner efforts to eradicate Guinea worm.
- Provide technical support to countries and global partners for training, tool development, implementation, monitoring, evaluation, and integration of NTD programs.

Performance: FY 2012 funds will be leveraged, with dollars received from USAID, to build technical capacity and provide operational research support to ministries of health for malaria control, to support malaria control efforts in the United States, and to support activities that seek to decrease the rate of all-

cause mortality in children under five in PMI target countries. Success will be measured by the number and outcome of technical assistance consultations provided, the number of monitoring and evaluation activities accomplished, and progress reached on research projects. Malaria prevention and treatment tools (IRS, ITNs, ACTs, and IPTp, see below) are among the most cost effective interventions available to improve maternal and child survival and health. (Measures 10.C.1 through 10.C.3)

Program Description and Recent Accomplishments: CDC works to prevent and control malaria and other parasitic diseases throughout the world, including in the United States. As a key implementing partner for 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 ministries of health and other partners to conduct essential operations research to develop new tools and strategies to prevent and control malaria. CDC also conducts activities to 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 offers technical support and expertise in monitoring and evaluation to partners developing or operating NTD programs, and conducts critical operational research that helps to 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 and evaluation 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 include:

- Distributed more than 19 million insecticide-treated mosquito nets (ITNs), supported the re-treatment of more than 1.1 million regular nets, distributed more than 3.5 million treatments with sulfadoxine-pyrimethamine (SP) for intermittent preventive treatment of malaria during pregnancy (IPTp), and distributed more than 40 million treatment courses of highly-effective artemisinin-based combination therapies (ACTs). CDC produced the following specific accomplishments related to malaria:
  - Conducted a Phase III evaluation of RTS,S the world's first advanced candidate malaria vaccine. To date 1700 of 2000 children have been enrolled; results from the 5- to 18-month age group are to be analyzed in early 2011.
  - Evaluated the combined impact of indoor residual spraying (IRS) and insecticide-treated bed nets (ITNs); results found a 70 percent decrease in incidence of clinical malaria and 61 percent decrease in malaria infection among all household members who received IRS plus ITNs compared to a cohort that received ITNs alone. Greatest increases were seen among children less than five years of age.
- Produced guidelines with WHO for integrated mapping of NTDs in the African region. The guidelines will maximize program impact and cost-effectiveness by identifying target populations and defining optimal treatment frequencies.
- Collaborated with the Council of State and Territorial Epidemiologists (CSTE) to make babesiosis, currently the leading cause of transfusion-transmitted infection in the United States, a nationally-notifiable disease and summarized 30-year national data on transfusion-transmitted babesiosis. These measures will strengthen the evidence base to screen the blood supply for this infection.

Global Public Health Capacity Development

CDC's FY 2012 request of $35,786,000 for Global Public Health Capacity Development reflects an increase of $18,073,000 above the FY 2010 level. Within the program level, $15,293,000 will support the Field Epidemiology and Laboratory Training Program (an increase of $6,775,000 above the FY 2010 level), $10,000,000 will support the Global Safe Water, Sanitation, and Hygiene (WASH) program, and $2,000,000 will support Maternal and Child Health. The FY 2012 request also includes the Afghan Health Initiative ($5,789,000) and Health Diplomacy ($2,000,000) programs, which will be transferred from the Department of Health and Human Services. Global Public Health Capacity Development funding will be invested in developing critical public health functions that account for high global burden: training and sustaining quality public health workforce; global water, sanitation, and hygiene; and integrated maternal, newborn, and child health.

In FY 2012, CDC will:

- Support global public health capacity development activities through the Field Epidemiology and Laboratory Training and Sustainable Management Development Programs, and through global water, sanitation and hygiene activities.
- Strengthen global health diplomacy in the Latin America & Caribbean Region. Activities include support for partner countries in the region in the areas of health policy development, workforce development in epidemiology, and partnerships for health system strengthening.
- Support the Afghan Health Initiative by providing OB/GYN training at Rabia Balkhi Hospital in Kabul to address high rates of maternal and infant mortality. Activities include a Quality Assurance Collaborative on Caesarian sections; strengthening health management information systems; infection control and prevention; occupational health; community-based maternal and perinatal surveillance; and capacity building of the Afghan Ministry of Public Health.
- Support country-specific maternal, newborn, and child health (MNCH) activities that emphasize integrated service delivery and building host country capacity in laboratory, surveillance, and monitoring and evaluation activities; and evaluate the impact on maternal, infant, and early childhood outcomes of an integrated approach to MNCH health services delivery using a standard package of services.
- Help reduce the high burden of morbidity and mortality due to non-communicable diseases (NCDs), which account for an ever-growing share of the global burden of disease. For example, tobacco alone accounts for more deaths worldwide each year than AIDS, tuberculosis, and malaria combined, and road traffic injuries cause more than 1.2 million deaths each year, primarily in the developing world. Activities include advancing comprehensive chronic disease epidemiology; tobacco prevention and control; decreasing road traffic injuries and deaths; building national capacity for reduction of maternal mortality; and strengthening vital registries.

Field Epidemiology and Laboratory Training and Sustainable Management Development

CDC's FY 2012 request of $15,293,000 for the Field Epidemiology and Laboratory Training Program (FE(L)TP) and the Sustainable Management Development Program (SMDP) reflects an increase of $6,775,000 above the FY 2010 level.

In FY 2012, CDC will:

- Maintain capacity of existing programs, which includes conducting assessments, preparing comprehensive training plans, identifying local and international partners, and supporting resident technical advisors.

- Continue early development activities to initiate FE(L)TP in one large province in a country, to be determined in partnership with the ministry of health, to serve as a model for FE(L)TP implementation in large countries.
- Maintain at least two regional networks in areas of strategic importance, such as Africa, the Middle East, or Central Asia, to provide shared training and capacity building opportunities, staff multi-country outbreak response teams, and help expand the reach of individual country programs.
- Expand workforce capacity and systems strengthening in disease control programs such as non-communicable diseases and injury through FE(L)TPs.
- Implement a country workforce development planning framework to assist partner countries in evaluating current epidemiology, surveillance, and response capacity and develop a set of programmatic targets to meet those needs.
- Provide training in, expand use of, and validate the existing monitoring and evaluation strategy for supported programs to report on a set of performance indicators and track their progress.

Performance: Data indicate that FE(L)TP and SMDP graduates go on to serve in key public health positions within the ministries of health of their own country. For example, approximately 80 percent of FE(L)TP graduates work with the ministry of health after graduation and many are assigned to positions of leadership, including a recent graduate in Kenya, for example, who now serves as the Director of the Division of Disease Surveillance and Response in the Ministry of Public Health. Their presence results in enhanced, sustainable public health capacity in these countries, which is critical to support the transition of USG global health investments to long-term host country ownership. Quantitative and qualitative evaluation measures linked to performance and sustainability are tracked and monitored by CDC. (Measures 10.F.1a and 10.F.1b)

Program Description and Recent Accomplishments: Since 1980, CDC has worked in collaboration with local and international organizations to help MOHs develop FE(L)TPs that build capacity in a range of areas, including epidemiology, outbreak investigation, health surveillance systems, applied research, program evaluation, communications, and program management. CDC generally supports a FE(L)TP program for about five years, with gradual transfer of responsibility and program costs to ensure that the country can sustain the program once CDC staff is no longer present. The 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 ministries of health to build sustainable public health capacity around the world.

Recent accomplishments include:

- Supported 25 participants working in PMTCT teams in Ethiopia's Oromia Region, which participated in a Process Improvement course and conducted follow-up projects that significantly improved desired PMTCT outcomes, such as increasing the percentage of infected mothers delivering in a medical setting, and percentage of infected partners being tested for HIV/AIDS.
- Provided a resident advisor for consultation and support to 34 FE(L)TPs and similar programs from 1980 to 2010, 20 of which are now self-sustaining. As of 2010, CDC provides 19 resident advisors and consultation to 14 programs in 28 countries. CDC is also providing technical assistance for the development of ten new programs in 12 countries.

- Completed assessments of non-communicable disease capacity in five targeted countries as a first step in strengthening human capacity and systems to conduct surveillance and prevention of NCD.

Global Water, Sanitation, and Hygiene

CDC's FY 2012 request of $10,000,000 for the Global Safe Water, Sanitation, and Hygiene (WASH) program will improve global access to clean water, sanitation, and hygiene.

In FY 2012, CDC will:

- Expand the Safe Water System (SWS), a household drinking water treatment and storage program to two additional countries and expand the scope of the SWS to integrate with other programs including HIV/AIDS, Neglected Tropical Diseases (NTDs), immunizations, maternal and child health, and nutrition.
- Continue implementing Water Safety Plans (WSPs) in 5-6 priority countries and conduct long-term evaluations of sustainability of WASH interventions in 10-15 communities in four countries, with results benefiting multiple communities worldwide through partners' programmatic changes.
- Enhance efforts to improve the impact of water and sanitation interventions in humanitarian emergencies by assisting partners to improve monitoring of WASH interventions, conduct research on innovative WASH interventions, and improve disease surveillance for WASH-related illness among refugees, displaced persons, and emergency affected populations.
- Provide laboratory support for WASH activities, improve diagnostic and environmental sampling and testing, and develop and evaluate new methods of sampling.

Performance: Global investment in WASH has been shown to produce significant health and economic benefits. A detailed analysis of the impact of clean water technologies on public health in the U.S estimated a rate of return of 23 to 1 for investments in water filtration and chlorination during the first half of the 20th century. Similar results have been obtained for contemporary investments in developing countries. A WHO study of the cost effectiveness of meeting the Millennium Development Goal of halving the proportion of people without access to safe water by 2015 would lead to an economic return of between $5 and $28 for every dollar invested. On the public health level, safe water programs contributed to the reduction of Guinea worm disease cases from an estimated 3.5 million annual cases in 20 countries in the mid-1980s to 3,203 cases in 4 countries in 2009 and 1,633 cases in 5 countries through October 2010, with eradication now possible in the near future.

Program Description and Recent Accomplishments: Worldwide, 884 million people do not have access to an improved water source; many more obtain drinking water from improved but unsafe sources. In addition, an estimated 2.5 billion people, half of the developing world, lack access to adequate sanitation. The FY 2012 request will help maintain CDC's efforts to identify the most effective WASH interventions and provide technical assistance in scaling up those interventions. Such interventions include proven technologies to treat and safely store drinking water in homes, identify hazards and solutions to contamination of community water sources, and improve structural and operational water treatment and distribution systems in low- and middle-income countries. By identifying the most effective interventions for different settings, CDC helps to make large scale investments by USAID, multilateral banks and NGOs more efficient and sustainable.

Recent accomplishments include:

- Demonstrated 50 percent reductions in diarrheal disease due to household drinking water treatment in numerous epidemiologic studies. Sales of household water treatment products in 2009 were sufficient to treat at least 16 billion liters of worldwide, enough treated drinking water to meet the needs of 22 million people for the entire year. Efforts are currently underway to broaden this work to identify the impacts of WASH on non-diarrheal illnesses such as Neglected Tropical Diseases.
- Assisted in implementing Water Safety Plans (WSPs) and long term evaluations of sustainability in numerous countries in Latin America and the Caribbean. These projects have led to national-level policy changes to incorporate WSPs into national drinking water regulations in Jamaica and Brazil, while sustainability evaluations have shown that rural communities need ongoing technical assistance to sustain WASH interventions, especially those related to hygiene.
- Responded to the earthquake and cholera outbreak in Haiti, including working with partners to improve WASH conditions in settlements for displaced persons, conducting studies of WASH interventions to improve cholera prevention efforts, establishing water quality monitoring and a water quality laboratory to determine the safety of drinking water supplies, and creating training materials used by community health workers to educate residents on how to protect themselves against cholera through household drinking water treatment and hygiene. These activities will not only help contain cholera in Haiti but also help prevent its spread to other Caribbean countries and other countries in the Americas, including the United States.

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. CDC Division of Global HIV/AIDS Country Specific Infrastructure 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. In addition to HIV/AIDS IT investments, 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. (For funding information, see Exhibit 53.)

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

There are no activities included.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Global Health	**$354,403**	**$354,453**	**$381,245**	**+$26,842**
Global HIV/AIDS	$118,961	$118,979	$118,023	-$938
Global Immunization	$153,653	$153,676	$163,602	+$9,949
Global Disease Detection and Emergency Response	$44,196	$44,203	$44,191	-$5
Parasitic Diseases and Malaria	$19,880	$19,881	$19,643	-$237
Global Public Health Capacity Development	$17,713	$17,714	$35,786	+$18,073

MEASURES TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Global AIDS Program				
Long Term Objective 10.A.1: The Division of Global HIV/AIDS (DGHA) will help implement PEPFAR in 31 countries and 3 Regional Programs by partnering with other 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.				
10.A.1.1: Number of individuals receiving antiretroviral therapy (Output)	FY 2010: 3,209,900 (Target Exceeded)	3,183,800	3,639,500	+455,700
10.A.1.2: Number of individuals infected and affected by HIV/AIDS, including OVCs, receiving care and support services (Output)	FY 2010: 11,361,600 (Target Not Met)	11,845,700	13,346,700	+1,501,000
10.A.1.3: Number of pregnant women receiving HIV counseling and testing (Output)	FY 2010: 8,385,022 (Target Exceeded)	8,377,100	10,026,000	+1,648,900
10.A.1.4: Number of HIV+ pregnant women receiving ARV prophylaxis (Output)	FY 2010: 602,500 (Target Exceeded)	600,000	840,000	+240,000
Global Immunization				
10.B.E.1: The portion of the annual budget that directly supports the program purpose in the field (Efficiency)	FY 2009: 93% (Target Exceeded)	>=90%	>=90%	Maintain
Long Term Objective 10.B.1: Help domestic and international partners achieve World Health Organization's goal of global polio eradication.				
10.B.1.1: Number of doses of oral polio vaccine (OPO) purchased for use in OPV mass immunization campaigns in Asia, Africa, and Europe (1 dose = 1 child reached) (Output)	FY 2009: 298,400,000 (Target Exceeded)	240,000,000	254,000,000	+14,000,000
10.B.1.2: Number of children reached with OPV as a result of non-vaccine operational support funding provided to implement OPV mass immunization campaigns in Asia, Africa, and Europe (Output)	FY 2009: 35,600,000 (Target Not Met)	45,000,000	51,400,000	+6,400,000
10.B.1.3: Number of countries in the world with endemic wild polio virus (Outcome)	FY 2009: 4 (Target Not Met)	0	0	Maintain

Long Term Objective 10.B.2: Work with global partners to reduce the cumulative global measles-related mortality by 90% compared with 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.				
10.B.2.1: Number of global measles-related deaths (Outcome)	FY 2008: 164,000 (Target Exceeded)[17]	75,000	50,000	-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 2009: 0 (Target Met)	0	0	Maintain
Global Malaria				
Long Term Objective10.C.1: Decrease the rate of all-cause mortality in children under five in the President's Malaria Initiative target countries.				
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 (Outcome)	FY 2008: 13.1% (Target Met)	N/A	85% (median) in 2007 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 (Outcome)	FY 2008: 29.5% (Target Met)	N/A	85% (median) in 2007 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 (Outcome)	FY 2008: 4.9% (Target Met)	N/A	85% (median) in 2007 countries	N/A

[17] Recent measles outbreaks in Africa have delayed the completion of WHO country consultations to validate global measles mortality data for 2009; these data are expected to be released by WHO in March 2011.

Afghan Health Initiative				
Long Term Objective 10.D.1: Reduce Maternal and Neonatal Morbidity and Mortality Associated with High-Risk C-Section Deliveries.				
10.D.1.5: The rate of fetal deaths occurring during labor or delivery among newborns who weigh at least 2500 grams at birth at Rabia Balkhi Women's Hospital in Kabul, Afghanistan per 1,000 such births (Outcome)	FY 2009: 3.4 (Target Not Met)	5.2	4.8	-0.4
10.D.1.1: The in-hospital maternal mortality rate per 1,000 caesarean sections at Rabia Balkhi Women's Hospital in Kabul, Afghanistan (Outcome)	FY 2010: 6.8 (Baseline)	Baseline	4.5	-1
10.D.1.8: The number of women who have a cesarean section that subsequently develop a post-operative infection at Rabia Balkhi Women's Hospital (Outcome)	FY 2010: 28 per 1,000 (Baseline)	Baseline	6.5 per 1,000	-1.5
Global Disease Detection and Emergency Response				
Long Term Objective 10.E.1: The Division of Global Disease Detection 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).				
10.E.1: Percentage of outbreak and possible Public Health Emergencies of International Concern assistance requests that are handled in a timely manner (Outcome)	FY 2010: 77 % (Target Exceeded)	73%	79 %	+6
Global Public Health Capacity Development				
Long Term Objective 10.F.1: To increase the number of skilled Epidemiologists providing sustained public health capacity in low and middle income countries.				
10.F.1a: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP), new trainees (Outcome)	FY 2009: 134 (Baseline)	149	179	+30
10.F.1b: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP), total graduates (Outcome)	FY 2010: 2,305 (Target Not Met)	2,316	2,676	+360

PUBLIC HEALTH LEADERSHIP AND SUPPORT

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012+/- FY 2010
Budget Authority	$144,237	$144,260	$121,368	-$22,869
PHS Evaluation Transfers	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$50,142	$41,200	$41,200	-$8,942
Total	**$194,379**	**$185,460**	**$162,568**	**-$31,811**
FTEs	209	210	210	+1

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $162,568,000 for Public Health Leadership and Support (formerly known as Public Health Leadership and Improvement), including $41,200,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an overall decrease of $31,811,000 below the FY 2010 level. The FY 2012 request reflects a reduction of $9,800,000 to the National Public Health Improvement Initiative, and an elimination of Congressional Projects ($20,620,000). FY 2012 funds will support the CDC's Office of the Director, the Office of State, Tribal, Local and Territorial Support, and Urgent and Emergent Public Health Response activities. Leadership and support activities are critical to accomplishing greater health impact while balancing health protection and science needs with available resources.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 306, 307, 308, 310, 311, 317, 319, 319A, 322, 325, 327, 352, 399G, 1102, Bayh-Dole Act of 1980, P.L. 96-517

Specific Authorities: PHSA §§ 317F, 361-369, 391, 2315, 2341: Federal Technology Transfer Act of 1986, (15 U.S.C. 3710: Clinical Laboratory Improvement Amendments of 1988, § 4; Pandemic and All-Hazards Preparedness Act, P.L. 109-417 (S. 3678); The Affordable Care Act of 2010 (P.L. 111-148), §4001.

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

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

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$202,559,000
FY 2008	$224,899,000
FY 2009	$209,136,000
FY 2010*	$194,379,000
FY 2011CR	$185,460,000

*Funding levels prior to FY 2010 have not been made comparable to the FY2012 budget realignment.

BUDGET REQUEST

Urgent and Emergent Public Health Response

CDC's FY 2012 request includes $2,500,000 for Urgent and Emergent Public Health Response. CDC has renamed this budget activity, it was formerly known as the Director's Discretionary Fund.

Congressional Projects

CDC's FY 2012 request eliminates funding for Congressional Projects an overall decrease of $20,620,000 below the FY 2010 level.

Other Public Health Leadership and Support

CDC's FY 2012 request of $118,868,000 for Public Health Leadership and Support (formerly known as Public Health Leadership and Improvement), reflects a decrease of $1,750,000 below the FY 2010 level for administrative savings. FY 2012 funding will support activities critical to accomplishing greater health impact across CDC.

In FY 2012, CDC will:

- Support cross-cutting areas within CDC to achieve more efficient and effective science and program development.
- Enhance the effectiveness of public health programs, science, and practice by developing and supporting minority health efforts, internal and external partnerships, cooperative agreements with academic institutions, management of intellectual property, communications and issues management, state and local support, and coordination of science-based, practice-oriented standards, policies, and laws.
- Improve capacity and performance of the public health system and provide guidance and oversight of CDC's investments with state, local, and other partner public health agencies.

Program Description and Recent Accomplishments: CDC's Office of the Director, the Office of State, Tribal, Local and Territorial Support, and Urgent and Emergent Public Health Response activities provide leadership and support activities critical to accomplishing greater health impact while balancing health protection and science needs with available resources. These offices improve policy effectiveness and the ability to address the leading causes of illness, death, and disability, consistent with the agency's mission.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

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 will outline 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 will focus on improving the health of communities, in addition to promoting access 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

National Public Health Improvement Initiative

The National Public Health Improvement Initiative (NPHII) to increase the nation's health departments' performance management capacity and increase their ability to meet national public health standards. CDC is funding directly or through bona fide agents a total of forty-nine states; eight federally recognized Tribes; Washington, D.C.; nine large local health departments; five U.S. Territories; and 3 U.S. affiliated Pacific Island jurisdictions. Grantees are working to: (1) 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; (2) 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; and (3) increase the number of public health organizations focused on (a) re-engineering programs, systems, and services (such as regionalization), (b) improving performance, (c) increasing return on investment, and (d) integrating with the healthcare sector, the key to long-term cost savings and system transformation.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Public Health Leadership and Support	**$194,379**	**$185,460**	**$162,568**	**-$31,811**
Urgent and Emergent Public Health Response	$2,999	$3,000	$2,500	-$499
Congressional Projects	$20,620	$20,620	$0	-$20,620
Other Public Health Leadership and Support	$120,618	$120,640	$118,868	-$1,750
ACA/PPHF	$50,142	$41,200	$41,200	-$8,942

MEASURES TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Office of Minority Health and Health Disparities				
Long Term Objective 11.B.1: Improve access to and reach CDC's scientific health information among key audiences to maximize health impact				
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)	FY 2010: 79% (Target Not Met)	82%	82.5%	+0.5%
11.B.1.1b: Percentage of inquirers making a behavior change as a result of information gained from their experience with CDC-INFO (Outcome)	FY 2010: 44% (Target Not Met)	50%	52.5%	+2.5%
11.B.1.1c: Health Behavior impact of CDC.gov (Outcome)	FY 2010: 66% (Target Not Met)	69%	71%	+2%
Long Term Objective 11.B.2: Prepare minority, medical, veterinary, pharmacy, undergraduate, and graduate students for careers in public health.				
11.B.2.1: Increase the number of minority students participating in 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 (Output)	FY 2009: 112 (Target Exceeded)	95	95	Maintain
Long Term Objective 11.B.3: Support policy strategies of existing national and regional minority organizations.				
11.B.3.1: Identify program and organizational infrastructure needs (i.e., policy analysis, program 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 (Output)	FY 2009: 240 (Target Exceeded)	250	250	Maintain

BUILDINGS AND FACILITIES

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$69,140	$69,150	$30,000	-$39,140
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$0	$0	$0	$0
Total	**$69,140**	**$69,150**	**$30,000**	**-$39,140**
FTEs	0	0	0	0

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $30,000,000 for Buildings and Facilities (B&F) reflects an overall decrease of $39,140,000 below the FY 2010 level.

FY 2012 funds will support the critical and necessary repairs and improvements (R&I) to maintain or improve the condition of CDC's portfolio of assets, and to improve the efficiency of the buildings' mechanical, electrical, and water systems. The FY 2012 request does not include funds for construction.

B&F funding supports capital projects, such as major new construction and modernization, real property acquisition, and the National R&I Program to remain in compliance with the Federal Real Property Council (FRPC) metrics.

AUTHORIZING LEGISLATION

Specific Authorities*: PHSA §§ 304(b)(4), 319D, 321

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………….Expired/Indefinite

Allocation Method: Direct Federal/Intramural; Contracts

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$134,400,000
FY 2008	$55,022,000
FY 2009	$151,500,000
FY 2010	$69,140,000
FY 2011CR	$69,150,000

BUDGET REQUEST:

Buildings and Facilities

CDC's FY 2012 request of $30,000,000 for R&I reflects a decrease of $39,140,000 below the FY 2010 level.

In FY 2012, CDC will:

- Complete necessary R&I projects to maintain or improve the condition of CDC's portfolio of assets, improve the energy efficiency of mechanical/electrical/water systems. CDC will also support program mission needs, to ensure secure, healthy, and safe facilities.
- Support CDC's nationwide R&I program to remain in compliance with the Federal Real Property Council (FRPC) metrics.

Program Description and Recent Accomplishments: The 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 the mission of CDC. 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:

- 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 (such as chemical fume hoods, biological safety cabinets, sterilizers, autoclaves, etc.).
- 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 building 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 Building and Facilities Office. For more information refer to the Business Services Support narrative.

Recent accomplishments include:

- Completed Building 23 in FY 2010 and met the performance assessment goal of having 100 percent of the infectious diseases laboratories in standard laboratory space.
- Combined the 107 and 108 building design funds and reduced the scope of Building 107 in order to continue with the consolidation efforts of the Chamblee Campus Master Plan.
- Incorporated sustainable design principles and effective operations and maintenance, to reduce resource consumption (energy, water, and capital), and maintain the facilities in good condition.

National Repair and Improvements

In accordance with the 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.

Repair and Improvements Funding History

Fiscal Year	Repair and Improvements Amount
FY 2007	$21,059915
FY 2008	$22,427,920
FY 2009	$23,065,631
FY 2010	$25,022,209
FY 2011CR	$37,103,481*

*Estimate based on new projects started in FY 2011 and continuing projects from FY 2010 and prior fiscal years.

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 Sustainment strategy. Repair funds are used to sustain buildings in an operational status. Improvement funds are used to modify space to bring it into alignment with current codes and reduce over-utilized space.
Facility Utilization		
Utilization Status	Positive	R&I funds will be used for over-utilized and utilized facilities in accordance with CDC's sustainment strategy.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition that allows 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	Positive	R&I funding will support CDC's sustainment strategy to maintain a portfolio Condition Index (CI) of 90 or better.
Sustainment and Improvement Strategy	Positive	A strategy of capital replacement of non-performing assets along with R&I funding at current levels will allow CDC to achieve a portfolio – wide CI of 100 over the 2010 – 2020 planning horizon.
Facility Cost		
Operations and Management (O&M) Cost	Positive	CDC anticipates a positive, but un-quantified impact on O&M costs resulting from sustainment-level 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.

Incorporating Sustainability into Capital Planning

CDC continues to implement a high performance sustainable building design and construction program supported by a third party green building certification program. Larger capital projects meeting the HHS threshold limits are certified by an American National Standards Institute (ANSI) approved green building certification system. CDC currently has four U.S. Green Building Council (USGBC) "leadership in energy and environmental design" (LEED) certified projects in its inventory and Building 24 is registered with the goal of LEED certification. The CDC B&F Office has 10 LEED accredited professional credential holders. CDC is on schedule with the existing building assessments. Each building is evaluated to determine if it is in compliance with the existing building assessment tool. Assessments emphasize energy and water conservation to meet the challenges required by Energy Independence and Security Act (EISA), E.O. 13423 and 13514. CDC continues to meet all EISA and E.O. 13423 energy and water conservation targets. Project lists generated by the assessments are incorporated into the annual business plan. 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 will conduct an environmental impact statement/assessment (EIS) of the Roybal Campus to identify and describe potential environmental impacts of proposed campus modifications surrounding the 2010-2020 Roybal Campus Master Plan.

CDC continues to implement a transportation management program through the Buildings and Facilities Office. CDC implements the Fare Share Program, providing 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 (TMAs), The Clear Air Campaign, Atlanta Regional Commission's RideSmart Program, and other related agencies to address common transportation concerns, improve accessibility and mobility, share services, improve air quality, and mitigate traffic congestion by promoting alternative forms of transportation.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

There are no activities included.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Buildings and Facilities	$69,140	$69,150	$30,000	-$39,140

MEASURES TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
12.E.1: Reduce Energy and Water consumption. Implement high performance energy and water sustainability requirements (Efficiency)	FY 2010: 17.08%(E); 13.1%(W) (Target Exceeded)	15% (E); 6% (W)	21%(E); 10%(W)	+6 (E) +4 (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 2010: 17.4% (Target Exceeded)	5%	9%	+4
Long Term Objective 12.1: Execute Earned Value Analysis/Earned Value Management for Project Management				
12.1.1: Aggregate of scores for capital and repair/improvement projects rated on scope, schedule, and cost (Output)	FY 2010: .99 (Target Met)	1.00±0.09	1.00±0.08	-.01
Long Term Objective 12.2: Execute Business and Project Tactics				
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 2010: 94 % (Target Exceeded)	89%	91%	+2
12.2.1b: 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: Customer Satisfaction Survey Results (Output)[1]	FY 2010: N/A	80%	N/A	N/A
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 2010: 86.39 CI (Target Not Met)	90 CI	90 CI	Maintain

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2010: .61% (Target Exceeded)	5%	2%	-3
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 2010: 2.14%O; 1.84%U (Target Exceeded)	6.7%O, 5.00%U	6.7%O, 5.00%U	Maintain
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 2010: $8.57 /sq. ft. (Target Exceeded)	$10.29 /sq. ft.	$10.29 /sq. ft.	Maintain

[1]The Customer Satisfaction Survey System previously in use at the CDC was deactivated on March 16th, 2010. BFO will be working in the next two years to implement its own Customer Satisfaction Survey System.

CDC BUILDINGS AND FACILITIES 5 YEAR FACILITIES PLAN

The Centers for Disease Control and Prevention, Buildings and Facilities Offices
5-Year Facilities Plan - Years 2011 - 2017 (25 Jan 11)

Capital Projects (B&F), Major and Minor Construction					Projected Costs and Funding Year (millions of 2010$)									
Project Location, Building Number, Building Name	**Capital Plan**	Project Status*	Project Type/1	Project Purpose/2	Actual FY2009	Actual FY2010	C.J FY2011	OMBJ FY2012	Planning FY2013	Planning FY2014	Planning FY2015	Planning FY2016	Planning FY2017	Est. Total Project Cost
Roybal, B24, Infectious Diseases Research Support Building 5/	2000-2009	Cons	NC	Repl	$69.3									$132.3
Chamblee, B107, Research Support Building 3/ 5/	2000-2009	FPAA	NC	LC	$50.7	$39.1	$8.5							$90.7
Chamblee, B108, Research Support Building 5/	2000-2009	FPAA	NC	LC										
San Juan, PR, Laboratory Expansion 6/	2010-2020	FPAA	NC	NP										$7.9
NIOSH HERL Laboratory Addition, Morgantown 6/	2010-2020	FPAA	NC	NP										$3.8
Cincinnati, Laboratory Consolidation	2010-2020	Planned	NC	Repl					$5.0	$125.0	$124.0			$254.0
Chamblee, B112, Environmental Health Laboratory	2010-2020	Planned	NC	NP										
Roybal, B25, Infectious Disease Laboratory	2010-2020	Planned	NC	NP										
Roybal, B22, Research Support Building	2010-2020	Planned	NC	LC										
Roybal, B26, Research Support Building	2010-2020	Planned	NC	LC										
Pittsburgh, Consolidated Laboratory	2010-2020	Planned	NC	NP										
Pittsburgh, Transshipment and Visitor Processing Facility	2010-2020	Planned	NC	NP										
Atlanta Area, NCEH COOP Lab	2010-2020	Planned	NC	NP										
Real Property Acquisition Projects (B&F)														
Fairchance, PA, Lake Lynn Laboratory 4/	2000-2009	FPAA	Purch	LC	$4.8									$4.8
Morgantown, WV, Security Setback	2010-2020	Planned	Purch	Sec							$13.7			$13.7
Sub-Total, Capital Projects (B&F)					$124.8	$39.1	$8.5	$0.0	$5.0	$125.0	$137.7	$0.0	$0.0	
Nationwide Repair & Improvement (R&I) Program														
Projected Line-Item Projects														
Spokane, NIOSH Laboratory Modernization	2010-2020	FPAA	Mod	Repl/NP		$4.5								$4.5
NIOSH Mine Rescue & Escape Training Lab, PRC 7/	2010-2020	FPAA	Mod	NP		$1.2								$2.3
HSPD-12 Cardkey System Conversion, Multiple Campuses	2010-2020	Planned	Equip	Sec				$10.0						$10.0
Sub-Total Major (Line-Item) Repair & Improvement Projects					$0.0	$5.7	$0.0	$10.0	$0.0	$0.0	$0.0	$0.0	$0.0	
Planning	Annual													
Lump Sum R&I Program (R&I)	Annual		Various	Various	$25.2	$24.3	$6.5	$20.0	$30.0	$30.0	$30.0	$30.0	$30.0	
Sub-Total R&I Funding					$25.2	$30.0	$6.5	$30.0	$30.0	$30.0	$30.0	$30.0	$30.0	
Overseas Facility Program														
TBD														
Other														
Ft. Collins Laboratory					$1.5									
Total B&F Requirement (Sum of Construction, Acquisition, and R&I)					$151.5	$69.1	$15.0	$30.0	$35.0	$155.0	$167.7	$30.0	$30.0	

1/ - **NC** = New Construction incl. Expansion; **Mod** = Asset Modernization/Improvement; **Purch** = Asset/Real Property Purchase; **Rep** = Repair; **Equip** = Equipment Upgrades or Provision
2/ - **NP** = New Program Requirement; **Repl** = Facility-Driven Building Replacement/Modernization; **Sec** = Security Project; **OPS** = Operations Project; **LC** = Lease Consolidation
3/ - Included in Total Project Cost, $.6M of optional Program - funded Project (OPS) component - non-B&F funding for AV equipment or similar and R&I of $.096 in FY09 and $0.176 of funding from prior years.
4/- Subject to specific legislative authority to purchase property. In accordance with OGC opinion, FY09 funds of $4.75M are being used for Lake Lynn Acquisition.
CDC is reapportioning prior year funds of $4.75M to FY09 R&I to achieve required R&I funding level of $30M
5/ - Prior year recovered funds of $2M associated with Building #24 are being allocated to Building #108 and then reallocated to Building #107.
6/- These projects are proposed to be funded with reallocated prior year R&I funds as "urgent projects" in accordance with HHS and OMB policy. They are subject to OMB consideration upon receipt of FY11 appropriation.
7/- The Total Project Cost of $2.3M consists of $1.2M of B&F and R&I funds. The remainder of $1.1M is made up of program funded special equipment.
"**Planned**" = Project status preliminary projections only. Status to be verified by full PDS prior to budgetary submission
* Status: FPAA - Project is in FPAA development or approval phase; Acq - Project is in property acquisition phase; Des - Project is in design phase; Cons - Project is under construction
* *All outyear cost projections are in 2010$, and must be adjusted for inflation and other conditions per final PDS-level estimates prior to budget submission.*

CDC BUILDINGS AND FACILITIES CARRYOVER TABLE

CDC Buildings and Facilities Carryover by Fiscal Year Project	Carryover From FY2007	Carryover From FY2008	Carryover From FY2009	Carryover From FY2010	Projected Carryover FY2011	Projected Carryover FY2012
Roybal, Emerging Infectious Disease Lab, Bldg #18	0	0	0	0	0	**0**
Roybal, Scientific Communications Center, Bldg #19	0	0	0	37,729	0	**0**
Roybal, Transshipment/Infrastructure Project, Bldg #20	3,114,959	2,389,908	1,030,045	1,721,404	0	**0**
Roybal, Headquarters & Emergency Operations Center, Bldg #21	0	0	63,665	63,665	0	**0**
Roybal, Blast-Resistant Glazing, Bldgs 1E, 2, and 16	0	0	25,805	25,805	0	**0**
Roybal, Entrance Security Modifications	171	0	20,817	54,685	0	**0**
Chamblee, Secure Entrance/Site work	0	0	0	0	0	**0**
Bldgs. #107	0	0	24,350,000	26,423,396	11,400,000	**0**
Bldgs. #108	0	0	26,350,000	0	0	**0**
Chamblee, Parasitic Disease Lab, Bldg #109	1,831	0	17,295	17,295	0	**0**
Roybal, East Campus Consolidated Lab Project, Bldg # 23	39,753,289	37,330,929	10,849,877	6,456,901	0	**0**
Chamblee, Environmental Health Facility, Bldg # 106	1,604,303	524,822	518,662	522,077	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	1,251,844	1,201,844	1,219,744	1,219,744	0	**0**
All Campuses, Emergency Fire & Life Safety Initiative	479,853	270,563	270,563	270,563	0	**0**
Repairs and Improvement	50,438,393	27,195,778	34,130,141	39,103,481	2,000,000	**0**
CCID Roybal, B24 Epi Tower	10,671,211	56,507,000	39,777,808	28,777,847	0	**0**
Data Center/Recovery Site	817,575	580,927	976,936	1,398,474	0	**0**
Cincinnati Lab Consolidation Project	0	0	0	62,423	0	**0**
Ft. Collins Laboratory	0	0	572,328	572,328	0	**0**
Fort Collins, DVBID Replacement Lab	1,117,414	14,793	77,047	88,296	0	**0**
Ft. Collins, DVBID Shell Space Project	16,329,669	1,955,406	1,060,149	513,972	0	**0**
Roybal, Bldg #17	16,241	0	0	0	0	**0**
Lake Lynn Laboratory Property Acquisition	4,700,000	4,750,000	4,750,000	4,407,129	0	**0**
Arctic Investigation Program (AIP) Laboratory Renovation Addition	0	3,524,000	519,737	221,596	0	0
Totals	130,296,753	136,245,970	146,580,619	111,958,810	13,400,000	0

BUSINESS SERVICES SUPPORT

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$366,707	$366,762	$417,466	+$50,759
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
ACA/PPHF	$0	$0	$0	$0
Total	**$366,707**	**$366,762**	**$417,466**	**+$50,759**
FTEs	1,336	1,349	1,359	+23

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $417,466,000 for Business Services Support (BSS) reflects an overall increase of $50,759,000 above the FY 2010 level. This increase is critical to the success of CDC's program operations supporting key business services which serve CDC's public health programs. Information Technology (IT) services, rent and facilities maintenance, and utilities costs comprise approximately 80 percent of the BSS budget request.

In FY 2012, CDC will:

- Continue base funding for business services support for all of CDC's programs. These functions include rent, utilities, maintenance, security, financial management, grants and acquisition support, and all information technology hardware, software, security, and support for CDC's more than 10,000 employees. These services are essential to CDC program operations.
- Fund the necessary costs for:
  - Replace the expiring lease for the Hyattsville building at current market lease rates, including building preparations, moving, and outfitting expenses.
  - Operations and maintenance contracts for CDC-owned buildings.
  - Standardizing capabilities for the Unified Financial Management System.
  - Meeting requirements related to the Homeland Security Presidential Directive-12.
  - Upgrading CDC's information technology infrastructure.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 307, 308D, 310, 311, 317, 319, 319D, 327, 352, 399G, 1102; Bayh-Dole Act of 1980, P.L. 96-517 .

Specific Authorities: PHSA §§ 306, 308A-C, 317F, 319A, 321, 322, 325, 361-369, 391, 2315, 2341; Federal Technology Transfer Act of 1986 (15 U.S.C. 3710); Clinical Laboratory Improvement Amendments of 1988 § 4 (42 USC Sec. 263a)

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

Allocation Method: Direct/Federal; Contracts

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$378,289,000
FY 2008	$371,847,000
FY 2009	$359,877,000
FY 2010*	$366,707,000
FY 2011CR	$366,762,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Business Services Support

CDC's FY 2012 request of $417,466,000 for BSS reflects an increase of $50,759,000 above the FY 2010 level. This requested increase is critical to CDC's ability to accomplish its mission and maintain critical business services to support program operations.

Since FY 2005, CDC's scope, budget, and staffing have grown, leading to a significant increase in the demand for business services. Costs to support FTEs have increased due to inflation, and FTE growth has led to a greater demand for business services such as IT staff support, cabling/wiring, network connectivity, security systems, computer hardware and software, furniture, and rent. In addition, CDC continues to lead a number of national labor intensive efforts including the American Recovery and Reinvestment Act of 2009 requiring CDC expertise.

In FY 2012, CDC will:

- Continue base funding for business services support for all of CDC's programs. These functions include rent, utilities, maintenance, security, financial management, grants and acquisition support, and all information technology hardware, software, security, and support for CDC's employees and contractors. These services are essential to CDC program operations.
- Replace the expiring lease for the Hyattsville ($11,800,000) building at current market lease rates, including building preparations, moving, and outfitting expenses.
- Combine $18,100,000 from the increase in the FY 2012 request with $16,700,000 of base funding, to maintain operation and maintenance (O&M) contracts at current levels for CDC-owned buildings (consistent with the Condition Index and Sustainability Improvement Plan) for a full twelve months ($34,800,000).
- Upgrade the Unified Financial Management System (UFMS) by standardizing financial capabilities and enhancing information availability and reporting, including an increase in CDC's estimated share of the Department's planned upgrade from FY 2010 to FY 2012.
- Fulfill the FY 2012 requirements related to the Homeland Security Presidential Directive (HSPD-12) including logical access plan implementation, credentialing, physical access plan completion, and identity management processing.
- Maintain CDC's information technology infrastructure, including network modernization, storage and server replacements, and user hardware refreshment.

Program Description and Recent Accomplishments: CDC's 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 (BSO) 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:

- Building 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 Building and Facilities Line. Additional information on these expenditures can be found in the Business 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 the Department of Health and Human Services (HHS), the Office of Management and Budget (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.

Performance: Starting in FY 2012, CDC has included a number of performance measures to better quantify the impact of business services. Additionally, CDC has implemented a number of cost saving measures over the past five years. Examples are highlighted below:

- Building and Facilities Maintenance: Over the past five years CDC has pursued a number of strategies including aggressive contract negotiation and reducing the number of outside contractors to maintain service levels under fiscal restraints. For example, BFO renegotiated a major janitorial contract that reduced the annual cost by approximately ten percent or $3,000,000 and BFO retrained some members of the in-house workforce to maintain several cardkey systems saving $1,500,000 annually.

- IT Infrastructure: Over the past five years CDC has aggressively reduced IT infrastructure costs through consolidation, automation, and using industry best practices and technologies. Reduced energy usage for IT functions by reducing number of physical servers from 2,000 to 600, and using virtualization technologies to consolidate nine data centers down to two. However, BSS funding limitations have reduced CDC's IT infrastructure budget by greater than 40 percent, resulting in numerous deficiencies including technology refresh, keeping pace with CDC's growth in mission, systems, workforce, tremendous data growth, and global expansion. Additionally, the CDC network is currently probed by external hackers seven times a second, up from once every 1.5 seconds in 2007. Without additional investments in technology and IT security, CDC data could be compromised.
- Physical Security: The Office of Security and Emergency Preparedness renegotiated contracts by refining physical security activities which reduced projected costs by $3,000,000.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

There are no activities included.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Business Services Support	**$366,707**	**$366,762**	**$417,466**	**+$50,759**

INFORMATION RESOURCES PERFORMANCE METRICS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target
Increase Freedom of Information Act responsiveness by reducing overdue FOIA requests as part of HHS Open Government Plan	245	N/A	177
Publish CDC public health data sets on Data.Gov	6	N/A	12
Provide reliable and responsive IT infrastructure to support >500M page views per year by the public	99.8% reliability	N/A	99.9% reliability
Enhance remote access IT infrastructure to improve connectivity for mobile workforce, telework, and emergency continuity of operations	3,000 simultaneous users	N/A	10,000 simultaneous users

FINANCIAL MANAGEMENT PERFORMANCE METRICS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target
Maintain an unqualified, clean financial statements audit opinion	Unqualified	Unqualified	Unqualified
Prompt Payment -% invoices paid on time	98.66%	98%	98%
Limit interest penalties paid ($ interest per $1 million in payments)	$55	<=$200	<=$200

HEALTH CLINIC PERFORMANCE MEASURES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target
Provide deployment medical surveillance for staff requesting within 72 hours	Baseline to be established	N/A	90%

PROCUREMENT AND GRANTS PERFORMANCE METRICS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target
75% or more of eligible contract dollars over micro-purchase threshold awarded through competition	92%	75%	Maintain
Reduction in the number of actions involving high risk contract types (non-competitive, competitive one-bid, cost reimbursement, etc.)	2,548	N/A	-10%
Decrease the number of contracts/orders eligible for closeout at the end of the previous year	22,570	N/A	-20%

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$1,522,339	$1,522,565	1,422,618	-$99,721
PHS Evaluation Transfer	*$0*	*$0*	*$0*	*$0*
PHSSEF - Transfer[1]	$0	$0	$30,000	+$30,000
ACA/PPHF	$0	$0	$0	$0
Total	**$1,522,339**	**$1,522,565**	**1,452,618**	**-$69,721**
FTEs	412	414	414	+2

[1] The FY 2012 President's Budget proposed to partially finance Strategic National Stockpile activities with unobligated balances from the Public Health and Social Services Emergency Fund (PHSSEF).

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $1,452,618,000, including $30,000,000 from the Public Health and Social Services Emergency Fund (PHSSEF), for Public Health Preparedness and Response reflects an overall decrease of $69,721,000 below the FY 2010 level for administrative savings. The FY 2012 request also includes a decrease of $71,579,000 from the Public Health Emergency Preparedness Cooperative Agreement and an increase of $59,339,000 for the Strategic National Stockpile. The request also eliminates funding for the Academic Centers for Public Health Preparedness ($30,008,000) and Advanced Practice Centers ($5,262,000), as these programs did not demonstrate a clear return on investment. The elimination of the Anthrax Vaccine Research Program and a consolidation of agency-wide preparedness efforts resulted in a decrease of $19,122,000 from CDC Preparedness and Capacity budget, as compared to the FY 2010 level.

FY 2012 funds will be used to sustain CDC preparedness and response capabilities, provide critical support to state and local health departments, and manage the Strategic National Stockpile. The United States must continually improve the ability of the Federal government; State, local, tribal, and territorial governments; and health care systems to prevent, protect against, respond to, and recover from the consequences of public health events, whether man-made or naturally occurring. CDC continues to support and guide improvements in preparedness and response systems at the federal, state, and local levels. Funding supports CDC staff who coordinate strategic direction, provide preparedness and response resources, maintain a platform for public health preparedness and response, engage key stakeholders, and report on progress and challenges on CDC-wide preparedness and response efforts.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 307, 311, 317, 319, 319D

Program Specific Authorities: PHSA §§ 319C-1, 319F, 319F-2, 319G, 351A, 352, 369

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……………………………………………………………Expired/Indefinite

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

FUNDING HISTORY

Public Health Preparedness and Response	
Fiscal Year	**Amount**
FY 2007	$1,472,553,000
FY 2008	$1,479,455,000
FY 2009	$1,514,657,000
FY 2010*	$1,522,339,000
FY 2011CR	$1,522,565,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

Strategic National Stockpile	
Fiscal Year	**Amount**
FY 2002	$645,000,000
FY 2003	$298,050,000
FY 2004	$397,640,000
FY 2005	$466,700,000
FY 2006	$524,339,000
FY 2007	$496,348,000
FY 2008	$551,509,000
FY 2009	$570,307,000
FY 2010*	$595,661,000
FY 2011CR	$595,749,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Public Health Emergency Preparedness

CDC's FY 2012 request of $643,264,000 for the Public Health Emergency Preparedness Cooperative Agreement is $71,579,000 below the FY 2010 level. Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, CDC supports preparedness nationwide by providing technical assistance and funding to state and local public health agencies. The PHEP program will provide nearly $9 billion in funding from 2001-2012 for these efforts. Great progress in preparing for public health emergencies has been made with the Federal investment at the State and local level. As localities take on a greater role in preparedness, less support from the Federal government should be required. These grants support local public health preparedness efforts, and are coordinated with the Hospital Preparedness grants administered by the Assistant Secretary for Preparedness and Response.

In FY 2012, CDC will:

- Continue to improve the public health emergency preparedness and response capabilities of the 62 state and local public health department PHEP awardees to help ensure these agencies can effectively respond to consequences of infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies. In August 2011, a new five-year PHEP program announcement will go into effect, providing stronger focus on state and local public health preparedness capabilities that align with the National Health Security Strategy.

- Provide resources and a more structured technical assistance program based on the new PHEP capabilities model to improve State and local public health departments' emergency preparedness and response capabilities, as envisioned by the National Health Security Strategy. Technical assistance will be measured through the reporting of specifically-required performance measures contained within the PHEP Cooperative Agreement.

Performance: CDC continued to increase state and local performance accountability through required performance measure reporting, including reporting the time it takes for state and local public health emergency staff covering activated incident management roles to assemble, a measure currently designated as a High Priority Performance Goal (HPPG). By the end of 2011, CDC's HPPG is to increase the number of state public health agencies that can convene a team of trained staff that can make decisions about appropriate response and interaction with partners within 60 minutes of notification from a 2009 baseline of 70 percent to 90 percent. CDC provides focused technical assistance to awardees that are not meeting the 60 minute target to support their efforts to meet the HPPG performance measure. By improving the ability of state and local public health emergency staff to rapidly convene staff to integrate information and prioritize resource allocation, CDC ensured more timely and effective coordination within the public health system and with key response partners during an emergency response. (Measures 13.5.2, 13.5.3 and 13.5.4)

Program Description and Recent Accomplishments: CDC, through the PHEP cooperative agreement, supports preparedness nationwide by providing technical assistance and funding to state and local public health agencies. This program is designed to enable these agencies to carry out activities that align with the Pandemic and All-Hazards Preparedness Act's (PAHPA) priorities for national preparedness and response, leadership, organization, and planning, as well as public health security preparedness.

Recent accomplishments include:

- Built upon the PHEP cooperative agreement framework to rapidly distribute to PHEP awardees $1.35 billion of 2009 H1N1 Supplemental funding from the PHSSEF in four phases.
- Replaced obsolete chemical laboratory instruments (Agilent Technologies GC-MS system) with state-of-the-art instruments, that enable on-going testing of food and environmental samples to detect and investigate disease outbreaks, for awardees with chemical laboratories, 10 Biosafety Level 1 (BSL 1), and 35 Biosafety Level 2 (BSL 2) laboratories.
- Developed pandemic influenza response plans, including mass vaccination, antiviral distribution, and risk communication elements, that enabled awardees' response to 2009 H1N1 influenza.
- Released the report, "Public Health Preparedness: Strengthening the Nation's Emergency Response State by State." The report features national data and fact sheets on preparedness activities for each of the 50 states and 4 localities supported by CDC's PHEP cooperative agreement.

CDC Preparedness and Response Capability

CDC's FY 2012 request of $146,570,000 for Preparedness and Response Capabilities is $19,122,000 below the FY 2010 level as a result of the elimination of the Anthrax Vaccine Research Program and savings from consolidation of agency-wide preparedness efforts. CDC's preparedness and response capabilities directly protect the health and safety of Americans during emergencies, foster resilience in response to emergencies, and enhance the ability of the public health workforce to protect public health at home and abroad.

- In FY 2012, CDC will: Serve as the Federal government lead for public health incident management, providing a structure for collecting and using epidemiologic information to detect and respond to public health events, supporting information sharing during emergencies, and coordinating public health response activities.
- Participate in interagency planning efforts across the full spectrum of response operations, conduct public health contingency and crisis action planning, provide coordinated public health incident reporting, and identify public health preparedness strengths and areas for improvement. Serve as technical advisor to global, state, and local public health agencies in emergency risk communication.
- Improve public health situational awareness by integrating analytical and visualization tools, social-networking capabilities, and developing a virtual emergency operations center.
- Improve biosafety and biosecurity by: increasing the number of select agent-registered entities inspected on an 18- month schedule, implementing Executive Order 13546 to identify and take a risk-based approach to the regulation of Tier 1 and other agents, and enhancing the review and issuance of CDC Import Permits and Select Agent Entity Amendments.
- Implement a new IT infrastructure for the registration of select agent-registered entities and enable improved communication and sharing of information among federal departments and agencies.
- Expand the network of state and local syndromic surveillance systems by eight jurisdictions to provide a regional and national common operating picture during a public health response.
- Provide direct technical assistance to state and local public health departments, labs, hospitals, and national partner organizations to modify/enhance public health information systems, certify compliance with data exchange standards, and implement data exchanges.
- Expand, upgrade, and maintain CDC laboratory capacity to respond to chemical emergencies, including using blood and urine measurements to identify to which chemical agents people may have been exposed.
- Develop and conduct 45 training sessions to enhance and expand state public health laboratories chemical agent threat capabilities and capacity, conduct a minimum of 24 proficiency challenges with state public health laboratories, and coordinate two national surge capacity exercises for a chemical threat event.
- Improve selected laboratory assays for identifying public health threat agents through additional validation processes against the new Public Health Actionable Assay (PHAA) standards co-developed by CDC and the Department of Homeland Security for enhanced performance in rapid agent detection.
- Develop a more robust Bioterrorism Rapid Respond and Advance Technology Laboratory, which will facilitate and collaborate to increase the number of antigen detection assays for rapid identification of biothreat toxins by Laboratory Response Network (LRN) member facilities.

<u>Performance</u>: CDC investments in preparedness contributed toward improved performance across the spectrum of preparedness and response, from identification of public health threats to response. In order to ensure Laboratory Response Network (LRN) laboratories were able to readily identify biological and chemical threat agents, 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 report test results. LRN Real Time Laboratory Information Exchange provided

LRN laboratories with a common platform for data exchange using consistent data elements and terminology across the LRN. 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. Emergency communication system activities increased the strategic integration of traditional and new media and better engaged hard-to-reach populations and stakeholders with critical information about these public health events. Epi-X strengthened informational awareness and improved public health response by rapidly communicating about events and rapidly inputting surveillance information from users and others in the field. The increased number of investigations by EIS officers and training activities for EIS officers has improved front-line capability to collect and analyze epidemiological data during an emergency response. (Measures 13.1.1, 13.1.2, 13.1.3, 13.3.1, 13.5.1 13.4.8, 13.4.15, 13.E.2)

Program Description and Recent Accomplishments: CDC Preparedness and Response Capability funds activities across CDC that directly protect the health and safety of Americans during emergencies, foster resilience in response to emergencies, and enhance the ability of the public health workforce to protect public health at home and abroad. This includes activities to systematically prepare for, respond to, investigate, intervene in, and recover from public health threats, such as outbreak investigations, laboratory analysis, emergency response and support, emergency exercises, health hazard evaluations, hazardous substances assessments, and risk and emergency communications.

CDC's preparedness and response capability funding supports many critical activities for public health preparedness and response. For example, to ensure the capability to detect public health events when they occur, CDC supports the LRN, a network of state, local, federal, and international laboratories which provides rapid testing capacity to respond to biological, chemical, radiological and nuclear terrorism and other public health emergencies. CDC's Real Time Laboratory Information Exchange effort equips LRN laboratories with tools and processes to share electronic data securely with public health partners in real-time, according to industry standards. The LRN Results Messenger is a software solution created to provide LRN labs with the immediate ability to manage and share standard LRN-specific laboratory data. The Laboratory Information Management System Integration (LIMSi) project is developing a "next generation" approach that will provide a uniform, secure mechanism for labs to share LRN-related lab results in real-time to improve data messaging efficiency and reduce transcription error.

To prevent the accidental or intentional release of certain high-threat agents, CDC's Select Agent program regulates the possession, use, and transfer of 51 biological agents and toxins that could pose a severe threat to public health and safety. CDC maintains active registrations and inspects more than 300 entities that possess select agents and toxins in the United States, including government agencies, academic institutions, and corporations, and works in collaboration with the U.S. Department of Agriculture (USDA) Animal and Plant Health Inspection Service (APHIS), and the Department of Justice's (DOJ) Criminal Justice Information Services (CJIS).

Funding also supports the CDC Emergency Operations Center (EOC). The EOC operates 24 hours a day, 365 days of the year, and serves as the central public health incident management center for strategy development, information collection, analysis and distribution, and communications during a response. The EOC provides a scalable platform for the agency's response to public health events, providing scientists and subject matter experts with the tools and capabilities to rapidly respond.

Recent accomplishments include:

- Provided the platform for CDC and the Federal government's response to major public health events such as the 2009 H1N1 influenza pandemic, *Salmonella*, anthrax disease in New Hampshire, the Haiti earthquake, the Pakistan Cholera/Flood, 49 Epi-AID missions, and the Deepwater Horizon Gulf Oil Spill. Assisted in the management of three multistate *Salmonella* outbreak investigation call centers. Provided the EOC staff and infrastructure to stand up CDC's Incident Management System, before supplemental funds were awarded, to rapidly move more than 1,000 CDC responders out into the field for events such as the 2009 H1N1 and the Haiti earthquake. Staff developed and disseminated 2,000 communications documents, as well as the translation of multiple documents in support of numerous response activities, implemented the GPS tracking system, and LifeGuard for CDC deployers.
- Responded to 47 requests from state and local public health agencies in the first half of FY 2010 for CDC's epidemiologic assistance by deploying trained epidemiologists, medical officers, and scientists to provide advice and technical assistance to prevent the spread of disease or continuing exposure to hazardous substances.
- Conducted 184 inspections (167 routine and 17 non-routine) in 2010 to ensure that appropriate security and safety measures were in place to deter the theft, loss, or release of select agents. Established, in collaboration with APHIS, a confidential means for reporting safety and security issues associated with the possession, use, and transfer of select agents and toxins.

BioSense

As mandated in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, CDC's BioSense program has the aim of establishing an integrated system of nationwide public health surveillance for the early detection and prompt assessment of potential bioterrorism-related illness. Since that time, the scope of the BioSense program has broadened to provide timely situational awareness throughout the course of public health emergencies. Since 2004, the BioSense program has received patient data and, since 2005, real-time clinical data. Laboratory and pharmacy data are also received from national data sources.

By 2012, through integration of local and state-level information, CDC will provide a more timely and cohesive picture at the regional (i.e., multistate) and national levels and improve BioSense's utility. Key components to improve regional and national situation awareness include: 1) adoption of a user-centered approach to program implementation to increase local and state jurisdictions' participation in BioSense; 2) building health monitoring infrastructure and workforce capacity where needed at the state, local, tribal, and territorial levels; and 3) support for syndromic surveillance functionality as a Meaningful Use of electronic health record adoption at the State, local, tribal, and territorial levels.

In FY 2012, CDC will:

- Provide shared situation awareness for the public health community and connect existing systems and networks. This approach focuses on reducing incompatible surveillance systems; sharing of data across jurisdictions and at the national level that can support planning and decision making during an outbreak; and communicating across jurisdictions thereby contributing to a comprehensive and coordinated approach to surveillance.
- Redesign the BioSense program to enhance and expand nationwide and regional situational awareness for all-hazard health threats (beyond bioterrorism) and to support national, state, and local responses to those threats.

- Improve the ability to detect emerging health threats by supporting the enhancement of existing State, local, tribal, and territorial public health surveillance systems to signal alerts for potential health problems, facilitate exchange of health-related information that can be used to coordinate responses, monitor events, and assess health care capacity during an event.
- Improve BioSense surveillance and health indicator data quality, timeliness, and representativeness.

Program Description and Recent Accomplishments:

BioSense is a national program to improve capabilities for rapid disease detection, monitoring, and real-time situation awareness through access to existing data from health care organizations. The BioSense program's long-term business case is to support the enhancement of existing State, local, tribal, and territorial public health surveillance systems to enable: 1) all-hazards regional and federal public health situation awareness, 2) effective use of information supporting routine public health practice, and 3) improved health outcomes and population health. This updated direction to the BioSense program will ensure a collaborative environment for all stages of public health preparedness and response activities. It will further help improve the effectiveness of the interactions between health department electronic surveillance systems and human analysts, decision makers and responders. Additionally, the BioSense program will support development of state and local capability to conduct syndromic surveillance as a Meaningful Use of electronic health record technology at State, local, tribal, and territorial levels.

BioSense has made tremendous progress in enhancing public health capacity at the state and local level to participate in and contribute to a national public health surveillance network. In FY 2010, the BioSense Program monitored 425 outpatient and emergency department (ED) patient visits per 1,000 population in United States (Measure 13.1.1), exceeding its target. In FY 2010, CDC started redesigning the BioSense program based on input and guidance from CDC programs and our local, state, and federal partners. The goal of the redesign effort is to be able to provide nationwide and regional situational awareness for all-hazard health-related events (beyond bioterrorism) and to support national, state, and local responses to those events. The strategy is to increase BioSense program participation and utility through improving health monitoring infrastructure and workforce capacity where needed at the state and local level.

Improved internal contracts-management resulted in savings being applied directly to support state health departments' syndromic surveillance efforts (approximately 11 percent, or $3 million, of FY 2010 BioSense program funds). Jurisdictions requested funding to support personnel costs (e.g., epidemiologists, statisticians, informaticians), surveillance software enhancements and modifications, and expansion of surveillance networks. Currently, seven jurisdictions have expressed interest in joining BioSense in FY 2011. Additionally, BioSense funded (>$1 million) the Council of State and Territorial Epidemiologists (CSTE), the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the International Society for Disease Surveillance (ISDS) to assist with BioSense redesign and the syndromic surveillance Meaningful Use of electronic health record technology initiatives.

Biosurveillance Coordination Activity

The Biosurveillance Coordination (BC) Activity continues to lead the development and implementation of the national strategy and approach for an integrated human health surveillance system that enhances early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and other public health emergencies originating domestically or abroad. In FY 2010, working with federal, state, local, tribal and territorial partners, BC coordinated activities necessary to enhance the nation's next-generation biosurveillance capability. These activities supported requirements and objectives outlined in the Pandemic and All Hazards Preparedness Act (P.L. 109-417), HSPD-21, the National Biosurveillance Strategy for Human Health, and the National Health Security Strategy (NHSS).

In FY 2012, CDC will:

- Lead the continued development and implementation of the national strategy and approach for an integrated and enhanced biosurveillance capability for human health.
- Establish, promote, and enhance priorities for the nation's next-generation biosurveillance capability to provide timely, comprehensive, and accessible information to strengthen public health practice, provide value to clinicians, and build upon current systems and resources.
- Coordinate development of a plan for a federal registry of cross-agency biosurveillance activities to identify, track, and understand the number and type of surveillance systems and programs.

Program Description and Recent Accomplishments:

Biosurveillance Coordination Activity seeks to integrate and efficiently manage health-related data and information across a range of information systems with the primary goal of timely and accurate population health situation awareness. The nation's current biosurveillance for human health capability rests primarily in the functions of public health surveillance and investigation and is widely distributed across local, tribal, territorial, state, federal, and international jurisdictions. CDC is uniquely positioned to lead the integration and efficient management of this health-related data and information.

CDC completed the first-ever comprehensive registry of surveillance activities that reside within CDC. The National Public Health Surveillance and Biosurveillance Registry for Human Health will provide information on over 280 surveillance systems and programs with a goal of fostering collaboration among subject matter experts within CDC.

Strategic National Stockpile

CDC's FY 2012 request of $655,000,000 for Strategic National Stockpile (SNS) reflects an increase of $59,339,000 above the FY 2010 level. The request includes $30,000,000 from the Public Health and Social Services Emergency Fund (PHSSEF). The SNS is a national repository of life-saving pharmaceuticals, medical supplies, Federal Medical Station (FMS) units, and equipment available and managed for rapid delivery in the event of a catastrophic health event. SNS also provides for planning, training, and exercises of state and local public health representatives and emergency response personnel to quickly receive, store, stage, distribute, and dispense assets from the SNS.

In FY 2012, CDC will:

- Support the replacement of expiring medical countermeasures in high priority public health preparedness categories in accordance with recommendations by the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) in order to build and ensure the capacity to limit morbidity and mortality from public health threats. In addition, the increase will support expenses associated with initial purchase, shelf-life extension, repackaging, relabeling, replacement, and storage.
- Procure the next high-priority medical countermeasure need as determined with PHEMCE and the Biomedical Advanced Research and Development Authority.
- Continue to purchase, warehouse, and manage medical countermeasures throughout their life cycle in order to provide an adequate response during a catastrophic public health event to treat affected populations, prevent additional illness, and provide medical supplies and equipment.
- Maintain an SNS aircraft for public health emergencies. This aircraft will be used to transport CDC personnel to a site of a public health emergency to help receive and distribute SNS assets.

- Continue to sustain FMS units to provide a deployable low- to mid-acuity patient hospital bed surge for victims of catastrophic health events. This emergency response support and forward deployment strategy will contribute to mitigating the potential effects of a public health emergency.
- 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 (POD) concept. POD 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.
- Strengthen technical assistance to state and local health departments through the placement and integration of SNS field staff in high priority areas of the country.

Performance: In FY 2009 and FY 2010, CDC sustained the SNS ready for delivery within 12 to 48 hours in the event of a public health emergency, depending on the threat, in order to mitigate loss of life. CDC increased the level of state and local preparedness for dispensing countermeasures at the local level. At the end of FY 2010, 98 percent of states and directly-funded cities received acceptable SNS preparedness ratings (Measures 13.4.2–13.4.6). 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 86 percent in September 2010.

SNS demonstrated improvement in management and distribution through systems derived from proven practices and innovative solutions for acquisition, flexible storage, configuration, and emergency response support. SNS provided technical assistance and conducted 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, which lead to rapid and effective response and enhanced preparedness levels.

Program Description and Recent Accomplishments: CDC manages the science, acquisition, storage, and logistical operations of the SNS national countermeasures inventory for use during a public health emergency. CDC also provides training and technical assistance to support state and local capabilities to receive, stage, store, distribute, and dispense federal medical supplies. CDC conducts an annual formulary review process to link every item in the SNS with its source threat and requirement and determines cost projections, including costs associated with storage and replacement. A team of interagency experts led by HHS recommends new medical priority countermeasures to be contained in the SNS. The SNS, through the Department of Veterans Affairs, leverages federal purchasing power for cost efficiencies and participates in the Federal Drug Administration and Department of Defense Shelf Life Extension Project process to extend the shelf life of eligible products.

The Cities Readiness Initiative (CRI) is designed to increase bioterrorism preparedness by improving dispensing strategies and capabilities in 72 metropolitan statistical areas, covering about 55 percent of the nation's population and funding at least one city in every state. Critical to protecting public health, CRI aids state and local officials to develop and test their ability to dispense prophylaxis to 100 percent of the identified population within 48 hours of a federal decision to deploy SNS assets. CRI metropolitan statistical areas receive funding from the PHEP cooperative agreement through the states to support this goal.

Recent accomplishments include:

- Conducted the following lifesaving missions during FY 2010: Anthrax Immune Globulin (AIG) to treat a patient exposed to anthrax in Scotland; AIG to treat a patient suffering from gastrointestinal anthrax at a Boston Hospital; Anthrax Vaccine Absorbed (AVA) to provide treatment to 80 individuals exposed to anthrax through a drum circle in New Hampshire; Vaccine Immune Globulin (VIG) to treat a service member in Nashville; VIG to treat a patient with suspected smallpox injection site exposure in Kenmore, NY; and one FMS and pharmacy module and 6,500 additional beds to aid in the Haiti response.
- Increased the number of participants in the CRI that achieved major improvement in SNS readiness levels. The initiative continues to strengthen community readiness by improving staffing and resources to streamline distribution and dispensing methods, and ultimately raises the bar on the preparedness measurement scale.

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. The PHEP cooperative agreement calls for implementing interoperable systems that are consistent with the Public Health Information Network (PHIN), coordinating early warning infectious disease surveillance efforts for states sharing a common border with Mexico or Canada, and reporting influenza vaccination data. A complement to the cooperative agreement is the PERFORMS database system, which tracks the performance of individual awardees in order to monitor and evaluate individual projects. Intergovernmental partnerships also benefit from IT investment, as in the case of the National Select Agents Registry (NSAR) Program. CDC, in collaboration with APHIS, manages this 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.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

There are no activities included.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Public Health Preparedness and Response	**$1,522,339**	**$1,522,565**	**$1,452,618**	**-$69,721**
Preparedness and Response Capability	**$926,678**	**926,816**	**$797,618**	**-$129,060**
State and Local Capacity	$760,986	$761,100	$651,048	-$109,938
CDC Capacity	$165,692	$165,716	$146,570	-$19,122
Strategic National Stockpile	**$595,661**	**$595,749**	**$655,000***	**+$59,339**

*Includes $30,000,000 to be administratively transferred from PHSSEF.

MEASURES TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
13.5.E.1a: Decrease the amount of 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 2009: 12 days (Target Exceeded)	20 days	35 days	+15
13.5.E.1b: Decrease the 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 2009: 56% reduction (Target Exceeded)	23.3% reduction	0% reduction	Maintain
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 2010: $12 (Target Not Met)	$20	$18	-2
Long Term Objective 13.1: Integrate and enhance existing surveillance systems at the local, State, national, and international levels to detect, monitor, report, and evaluate public health threats.				
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) 1	FY 2010: 424 patient visits (Target Exceeded)	413 patient visits	499 patient visits	+86
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 (days) (Outcome)	FY 2010: 6.74 days (Target Not Met but Improved)	6.26 days	6 days	-0.26 days

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
13.1.3: Increase the 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 2010: 3 (Target Not Met but Improved)	5	15	+10
13.1.4a: Reduce the time needed for a Laboratory Response Network (LRN) laboratory to enter and message LRN-related standardized results to the CDC: Chemical (Outcome)	FY 2010: 10 Minutes (Target Met)	10 Minutes	7 Minutes	-3 minutes
13.1.4b: Reduce the time needed for a Laboratory Response Network (LRN) laboratory to enter and message LRN-related standardized results to the CDC: Biological (Outcome)	FY 2010: 5 Minutes (Target Met)	5 Minutes	4 Minutes	-1 minutes

Long Term Objective 13.3: 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.				
13.3.1: Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents (Output)	FY 2010: 95 % (Target Exceeded)	92 %	92 %	Maintain
Long Term Objective 13.4: Assure an integrated, sustainable, nationwide response and recover capacity to limit morbidity and mortality from public health threats.				
13.4.2: Increase the 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 2010: 98 % (Target Exceeded)	90 %	100 %	+10
13.4.4: The number of successful annual exercises that test response to multiple events with a 12-hour response time (Outcome)	FY 2010: 1 (Target Met)	1	1	Maintain
13.4.5: Number of trained and ready preparedness and response personnel available for response to multiple events (Output)	FY 2010: 19 (Target Exceeded)	15	19	+4
13.4.6: Percentage of inventory discrepancies that are reduced by using quality inventory management systems (Outcome)	FY 2010: 2.56% (Target Exceeded)	<5%	<5%	Maintain
Long Term Objective 13.5: Enhance and sustain preparedness and response capability across State, local, and territorial health departments.				
13.5.1: Percentage of states that have level three chemical lab capacity, and have agreements with and access to (specimens arriving within eight hours) a level-one chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins (Output)	FY 2010: 100% (Target Met)	100% %	Unable to report	N/A
13.5.2: Increase the 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 2009: 62 % (Target Not Met but Improved)	64 %	65 %	+1
13.5.3: Increase the percentage of public health agencies that directly receive CDC PHEP 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 2009: 68 % (Target Not Met)	75 %	91 %	+16
13.5.4: Increase the 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 2009: 60 % (Target Not Met)	66 %	68 %	+2
13.5.5: Increase the percentage of the PHPR allocation for which budget execution matches strategic funding priorities (Output)	FY 2010: 100 % (Target Met)	100 %	100 %	Maintain
13.5.6: Improve the on-time achievement of individual project milestones for Epidemiology, Laboratories and Emergency Response (Output)	FY 2010: 94 % (Target Not Met but Improved)	96 %	96 %	Maintain

13.5.7: Achieve progressive improvements in the quality of projects submitted for PHPR funding consideration (Output)	FY 2008: 83 % (Target Exceeded)	87%	90 %	+3
Long Term Objective 13.6: Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.				
13.6.1a: Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Outcome)	FY 2008: 88 % (Target Exceeded)	85 %	N/A	N/A
13.6.1b: State grantees will have a protocol for testing and documenting send/receive capabilities (Outcome)	FY 2008: 60 % (Target Not Met)	N/A	N/A	N/A
13.6.3: Number of treatments/prophylaxis for the appropriate response to known terrorist threats or public health emergencies for chemical, biological, radiological, and nuclear threats in millions (Intermediate Outcome)	FY 2008: N/A (In Progress)	N/A	N/A	N/A
13.6.7: By 2010, CDC's response operations system will decrease the time from event to actions that will minimize morbidity and mortality (Outcome)	FY 2009: N/A (In Progress)	Targets under development	N/A	N/A

[1] Measure 13.1.1 is intended to replace the former BioSense measure regarding metropolitan statistical areas covered.

OTHER OUTPUTS

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
13.A: Academic Centers for Public Health Preparedness and Emergency Response Research Centers[1]	FY 2008: 27	27	0	-27
13.B: Maintain the number of states, territories, and major metropolitan areas formally assessing public health capacity and preparedness	FY 2008: 62	62	62	Maintain

[1] Funding for the Academic and Research Centers has been eliminated in FY 2012; therefore, FY 2012 targets have been reduced to zero.

STATE TABLES

CENTERS FOR DISEASE CONTROL AND PREVENTION
FY 2012 DISCRETIONARY STATE GRANTS
Public Health Emergency Preparedness (PHEP) Program

State/Territory/Grantee	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Alabama	$10,048,585	$10,048,585	$9,200,822	-$847,763
Alaska	$5,165,000	$5,165,000	$5,015,000	-$150,000
Arizona	$14,047,671	$14,047,671	$12,928,122	-$1,119,549
Arkansas	$7,393,805	$7,393,805	$6,816,004	-$577,801
California	$49,301,738	$49,301,738	$44,856,013	-$4,445,725
Colorado	$10,875,195	$10,875,195	$9,988,981	-$886,214
Connecticut	$8,719,806	$8,719,806	$8,047,253	-$672,553
Delaware	$5,150,000	$5,150,000	$5,000,000	-$150,000
Florida	$33,481,834	$33,481,834	$30,273,439	-$3,208,395
Georgia	$18,481,819	$18,481,819	$16,885,137	-$1,596,682
Hawaii	$5,249,782	$5,249,782	$5,000,000	-$249,782
Idaho	$5,495,096	$5,495,096	$5,117,229	-$377,867
Illinois	$19,496,622	$19,496,622	$17,856,381	-$1,640,241
Indiana	$12,995,857	$12,995,857	$11,892,876	-$1,102,981
Iowa	$7,565,448	$7,565,448	$6,968,818	-$596,630
Kansas	$7,530,021	$7,530,021	$6,962,720	-$567,301
Kentucky	$9,455,848	$9,455,848	$8,816,193	-$639,655
Louisiana	$9,999,458	$9,999,458	$9,185,400	-$814,058
Maine	$5,259,067	$5,259,067	$5,068,768	-$190,299
Maryland	$12,720,551	$12,720,551	$11,726,417	-$994,134
Massachusetts	$15,229,770	$15,229,770	$13,793,625	-$1,436,145
Michigan	$20,143,034	$20,143,034	$18,190,906	-$1,952,128
Minnesota	$12,911,644	$12,911,644	$11,671,371	-$1,240,273
Mississippi	$7,527,286	$7,527,286	$6,938,678	-$588,608
Missouri	$12,572,343	$12,572,343	$11,533,803	-$1,038,540
Montana	$5,166,198	$5,166,198	$5,016,198	-$150,000
Nebraska	$5,876,388	$5,876,388	$5,460,564	-$415,824
Nevada	$7,511,623	$7,511,623	$6,971,413	-$540,210
New Hampshire	$5,349,356	$5,349,356	$5,015,000	-$334,356
New Jersey	$18,015,661	$18,015,661	$16,573,292	-$1,442,369
New Mexico	$7,643,606	$7,643,606	$6,887,230	-$756,376

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2012 DISCRETIONARY STATE GRANTS Public Health Emergency Preparedness (PHEP) Program				
State/Territory/Grantee	**FY 2010 Actual**	**FY 2011 Continuing Resolution**	**FY 2012 President's Budget**	**FY 2012 +/- FY 2010**
New York	$22,932,149	$22,932,149	$20,815,690	-$2,116,459
North Carolina	$16,552,440	$16,552,440	$15,022,992	-$1,529,448
North Dakota	$5,021,860	$5,021,860	$5,021,860	$0
Ohio	$20,947,527	$20,947,527	$19,227,819	-$1,719,708
Oklahoma	$8,487,239	$8,487,239	$7,943,639	-$543,600
Oregon	$8,871,324	$8,871,324	$8,306,994	-$564,330
Pennsylvania	$22,808,671	$22,808,671	$20,784,074	-$2,024,597
Rhode Island	$5,150,000	$5,150,000	$5,000,000	-$150,000
South Carolina	$11,034,653	$11,034,653	$9,902,873	-$1,131,780
South Dakota	$5,150,000	$5,150,000	$5,000,000	-$150,000
Tennessee	$12,711,428	$12,711,428	$11,630,503	-$1,080,925
Texas	$43,194,539	$43,194,539	$39,418,929	-$3,775,610
Utah	$7,328,511	$7,328,511	$6,771,657	-$556,854
Vermont	$5,193,078	$5,193,078	$5,043,078	-$150,000
Virginia	$17,063,098	$17,063,098	$15,440,210	-$1,622,888
Washington	$13,731,541	$13,731,541	$12,602,043	-$1,129,498
West Virginia	$5,898,188	$5,898,188	$5,477,453	-$420,735
Wisconsin	$13,276,438	$13,276,438	$11,976,935	-$1,299,503
Wyoming	$5,000,000	$5,000,000	$5,000,000	$0
Chicago	$10,639,521	$10,639,521	$10,213,906	-$425,615
Los Angeles County	$22,219,547	$22,219,547	$20,598,368	-$1,621,179
New York City	$20,602,882	$20,602,882	$19,355,220	-$1,247,662
Washington, D.C.	$6,616,482	$6,616,482	$6,378,195	-$238,287
American Samoa	$390,413	$390,413	$380,741	-$9,672
Guam	$545,470	$545,470	$519,211	-$26,259
Marshall Islands	$388,143	$388,143	$378,714	-$9,429
Micronesia	$450,174	$450,174	$434,109	-$16,065
Northern Mariana Islands	$377,263	$377,263	$368,998	-$8,265
Palau	$328,877	$328,877	$325,788	-$3,089
Puerto Rico	$8,514,449	$8,514,449	$7,924,541	-$589,908
Virgin Islands	$453,195	$453,195	$436,807	-$16,388
Total States/Cities/Territories	**$698,259,211**	**$698,259,211**	**$643,359,000**	**-$54,900,211**

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$76,792	$76,792	$76,337	-$455
ACA[1]	$23,000	$0	$0	-$23,000
Total	**$99,792**	**$76,792**	**$76,337**	**-$23,455**
FTEs	290	290	290	0

[1] The FY 2010 total reflects $23,000,000 appropriated to ATSDR under the Affordable Care Act, available for five years.

SUMMARY OF THE REQUEST

ATSDR's FY 2012 request of $76,337,000 is an overall decrease of $455,000 below the FY 2010 level for administrative savings. The FY 2012 budget request includes $2,000,000 to continue the epidemiological studies of health conditions caused by non-occupational exposures to uranium released from mining and milling operations in the Navajo Nation. The FY 2012 request also reflects a decrease of the one-time appropriation of $23,000,000, from the Affordable Care Act, that is available from FY 2010 through FY 2014 to conduct medical monitoring of persons living in (or have lived in) communities declared a public health emergency.

FY 2012 funds will support public health activities to assess and mitigate the health risks of hazardous exposures, advance the science on the health effects of hazardous substances, and deliver information on hazardous substances to health providers and the public. As a Congressionally-mandated federal public health agency, ATSDR strives to prevent hazardous exposures and related health effects in communities across America. ATSDR works with public health and environmental officials to prevent harmful exposures and protect the health of people impacted by hazardous wastes. ATSDR and funded partners meet with individuals to listen to their environmental health concerns, provide information, and conduct investigations. By working with communities, ATSDR helps to ensure that the places where people live, work and play are safe and healthy.

AUTHORIZING LEGISLATION

Specific Authorities: The Great Lakes Critical Programs Act of 1990 (33 U.S.C. 1268); Section 104(i) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA), as amended by the Superfund Amendments and Reauthorization Act of 1986 (SARA) (42 U.S.C 9604(i)); The Defense Environmental Restoration Program (10 U.S.C. § 2704); The Resource Conservation and Recovery Act, as amended (42 U.S.C 6939); The Clean Air Act, as amended (42 U.S.C. 7401 et seq); The Affordable Care Act Prevention and Public Health Fund of 2010 (P.L.111-148); Social Security Act § 2009 (42 USC 1397h).

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization…..……………………………………………………….………..……….Indefinite

Allocation Methods: Direct Federal/Intramural; Competitive Grants/Cooperative Agreements; Contracts; Other

FUNDING HISTORY

Fiscal Year	Amount
FY 2007	$74,905,000
FY 2008	$75,212,000
FY 2009	$74,039,000
FY 2010	$76,792,000
FY 2011CR	$76,792,000

BUDGET REQUEST

ATSDR's FY 2012 request of $76,337,000 is $455,000 below the FY 2010 level for administrative savings. ATSDR's FY 2012 budget request will support work to safeguard communities from chemical exposures. ATSDR will continue to work closely with Federal, Tribal, State, and local agencies to identify potential exposures; assess associated health effects; and recommend actions to stop, prevent, or minimize these harmful effects. ATSDR's field staff, located in Environmental Protection Agency (EPA) regional offices, and state-level staff supported by the cooperative agreement program, comprise a national network of public health experts who respond to a broad range of hazardous waste and chemical release related issues. ATSDR's FY 2012 activities will serve three complementary functions: assess and mitigate health risks from hazardous exposures; advance the science on hazardous exposures; and deliver information on hazardous substances to health professionals and the public. Additional information about these areas is presented below.

Assess and Mitigate Health Risks from Hazardous Exposures

In FY 2012, ATSDR will:

- Fund up to 25 State health departments and one Tribal government (average award of $400,000) to assess risks from hazardous exposures at sites, make recommendations for risk mitigation, and deliver health education and community-based interventions.
- Assess possible hazards at 300-400 sites to identify sites where corrective actions are necessary. The recommendations from these assessments will be used to protect communities from hazardous exposures to chemicals.
- Provide over 1,400 technical assists in response to requests from external stakeholders (e.g., regulatory agencies, public health agencies, and the public). ATSDR's technical input and/or educational information will inform decision-making regarding environmental health issues.
- Implement public health activities to mitigate exposures in at least 50 sites with a significant public health focus that requires enhanced collaboration with regulatory agencies, communities, and/or others. ATSDR will collect and analyze data regarding site activities, goals and objectives, findings, recommendations, follow-up activities, and public health impacts in order to inform specific mitigation recommendations.
- Provide health expertise to local governments and developers to inform policy and practice at 20 Brownfield redevelopment sites. This includes support for site assessment activities, emergencies, national exposure issues, and community education and outreach.
- Respond to at least 100 time-critical requests from Federal, State, and/or local emergency response personnel addressing chemical releases associated with emergency events. These time critical requests will result in reduction of exposures to chemical contaminants in air, soil, and water to the public. These time-critical responses will initiate from the 10 ATSDR regional offices.

Performance: ATSDR works to prevent and eliminate harmful environmental exposures by recommending and implementing effective public health protection actions. Human exposures to hazardous substances decrease when ATSDR's recommendations are followed, resulting in a reduction in the negative health impacts that are associated with exposures. In FY 2010, the EPA, state regulatory agencies, or private industries accepted ATSDR's recommendations at 87 percent of sites with documented exposures. Since FY 2005, ATSDR exceeded all of the performance targets that track acceptance of their recommendations at sites with documented exposures (Measure 14.1.1). Additionally, ATSDR works to protect human health by preventing or mitigating human exposures to toxic substances or related health effects at sites with documented exposures. Based on current data, interventions have been implemented at 78 percent of sites posing an urgent or public health hazard (Measure 14.3.1). Since FY 2006, ATSDR has met or exceeded targets that track the percent of sites where ATSDR and funded partners have assessed environmental hazards and actions were taken to reduce or eliminate health risks. (Measures 14.1.1, 14.3.1, 14.B, 14.C, 14.D, and 14.F)

Program Description and Recent Accomplishments: ATSDR works to decrease exposures that can lead to a range of adverse health outcomes. This includes: investigating and preventing health effects related to human exposures to environmental hazards; preparing for and responding to emergencies, man-made disasters, and natural disasters; investigating and responding to acute hazards and exposures; and promoting prevention, control, and elimination of long-term hazardous exposures. While the complete impact of ATSDR's evaluation work is difficult to quantify, the examples described below provide a glimpse into the substantial health benefits that result from ATSDR's work.

Recent accomplishments include:

- Completed evaluations of environmental exposures at more than 500 sites in 2010 by issuing more than 200 public health assessments and consultations. Federal, State, and local authorities adopted 87 percent of ATSDR's recommendations made in these assessments, resulting in healthier and safer environments for communities.
- Released a public health advisory alerting EPA leadership of the need to take immediate actions because of very high levels of hexavalent chromium from groundwater infiltrating basements of homes and other buildings in Garfield, New Jersey. As a result, EPA took immediate action to clean up basements, thus eliminating the threat. In September 2010, the EPA began an assessment of this site for inclusion on the Superfund National Priorities List and the need to implement a permanent remedy to groundwater contamination.
- Conducted a Health Promotion Campaign in Mossville, Louisiana, a community surrounded by 14 industrial facilities, including vinyl production facilities, an oil refinery, a coal-fired power plant, and several petrochemical manufacturers. This campaign provided 30 individuals free health education on at least nine different topics that provided the community with actionable behaviors that they could employ to improve or maintain good health.
- Completed an evaluation (both peer-review and public comment) of exposures and associated public health effects of a release of 5.4 million cubic yards of coal ash that covered more than 300 acres and caused the evacuation of 22 residents in Kingston, Tennessee ATSDR and its Sate partners within the Tennessee Department of Health did not identify any exposures to coal ash contaminants at levels of health concern.

- Assessed the urgent public health hazards posed by a phosphine gas leak in Eastern Michaud Flats, Idaho in cooperation with the Idaho Department of Health and Welfare. This request from EPA included working with regulatory agencies and the site owner to install fencing and additional warning signs to prevent trespass and alert on-site workers of the hazards posed by phosphine gas, as well as implementing a robust fence line-monitoring program, and educating local emergency responders.
- Identified public health concerns that prompted Mirant Corporation and the City of Alexandria to work together to find solutions to reduce local emissions from the Mirant power plant in Virginia. The pant made changes to its boiler stack emissions configuration to increase emission velocity, thereby reducing local sulfur dioxide concentrations and resulting human exposure. At the time of ATSDR's evaluation of the ambient air data, EPA's national ambient air quality standards for sulfur dioxide did not include short-term peak levels. ATSDR identified levels for short-term public health concern. EPA recently changed the national standards to include short-term peak levels and these levels are in line with the values identified by ATSDR.
- Responded to 35 mercury spills in 2010 that affected children, some of who required medical interventions from their exposures. To reduce these events, ATSDR and EPA are working on a national outreach campaign "Don't Mess with Mercury." Materials produced for this campaign include a video, video game, and educational outreach materials for teachers and school nurses. The campaign will be posted on the EPA's national website (http://www.dontmesswithmercury.org/). Educational efforts will be conducted at schools and in areas where recent mercury spills have occurred involving adolescents.

Advance the Science on Hazardous Exposures

In FY 2012, ATSDR will:

- Establish a "Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards" pursuant to the Affordable Care Act. This program will provide screening, health education, and outreach services for residents of a geographic area subject to declared public health emergencies under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA)**.**
- Collaborate with industry and other Federal agency partners on epidemiologic research to fill up to 13 scientific information gaps that have been identified related to the health effects of hazardous substances.
- Apply emerging technological tools and methods (including computational toxicology, exposure-dose reconstruction, and geospatial information systems) to enhance ATSDR's effectiveness in assessing exposures and studying linkages between environmental contamination and health effects.
- Continue to fund seven state and local health departments to collect data on uncontrolled or illegal releases of hazardous substances and the injuries and evacuations associated with those events for the National Toxic Substance Incidents Program (NTSIP) database.
- Study health effects and exposures in specific communities through applied epidemiological studies, including exposures to solvent-contaminated drinking water in Camp LeJeune, North Carolina and uranium exposure and pregnancy and neonatal complications of mothers on the Navajo Reservation.

- Provide assistance to CDC to maintain up to three registries to identify people with exposures to toxic substances, track them over time, and provide appropriate health information, including the National Amyotrophic Lateral Sclerosis (ALS) Registry to describe the incidence and prevalence burden of ALS in the United States. The registry will also examine factors, such as environmental and occupational, that might be associated with the disease. Using the ALS registry, ATSDR will provide technical assistance to the medical, public health and stakeholders' communities to advance the understanding of the contributing factors of ALS. These activities are funded by, and coordinated with, CDC.

Performance: ATSDR engages in surveillance and research activities to increase the knowledge base on the health effects of toxic substances. The findings are used by scientists, health providers, and policy makers across the country to design and implement community/site clean-up activities, emergency responses, individual treatments and environmental/land use policies. ATSDR develops and applies new tools, like modeling and geographic analysis, in order to answer questions from communities. ATSDR's research and registries allow policy-makers, government agencies, and health providers to make science-based decisions to protect the public from exposures to hazardous substances and their associated health impacts. For example, ATSDR provides technical assistance for the National Toxic Substance Incidents Program (NTSIP) database. The NTSIP—a surveillance system for chemical events—collects data regarding (1) the number of spills each state experiences per year, (2) the amount of chemicals stored, produced and transported in states, (3) the population demographics and proximity to where chemicals are released, stored, produced and transported, (4) the health impact of spills, and (5) increased focus on the use of the data, including increased prevention, treatment, and evaluation activities. No other surveillance system collects both chemical release and public health data. (Measures 14.2.2, 14.E, 14.G, 14.H, 14.I, and 14.J)

Program Description and Recent Accomplishments: ATSDR works to educate and enhance awareness of the scientific community, policymakers, and medical professionals regarding the effects of hazardous substances on humans. ATSDR conducts applied research using toxicological and epidemiological methods and often collaborates with other government agencies, universities, and volunteer organizations to address critical data needs. ATSDR's scientific research often grows out of site-specific public health activities.

Recent accomplishments include:

- Launched the website for the NTSIP and developed and distributed a training manual to the seven funded NTSIP state partners. Additionally, the HazMat Intelligence Portal portion of the NTSIP webpage was launched to estimate the number of events in non-NTSIP states (only transportation events currently available).

- Supported development of the web portal for the National ALS Registry in response to a congressional directive. This registry gathers information that can be used to; (1) estimate the number of new cases of ALS each year; (2) estimate the number of people who have ALS at a specific point in time; (3) better understand who is diagnosed with ALS and what factors affect the disease; (4) examine the connection between ALS and other motor neuron disorders that can be confused with ALS, misdiagnosed as ALS, and in some cases progress to ALS; and (5) improve care for people with ALS. From October 19 to December 1, 2010, over 1,900 ALS patients enrolled in the registry.

- Completed a multiyear, multisite study in North Carolina of health effects due to toluene diisocyanate (TDI), a substance known to be the largest contributor to occupationally-induced asthma. While much is known about job-related exposures, there is very little information on how low levels of TDI exposure affects the health of the general public. To examine community-level health effects, ATSDR utilized new methods for detecting the chemical in the communities' ambient air, by testing people's blood for exposures, and by assessing the prevalence of asthma and other respiratory diseases in participants near emitting facilities as compared to residents further from these TDI emitting facilities.

- Completed a research study of immunoglobulin gene sequencing for monoclonal B-Cell lymphocytosis (MBL) cases to help increase knowledge of fundamental events associated with the neoplastic process in B-cell lymphoproliferative diseases (BLPD) and permit early detection of the BLPD. The study helped determine whether MBL can be used as a biomarker associated with exposure to hazardous wastes and whether individuals with MBL, who are more likely to progress to a BLPD, can be identified.

Deliver Information on Toxic Chemicals to Health Professionals and the Public

In FY 2012, ATSDR will:

- Continue to develop toxicological profiles (ToxProfiles™). The ToxProfiles™ are used by health and environmental professionals around the world to make decisions about cleaning up sites, responding to emergencies, and treating patients exposed to chemicals. ToxProfiles™ were cited 900 times in peer reviewed health and environmental literature. ToxProfiles™ and associated documents (e.g. ToxFAQs™, ToxGuides™, Public Health Statements) are among the most widely accessed agency webpages. ATSDR will also continue to update literature databases for the 172 existing ToxProfiles™ in order to provide the most current toxicological and epidemiological data to scientists, health providers, and the public.

- Support a network of 11 regional Pediatric Environmental Health Specialty Units (PEHSU) that provide unique pediatric environmental health services, including medical consultation to pediatric care providers, and education to both health professionals and the public.

- Continue to support the Michigan Blue Cross/Blue Shield Pilot Project. This pilot project has prepared 370 physicians in the Blue Cross/Blue Shield provider network to integrate environmental health knowledge with clinical preventive practice to identify environmental exposures and reduce the burden of environmentally-based disease.

- Provide health professional education to more than 29,000 health care professionals through ATSDR online services and cooperative agreement partner training activities.

- Develop more than 30 chemical and general topic plain language fact sheets to assist the general public and raise awareness of ways to mitigate exposure.

- Educate more than 133,000 community members through public meetings, emails, factsheets, and online videos. Community members can trust the guidance to make informed and unbiased decisions about minimizing exposures and seeking appropriate treatment. Work with communities to use available resources to address their health concerns as part of an enhanced community engagement model (Corpus Christi, Texas, Mossville, Louisiana, Elkhart, Indiana, and Papelera, Puerto Rico, Millsboro, Delaware, Blackwell, Oklahoma, Lincoln Park, Colorado, Hormigas and Cabo Rojo, Puerto Rico and Dwyer, Maryland. Community partners can rely on information to the develop community involvement initiatives and guide planning to reduce the health disparities in their neighborhoods.

Performance: ATSDR plays a primary communication role by sharing environmental health information with health-care providers; Federal, Tribal, State, and local leaders; and affected communities. ATSDR educates the public about chemicals present in their homes, schools, and communities. Informed community members can take the steps they need to reduce their exposures to chemicals and other hazardous exposures, thus reducing health effects associated with those exposures. ATSDR's support for the education of healthcare providers care providers and other health professionals will ensure that these health professionals know how to prevent, diagnose, and treat illnesses caused by hazardous substances to ensure people exposed to chemicals can then obtain early and proper treatment. (Measures 14.2.1, 14.K, 14.L, and 14.M)

Program Description and Recent Accomplishments: ATSDR translates and communicates scientific information on the human health effects of exposures to toxic substances and provides education to community groups and health professionals on how to prevent the health effects of toxic substance exposures. ATSDR provides targeted education at the community level to meet local needs and also broadly distributes educational materials through the internet and other mechanisms. ATSDR develops and provides medical education to assist health professionals in diagnosing and treating conditions related to hazardous exposures. During chemical spills and other emergency events, ATSDR provides medical guidance to healthcare providers, addressing exposure to chemicals advises local officials about when to evacuate communities, when to allow residents to return, and how to ensure the safety of responders and medical professionals.

Recent accomplishments include:

- Released six final and six draft-for-public-comment ToxProfiles™ in FY 2010, including corresponding English and Spanish Public Health Statements, ToxFAQs™, and ToxGuides™.
- Developed and verified 19 health guidance values, known as minimal risk levels, for 11 different hazardous substances published in the corresponding ToxProfiles™.
- Released 12 literature update addenda to existing ToxProfiles™.
- Supported the Pediatric Environmental Health Specialty Unit (PEHSU) University of California at San Francisco (Region 9) to assist medical educators in California and Arizona to integrate pediatric environmental health into medical school and pediatric residency curricula. This action was prompted by a 90-minute education module developed by PEHSU and ATSDR to train pediatric care providers to deliver preventive environmental health counseling to parents of their patients.
- Collaborated with EPA on the development of human health benchmarks for chemical contaminants in the Gulf of Mexico from the Deepwater Horizon Oil Spill.

IT INVESTMENTS

ATSDR invests in Information Technology (IT) systems that support strategic and performance outcomes. The Sequoia Database System is a scientific and administrative database developed to track, retain, and report information on the planning, execution, follow-up, and evaluation of activities at hazardous waste sites (e.g., Superfund sites, emergency events) and releases. The Geographic Information Systems (GIS) provides a visual tool for identifying the location of events, the spatial relationship between incidents and the population they may impact. Mapping technology also assists in the collection of information from exposed individuals to help identify the source of an unknown release. Another IT investment, Project Profile, is a centralized database, management tool, and reporting mechanism that capture ATSDR's projects and activities. This database is a tool that captures agency and center strategic planning and performance, current project status, and final agency expenditures.

AFFORDABLE CARE ACT

The Affordable Care Act, Public Law 111-148, contains provision for establishing a program to make competitive grants to eligible entities for the purpose of (1) screening at-risk individuals for environmental health conditions, such as current and past residents of Libby and Troy, Montana; (2) developing and disseminating public information and education concerning the availability of screening, the detection, prevention, and treatment of environmental health conditions; and the availability of Medicare benefits for certain individuals diagnosed with these environmental health conditions. The screening will include evaluation via chest radiographs, chest high-resolution computed tomography scans, and fecal occult blood testing (FOBT), as appropriate. Participants with radiologic asbestosis, pleural thickening or plaques, positive FOBT test results, or diagnosis of select cancers will be eligible for Medicare benefits. The first phase of the screening program will focus on current residents of Libby, Montana. A second phase will include previous residents of Libby and Troy who have since moved away. The Affordable Care Act appropriated $23,000,000 for the period of fiscal years 2010-2014 and $20,000,000 for each five fiscal year period thereafter for this program. Funds appropriated are available until expended.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Agency for Toxic Substances and Disease Registry	**$99,792**	**$76,792**	**$76,337**	**-$23,455**
Affordable Care Act[1]	$23,000	$0	$0	-$23,000
Agency for Toxic Substances and Disease Registry	$76,792	$76,792	$76,337	-$455

[1] The FY 2010 total reflects $23,000,000 appropriated to ATSDR under the Affordable Care Act available for five years.

MEASURE TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
14.E.2: Increase the percentage of cost savings each year for NCEH/ATSDR as a result of the Public Health Integrated Business Services HPO (Efficiency)	FY 2009: 38 % (Target Exceeded)	39%	N/A	N/A
Long Term Objective: Assess current and prevent future exposures to toxic substances and related human health effects.				
14.1.1: Reduce exposures to toxic substances and mitigate the likelihood of future toxic exposures by increasing EPA's, state regulatory agencies', or private industries' acceptance of ATSDR's recommendations at sites with documented exposures (Outcome)	FY 2010: 87% (Target Exceeded)	85%	87%	+2
Long Term Objective: Determine human health effects associated with exposures to priority hazardous substances.				
14.2.1: Advance understanding of the relationship between human exposures to hazardous substances and adverse health effects by completing toxicological profiles for substances hazardous to human health. (Outcome) [1]	FY 2010: 12 (Target Exceeded)	11	11	Maintain
14.2.2: Fill data needs for human health effects/risks relating to hazardous exposures. (Output) [2]	FY 2010: 10 (Target Met)	10	10	Maintain
Long Term Objective: Mitigate the risks of human health effects from toxic exposures.				
14.3.1: Protect human health by preventing or mitigating human exposures to toxic substances or related health effects at sites with documented exposures (Outcome)	FY 2010: 78% (Target Exceeded)	74%	76%	+2
14.3.2: Provide services to mitigate the risks of health effects from exposure to hazards from disasters (Output)	FY 2010: 100% (Target Exceeded)	Deploy staff as requested to emergency events in a timely manner 100% of the time.	Deploy staff as requested to emergency events in a timely manner 100% of the time.	N/A

[1]Measure 14.2.1 reflects the number of Toxicological Profiles released rather than number of priority data needs filled. ATSDR will report the number of ToxProfiles™ released to the public.
[2]ATSDR revised the methodology for measuring data needs. The target will now reflect data needs filled (i.e. brought to closure) and not those that are still in progress.

OTHER OUTPUTS

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2011
14.A: Cooperative Agreements	FY 2010: 30	≤ 25	≤ 25	Maintain
14.B: Sites Evaluated/Chemical Release Responses	FY 2010: 818	500	500	Maintain
14.C: Public Health Assessments/Health Consults (includes chemical specific health consults)	FY 2010: 332	≤ 260	≤ 300	+40
14.D: Technical Assists	FY 2010: 800	≤ 1400	≤ 1400	Maintain
14.E: Exposure Investigations	FY 2010: 3	2	2	Maintain
14.F: Emergency Responses and Exercises[1]	FY 2010: 94	58	58	Maintain
14.G: Registries (# of registries by exposure type)	FY 2010: 1	2	2	Maintain
14.H: National Toxic Substances Incident Program (surveillance states and events)[2]	FY 2010: 7 states/3,578 events	7 states/3,000 events[2]	7 states/3,000 events[2]	Maintain
14.I: Great lakes Research Projects (studies)	FY 2010: 4	4	4	Maintain
14.J: Minority Health Professions Foundation (grants)	FY 2010: 2	2	2	Maintain
14.K: Pediatric Environmental Health Specialty Units	FY 2010: 11	11	11	Maintain
14.L: Health Professionals Trained	FY 2010: 62,112	47,097	47,097	Maintain
14.M: Community Members Educated[3]	FY 2010: 336, 263	133, 000	133, 000	Maintain

[1] Emergency response support at ATSDR is provided on-demand at the request of the lead federal agency or our partners; there is no requirement to access ATSDR support. Projections have been based on past performance. Maintenance is based on marketing the program to potential clients. Marketing efforts have curtailed over the past several years and it is anticipated that requests will decrease over the next two years.
[2] The target was lowered from 14 in 2009 to 7 in 2010 and future years because CERCLA funding is no longer available to support the states in HSEES surveillance activities.
[3] There was a drastic increase in the FY 2009 number of community members educated due to a prevention activity that targeted 250,000 local utility customers by giving out a fact sheet in a newsletter. Since these large activities cannot be foreseen the targets for 2011 and 2012 have not been increased based on this result.

REIMBURSEMENTS AND TRUST FUNDS

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$563,587	$575,000	$712,200	+$148,613

SUMMARY OF THE REQUEST

The FY 2012 Request of $712,200,000 for Reimbursements and Trust Funds reflects an overall increase of $148,613,000 above the FY 2010 level.

AUTHORIZING LEGISLATION

Public Health Services Act §§ 301, 306(b)(4), 353; User Fee: Labor-HHS FY Appropriations.

PROGRAM DESCRIPTION

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 public health improvement and prevention programs.

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 and diagnostic reagents, 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 United States Agency for International Development on various projects to support infectious disease and family planning. In another agreement, CDC is assisting the Department of Homeland Security in evaluating and assessing fire prevention grants to firefighters. CDC also works with the Department of Justice on the assessment of hand-held assays for threat agents. Also, CDC collaborates with the Environmental Protection Agency and the Federal Emergency Management Administration on several projects of public health concern.

The CDC is also working with the Environmental Protection Agency to build global capacity and collaboration to better understand, investigate, control and prevent environmental and occupational health problems in developing countries and the United States. During the previous agreements, the major emphasis of the program was on epidemiology, risk assessment and surveillance. Subsequently, the major emphasis became prevention and intervention research to reduce risks in participating collaborating countries. The focus in the future will be to address relevant environmental and occupational health issues in the target developing countries and in-country infrastructure development, including human capacity for research (including clinical research), research implementation, bettering public health, information dissemination and mitigation of adverse consequences of environmental exposures and evaluation of success.

CDC also performs vessel sanitation inspections to ensure vessels are in compliance with the health and sanitation requirements for the federal government and specimen testing for customers, issues certifications, and sells biological projects and tapes of statistical data. Fees are collected for these activities to offset program costs.

In addition to reimbursable agreements and user fees, CDC receives funds from entering into Cooperative Research and Development Agreements (CRADAs) to enhance and facilitate collaboration between the Agency's laboratories and various partners. CDC typically provides research personnel, laboratory facilities, materials, equipment, supplies, intellectual property, and other in-kind contributions to the collaborator. CDC uses the income from CRADAs to continue to improve programs.

OUTPUT TABLES

#	(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget
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).	$56,598	$56,598	$56,598
18.B	**Department of Agriculture** 5 Agreements for National Health and Nutrition Examination Survey from 2007 thru 2010; Pilot Demo Project, and Support for the Forum on Aging Related Stat.; 4 Agreements to support Outbreak, and Plant Health Inspection.	$8,417	$8,417	$8,417
18.C	**Department of Commerce** 6 Agreements for coordinating a National Survey of Adoptive Parents (SLAITS); NHANES; and Forum on Aging Related Statistics.	$415	$415	$415
18.D	**Department of Defense** 28 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 to Border Infectious Disease Surveillance Project (BIDS). Survey and diagnose cases of Febrile Respiratory Illnesses (FRI) on the Mexican border; clothing and studies. 3 Agreements for assessing the presence and nature of health hazards at specific DOD sites; 1 Agreement to Support the Design and Deployment of the Healthcare Safety Network & Electronic Disease Surveillance System for Saudi Arabia National Guard.	$53,413	$64,826	$63,911

#	(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget
18.E	**Department of Energy** 5 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.	$5,274	$5,274	$5,274
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 $490,472,000 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.	$352,357	$352,357	$490,472
18.G	**Department of Homeland Security** 18 Agreements for Design & Develop of Rapid Method for AMR Susceptibility Testing for Potential BT Agents.	$11,935	$11,935	$11,935
18.H	**Department of Housing and Urban Development** 2 Public Health Assessment of Air Quality in Temporary Housing.	$841	$841	$841
18.I	**Department of Interior** 1 Agreement for Prevention and Control of Viral Hepatitis Infections	$0	$0	$0
18.J	**Department of Justice** 4 Agreements for Supporting of the Federal Intra-Agency Forum on Child and Family Statistics 4 Agreements for 2009 Nat'l HIVP Clinical Indicator of Sexual Violence Surveillance System.	$1,537	$1,537	$1,537
18.K	**Department of Labor** 1 Agreements 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 the Energy Employees Occup Illness Compensation Program.	$57	$57	$57

#	(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget
18.L	**Department of State** 12 Agreements for Field Assignee to assist with various States: Delaware and Iowa and Laboratory Testing.	$9,112	$9,112	$9,112
18.M	**Department of Transportation** 1Agreement for National Survey on Youth Traffic Safety Issues	$66	$66	$66
18.N	**Environmental Protection Agency** 10 Agreements to Collaborate Studies 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/temp housing, the Love Canal, and Tar Creek & Indian Colony (DHAC).	$8,060	$8,060	$8,060
18.O	**Federal Emergency Management Agency** 3 Agreements for Emergency Responses; and Public Health Assessment of Air Quality in Temporary Housing.. 1 Agreement to assist with the Bioelectrical impedance analysis (BIA).	$17,541	$17,541	$17,541
18.P	**Various Agencies/Organizations** 22 Agreements for surveillance and Standardization of Genetic Testing; various agreements with WHO, UN, Peace Corp, and Exec Office of the President.	$23,620	$23,620	$23,620
18.Q	**Department of Education** 1 Agreement for a School Associated Violent Death Study (SAVDS)	$0	$0	$0
18.R	**Department of Veterans Affairs** 3 Agreements for the Development of Electronic Surveillance and Control of Nosocomial Infections and Antibiotic Resistance. Salary & Benefits for Robert Gaynes. 3 Agreements to assist with the National Death Index Services	$1,014	$1,014	$1,014
18.S	**Other** 7 Agreements to assist with the Mail Supplement, and Public Health Assessment of Air Quality in Temporary Housing	$950	$950	$950

#	(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget
18.T	**Department of Navy** 3 Agreements to provide assistance to Camp Lejune (6 projects), DERA DTEM, and Veques.	$8,986	$8,986	$8,986
18.U	**Social Security Administration**	$168	$168	$168
18.V	**CRADA** 21 Agreements with Commercial and Non-Profit Organizations and Foundations.	$1,000	$1,000	$1,000
18.W	User Fees	$2,226	$2,226	$2,226
	TOTAL	**$563,587**	**$575,000**	**$712,200**

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SUPPLEMENTAL INFORMATION

BUDGET AUTHORITY BY OBJECT

FY 2012 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
OBJECT CLASSIFICATION - DIRECT OBLIGATIONS
(DOLLARS IN THOUSANDS)

Object Class	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2011
Personnel Compensation:			
Full-Time Permanent(11.1)	$661,120	$618,906	($42,215)
Other than Full-Time Permanent (11.3)	$77,681	$71,197	($6,484)
Other Personnel Comp. (11.5)	$36,674	$35,356	($1,317)
Military Personnel (11.7)	$67,359	$63,398	($3,962)
Special Personal Service Comp.	$1,822	$1,822	$0
Total Personnel Compensation	**$844,656**	**$790,679**	**($53,977)**
Civilian personnel Benefits (12.1)	$218,652	$205,358	($13,294)
Military Personnel Benefits (12.2)	$50,505	$49,071	($1,434)
Benefits to Former Personnel (13.0)	$140	$140	$0
SubTotal Pay Costs	**$1,113,954**	**$1,045,248**	**($68,706)**
Travel (21.0)	$58,625	$51,814	($6,811)
Transportation of Things (22.0)	$14,594	$13,013	($1,581)
Rental Payments to GSA (23.1)	$45,125	$46,984	$1,859
Rental Payments to Others (23.2)	$10,139	$10,302	$163
Communications, Utilities, and Misc. Charges (23.3)	$43,192	$39,638	($3,554)
NTWK Use Data TRANSM SVC (23.8)	$460	$419	($41)
Printing and Reproduction (24.0)	$6,284	$5,607	($677)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	$469,546	$407,703	($61,843)
Other Services (25.2)	$221,949	$229,595	$7,646
Purchases from Government Accounts (25.3)	$313,713	$288,789	($24,924)
Operation and Maintenance of Facilities (25.4)	$46,287	$62,995	$16,708
Research and Development Contracts (25.5)	$46,499	$40,933	($5,566)
Medical Services (25.6)	$12,436	$11,345	($1,091)
Operation and Maintenance of Equipment (25.7)	$43,382	$39,563	($3,819)
Subsistence and Support of Persons (25.8)	$113	$103	($10)
Consultants, other and misc (25.9)	$20,569	$18,753	($1,816)
Subtotal Other Contractual Services	**$1,174,494**	**$1,099,779**	**($74,715)**
Supplies and Materials (26.0)	$699,678	$670,855	($28,823)
Equipment (31.0)	$56,592	$49,230	($7,362)
Land and Structures (32.0)	$22,314	$19,966	($2,348)
Investments and Loans (33.0)	$0	$0	$0
Grants, Subsidies, and Contributions (41.0)	$3,151,710	$2,763,648	($388,062)
Insurance Claims and Indemnities (42.0)	$670	$599	($71)
Interest and Dividends (43.0)	$346	$310	($36)
Refunds (44.0)	$0	$0	$0
Subtotal Non-Pay Costs	**$5,284,222**	**$4,772,164**	**($512,058)**
Total Budget Authority	**$6,398,176**	**$5,817,412**	**($580,764)**

SALARIES AND EXPENSES

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SALARIES AND EXPENSES (DOLLARS IN THOUSANDS)			
	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY2011
Personnel Compensation:			
Full-Time Permanent(11.1)	$661,120	$618,906	($42,215)
Other than Full-Time Permanent (11.3)	$77,681	$71,197	($6,484)
Other Personnel Comp. (11.5)	$36,674	$35,356	($1,317)
Military Personnel (11.7)	$67,359	$63,398	($3,962)
Special Personal Service Comp. (11.8)	$1,822	$1,822	$0
Total Personnel Compensation	**$844,656**	**$790,679**	**($53,977)**
Civilian personnel Benefits (12.1)	$218,652	$205,358	($13,294)
Military Personnel Benefits (12.2)	$50,505	$49,071	($1,434)
Benefits to Former Personnel (13.0)	$140	$140	$0
SubTotal Pay Costs	**$1,113,954**	**$1,045,248**	**($68,706)**
Travel (21.0)	$58,625	$51,814	($6,811)
Transportation of Things (22.0)	$14,594	$13,013	($1,581)
Communications, Utilities, and Misc. Charges (23.3)	$43,192	$39,638	($3,554)
Printing and Reproduction (24.0)	$460	$419	($41)
Other Contractual Services:			.
Advisory and Assistance Services (25.1)	$469,546	$407,703	($61,843)
Other Services (25.2)	$221,949	$229,595	$7,646
Purchases from Government Accounts (25.3)	$313,713	$288,789	($24,924)
Operation and Maintenance of Facilities (25.4)	$46,287	$62,995	$16,708
Research and Development Contracts (25.5)	$46,499	$40,933	($5,566)
Medical Services (25.6)	$12,436	$11,345	($1,091)
Operation and Maintenance of Equipment (25.7)	$43,382	$39,563	($3,819)
Subsistence and Support of Persons (25.8)	$113	$103	($10)
Subtotal Other Contractual Services	**$1,153,925**	**$1,081,026**	**($72,899)**
Supplies and Materials (26.0)	$699,678	$670,855	($28,823)
Subtotal Non-Pay Costs	**$1,970,473**	**$1,856,765**	**($113,709)**
Rental Payments to Others (23.2)	$10,139	$10,302	$163
Total, Salaries & Expenses and Rent	**$3,094,566**	**$2,912,314**	**($182,252)**
Direct FTE	**8,911**	**8,608**	**(303)**

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)						
	FY 2010		FY 2011		FY 2012	
Direct FTEs	Civilian	Comm Corp	Civilian	Comm Corp	Civilian	Comm Corp
Immunization and Respiratory Diseases	615	90	624	95	624	95
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	1,264	125	1,275	132	1,275	132
Emerging and Zoonotic Infectious Diseases	1,029	137	1,041	145	1,053	145
Chronic Disease Prevention and Health Promotion	881	67	907	71	947	71
Birth Defects, Developmental Disabilities, Disability and Health	198	6	198	6	198	6
Environmental Health	267	38	267	40	267	40
Injury Prevention and Control	173	11	173	12	173	12
Public Health Scientific Services	659	139	688	147	710	147
Occupational Safety and Health	806	59	806	51	399	51
Global Health	234	14	245	15	265	15
Public Health Leadership and Support	198	11	198	12	198	12
Business Services Support	1,313	23	1,325	24	1,335	24
Public Health Preparedness and Response	371	41	371	43	371	43
Agency for Toxic Substances and Disease Registry	247	43	247	43	247	43
Subtotal, Direct FTE	*8,256*	*803*	*8,365*	*836*	*8,062*	*836*
Reimbursable FTEs						
Immunization and Respiratory Diseases	0	1	0	1	0	1
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	2	2	2	2	2	2
Emerging and Zoonotic Infectious Diseases	71	11	71	10	68	10
Chronic Disease Prevention and Health Promotion	18	3	18	3	17	3
Birth Defects, Developmental Disabilities, Disability and Health	4	0	4	0	4	0
Environmental Health	7	13	7	12	7	12
Injury Prevention and Control	2	0	2	0	2	0
Public Health Scientific Services	555	20	558	18	528	18
Occupational Safety and Health	323	28	323	37	714	37
Global Health	21	3	23	3	20	3
Public Health Leadership and Support	15	0	15	0	14	0
Business Services Support	4	0	4	0	4	0
Public Health Preparedness and Response	1	0	1	0	1	0
Agency for Toxic Substances and Disease Registry	20	1	19	2	19	2
Subtotal, Reimbursable FTE	*1,044*	*83*	*1,047*	*88*	*1,400*	*88*
TOTAL, CDC/ATSDR FTE	**9,300**	**886**	**9,412**	**924**	**9,462**	**924**

DETAIL OF POSITIONS

FY 2012 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION PROGRAM ADMINISTRATION DETAIL OF POSITIONS [1]			
	FY 2010 Actual	FY 2011 CR	FY 2012 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	***31***	***33***	***33***
Total - SES Salary	**$5,287,725**	**$5,287,725**	**$5,287,725**
GS-15	570	535	535
GS-14	1,683	1,470	1,470
GS-13	2,474	2,184	2,184
GS-12	1,408	1,225	1,225
GS-11	845	761	761
GS-10	58	65	65
GS-9	548	465	465
GS-8	74	101	101
GS-7	331	366	366
GS-6	79	85	85
GS-5	72	76	76
GS-4	56	56	56
GS-3	26	23	23
GS-2	6	3	3
GS-1	1	0	0
Subtotal	***8,231***	***7,415***	***7,415***
Total - GS Salary	**$759,135,093**	**$781,150,011**	**$803,803,361**
Average GS grade	12.0	12.0	12.0
Average GS salary	92,229	105,347	108,402
Average Special Pay Categories			
Average Comm. Corps Salary	83,399	86,235	89,167
Average Wage Grade Salary	59,312	56,953	58,604
Recovery Act	8	8	0

[1] Includes special pays and allowances.

[2] This table reflects "positions" not full-time equivalent(s) (FTEs)

PROGRAMS PROPOSED FOR ELIMINATION

The following table shows the programs proposed for elimination in the FY 2012 President's Budget Request. These activities may not have a demonstrated record of success, or hold significant promise for increasing accountability and improving health outcomes, or may be duplicative of other Federal efforts. Following the table is the rationale for the elimination of each program.

PROGRAM	REDUCTION AMOUNT (dollars in millions)
Preventive Health and Health Services Block Grant	$100.240
World Trade Center	$70.712
Racial and Ethnic Approaches to Community Health	$39.274
Academic Centers for Public Health Preparedness and Advanced Practice Centers	$35.270
Education and Research Centers	$24.370
National Occupation Research Agenda – AgFF	$23.000
Healthy Communities	$22.609
Prion Disease	$5.473
Built Environment	$2.683
Total	**$323.631**

Preventive Health and Health Services Block Grant (-$100.240 million)

The FY 2012 budget request reflects an 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 $860 million annually and the PHHSBG now represents a much smaller percentage of state budgets when compared to total available CDC funding. In addition, the FY 2012 Budget proposes a new comprehensive Chronic Disease Prevention and Health Promotion Grant Program that will provide funding for every state to reduce the prevalence of chronic diseases.

World Trade Center (-$70.712 million)

The FY 2012 budget request reflects an elimination of discretionary funding for World Trade Center activities ($70.712 million). In FY 2012, $313.000 million in mandatory funding, which is reflected in the budget of the Department of Health and Human Services Office of the Secretary, will be provided for the World Trade Center Health Program as result of the passage of the James Zadroga 9/11 Health and Compensation Act of 2010.

Racial and Ethnic Approaches to Community Health (-$39.274 million)

The FY 2012 budget request reflects an elimination of the Racial and Ethnic Approaches to Community Health program ($39.274 million). The goal of this program will be addressed through the new Community Transformation Grants (CTGs), as part of the ACA Prevention and Public Health Fund. The CTGs will focus on reducing the Leading Causes of Death (LCD) and racial and ethnic disparities by providing sustained investments in the health systems of big cities and large

metropolitan areas. CDC will transfer the lessons learned from both REACH and Healthy Communities to the CTGs in FY 2012. All grant recipients directly funded through REACH in FY 2011 will be eligible to apply for funding under the new CTGs.

Academic Centers for Public Health Preparedness and Advanced Practice Centers (-$35.270 million)

The FY 2012 Budget request reflects an elimination of the Academic Centers for Public Health Preparedness and Advanced Practice Centers ($35.270 million). These programs have not demonstrated a large return on investment or significant impact improving public health.

Education and Research Centers (-$24.370 million)

The FY 2012 budget request reflects an elimination of the Education and Research Centers (ERCs) ($24.370 million). The intended goals of the ERCs Program have been met, and the Administration proposes to redirect these funds to other Federal priorities. The ERCs were created in the mid-1970s to provide seed money for academic institutions to develop or expand occupational health and safety training programs for specialists currently practicing in the field. The original programmatic plan was to provide money for five years for institutions to develop and/or expand existing occupational health and safety training programs and for the grantees to become self-sustaining over time. In addition, the ERCs overlap activities offered by the Department of Labor's Occupational Safety and Health Bureau through their Outreach Training Program, Resource Center Loan Program, and Training Institute Education Centers.

National Occupation Research Agenda (-$23.000 million)

The FY 2012 budget request reflects elimination of the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupation Research Agenda (NORA) ($23.000 million). Research from the AgFF sector of NORA has not developed relevant or effective results to impact the safety and health of workers in the agricultural, forestry and fishing industries. AgFF program activities could also be more aligned with the missions and activities of similar efforts at the Departments of Labor (DOL) and Agriculture (USDA). Recent program evaluations have emphasized the need to develop a more coordinated approach to its intramural and extramural programs, and the DOL and USDA have more direct programs that address these issues and could be in a better place to achieve intended outcomes. For example, the DOL's website contains extensive information on how to improve farm safety and the Occupational Safety and Health Administration has approved more than 25 State and US Territory plans to adopt standards and enforcement policies related to agricultural farming.

Healthy Communities (-$22.609 million)

The FY 2012 budget request reflects an elimination of the Healthy Communities program ($22.609 million). The goal of this program will be addressed through the new Community Transformation Grants (CTG), as part of the ACA Prevention and Public Health Fund. The FY 2012 Budget will transition to a large-scale national program with specific health outcome measures focusing on evidence-based interventions through the CTGs authorized in the ACA. The CTGs will focus on reducing the Leading Causes of Death (LCD) and racial and ethnic disparities by providing sustained investments in the health systems of big cities and large metropolitan areas.

Prion Disease (-$5.473 million)

The FY 2012 budget request reflects an elimination of the Prion Disease line ($5.473 million). This program takes a disease-specific approach rather than a broad public health approach to infectious and zoonotic diseases. In addition, CDC is not able to demonstrate significant public health impact within this program at the current funding level.

Built Environment (-$2.683 million)

The FY 2012 budget request reflects an elimination of Built Environment activities ($2.683 million). As many Federal agencies continue to engage in this important issue, CDC is not able to demonstrate significant impact at this funding level. CDC will promote these types of activities through the Community Transformation Grants.

Discussion of the Administrative Cap

In FY 2009 and FY 2010, the administrative charge to ATSDR was $12,090,000. ATSDR provided these funds to CDC via an interagency agreement to fund activities including, but not limited to, rent/utilities/maintenance, Human Resources Management, Information Technologies Systems, Telecommunications and Financial Management.

In FY 2011, the administrative charge will remain at $12,090,000. Over the past several fiscal years, reorganizations and changes in budget structure have rendered CDC's administrative cost formula outdated. CDC re-commissioned a study to update the method for determining administrative costs to programs such as ATSDR. The results of the impending study will be used in determining ATSDR's administrative charge in FY 2012. Until a new formula is determined, CDC will continue to apply the existing method to determine administrative charges.

e-gov initiative

FY 2012 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

The CDC will use $4,795,707.00 of its FY 2012 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, $667,395.00 is allocated to developmental government-wide E-Government initiatives for FY 2012. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$19,158.00
Line of Business - Grants Management	$35,098.00
Line of Business - Financial	$18,063.00
Line of Business - Budget Formulation and Execution	$13,263.00
Disaster Assistance Improvement Plan	$12,934.00
Federal Health Architecture (FHA)	$535,100.00
Line of Business - Geospatial	$33,779.00
FY 2012 Developmental E-Gov Initiatives Total	**$667,395.00**

* 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, **$1,565,409.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2012**. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Ongoing E-Gov Initiatives*	
E-Rule Making	$69,744.00
Integrated Acquisition Environment	$661,304.00
GovBenefits	$35,407.00
Grants.Gov	$798,954.00
FY 2012 Ongoing E-Gov Initiatives Total	**$1,565,409.00**

* 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 2012 is $465.27M. Our major investments are posted on the OMB 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.

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SIGNIFICANT ITEMS

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – HOUSE

SIGNIFICANT ITEMS FOR INCLUSION IN

THE FY 2012 CONGRESSIONAL JUSTIFICATION

AND OPENING STATEMENTS

HOUSE REPORT

CENTERS FOR DISEASE CONTROL AND PREVENTION

A House report was not filed for FY 2011; significant items were not available for CDC's response.

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – SENATE

SIGNIFICANT ITEMS FOR INCLUSION IN

THE FY 2012 CONGRESSIONAL JUSTIFICATION

AND OPENING STATEMENTS

SENATE REPORT NO. 111-66

CENTERS FOR DISEASE CONTROL AND PREVENTION

Item

Biosurveillance Activities - The Committee supports efforts by the CDC and State public health laboratories to strengthen national and international biosurveillance systems for effective, rapid detection and identification of influenza, emerging infectious diseases, biothreats, and "all-threats" detection. The Committee encourages the CDC to collaborate with other global and Federal agencies and continue to assist State laboratories in advancing these important efforts. (Page 93)

Action taken or to be taken

CDC extends funding and highly sophisticated training and technical assistance to assist States and international partners in developing their laboratories' capacity to support their development and ongoing operation.
CDC will continue collaborating with partners to enhance and strengthen state and international laboratory systems for effective, rapid detection and identification of influenza, emerging infections and "all-threats" detection. Examples of these collaborations include but are not limited to:

- Funding the Association of Public Health Laboratories (APHL) utilizing H1N1 funds through the Public Health Laboratory Improvement Program (PHLIP). One of the goals of PHLIP is to achieve bi-directional laboratory data exchange between state Public Health Laboratories and CDC.
- Laboratory Response Network (LRN) – Real Time Lab Information Exchange. This project equips LRN labs to securely share data with public partners in real time and in accordance with industry standards.
- CDC BioSense Program – Contribute to funding the Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreement to enhance syndromic surveillance for emergency room and clinical data.
- CDC Biosurveillance Coordination Unit's focus on a complementary "system of systems" that leverages the data collection and analyses performed at the local level while incorporating broader national perspectives.

CDC's Global Disease Detection (GDD) Program focuses on capacity building for enhanced surveillance (in particular for public health events of international concern) and laboratory systems development. In particular, GDD focuses on identification and response to a wide range of emerging infections (including respiratory syndromes, diarrheal diseases, foodborne illnesses, zoonotic diseases, and others) through integrated disease surveillance, prevention, and control activities. GDD works on strengthening laboratory operations by standardizing test procedures, laboratory protocols,

and management practices. CDC establishes Global Disease Detection Centers in Strategic international locations.

Item

Hepatitis Testing - The Committee recognizes the high incidence of hepatitis and its often undocumented state. In fiscal year 2010, the Committee requested the CDC to formulate a plan for significant testing for hepatitis, including the implementation of rapid testing technology as a means of ascertaining the prevalence of hepatitis and updating its testing guidelines. The Committee encourages the development of a pilot testing program to enhance this effort. (Page 72)

Action taken or to be taken

CDC supports a number of activities to increase screening and testing for viral hepatitis, including the development of rapid testing technology. CDC is in the process of conducting research and evaluation to update existing HCV screening recommendations by 2012. In September 2010, a multi-site study was funded to examine current HCV screening practices followed by the implementation and evaluation of routine one-time screening of all persons born in the selected high prevalence cohort. CDC is exploring collaborations with industry to assess new assays for detection of active HCV infection that are more affordable to state and local health departments than current polymerase chain reaction (PCR) tests. CDC is also in the process of conducting laboratory and field evaluations on the performance of pre-market rapid HCV tests. Finally, CDC is seeking to determine the feasibility of implementing hepatitis B screening in refugee and immigrant populations from countries where hepatitis B is endemic. In addition, CDC's FY 2012 request includes an increase for viral hepatitis.

Item

HIV Prevention - The Committee fully supports the goals of the National HIV/AIDS Strategy. Racial and ethnic minorities, men who have sex with men [MSM], and women are disproportionately affected by HIV in the United States. The Committee encourages the CDC to expand the range of interventions available through the Diffusion of Evidence-based Interventions program by increasing support for the development of promising "home grown interventions" that can be rapidly evaluated and disseminated into the field. The Committee also encourages the CDC to increase technical assistance and training activities to community-based organizations involved in adapting promising evidence-based interventions to new settings. (Page 72)

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. The results of this research are anticipated to be available in 2013. 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

Special Populations - Recent CDC reports have shown that MSM account for more than one-half of all new HN infections each year, with African-American MSM making up a disproportionate share of

these infections, and that MSM are 44 times more likely to acquire HIV than other men. The Committee urges the CDC to enhance prevention programs tailored to gay and bisexual men that integrate behavioral and biomedical interventions, community-level interventions, and structural interventions to shift social norms in support of safer sex and family acceptance of young gay men. (Page 73)

Action taken or to be taken

CDC will continue to prioritize HIV prevention activities for MSM of all races. This approach is consistent with the National HIV/AIDS Strategy (NHAS). CDC's HIV testing program was recently expanded to address MSM as a target population, and the recently recompeted CDC-funded program to support community-based organizations also emphasized prevention among MSM, with approximately half of the funded organizations targeting MSM. CDC will continue to support activities to advance the goals of the NHAS and to reduce HIV incidence and HIV-related health disparities by supporting evidence-based prevention interventions at the individual, community, and structural levels. CDC's National Act Against AIDS campaign is raising awareness of the continued impact of HIV on MSM health and promoting HIV testing and risk reduction. In addition, the FY 2012 request aims to expand the reach and impact of HIV prevention activities for MSM by supporting demonstration projects that will employ cost effective evidence-based approaches to reduce HIV incidence, improve the sexual health of MSM, and conduct research to develop and test innovative prevention interventions.

Item

Viral Hepatitis - The Committee is aware of the January 2010 Institute of Medicine report that outlined a national strategy for prevention and control of hepatitis Band C. Therefore, the Committee encourages the CDC to address the report's recommendations and continue to validate interventions focused on the mother child transmission issue. Also, as the hepatitis B virus is the single greatest health disparity impacting the Asian and Pacific Islander 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 these populations.

Action taken or to be taken

HHS has established an interagency workgroup to address the IOM report, and CDC is staffing this effort. CDC has developed an extensive plan to address the IOM's recommendations, including increased surveillance activities, research to better understand barriers to screening and other prevention services, and increased professional education on best practices for screening and vaccination, prevention of perinatal transmission, and HBV vaccination. CDC funds perinatal hepatitis B prevention programs to identify HBV-infected pregnant women, refer them for medical management of HBV infection, screen and vaccinate or refer to care contacts of infected women, and ensure their infants receive time-sensitive interventions during the first year of life. In addition, CDC's FY 2012 request includes an increase for viral hepatitis. (Page 73)

Item

Hepatitis B - The Committee notes that there are 400 million people chronically infected with hepatitis B worldwide, with more than 120 million of these individuals in China. While hepatitis B transmission requires direct exposure to infected blood, worldwide misinformation about the disease

has fueled inappropriate discrimination against individuals with this vaccine-preventable, blood-borne and treatable disease. The Committee encourages the CDC to consider global programs to increase the rate of vaccination, reduce mother-child transmission and promote educational programs to prevent the disease and to reduce discrimination targeted against individuals with the disease. (Page 92)

Action taken or to be taken

CDC supports several international hepatitis control activities to increase vaccination and prevention education and reduce perinatal transmission. CDC provides full support for a hepatitis medical officer based at WHO Headquarters in Geneva to support WHO hepatitis prevention and control activities. This medical officer is housed in the Family and Child Health Cluster (FCH), Immunization, Vaccines and Biologicals Department (IVB), Expanded Programme on Immunization Team (EPI) and focuses primarily on vaccine policy development and evaluation, as well as other prevention activities to decrease morbidity and mortality associated with viral hepatitis. CDC also supports a medical officer in Beijing, China through the World Health Organization. In addition, CDC provides support for numerous bilateral and multilateral viral hepatitis surveillance and prevention efforts in Asia, Africa, the Pacific Islands, and the US-Mexico border area.

Item

Immunization - The Committee requests that the CDC identify in the fiscal year 2012 budget justification a detailed breakdown of adult vaccines purchased by the States using the new authority. The Committee encourages the CDC to create and manage a broad public education campaign targeted at improving adult immunization rates, with active participation by and collaboration with State and local public health departments. The Committee further encourages the CDC to increase its capacity to measure adult immunization coverage rates and support enhanced development, interoperable functionality, and use of State and regional immunization registries and/or take advantage of advances in electronic medical health records. (Page 70)

Action taken or to be taken

Under the Affordable Care Act (ACA) Section 4204, states have been given the authority to purchase recommended vaccines for adults, which provides new authority to states to purchase adult vaccines with state funds from federally negotiated vaccine contracts. This new authority was not included in the federal adult vaccine contracts negotiated in FY 2010 as they were negotiated prior to the implementation of ACA, and therefore, CDC has no data to report in the FY 2012 Congressional Justification. CDC is preparing for the inclusion of this new authority in the annual adult vaccine contract negotiation that will take place with vaccine manufacturers in the Spring of 2011. CDC can provide a report on the detailed breakdown of adult vaccines in future year budget submissions.

CDC promotes adult vaccinations through a variety of efforts at both the national level and in collaboration with State and local public health departments. CDC works with the Centers for Medicare and Medicaid (CMS) on education efforts related to Medicare beneficiaries and the importance of pneumococcal and influenza vaccination. CDC supports broad public awareness and education campaigns each year to promote influenza vaccination for all populations, including annual National Influenza Vaccination Week, which has specific campaigns to promote influenza vaccination among young and older adults. CDC also provides technical support to State and local public health departments in implementing local public education campaigns. For example, during the 2010 pertussis epidemic, CDC worked with California on a comprehensive communications approach to promote Tdap vaccination among target populations, including pregnant women and

young adults. This effort included ethnic media round tables in Los Angeles and San Francisco that were attended by nearly 50 members of broadcast and print news media; and radio media tours were broadcast on 10 California radio stations.

CDC has undertaken the following efforts to increase capacity to measure adult immunization coverage rates: 1) In the aftermath of the 2009 H1N1 response, influenza vaccination coverage has been enhanced with rapid turn-around coverage assessment surveys in 20 local areas, as well as among healthcare personnel and among pregnant women. Coverage estimates for influenza vaccination will be available online during the 2010-2011 influenza season; and 2) CDC is currently working with CMS to assess the effectiveness and feasibility of establishing a mechanism for public reporting of influenza vaccination coverage among health care personnel by making this a national quality performance measure for healthcare institutions.

The Health Information Technology for Economic and Clinical Health Act (HITECH) was passed in early 2009 to achieve significant improvements in care through Meaningful Use of Electronic health Records (EHR) by health care providers. Meaningful Use has a number of required core objectives and a menu set of objectives with three public health objectives which include the submission of electronic immunization data to immunization registries or immunization information systems. To assist the achievement this Meaningful Use objective, HITECH\ARRA 317 funding provided CDC the opportunity to support enhanced development, interoperable functionality, and use of State and local immunization registries and/or take advantage of advances in electronic health records.

Also, ARRA funding is supporting the harmonization of clinical decision support algorithms by developing consensus-based business rules and logic for each vaccine on the Advisory Committee on Immunization Practices (ACIP) immunization schedule. This approach will ensure that a common clinical decision support algorithm will be used by Immunization Information Systems, EHRs, and other vendors.

Item

Diabetes - 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 is impressed by the success of the National Diabetes Prevention program and is encouraged by private-sector implementation of this evidence-based model. The Committee encourages the CDC to continue expanding this model through public and private efforts including wide-spread distribution of training standards and models for training programs. The Committee further encourages the CDC to continue translating research findings into clinical and public health practice; supporting the National Diabetes Education Program; and strengthening public health surveillance. The Committee feels strongly that CDC efforts to develop, advance, and implement innovative interventions and national programs will improve diabetes outcomes and prevent diabetes. (Page 77)

Action taken or to be taken

Implementation of the National Diabetes Prevention Program is continuing through actions around its four levers: Training, Program Recognition, Model Sites and Health Marketing. Program collaborators include health payers, public health, academia and others like YMCA-USA, with the community-based infrastructure best suited for reducing type 2 diabetes. In April 2010, a memorandum of understanding between CDC and United Health Group (UHG) defined roles needed to support the National Diabetes Prevention Program. The involvement of a health plan like UHG, with an interest in paying for evidence-based diabetes prevention programs in a scalable, sustainable manner, will maximize the public health benefit and model the health and economic utility of this approach for other third-party payers. The partnership with CDC and the National Diabetes Prevention Program prompted UHG to cover their beneficiaries at CDC funded intervention sites.

Eighteen YMCA sites were funded by CDC to deliver the evidenced-based type 2 diabetes lifestyle intervention. UHG has funded an additional 7 lifestyle intervention sites at YMCA's. This unique agreement will include reimbursement to the funded sites for achieving program goals and will serve as a model for other third-payers in providing reimbursement for lifestyle intervention programs.

CDC will continue to support Diabetes Prevention and Control Programs (DPCPs) in the fifty states, the District of Columbia, eight current or former territories, and other organizations to identify and focus on populations with greatest diabetes burden and risk. DPCPs and other organizations work with health care systems to implement evidence-based and promising models in their communities, Federally Qualified Health Centers, community health centers, and other systems that provide services for under/uninsured populations and racial/ethnic minorities.

CDC's National Diabetes Education Program offers tools and materials tailored for populations with greatest diabetes risk/burden. These materials are used by DPCPs and their partner organizations at the state and local level in their work to: influence improvements in health care systems, build clinic-community linkages to support lifestyle change, and expand the reach of diabetes self management education.

Item

Diabetes in Native Americans/Native Hawaiians - The high incidence of diabetes among Native American, Native Alaskan, and Native Hawaiian populations persists. The Committee is pleased with the CDC's efforts to target this population and assist the leadership of the Native Hawaiian and Pacific Basin Islander communities in addressing this disease. The Committee encourages the CDC to build on its historical efforts in this regard. (Page 77)

Action taken or to be taken

CDC's Native Diabetes Wellness Program (NDWP) works with partners to build, expand, evaluate, and disseminate promising practices for diabetes intervention and prevention in American Indian and Alaska Native (AI/AN) communities.

In FY 2008, CDC entered into a five year cooperative agreement with 11 tribes and tribal organizations to support community use of traditional foods and sustainable ecological approaches for diabetes prevention and health promotion in American Indian and Alaska Native communities. Additionally, grantees will engage communities in identifying and sharing the stories of healthy traditional ways of eating, being active, and communicating health information and support for diabetes prevention and wellness. In FY 2010, this program included a total of 17 grantees.

CDC will continue to develop expertise in diabetes prevention and control; establish systems to define the burden of diabetes; identify gaps in diabetes care; evaluate limited intervention projects; and develop partnerships to leverage resources and extend outreach.

Item

The Committee urges the CDC to continue its work with communities, other Federal agencies, and food manufacturers to reduce sodium in food, thus helping control heart disease and stroke. (Page 78)

Action taken or to be taken

In FY 2010, CDC convened the Public Health Law Summit on Sodium Reduction. Participants included state and local policy makers and implementers, food industry representatives, and partners. Guidance for CDC-funded States and communities on sodium reduction opportunities is being developed as an outcome of the meeting. Products will include a procurement guide for communities to use when setting sodium standards for food purchased and served, as well as venue based guides

for sodium reduction in different settings, including schools, hospitals, worksites, and congregate populations. In FY 2010, CDC funded five communities under a new FOA, *Sodium Reduction in Communities*. The work of the funded communities will increase the number of policies and programs that support reduction in sodium intake and expand the public health application and implementation of sodium-related policies, surveillance, and evaluation.

CDC will continue to strengthen surveillance systems for sodium intake and consumption, which is critical for monitoring cardiovascular health and the impact of public health/preventive policies and programs. CDC is developing a sodium surveillance plan as a component of its National Cardiovascular Disease Surveillance System to expand surveillance of sodium intake to monitor:

- The amount of sodium in the food supply.
- Dietary intake of sodium.
- Policy changes at the Federal, State, and local levels.
- Knowledge, attitudes, and behaviors pertaining to individual sodium intake.

CDC will finalize the comprehensive evaluation plan for sodium reduction, which began in FY 2010. The plan will specify key indicators and set the stage for progress nationally in reducing sodium intake. Additionally, CDC will continue to provide technical assistance to States and communities working on sodium reduction.

Item

Aortic Aneurysms - The Committee notes the release of new treatment guidelines for the management of aortic aneurysms by leaders in the professional cardiology community. The Committee encourages the CDC to raise awareness of the guidelines, which are of importance to millions of patients suffering from familial aortic aneurysms, Marfan syndrome, and other related conditions

Action taken or to be taken

CDC recognizes that early diagnosis and aggressive treatment are critical to improve the prognosis of Aortic Aneurysms. CDC has developed a comprehensive fact sheet on risk factors for Aortic Aneurysms and continues to explore opportunities to work on collaborative projects with partners such as the American Heart Association and Preventive Partnerships to increase provider awareness and adherence to clinical guidelines. In addition, CDC continues to promote Heart Disease and Stroke Prevention by identifying opportunities and encouraging the transition to Electronic Health Records and standardizing Heart Disease and Stroke Prevention indicators within those records.

Item

Chronic Obstructive Pulmonary Disease - COPD is the fourth leading cause of death in the United States and the only 1 of the top 5 causes of death that is on the rise. The Committee encourages the CDC to develop, in consultation with appropriate stakeholders, a Federal plan to respond to this disease. (Page 80)

Action taken or to be taken

CDC supports the initial assessment and planning for public health activity in this important area. COPD represents a public health problem that is increasing and is now the third leading cause of death, but could be almost completely prevented with the elimination of smoking. CDC has consulted with experts to develop a public health strategic framework to explore the public health issues related to COPD, which would include addressing the public health role in prevention,

treatment, and management. This would include the examination of the best strategies, actions, and performance measures to address surveillance of COPD.

In 2010, CDC developed and tested a module for the Behavioral Risk Factor Surveillance Survey (BRFSS) that would assess quality of life, medication use, and annual visits to hospitals, emergency rooms, and physicians for COPD-related symptoms among respondents with COPD. The National Heart, Lung and Blood Institute provided financial support for states to implement this module in the 2011 BRFSS. CDC also launched a webpage that provides information about COPD risk factors and provides links to several national partners.

In FY 2012, CDC is **creating a** new comprehensive chronic disease program that will provide CDC greater flexibility to better address the significant national burden of chronic disease including COPD. The new program will address the top five leading causes of death and disability (e.g. heart disease, cancer, stroke, diabetes, and arthritis) and associated risk factors. The FY 2012 Budget includes an increase of $72 million over the FY 2010 Enacted level when comparably adjusting for the new program.

Item

Chronic Pain Conditions in Women - The Committee encourages the CDC to build on its previous related epidemiological work to undertake a study of the prevalence, overlapping nature, and shared risk factors of chronic pain conditions which solely or disproportionately impact women, including vulvodynia, TMJ disorders, endometriosis, fibromyalgia, interstitial cystitis, and chronic fatigue syndrome. The Committee further encourages the CDC to educate the public about the seriousness and societal costs of these conditions; make available and promote sources of reliable information on the symptoms, diagnosis, treatment, and overlapping nature of the conditions; and make available information to women with chronic pain about how to communicate effectively with their health professionals about these conditions. (Page 80)

Action taken or to be taken

CDC's reproductive health activities include research and surveillance into women's health and chronic pain conditions like Endometriosis. CDC presently publishes research findings on Endometriosis, which helps to inform the public health, health care provider and patient communities.

CDC is active in educating the public about the health burden of fatiguing illnesses and Chronic Fatigue Syndrome (CFS) by providing evidence-based information on societal costs, diagnosis, symptoms, and management options for these chronic conditions. CDC's website offers online materials to encourage patient-provider communication through continuing medical education courses, peer-reviewed publications, a pocket resource guide for healthcare providers, a CFS booklet, and CFS toolkits for patients and families that are available in English and Spanish.

Item

Oral Health -The Committee understands that preventing oral disease through broad-based community programs can ultimately result in significant cost savings. The Committee has increased funding for the Division of Oral Health to invest in community prevention of oral disease and to expand its program to States to strengthen their oral health infrastructure programs. The Committee remains concerned about the high incidence of tooth decay among American Indian/Alaska Native [AI/AN] children and therefore encourages the Division to collaborate with the Indian Health Service to assess the current Early Childhood Caries [ECC] epidemiology in AI/AN children. The Committee encourages the CDC 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 and reduce the large disproportionate disease burden in Native American children. (Page 81)

Action taken or to be taken

CDC is concerned about the high levels of tooth decay in American Indian/Alaska Native [AI/AN] children. The Division of Oral Health began a collaboration with the Division of Diabetes Translation to develop oral health promoting messages for the next book in the Eagle Book series of educational books for children. A CDC health communications specialist provided technical assistance on how to best communicate the results of an investigation in the Yukon Kushkokwim region of Alaska that examined tooth decay, fluoridation, and soda pop intake in children in several villages.

In Oct. 2010, a CDC epidemiologist participated in a symposium on ECC in the AI/AN population convened by the American Dental Association that addressed effective etiologic factors related to ECC, measures to prevent ECC, and research gaps. CDC is supportive of collaborating with the IHS and other government agencies and appropriate NGOs to fill information gaps about the onset, prevalence, severity, and microbiology of early childhood caries in the AI/AN population.

Item

Psoriasis — As many as 7.5 million Americans are affected by psoriasis and/or psoriatic arthritis—chronic, inflammatory, painful, and disfiguring autoimmune diseases for which there are limited treatment options and no cure. Recent studies show that people with psoriasis are at elevated risk for other chronic and debilitating health conditions, such as heart attack, diabetes, Crohn's disease, obesity, and liver disease, and that people with severe psoriasis have a 50 percent higher risk of mortality. The Committee encourages the CDC to continue to refine and implement the psoriasis and psoriatic arthritis data collection and registry process.

Action taken or to be taken

Psoriasis and psoriatic arthritis can compromise the quality of life for people affected by the condition by affecting basic life functions such as sleeping, preventing work in certain occupations, staying physically active, and causing psychological distress. CDC is focusing on understanding what is currently known about these conditions from a public health perspective and developing a public health agenda to address them. In cooperation with the National Psoriasis Foundation, the Society for Investigative Dermatology and the American Academy of Dermatology, CDC has conducted literature reviews and regular meetings of experts on the topic. These efforts have provided a draft public health agenda that includes: current knowledge of psoriasis and psoriatic arthritis from a public health perspective; gaps in our public health understanding of psoriasis and psoriatic arthritis; a prioritized list of recommendations and activities to address those gaps; and, a discussion of the role of CDC and other organizations in addressing those recommendations and activities. CDC is currently working with experts to implement this agenda, which includes basic work on validated case definitions that will allow better surveys and analyses of existing data sources to help define the public health burden in more detail.

Item

Pulmonary Hypertension - The Committee notes the significant increase in FDA-approved therapies for pulmonary hypertension in recent years and encourages the CDC to expand awareness of the disease and its new treatment options among the general public and healthcare providers. (Page 82)

Action taken or to be taken

CDC recognizes that early diagnosis and aggressive treatment are critical to improve the prognosis of pulmonary hypertension. The diagnosis of pulmonary hypertension is usually made many years after most patients have had the illness and have suffered the many disabling symptoms. CDC has a comprehensive

28 page report on Pulmonary Hypertension Surveillance increasing public and health care provider awareness. CDC continues to explore opportunities to work on collaborative studies and surveillance reports with the Pulmonary Hypertension Association and other partners such as the American Heart Association and National Heart, Lung, and Blood Institute.

Item

***Safe Motherhood/Infant Health* —** The Committee is concerned about late preterm infants, who are at greater risk of morbidity and mortality, and it encourages the CDC to expand work in this area and to improve national data systems to track preterm birth rates and expand epidemiological research that focuses especially on the causes and prevention of preterm birth and births at 37–38 weeks gestation. (Page 82)

Action taken or to be taken

Although a recent CDC report shows that there has been a small decline in the preterm birth rate in the United States, levels of preterm births remain higher than at any point in the 1980s and 1990s. More than one-third of infant deaths can be directly attributed to preterm birth and disparities remain large. CDC's Safe Motherhood program is dedicated to working with other federal agencies and national partners to reduce late preterm birth rates.

CDC's Safe Motherhood program supports the Pregnancy Risk Assessment Monitoring System (PRAMS), a collaborative surveillance project between CDC and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. This data is a vital tool in the scientific exploration of factors that may contribute to a successful full term birth. Additionally, CDC provides technical assistance to states to strengthen epidemiologic investigations of infant mortality and preterm birth, identify populations at risk, and evaluate strategies for prevention.

Item

***Maternal Mortality* —** The Committee encourages the CDC to address maternal mortality, given that each day two to three women in the United States die from delivery complications. The Committee encourages the CDC to expand its work gathering information on pregnancy-related deaths, collecting and providing information. (Page 85)

Action taken or to be taken

CDC's Safe Motherhood program has recognized for over 40 years the importance of reducing maternal mortality. CDC contributes by providing epidemiologic, surveillance, and technical assistance aimed at identifying and reducing maternal mortality and morbidity. CDC has conducted ongoing national surveillance of pregnancy-related mortality since 1987. The Pregnancy Mortality Surveillance System (PMSS) detects pregnancy-related deaths, analyzes factors associated with these deaths, and publishes information that may lead to state and national prevention strategies. CDC has published a manual describing strategies for conducting pregnancy-related or maternal mortality surveillance in the United States available for use by state or local health departments. In 2010, a CDC Safe Motherhood scientist published an article showing a significant increase between 1995 and 2006 of severe complications at delivery among women with chronic heart disease.. CDC's Safe Motherhood program also tries to reduce maternal mortality through teen pregnancy prevention efforts.

Item

***Deep Vein Thrombosis [DVT] and Pulmonary Embolism [PE]* —** The Committee believes that public education and awareness are key to reducing the death rate blood clots that form in the legs

[DVT] and then travel to the lungs [PE]. Therefore, the Committee encourages the CDC to expand its efforts to increase public and health provider awareness about the causes and prevention of DVT and PE, expand surveillance activities, and stimulate research. (Page 80)

Action taken or to be taken

DVT/PE is an under diagnosed, serious, and preventable medical condition. Currently there is no national surveillance for DVT/PE and therefore the true burden of DVT/PE is unknown. CDC is working with its colleagues, partners and investigators to identify the most effective surveillance approach for monitoring the incidence, prevalence and burden of DVT/PE and the effectiveness of prevention efforts. In addition, CDC continues to foster collaborative epidemiologic research through the Thrombosis and Hemostasis Centers Research and Prevention Network to identify risks (both genetic and acquired) for DVT/PE and to investigate associated adverse outcomes. CDC is committed to increasing awareness of DVT and Pulmonary Embolism among the public and providers. CDC is initiating a prevention research plan that will guide the development of innovative health communication strategies to translate health information for the general public, health care providers, and community-based organizations to help increase knowledge and awareness about the prevention of DVT/PE and its secondary conditions.

Item

***Congenital Disabilities* —** The Committee encourages the CDC to continue to increase scientifically sound information and support services provided to patients receiving a positive test result for Down syndrome or other pre- or postnatally diagnosed conditions. The Committee further urges CDC to disseminate current and accurate information about the tested condition; coordinate the provision of, and access to, supportive services for patients and families; and provide assistance to State and local health departments to integrate the results of prenatal testing and pregnancy outcomes into State-based vital statistics and birth defects surveillance programs. (Page 84)

Action taken or to be taken

CDC currently funds 14 population-based birth defects programs to track babies born with major birth defects, including Down syndrome, and to connect families and infants born with these conditions to medical, social, and support services in the community. CDC works with the National Birth Defects Prevention Network to publish annual state data on 45 major birth defects and works to develop best practices and standards for collecting data from all available data sources, including prenatal and genetic testing. CDC supports a number of research efforts to improve the knowledge of modifiable risk factors of birth defects, including undertaking the largest population-based case-control study of birth defects ever conducted in the United States, the National Birth Defects Prevention Study. This information has been used to examine environmental and genetic factors associated with dozens of birth defects. CDC recently published findings from a multi-state study that produced prevalence estimates for Down syndrome and spina bifida among children and adolescents, and investigators are currently examining patterns of health care utilization and looking at factors associated with survival among infants and children with these conditions.

State birth defects programs educate families about birth defects prevention and about available community resources to support children born with birth defects and their families. CDC works with state and local public health departments to increase knowledge of birth defects prevention. These efforts include educating the public on folic acid, pre-gestational and gestational diabetes, preconception health, alcohol consumption during pregnancy, and other potential risk factors.

Item

Folic Acid Education Campaign — The Committee strongly supports the folic acid education campaign. The Committee encourages the CDC to explore strengthening this campaign by incorporating its message in other prevention education initiatives aimed at improving birth outcomes, such as obesity prevention and medication use during pregnancy. (Page 84-85)

Action taken or to be taken

In an effort to help reduce existing disparities in neural tube defect rates among Latinas in the United States, CDC has developed and disseminated folic acid educational materials and public service announcements to address the needs of Hispanic women of childbearing age. CDC is also working with *promotoras*, or lay health outreach workers, in four states to develop and deliver culturally appropriate messages about folic acid to Spanish-speaking women.

Item

***Hereditary Hemorrhagic Telangiectasia [HHT]* —** The Committee is aware of a recent conference on HHT and encourages the CDC to review strategies and recommendations from that conference aimed at increasing the knowledge, education, and outreach on this preventable condition. (Page 85)

Action taken or to be taken

HHT has been subject to under reporting and under diagnosis for many years. As a result, true prevalence is not known. The most recent HHT conference occurred in 2008, and in response CDC has engaged in several ongoing activities. For example, researchers continue to provide technical assistance to the HHT Foundation International and its medical advisors in the areas of epidemiological research and surveillance. Today, CDC's primary activity is assessing prevalence of HHT among the privately insured population through the analysis of an administrative database.

Item

Obesity Research, Treatment, and Prevention - Obese pregnant women are at increased risk for poor maternal and neonatal outcome. The Committee urges the CDC to conduct research and interventions to address the increased risk of birth defects and stillbirths in obese women, especially those receiving infertility treatment; ways to optimize outcome in obese women who become pregnant after bariatric surgery; and the increased future risk of childhood obesity in their offspring. (Page 85)

Action taken or to be taken

CDC efforts will focus on the identification of factors that contribute to or modify the association between maternal obesity and birth defects. The maternal questionnaire used in the CDC-funded National Birth Defects Prevention Study (NBDPS) has recently been expanded to include a brief set of validated physical activity questions. Physical activity may act as an independent protective factor in the etiology of birth defects; it may also act as an effect measure modifier of associations with pre-pregnancy obesity, gestational diabetes and pre-existing diabetes. CDC will assess the role of other key factors (e.g., type of obesity, diet quality) in influencing the association between maternal obesity or diabetes and major birth defects by conducting a literature review and using data from existing case-control studies. Efforts will be focused on congenital heart defects because of their prevalence (affect ~1% of all births) and on spina bifida because it is the defect that has demonstrated the most consistent association with maternal obesity. CDC is currently conducting an analysis to estimate the annual number of birth defects and other adverse reproductive disorders (fetal deaths, pregnancies affected by gestational diabetes) associated with pre-pregnancy obesity in the United States. In addition, CDC continues to evaluate the association between fertility treatments and major birth defects to better understand the risks associated with these increasingly common exposures.

Item

Tourette Syndrome **—**The Committee commends CDC for its work in developing a public health education and research program on Tourette syndrome. The Committee encourages CDC to use these funds to continue to educate physicians, educators, clinicians, allied professionals, and the general public about the disorder and to expand on the scientific knowledge base on prevalence, risk factors, and co-morbidities of Tourette syndrome.

Action taken or to be taken

CDC is committed to its public health education and research program on Tourette Syndrome (TS). Systematic efforts to educate medical and allied health professionals, educators, families, and the public about this disorder contribute toward the goal of better identification, diagnosis, and management of individuals with TS. To date, CDC's partnership with the Tourette Syndrome Association (TSA) has conducted over 438 educational programs reaching 27,639 medical, allied health and educational professionals in all fifty states. Continued outreach is critical to ensure all families have access to providers and educators who understand TS and can successfully work with patients and students to manage it. By participating, providers and educators also become more familiar with common co-occurring conditions, including ADHD and anxiety disorders.

CDC continues to expand on the scientific knowledge of TS and co-occurring conditions. In 2009, CDC published the first U.S. prevalence estimate based on a nationally representative sample. CDC collaborates with investigators at the University of Oklahoma, University of Rochester, and University of South Florida to document the impact of tic disorders, including TS, on quality of life, family stress, education, health care needs, health risk behaviors, and use of community services. CDC continues to use national surveys to document prevalence and impact in nationally representative samples of children.

Item

National Health and Nutrition Examination Survey {NHANES} - Since 1959, NHANES has provided critical data about the state of the Nation's health. This information has resulted in a number of highly successful public health actions, including removing lead from gasoline and vaccinating all infants and children against hepatitis B infections. While these national data have been extremely important, many of our most pressing public health challenges are faced at the State and local level. The Committee encourages NHANES to consider ways to expand the applicability of NHANES reports to the State and local level. (Page 86)

Action taken or to be taken

CDC is exploring ways in which the National Health and Nutrition Examination Survey (NHANES) can continue to obtain high quality national data on the U.S. population and population subgroups while making some local estimates. As currently designed, NHANES examines a nationally representative sample of about 5,000 persons - located in 15 local areas - each year. To make local (or state) estimates, NHANES must have visited a local area often enough to meet sample size requirements for making local estimates. Given the current design, only a few local areas or states fall into the NHANES sample frequently enough to meet these sample size requirements. NCHS is using data obtained from 1999-2006 to evaluate whether it can produce estimates for these local areas that would be valid and reliable estimates for chronic conditions such as hypertension, obesity, diabetes, and cholesterol.

Item

Sodium **—** The Committee is strongly supportive of the work that the CDC is doing to determine the most appropriate method for ongoing surveillance of sodium intake. The Committee requests to be

briefed by the CDC on the results of the various survey-design research efforts. The Committee further requests that the briefing include cost estimates for implementation. (Page 86)

Action taken or to be taken

Activities are underway within CDC to assess current National Health and Nutrition Examination Survey (NHANES) methods for measuring dietary sodium intake. NHANES monitors dietary intake but dietary recalls are considered inadequate measures of dietary sodium intake at this time. Urinary excretion better characterizes sodium consumption but is extremely variable. Several studies have concluded that casual urine samples correlate sufficiently with 24 hour urine collections to monitor population intake of sodium. NHANES currently collects two urine specimens under conditions more rigid than "casual" – one is a timed urine collection and the second is the first morning void. CDC understands that 24-hour urine specimens have the potential of providing the best assessment of sodium intake. There are, however, logistical challenges to this data collection that can affect data quality and must be evaluated. CDC has initiated research activities to determine the most appropriate method for ongoing surveillance of sodium intake and expects to have obtained sufficient information to brief committee staff in the fall of 2011.

Item

Vital Statistics - The Committee strongly supports the effort to transition vital statistic collection to electronic systems, in particular the effort to phase in electronic death records. The Committee also encourages the CDC to work with the Centers for Medicare and Medicaid Services and the Office of the National Coordinator to pilot test the integration of electronic birth and death records and electronic medical records. (Page 86)

Action taken or to be taken

In recent years, CDC has sought to improve vital event reporting by transitioning to electronic collection and reporting systems. These ongoing efforts, including phasing in electronic death records at the state level, are important to maximize the timeliness and quality of the National Vital Statistics System.

CDC is involved in a number of activities related to integration of electronic vital records and electronic medical records (EMRs), including standard setting efforts and implementation of "meaningful use" for public health activities. CDC is not aware, however, of any activities related to pilot testing the integration of electronic birth and death records and EMRs. CDC will advise the Office of the National Coordinator and the Centers for Medicare and Medicaid Services of the Committee's interest in a pilot test.

In addition, CDC's FY 2012 requests includes resources to collect at least a full 12 months of data needed for public health purposes currently collected by vital statistics jurisdictions birth data through the National Vital Statistics System (NVSS) to provide the nation's official vital statistics data based on the collection and registration of events in 57 jurisdictions, including all 50 states, two cities (D.C. and New York), and five territories.

Item

Asthma - The Committee continues to encourage the CDC to work with States and the asthma community to implement evidence-based best practices for policy interventions, with specific emphasis on indoor and outdoor air pollution. The Committee requests an update on the status of implementation in the CDC fiscal year 2012 budget justification. (Page 87)

Action taken or to be taken

CDC's National Asthma Control Program (NACP) continues collaborative efforts with states and the asthma community to implement evidence-based best practices and enhance surveillance systems for

asthma to reduce asthma morbidity, mortality, and the impact of indoor and outdoor air pollution on people with asthma. NACP funding of 34 states, one city, one territory, and a number of other partners has lead to a variety of successful interventions:

Many of the state asthma programs are incorporating asthma into chronic disease self-management programs. Utah has established these programs with 6 local health departments to provide workshops in community settings. In Michigan, the asthma program supports highly interactive workshops that emphasize disease action plans.

The Illinois asthma program provided technical assistance in the development of a Green Construction Executive Order concerning all state-funded road construction projects in non-attainment areas and the use of clean construction practices, such as using cleaner fuels and pollution controls on their diesel vehicles and equipment.

The Hawaii Community Rural Asthma Control Program developed a training curriculum to educate patients and their families about asthma triggers and how to assess their environment for those triggers. Washington, D.C. has collaborated with the District-based Children's Environmental Health Network to implement a program to assess local childcare facilities for asthma-related triggers and to provide training on the process and importance of reducing or eliminating triggers for enrollee health.

Connecticut is partnering with CT Children's Medical Center to implement a statewide program that trains pediatric providers in asthma diagnosis and medical management. Trainings are conducted in practitioner offices, community health centers, hospital out-patient clinics and school-based health clinics.

Additionally, CDC funds four non-governmental organizations to implement asthma and air quality education efforts that will lead to reduced illnesses and deaths related to the environmental risk factors of asthma. CDC continues to:

Explore the impacts of indoor air pollution, such as carbon monoxide exposures, on health to effectively develop evidence-based practices for policy interventions to reduce morbidity and mortality associated with indoor air pollution.

Develop an air pollution public health program with emphasis on fine particles (PM 2.5) which will assist in building state and local capacity to respond to air pollution issues and explore the effects of air pollutants such as PM 2.5 on vulnerable populations.

Develop exposure models and biomarkers of air pollutant exposures to better understand health impacts of air pollution.

Item

Built Environment — The Committee strongly supports efforts to integrate health impact assessments into community planning as universally as possible and as quickly as possible. For that reason, the Committee is concerned that the CDC's planned activities focus almost exclusively on adding personnel to health departments, rather than on designing toolkits and health assessment curricula that can be adopted by all actors in community planning. The Committee once again urges the CDC to design materials that can be used by non-health experts, and engage with urban planning schools and professional organizations. Further, the Committee notes that the new chronic disease State grant program seeks to incorporate State Departments of Transportation in the chronic disease planning and policy change process. The Committee urges the CDC to utilize the built environment resources to engage with State transportation officials to support this effort.

Action taken or to be taken

CDC's Healthy Community Design Initiative (or Built Environment Initiative), has endeavored to rapidly develop the accessibility, adoption, and practice of health impact assessments (HIAs) through

strategic partnerships, tool development, training, and HIA practice. Our strategy to deploy HIA includes: 1) translate research to use for HIA practitioners; 2) develop toolkits, such as the online training and toolkit created in conjunction with the National Association of City and County Health Officials (NACCHO) and the American Planning Association (APA); 3) improve surveillance – and translation of existing surveillance – so communities have useful data for HIAs; 4) develop guidance documents for HIA, including participating in the development of HIA practice standards; 5) train professionals from diverse sectors in HIA; 6) develop intra-agency partnerships, such as with the National Center for Chronic Disease Prevention and Health Promotion, to incorporate HIA into major grant activities and to align activities between Centers; 7) develop strategic partnerships with other HIA organizations, such as Pew Charitable Trust's Health Impact Project, to augment each other's activities and to share resources to conduct projects including an evaluation of HIA practice; 8) support interagency initiatives, including the HHS/HUD Livability Initiative, to include HIA as an activity; 9) engage transportation, planning, and other sectors outside of HIA, including helping to improve guidelines such as EPA's School Siting Guidelines or criteria such as the U.S. Green Building Council's LEED-ND (Leadership in Energy and Environmental Design – Neighborhood Development); and, 10) encourage innovation in HIA practice, including a recent project of HIA of transportation-related climate change policy which won a CDC award for innovations in public health policy.

The design of community environments, including the road networks and community design, is linked to major public health outcomes such as motor vehicle injuries, physical activity, and pollution-related disease. Because the environment is a modifiable risk factor for these health outcomes, engaging the sectors that control the design of the environment, our communities, is critical to improve health and support the cost-effective use of infrastructure resources. CDC will continue to offer tools, technical assistance, and other resources to enable effective collaboration.

Item

Polycythemia Vera Cluster - The Committee has not continued funding for research into polycythemia vera clusters. The Committee is pleased by the research completed and published in 2010, funded by the CDC. The Committee notes that the 2-year award made in fiscal year 2009 is complete and the Agency for Toxic Disease Registry closed its investigation in 2008. The Committee expects the CDC to continue funding ongoing surveillance through the cancer registry program in the National Center on Chronic Disease Prevention and Health Promotion. (Page 88)

<u>Action taken or to be taken</u>

ATSDR completed the initial investigation in 2008, confirming a cluster of polycythemia vera cases at the nexus of three Pennsylvania counties (Carbon, Luzerne, and Schuylkill counties). The initial investigation also identified significant problems with diagnosis of the condition and subsequent reporting to the state cancer registry as reported in 2009 (Seaman et al, Use of molecular testing to identify a cluster of patients with polycythemia vera in eastern Pennsylvania. Cancer Epidemiol Biomarkers Prev. 2009 Feb;18(2):534-40). ATSDR continues to study the potential cause(s) for this cancer cluster and to improve the diagnostic and reporting problems identified in the initial investigation. Many of the epidemiologic, toxicologic, and genetic studies were initiated in FY 2009 and FY 2010. ATSDR, along with our other research partners in academia and state or federal public health agencies, published a manuscript in 2010 detailing this portfolio of projects to raise awareness in the scientific community (Seaman et al, A multidisciplinary investigation of a polycythemia vera cancer cluster of unknown origin. Int J Environ Res Public Health. 2010 Mar;7(3):1139-52.). Over the next several years, ATSDR anticipates many more publications detailing the outcomes of specific studies. Many of these projects have an applied public health benefit that will increase the diagnostic accuracy amongst physicians, the quality of reporting to cancer registries, and possibly the

identification of risk factors that will help decrease the incidence of this disease in the cluster area as well as in the general population.

Item

Volcanic Emissions - The Committee has included increased funding for NIOSH to continue to study the impact of potentially toxic volcanic emissions. In particular, pre-existing respiratory conditions such as asthma, chronic bronchitis, and emphysema seem to be particularly susceptible to the effects of sulfur dioxide. Further study is warranted on the acute and long-term impact that these emissions have on both the healthy and the residents predisposed to illness. The Committee strongly advises the establishment of a dedicated center that embraces a multi-disciplinary approach studying the short- and long-term health effects of the volcanic emissions.

Action taken or to be taken

CDC continues to study and investigate potential short-and long-term health effects of volcanic emissions. CDC is currently providing technical assistance and funding to further establish and maintain a research center that will respond to and increase the understanding of exposures to air pollution of volcanic emissions experienced by Hawaiian residents. The center will collect and interpret air monitoring data, health effects experienced by residents through health studies and health outcome data, and the relationship between exposure to volcanic emissions and associated health effects. The center, established on Hawaii Island, includes state, local, and federal partners that are collaborating to explore short-and long-term health effects of volcanic fog (VOG) on children and adults with asthma and other respiratory symptoms and conditions including sinus congestion, wheezing, and chronic bronchitis. This Center represents a multi-disciplinary group that includes clinical experts from schools of medicine, health department staff, experts in air monitoring, fire departments and civil defense, US Geological Survey, National Park Service, and community partners.

Specifically, CDC is collaborating with university partners and others to expand a long-term study of nearly 2,000 Hawaii Island schoolchildren to explore the respiratory effects of *long-term* exposure to VOG. Additionally, to understand the impact of *short-term* exposures to VOG on respiratory health and symptoms, a community-based study is also being conducted to examine if episodes of high VOG concentration are associated with increased rescue bronchodilator use. Both of these studies will provide important information in developing and enhancing a multi-disciplinary approach for studying the short-and long-term health effects of the volcanic emissions.

Item

Neglected Tropical Diseases [NTDs] and Diarrheal Diseases - NTDs are infections that affect more than 1.4 billion people worldwide, many of them in the poorest nations. NTDs-including diarrheal and arboviral diseases-stigmatize, disable, and inhibit individuals from caring for themselves or their families, thereby promoting poverty. The Committee recognizes that the CDC has had a long history of working on NTDs and has provided much of the science that underlies those global policies and programs in existence today. The Committee encourages the CDC to continue its work on NTDs, diarrheal diseases believed to kill 2 million children ages 5 and younger worldwide each year, and arboviruses, such as Japanese encephalitis and dengue. (Page 92)

Action taken or to be taken

CDC is a key partner of the U.S. NTD Initiative. With support from the U.S. Agency for International Development (USAID), the Bill and Melinda Gates Foundation, and others, CDC aims to accelerate the control and elimination of NTDs, focusing specifically on lymphatic filariasis, onchocerciasis (river blindness), trachoma, schistosomiasis, arboviruses, and the soil-transmitted helminths (hookworm, roundworm and whipworm). CDC trains health workers, including Ministry officials;

conducts research to develop diagnostic and other tools for combating NTDs and integrating national responses to NTDs and other health issues; supports mass drug administration (MDA) for NTDs; monitors and evaluates MDA efforts; and helps develop global policy and guidelines for NTD programs. Through its WASH Away Neglected Tropical Diseases activity, CDC also aims to control and prevent NTDs through improved water, sanitation and hygiene. CDC studies additional NTDs to identify and develop tools and approaches needed to control and eliminate them.

CDC will continue its support towards achievement of global and USG targets related to NTDs. CDC's monitoring and evaluation activities will help to assess whether program investments are having the intended impact, through disease mapping to assess burden, coverage surveys to document adequacy of drug delivery, and technical assistance to countries and partners regarding when to stop MDA and post MDA surveillance to ensure any disease recurrence is rapidly detected. CDC is working with several Ministries of Health to evaluate the impact of a safe, effective, affordable vaccine against Japanese encephalitis. To combat dengue, CDC is working to develop effective vaccines and diagnostic tests, to develop field sites to measure vaccine efficacy and to conduct widespread education of clinicians in the United States, US territories and abroad in order to improve management of and reduce deaths due to dengue hemorrhagic fever. CDC researchers will develop laboratory and epidemiological tools needed for monitoring and assessing program impact, conduct surveillance for drug resistance, and help identify ways to accelerate efforts to control and eliminate lymphatic filariasis and onchocerciasis.

Contaminated drinking water is the source of many diarrheal illnesses in the developing world. CDC promotes and evaluates the impact of household water and hand washing interventions to prevent diarrheal illness and prevent rotavirus infections by vaccination.

Item

Chronic Fatigue Syndrome - The Committee urges the CDC to follow recommendations made by the CFS Advisory Committee and the 2008 peer review panel to prioritize laboratory efforts aimed at the identification of diagnostic subtypes and therapeutic biomarkers with increasing efforts in viral etiology. Intervention, including vaccination studies, against pathogens with known associations with CFS should be pursued in collaboration with other agencies and investigators to support genetic, genomic and intervention studies. (Page 71)

Action taken or to be taken

The CDC CFS program is prioritizing clinical, epidemiologic, and laboratory studies aimed at the identification of biomarkers for stratification of CFS into subtypes. As noted by CFSAC and others, identification of subtypes could be important to target therapeutic interventions and to facilitate identification of potential infectious etiologies of CFS. CDC continues to investigate potential infectious etiologies (not limited to viruses) of CFS, including most recently, partnering with others to examine the role of the retrovirus, XMRV.

Intervention studies incorporating genetic and genomic markers of risk and response will be pursued by the CDC CFS program in collaboration with other agencies and investigators who identify promising pharmacologic and non-pharmacologic therapies believed to improve the health of those suffering from CFS. Studies of the association of CFS with known and novel pathogens using genetic and genomic approaches will also continue with the aim of developing interventions such as anti-microbial drugs and vaccines. At present, however, CDC is not aware of any vaccination interventions for CFS that have been proposed and reviewed by an Institutional Review Board.

Item

Epidemiology and Laboratory Capacity [ELC] Grants - The Committee includes $50,000,000 for ELC grants from amounts transferred from the Prevention and Public Health Fund. The Committee

has included bill language exempting the awards from statutory funding floors that exceed the transferred amount. The administration transferred $20,000,000 for this purpose in fiscal year 2010. The Committee is aware that the number of genetic and metabolic disorders included in State newborn screening programs ranges from 4 to 36 and that most States screen for 8 or fewer disorders. Tandem mass spectrometry has greatly increased the number of disorders that can be detected, but States have varying resources to acquire this technology. The Committee encourages the CDC to consider bulk purchasing to increase States' ability to utilize this life-saving technology. (Page 73)

Action taken or to be taken

ELC currently funds state and local capacity for infectious disease surveillance, epidemiology, and laboratory capacity. Mass spectrometers are not currently included in ELC guidance to states, and there are no plans to purchase mass spectrometry equipment with ELC funds.

Item

***Explosives* —** The Committee recognizes the most likely cause of injuries in a man-made disaster will be related to explosives, and yet our emergency medical system is unprepared for bomb blast injuries, especially in a mass casualty situation. The Committee encourages the CDC to continue its ongoing work in preparing cities and hospital systems to respond to such events, with a special emphasis on assessing the bomb blast response capacity of high-risk cities and communities. (Page 89)

Action taken or to be taken

CDC provides leadership among all federal agencies in preparing cities and health care systems to respond to mass casualty events caused by explosions. CDC works in close collaboration with many health system partners and stakeholders to improve general injury care and health system response for acute mass casualty events. This work includes partners spanning the continuum of injury prevention and acute injury care, including those responsible for pre-hospital emergency medical services; emergency medicine; trauma surgery; pediatrics; federal, state and local government agencies; academic institutions; the private sector and international partners. Specific areas of focus include joint development of guidelines for improved management of the injured; education, training and capacity building for improved system response following acute mass casualty events; health system response in mass casualty events and crisis standards of care; research and surveillance activities related to acute injury care; helicopter EMS services; impact of trauma systems on injury outcomes; and use of trauma registry data for quality and system improvement.

Item

***National Violent Death Reporting System* -** The Committee supports the National Violent Death Reporting System (NVDRS), a State-based system aimed at preventing violent deaths by developing an understanding of the circumstances surrounding them. The program enables the collection and analysis of data from medical examiners, coroners, police, crime labs, and death certificates. NVDRS information is then used to develop, inform, and evaluate violence prevention programs at the national, State and community level. The Committee urges the CDC to continue to work with States to develop electronic portals at the State level for the submission of NVDRS data. States that apply for funding and demonstrate the ability to collect electronic data should be given priority. (Page 89)

Action taken or to be taken

Established in FY 2002, CDC's National Violent Death Reporting System (NVDRS) allows states and communities to develop a system to collect timely, complete and accurate information about violent deaths through the linkages of information from law enforcement agencies, medical examiners and coroners, health providers, crime laboratories and other agencies. CDC currently funds 18 states for NVDRS. Through the system, states can quickly see how their problems compare with other states

around the nation. Information from this system helps develop, inform and evaluate violence prevention strategies at both state and national levels. In an effort to harness the latest technology, CDC has drafted a strategic software plan that includes potentially moving NVDRS to a web platform in the future. Priority will be given to states that demonstrate the capacity to submit electronic information.

Item

Suicide Prevention — The Committee encourages the CDC to support evaluation efforts to identify promising and effective suicide prevention strategies that follow the public health model and prevent self-directed violence by promoting and strengthening connectedness among individuals, families, and communities. (Page 89)

Action taken or to be taken

CDC recognizes that suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. CDC develops, evaluates, and disseminates evidence-based programs, policies and practices that prevent suicidal behavior by promoting and strengthening connectedness at personal, family, and community levels. Connectedness is the degree to which an individual or group is closely interrelated or shares resources with other individuals or groups. CDC is currently conducting evaluations of two approaches to promoting and strengthening connectedness among two different populations (adolescents and older adults) to determine their effectiveness as a primary prevention tool to help prevent suicidal behavior in those populations.

Item

Violence Against Women - The Committee encourages the CDC to continue research on the psychological sequelae of violence against women and expand research on special populations and their risk for violence, including adolescents, older women, ethnic minorities, women with disabilities, immigrant women, and other affected populations. (Page 90)

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 has developed the National Intimate Partner and Sexual Violence Surveillance System (NISVSS). NISVSS will provide 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. In 2010, NISVSS included an oversampling of American Indian/Alaska Native women to provide more accurate data for this high-risk population.

CDC is also working to strengthen and broaden the evidence base for the prevention of teen dating violence by undertaking an initiative to promote respectful, nonviolent dating relationships among adolescents living in high-risk, inner-city communities by developing, implementing, and evaluating a comprehensive approach utilizing current evidence-based practice and experience. The focus on high-risk, inner-city communities is predicated on data that suggest that the prevalence of dating violence and intimate partner violence/sexual violence is higher in poorer communities than in their more advantaged counterparts. Moreover, this project aims to fill a gap in our understanding of teen dating violence prevention because effective teen dating violence prevention programs have not been identified for these high-risk populations.

Item

Construction Research - Construction is one of the most dangerous industries for its workers. Every year, some 1,200 construction workers are killed on the job and thousands more die from

occupationally related diseases. In 1990, Congress directed NIOSH to develop a comprehensive prevention program directed at health and safety problems affecting construction workers. The Committee is aware that the National Academy of Sciences Institute of Medicine's Review of the NIOSH Construction Research Program, published in 2009, concluded that the NIOSH Construction Research Program has been highly relevant and has had an impact in improving safety and health in the construction industry. The Committee requests NIOSH to include in the fiscal year 2012 budget justification a description of plans to implement the recommendations of the report. (Page 90-91)

Action taken or to be taken

In response to the National Academies (NA) report on NIOSH's Construction Research Program, NIOSH developed an implementation plan which reflects comments from the NIOSH Board of Scientific Counselors and the public (available at http://www.cdc.gov/niosh/nas/pdfs/NAConstructionResponseBSCReviewVersionB72709.pdf).

Three categories of NA recommendations that NIOSH is addressing include transferring research to practice, maximizing resources, and increasing communication with rule-making authorities. NIOSH crafted an extramural funding opportunity for a cooperative agreement for research to practice activities in construction. The National Construction Center successfully competed for funding and they are currently engaging experts and working with NIOSH to start the strategic diffusion. NIOSH is also integrating the National Construction Center into more of its construction research, surveillance, and related activities. To maximize resources and work more closely with other rule-making authorities, NIOSH has created a new NIOSH Office of Construction Safety and Health (a specific NA recommendation), which provides one place within NIOSH for direct communication on construction. This has enhanced effective communication between NIOSH and OSHA. For example, NIOSH and OSHA are developing new guidance on nail gun injuries (which are responsible for as many as 40,000 injuries requiring emergency department visits each year). In another step responsive to the NA recommendation of maximizing resources, NIOSH has also selected five priority goals relating to falls, noise, silica exposure, safety culture, and green buildings to guide project planning and partnerships in future years.

Item

***National Occupational Research Agenda* -**NIOSH continues to work with partners and stakeholders across the country to update the National Occupational Research Agenda [NORA]. This collaborative effort has produced strategic plans for priority research in each of the eight sectors into which the U.S. economy is divided. Several plans, such as that for agriculture, mining, and construction, are also informed by the major program reviews and positive feedback from the National Academies. Important issues cutting across all the different sectors are also addressed by NORA, such as developing methods of reducing the impact of stressful workplaces on psychological and physical health. The Committee is very concerned that the research coming from NORA be designed in a way that facilitates expeditious translation into practice. The Committee requests a report in the CDC fiscal year 2012 budget justification on the steps the agency is taking to integrate translational goals into the NORA prioritization system. (Page 91)

Action taken or to be taken

One of the key elements that guides NORA is the transfer and translation of research findings, technologies, and information into highly effective prevention practices and products that can be adopted immediately into the workplace (also called research to practice or r2p). This is largely facilitated through partnerships developed as a result of the NORA process. Examples of ongoing work with NORA partners to address specific translational goals included in the NORA sector strategic plans include: working with the Food and Drug Administration on the labeling of hazardous drugs; partnering with the Ambulance Manufacturers Division of the National Truck Equipment

Association and the General Services Administration to prevent head injuries in EMS workers; and collaborating with the leading scissor lift producer and several standards committees to design, develop, test, and market safer aerial lift equipment and fall-protection systems. In general, NIOSH requests that researchers develop r2p approaches for NORA projects, considering a variety of mechanisms for moving their research into practice based upon interested partners. Some researchers produce publications that influence the development of standards and regulations. For example, NORA-related research has influenced the development of several standards established by the National Fire Protection Association (NFPA) and the American National Standards Institute (ANSI). Others develop new technologies that can be immediately licensed and manufactured for adoption in workplaces, such as the personal dust monitor in the Mining sector and the emergency stop (e-stop) installed on commercial fishing boat winches in the Agriculture, Forestry, and Fishing sector. Still others work directly with government agencies, labor groups, and/or the media to raise awareness or influence behavior through the dissemination of new knowledge. For instance, the National Agricultural Statistics Service (NASS) distributed more than 150,000 NIOSH pamphlets to farm operators across the U.S. summarizing common causes of childhood farm injuries and prevention measures.

Item

Public Health Workforce - The Committee has included funding above the President's budget request for public health workforce efforts. Of the increase, the Committee intends that $5,000,000 be used for section 776 of the PHS Act and the remainder be used to supplement the Epidemiology Intelligence Service. In addition, the Committee is strongly supportive of the administration's proposed Health Prevention Corps and encourages the CDC to consider creating an inter-agency agreement with the Corporation for National and Community Service [CNCS] to provide loan repayment to participants through the CNCS Education Award Program. (Page 94)

Action taken or to be taken

CDC believes loan repayments would be an effective incentive to attract outstanding fellowship graduates to career positions in state/local health departments. CDC will explore ways to use such a loan program to support those placed in state and local health departments as federal assignees and those hired directly by state/local health agencies. CDC is not familiar with the Corporation for National and Community Service (CNCS) and would need to learn more about their business model.

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – CONFERENCE

SIGNIFICANT ITEMS FOR INCLUSION IN

THE FY 2012 CONGRESSIONAL JUSTIFICATION

AND OPENING STATEMENTS

CONFERENCE REPORT

CENTERS FOR DISEASE CONTROL AND PREVENTION

A Conference report for FY 2011 is pending; significant items are not available for CDC's response.

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