



DEPARTMENT of HEALTH and HUMAN SERVICES

**Fiscal Year
2007**

**Centers for Disease Control
and Prevention**

*Justification of
Estimates for
Appropriation Committees*

MESSAGE FROM THE DIRECTOR



As the leader of the Centers for Disease Control and Prevention (CDC), I am pleased to present the fiscal year (FY) 2007 Congressional Justification. CDC's budget request reflects a blend of preparedness and prevention activities necessary to protect the health and well-being of the nation's people.

This budget request also supports CDC's newly refocused health protection goals:

People – achieve optimal health during every life stage

Places – create and maintain healthy environments

Preparedness – protect people in all communities from infectious, environmental, occupational, and terrorist threats

Global Health – ensure health promotion, health protection, and health diplomacy

CDC has identified six strategic imperatives to support the effective implementation of its goals:

- **Health Impact Focus.** Align CDC's people, strategies, goals, investments, and performance to maximize our impact on people's health and safety.
- **Customer-Centricity.** Market what people want and need to choose health.
- **Public Health Research.** Create and disseminate the knowledge and innovations that people need to protect their health now and in the future.
- **Leadership.** Leverage CDC's unique capabilities, partnerships, and networks to improve the health system.
- **Global Health Impact.** Extend CDC's knowledge and tools to promote health protection around the world.
- **Accountability.** Sustain people's trust and confidence by making the most efficient and effective use of their investments in CDC.

In alignment with the President's and the Department of Health and Human Services (HHS) Secretary's priorities and guidance as well as CDC's goals and strategic imperatives, CDC's budget request supports the HHS FY 2005-2010 Strategic Plan and reflects the use of the PART process as a critical tool to evaluate program effectiveness.

Comprehensive performance measurement and reporting at CDC in 15 major areas provide results-oriented information that tracks CDC's progress toward achieving its health protection goals. This justification includes the FY 2007 Annual Performance Plan and FY 2005 Annual Performance Report as required by the Government Performance and Results Act of 1993 (GPRA). It directly links the budget discussion with program performance metrics. Additionally, we are proud to report increased efficiencies and effectiveness in administrative areas and information technology, which allow us to dedicate more resources to front-line public health.

CDC continues to link agency-wide goals with program priorities and resources, utilizing the expertise of our internal experts and the expertise of our partners to develop consistent and effective ways to measure our achievements in health impact. This FY 2007 budget request highlights our accomplishments, conveys our vision, and reflects a strategic approach to FY 2007 that protects and enhances the public's health.

Sincerely,

A handwritten signature in black ink that reads "Julie Louise Gerberding". The signature is written in a cursive, flowing style.

Julie Louise Gerberding, M.D., M.P.H.

Director, Centers for Disease Control and Prevention, and

Administrator, Agency for Toxic Substances and Disease Registry

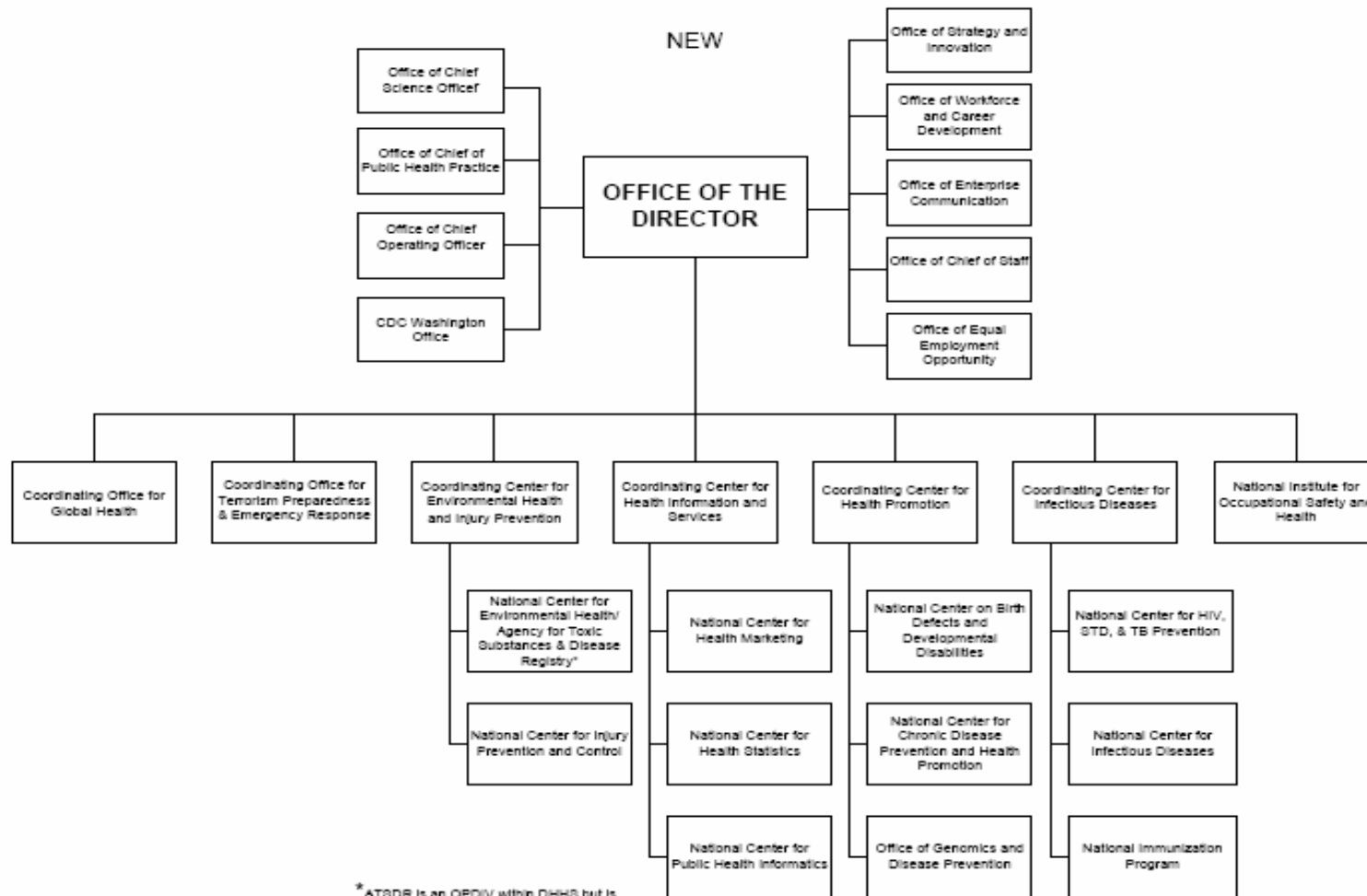
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ORGANIZATIONAL CHART

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**



* ATSDR is an OPOIV within DHHS but is managed by a common Ofc of the Director with NCEH

April 2005

PERFORMANCE BUDGET OVERVIEW

STATEMENT OF MISSION

Every day, Americans are reminded of the interconnectivity of our global community. From the security of our homeland to the stability of our economy, we are increasingly aware of how our global neighbors affect us and are affected by us. Infectious and chronic diseases, environmental hazards, and terrorist threats know no borders and dramatically affect the global economy, personal feelings of security, and hope for the future. The United States must maintain broad expertise and be acutely aware of and involved in prevention, control, and surveillance of threats, such as avian influenza in Thailand, Marburg virus in Angola, terrorist activities in Spain, and tsunamis in Southeast Asia to both prevent the spread of disease across our borders and to enable those abroad to prevent and control diseases in their own countries.

CDC's Mission: To promote health and quality of life by preventing and controlling disease, injury, and disability.

While infectious diseases, environmental toxins, and terrorist threats are worldwide concerns, chronic diseases such as diabetes, obesity, cancer, asthma, and cardiovascular disease are having an increasing impact on both Americans and people worldwide. Injury prevention, occupational safety, and prevention of birth defects and developmental disabilities are key areas of focus for public health, impacting health and the quality of life of millions of people everyday.

CDC works in the United States and abroad to ensure people have the opportunity and the ability to achieve the best quality of life at every life stage throughout the lifespan. Working with the Secretary to support his 500-Day Plan for HHS, CDC is focused on transforming public health to ensure that its science and programs continue to secure the homeland, improve the human condition around the world, and protect the lives of Americans.

DISCUSSION OF CDC STRATEGIC PLAN

CDC has strategically refocused its efforts, reflected in its set of Health Protection Goals, to accelerate health impact, reduce health disparities, and protect people from current and imminent health threats. These goals are organized in four thematic areas – **People** (to achieve optimal health during every life stage), **Places** (to create and maintain healthy environments), **Preparedness** (to protect people in all communities from infectious, environmental, occupational and terrorist threats), and **Global Health** (to ensure health promotion, health protection, and health diplomacy).

People - CDC is customizing science and programs in the areas where it can accelerate health impact by focusing on Americans' health protection needs during each stage of life. Recognizing that many health problems that occur in adulthood can be prevented by mitigating risk factors early in life, the life stage goals take an early and lifelong approach to prevention. By utilizing the unique routes by which people at various stages of life receive health information most effectively, CDC will improve its ability to develop targeted prevention-oriented health solutions.

Places – CDC is also examining the potential for accelerating health impact by improving the quality and safety of the places where Americans live, work, learn, and play. By bringing CDC science and programs together to focus on these environments, we will ensure that we are doing everything we can to improve the lives and health of Americans.

Preparedness – CDC has shifted the strategic focus of its preparedness investments from building infrastructure to improving the speed at which the agency and its partners respond to public health emergencies. Our preparedness goals are designed to directly measure how quickly we prevent, detect, investigate, and control public health emergencies resulting from natural disasters, terrorism, infectious disease, as well as occupational and environmental threats. CDC will use scenario analysis to identify key factors for improving response time. The first round of scenarios will include influenza, anthrax, plague, emerging infections, toxic chemical exposure, and radiation exposure.

Global Health – The pace at which global threats are emerging is accelerating with increasing global travel and the interconnectivity of national economies. Recognizing the growing health, economic, and political consequences of global health threats, CDC is working with American and international partners to dramatically increase the scale and effectiveness of its efforts to protect Americans at home and abroad and to promote health globally.

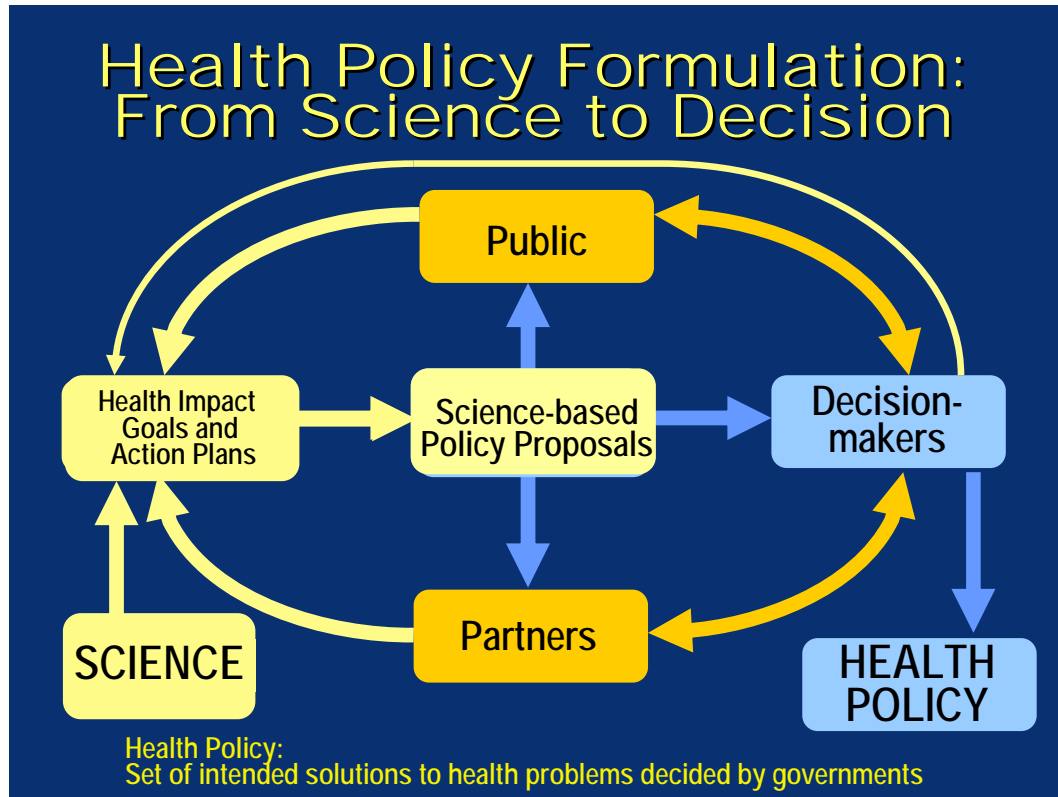
Working Strategically to Accelerate Health Impact: The reorganization of CDC has produced a more integrated, adaptable, and responsive agency. The National Centers conduct and support the highest quality science that drives the agency's work. CDC's new Coordinating Centers and Offices are the homes for the agency's goals and are structured to improve internal and external coordination to achieve them. In FY 2005, CDC put systems and processes in place to align its programs and science, budget, and procurement with its goals.

Goal teams, led by CDC senior staff, will bring together experts from inside and outside the agency to draft Goal Action Plans. Utilizing the best scientific evidence available, these plans will include a prioritized set of objectives, recommended alignment of resources to accomplish objectives, and roles and responsibilities of organizational units across the agency. A set of performance indicators will be developed to monitor progress. Goal Action Plans will integrate activities across CDC and identify opportunities for partner involvement and additional resources to accomplish the objectives.

The teams will seek input and review from CDC's Division and National Center leaders, HHS, CDC's Advisory Committees and partners, and the public, before final action plans are approved. As always, CDC's program Divisions and National Centers will be responsible for planning activities and projects, overseeing their quality, managing them, and measuring their results. The goals action planning and implementation cycle will align with the federal budget cycle, and CDC will continue to be guided by Congressional intent to be sure that categorical disease dollars target the appropriate activities. Over time, these health protection goals will allow CDC to objectively measure and clearly demonstrate the impact of its health protection activities, and can help inform the public, the administration, Congress, partners and stakeholders about the state of the public's health.

The diagram below illustrates the process:

From a foundation in science – to identify the public health problems and likely methods to address or ameliorate them – to seeking input from the public and partners on needs and opportunities to sustain public health interventions, the dynamic process of developing and implementing health protecting strategies must factor in a range of different and highly relevant perspectives.



CDC's Health Protection Goals

Healthy People in Every Stage of Life—All people, and especially those at greater risk of health disparities, will achieve their optimal lifespan with the best possible quality of health in every stage of life.

- **Start Strong:** Increase the number of infants and toddlers that have a strong start for healthy and safe lives. (Infants and Toddlers, ages 0-3 years; e.g., reduce infant mortality, increase immunization rates).
- **Grow Safe and Strong:** Increase the number of children who grow up healthy, safe, and ready to learn. (Children, ages 4-11 years; e.g., increase physical activity rates, improve nutrition).
- **Achieve Healthy Independence:** Increase the number of adolescents who are prepared to be healthy, safe, independent, and productive members of society. (Adolescents, ages 12-19 years; e.g., increase percentage who don't start to smoke, increase states with graduated license laws, increase seat belt use).
- **Live a Healthy, Productive, and Satisfying Life:** Increase the number of adults who are healthy and able to participate fully in life activities and enter their later years with optimum health. (Adults, ages 20-49 years; e.g., increase screenings for breast and cervical cancer, colon cancer, and blood pressure).
- **Live, Better, Longer:** Increase the number of older adults who live longer, high-quality, productive, and independent lives. (Older Adults and Seniors, ages 50 and over; e.g., increase vaccination rates for influenza and pneumococcal infections, vision screening to prevent falls, improve physical activity).

Healthy People in Healthy Places—The places where people live, work, learn, and play will protect and promote their health and safety, especially those at greater risk of health disparities.

- **Healthy Communities:** Increase the number of communities that protect, and promote health and safety and prevent illness and injury in all their members (e.g., safe food, safe water, built-in sidewalks).
- **Healthy Homes:** Protect and promote health through safe and healthy home environments (e.g., safe from falls, have smoke detectors, radon-free).
- **Healthy Schools:** Increase the number of schools that protect and promote the development, health, and safety of all students and staff (e.g. healthy food vending, physical activity programs).

- **Healthy Workplaces:** Promote and protect the health and safety of people who work by preventing workplace-related fatalities, illnesses, injuries, and personal health risks (e.g., smoke free, sponsored physical education programs).
- **Healthy Healthcare Settings:** Increase the number of healthcare settings that provide safe, effective, and satisfying patient care (e.g., reduce healthcare associated infections, reduce adverse events associated with biologic products).
- **Healthy Institutions:** Increase the number of institutions that provide safe, healthy, and equitable environments for their residents, clients or inmates.
- **Healthy Travel and Recreation:** Ensure that environments enhance health and prevent illness and injury during travel and recreation (e.g., increase seat belt use, safe playgrounds).

People Prepared for Emerging Health Threats—People in all communities will be protected from infectious, occupational, environmental, and terrorist threats.

Pre-event:

- Increase the use and development of interventions
- Decrease time needed to classify health events
- Decrease time needed to detect and report chemical, biological, and radiological agents

Event:

- Decrease time to identify causes, risk factors, and appropriate interventions
- Decrease time needed to provide countermeasures and health guidance

Post-event:

- Decrease time needed to restore health services and environmental safety to pre-event levels
- Improve long-term follow-up provided to those affected by threats
- Decrease time needed to implement recommendations from after-action reports.

Healthy People in a Healthy World—People around the world will live safer, healthier and longer lives through health promotion, health protection, and health diplomacy.

- **Health Promotion:** Global health will improve by sharing knowledge, tools and other resources with people and partners around the world (e.g., assistance in emergency response for disease outbreaks like the Marburg virus in 2004 and natural disasters like tsunami relief).
- **Health Protection:** Americans at home and abroad will be protected from health threats through a transnational prevention, detection and response network (e.g., CDC's Global Disease Detection (GDD) program which, in collaboration with the World Health Organization and other global health groups, monitors disease outbreaks around the world).
- **Health Diplomacy:** CDC and the United States Government will be a trusted and effective resource for health development and health protection around the globe (e.g., collaboration on pandemic influenza planning with World Health Organization and health officials in other governments).

CDC’s Six Strategic Imperatives

CDC has identified six strategic imperatives to support the effective implementation of its goals:

- **Health Impact Focus.** Align CDC’s people, strategies, goals, investments and performance to maximize our impact on people’s health and safety.
- **Customer-Centricity.** Market what people want and need to choose health.
- **Public Health Research.** Create and disseminate the knowledge and innovations that people need to protect their health now and in the future.
- **Leadership.** Leverage CDC’s unique capabilities, partnerships, and networks to improve the health system.
- **Global Health Impact.** Extend CDC’s knowledge and tools to promote health protection around the world.
- **Accountability.** Sustain people’s trust and confidence by making the most efficient and effective use of their investments in CDC.

LINKS TO HHS AND CDC STRATEGIC PLANS

The table below illustrates links from CDC’s overarching strategic goals to the HHS Strategic Plan.

HHS STRATEGIC GOALS	CDC STRATEGIC GOALS			
	People	Preparedness	Places	Global Health
GOAL 1: Reduce the major threats to the health and well-being of Americans.	X	X	X	X
GOAL 2: Enhance the ability of the nation’s health care system to effectively respond to bioterrorism and other public health challenges.		X	X	
GOAL 3: Increase the percentage of the nation’s children and adults who have access to health care services, and expand consumer choices.	X			
GOAL 4: Enhance the capacity and productivity of the Nation’s health science research enterprise.	X	X	X	X
GOAL 5: Improve the quality of health care services.	X			X
GOAL 6: Improve the economic and social well-being of individuals, families, and communities, especially those most in need.				
GOAL 7: Improve the stability and healthy development of our Nation’s children and youth.	X		X	
GOAL 8: Achieve excellence in management practices.	X	X	X	X

OVERVIEW OF PERFORMANCE

PEOPLE

ACHIEVE OPTIMAL HEALTH DURING EVERY LIFE STAGE

Improving Diagnosis Breast and Cervical Cancer – Through its National Breast and Cervical Cancer Early Detection Program, CDC has provided more than six million screening tests to over three million women since its inception in 1991. The program has also diagnosed 22,878 breast cancers, 76,921 precancerous cervical lesions, and over 1,500 cases of invasive cervical cancer.

(Reference Performance Detail Section/Detail of Performance Analysis for Chronic Disease Prevention and Health Promotion: Goal 3, Performance Measure 1)

Using Data Collection to Inform Public Health Interventions – Data have guided national policies on many issues, and across disciplines. Recently, data collection at CDC has guided national policy regarding folic acid fortification to prevent neural tube defects. Data helped to define a problem, set policy to address it, and now are being used to monitor the impact of that policy. Data on two neural tube defects, spina bifida and anencephaly, show declines in the rates. The data reflect successes in public health interventions that continue to show improvements as they are refined, tested, and improved.

(Reference Performance Detail Section/Detail of Performance Analysis for Health Statistics: Efficiency Measure, Performance Measure 1)

Declining Rates of Syphilis – Significant progress in addressing the syphilis epidemic in the United States has been made as a result of CDC's National Plan to Eliminate Syphilis, launched in 1999. Between 1999 and 2004, black primary and secondary syphilis rates have decreased 37 percent (14.3 to 9.0 cases per 100,000), while rates among women overall have decreased 55 percent (2.0 to 0.9 cases per 100,000). Rates of congenital syphilis have declined 39 percent between 1999 and 2004. Overall, there has been a 92 percent decrease in cases of congenital syphilis since 1991. The continuing decline in the rate of congenital syphilis likely reflects the substantial reduction in the rate of primary and secondary syphilis among women that has occurred in the last decade.

(Reference Performance Detail Section/Detail of Performance Analysis for HIV/AIDS, STD, and TB: Goal 8, Performance Measure 1, Goal 10, Performance Measure 3)

Evaluating the Cost Effectiveness of Immunizations – An economic evaluation of the impact of seven vaccines (DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella) routinely given as part of the childhood immunization schedule found that vaccines are tremendously cost effective. Routine childhood vaccination with these seven vaccines, which prevent over 14 million cases of disease and over 33,500 deaths over the lifetime of children born in any given year, resulted in annual cost saving of \$10 billion in direct medical costs and over \$40 billion in indirect societal costs. This study in the *Archive of Pediatrics and Adolescent Medicine* is the first time the seven vaccine series has been examined together with a common methodology.

(Reference Performance Detail Section/Detail of Performance Analysis for Immunization: Goal 2, Performance Measure 1)

Reducing Cases of Perinatal AIDS in the United States – The number of estimated perinatal AIDS cases continues to decline in the United States, decreasing from 912 in 1992 to 48 in 2004. One of the four key strategies of CDC's initiative, "Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic," announced in April 2003, is to further decrease perinatal HIV transmission. CDC focuses its perinatal HIV prevention efforts in the states, cities and jurisdictions that account for the highest number of perinatal HIV cases. CDC published results of its Mother Infant Rapid Intervention at Delivery (MIRIAD) study in JAMA, which showed that rapid HIV testing of women in labor with undocumented HIV status is feasible and can deliver accurate and timely results. It provides HIV-positive women with prompt access to antiretroviral prophylaxis, proven to reduce perinatal HIV transmission. CDC is revising its HIV screening guidelines for pregnant women to recommend that rapid testing during labor and delivery should be performed using the opt-out approach for women with undocumented HIV status at the time of labor.

(Reference Performance Detail Section/Detail of Performance Analysis for HIV/AIDS, STD, and TB: Goal 1, Performance Measure 2)

Identifying Developmental Delays—Approximately 19 percent of U.S. children suffer a developmental or behavioral disability. Fortunately, early recognition and treatment can significantly improve a child's development. CDC launched the Learn the Signs Act Early 2004-2005 Campaign to identify more children who are at risk. The campaign teaches parents to monitor the social and emotional milestones that children should reach by a certain age. It also reminds health care professionals to document developmental achievements, encourages dialogue between parents and healthcare professionals, and urges action when a developmental delay is suspected. As of August of 2005, the campaign reached more than three million health care providers, reached 26 million people through television and radio public service announcements, distributed 25,000 resource kits, and created a Web site accessed by more than 120,000 visitors.

Screening for Cystic Fibrosis—Cystic fibrosis is the second most common pediatric, genetic disorder in the U.S. Each year, approximately 1,000 individuals are diagnosed with cystic fibrosis. From 1984 to present, NIH has funded a clinical trial of newborn screening for cystic fibrosis in Wisconsin. Based on the results of this study, CDC developed evidence-based newborn screening for cystic fibrosis in FY 2005. In the nine months following the report, an additional seven states have acted to add cystic fibrosis to their newborn screening panels, for a total of 16 states. The benefits of newborn screening panels for cystic fibrosis include earlier diagnosis and treatment; reduction in growth retardation; and reduction in chronic malnutrition and cognitive impairment.

Eliminating Rubella—In March 2005, CDC announced a major public health milestone—the elimination of the rubella virus in the U.S. Rubella once caused disease in tens of thousands of infants, but is now a rare threat thanks to decades of vaccinations. This remarkable achievement is a tribute to having a safe and effective vaccine and a successful immunization program in place. The decades of experiences garnered by CDC will have a direct impact on the control of rubella globally.

(Reference Performance Detail Section/Detail of Performance Analysis for Immunization: Goal 1, Performance Measure 1)

PLACES

CREATE AND MAINTAIN HEALTHY ENVIRONMENTS

Preventing Residential Fire Deaths – A survey of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that 1,053 lives have been saved to date. Program staff have canvassed over 380,000 homes and installed almost 270,000 long-lasting or lithium-battery powered smoke alarms in high-risk homes, targeting households with children ages five years and younger and adults ages 65 years and older. Fire safety messages have reached millions of people as a result of these programs.

(Reference Performance Detail Section/Detail of Performance Analysis for Injury Prevention and Control: Goal 1, Performance Measure 2)

Ensuring the Safety of Respirators for Emergency Responders – CDC conducts a respirator certification program to ensure respiratory protective equipment conforms to established regulatory standards, issuing 376 approvals in 2005. These include 36 self-contained breathing apparatus (SCBA), five air-purifying respirators, and 32 air purifying escape respirators for occupational use by emergency responders against chemical, biological, radiological, or nuclear (CBRN) agents. To enable responders to obtain CBRN protection without purchasing new equipment, CDC initiated a CBRN SCBA retrofit certification program. Subsequently, over 30 retrofit kits have been approved for use in upgrading existing SCBA to current performance standards. In addition, CDC has implemented a CBRN temperature and vibration facility to improve the timing and decrease the expense of CBRN testing.

(Reference Performance Detail Section/Detail of Performance Analysis for Occupational Safety and Health: Goal 2, Performance Measure 5A)

Responding to Local Public Health Threats – In FY 2005, headquarters Epidemic Intelligence Service (EIS) officers responded to 66 outbreaks in multiple locations, of which 54 were in the United States and eight were in other countries. In the first three months of FY 2006, EIS officers have conducted 27 EPI-AIDS (24 domestic and three international). In addition, field EIS officers assigned to state or local health departments conducted another 273 field investigations in FY 2005, and another 94 in the first three months of FY 2006. Requests for assistance were primarily for infectious disease problems, but they also addressed environmental health, injuries, maternal and child health, and other problems.

(Reference Performance Detail Section/Detail of Performance Analysis for Public Health Workforce Development: Goal 1, Performance Measure 1)

Eating Better in Mississippi Schools—To reduce childhood obesity, CDC is helping public schools create wellness policies for the start of the 2006 academic year. This federally mandated policy engages school, parents, students, and communities in developing school-based activities, such as physical exercise and nutrition education, promote student wellness and reduce obesity. In FY 2005, CDC funded several innovative pilot programs that will help identify effective approaches. One program is distributing free fruits and vegetables daily in 25 Mississippi schools. Students also receive nutrition education that promotes fruit and vegetable consumption. While the U.S. Department of Agriculture expands the program to eight states this year, CDC is evaluating the Mississippi initiative to determine how children's attitudes toward fruits and vegetables have changed—and if they are eating more fruits and vegetables.

Sharing CDC Technology Improves Mold Detection—As residents from the Gulf States began returning to their hurricane-damaged homes, they were greeted by an infestation of mold that turned former living spaces into a wall-to-wall health hazard. Indeed, allergic and toxic reactions associated with mold exposure were one of the biggest health challenges posed by Hurricane Katrina. In 2003, CDC and EnviroLogix, a Maine-based biotechnology company, developed a commercially available mold test kit that detects spores of *S. chartarum* using the CDC-developed technology. The test, which is performed on-site and yields immediate results, was a critical tool for monitoring mold in Gulf Coast homes in 2005.

PREPAREDNESS

PROTECT PEOPLE IN ALL COMMUNITIES FROM INFECTIOUS, ENVIRONMENTAL, OCCUPATIONAL, AND TERRORIST THREATS

Enhancing the Laboratory Response Network (LRN) – CDC has increased the number of LRN labs to 152, up from 91 in 2001. These labs are now located in all 50 states and several installations abroad. Ninety-six percent of LRN labs can confirm the presence of *B. anthracis* (anthrax), 94 percent can confirm *F. tularensis* (tularemia), and 63 percent can perform presumptive screening for smallpox. The LRN increases the expertise and capacity of each lab and enables every lab in the network to have access to critical testing procedures. CDC has trained more than 8,800 clinical laboratorians to play a role in detecting, diagnosis, and reporting public health emergencies.

(Reference Performance Detail Section/Detail of Performance Analysis for Coordinating Office for Terrorism Preparedness and Emergency Response: Goal 3, Performance Measure 5)

Rapidly Identifying Botulinum – CDC's Environmental Health Laboratory developed a mass spectrometry method for detecting botulinum toxin and its seven subtypes in people and the nation's milk supply. Botulinum A, B, and F can now be measured in approximately 15 seconds, which means a total of 80 samples can be measured per day with first result in three or four hours. This new method is also reliable in detecting all seven subtypes, it can detect small amounts of the toxin, and it is a confirmatory test rather than a screening test. Overall, these breakthrough advances based on mass spectrometry techniques to detect and measure botulinum and other toxins will improve early detection and help ensure prompt, appropriate treatment and prevention of additional exposure.

Accessing Immunization Records for Children Displaced by Hurricane Katrina – Despite the devastation caused by Hurricane Katrina, the Immunization Information System (IIS) in Louisiana, Alabama, and Mississippi remained operational to ensure stability and accessibility for other grantees needing immunization histories for displaced children. IIS, or immunization registries, are confidential, computerized information systems that record, store, and provide fast access to children's immunization records. Because of these systems, schools or health agencies outside of the three Hurricane Katrina-impacted states were able to contact their own state or local immunization information system to access records of children displaced by the hurricane. The connections established by IIS enabled many immunization histories to be retrieved, thereby reducing or eliminating the need for costly re-vaccination of Hurricane Katrina displaced children. In Louisiana alone, CDC estimated that as early October 2005, more than 20,000 queries were made to the Louisiana Immunization Network for Kids Statewide (LINKS) regarding vaccination histories for children who were evacuated.

Getting the Word out for a Safe Return Home – Within the first 15 days after Hurricane Katrina, CDC posted nearly 200 documents on the Internet, including public health guidance on environmental health needs and an initial habitability assessment for New Orleans. Guidance on infection control in shelters helped prevent the spread of disease. Guidance on worker safety helped first responders and volunteers deal with the unique conditions of the environmental catastrophe. With power outages cutting off electronic technology, CDC prepared key materials in innovative formats such as door hangers, posters, flyers, and satellite video announcements in evacuation shelters. CDC also developed new lines of communication—the Katrina Information Network (later the Emergency Response Information Network).

GLOBAL HEALTH

ENSURE HEALTH PROMOTION, HEALTH PROTECTION, AND HEALTH DIPLOMACY

Preparing for Avian Influenza – Beginning in late June 2004, new outbreaks of lethal avian influenza A (H5N1) infection among poultry were reported by six countries in Asia: Cambodia, China, Indonesia, Malaysia, Thailand, and Vietnam. Since May 2005, outbreaks of H5N1 disease have been reported among poultry in Russia, China, Kazakhstan, Turkey, Romania, and Ukraine. China, Croatia, Mongolia, and Romania also have reported outbreaks of H5N1 in wild, migratory birds since May 2005. CDC has collaborated with the Association of Public Health Laboratories to conduct training workshops for state laboratories on the use of molecular techniques to rapidly identify H5 influenza viruses. CDC has developed and distributed a reagent kit for the detection of the currently circulating influenza A H5 viruses. In addition, CDC is working with other agencies, such as the Department of Defense and the Department of Veterans Affairs, on antiviral stockpile issues. CDC is one of four WHO Collaborating Centers and in this capacity provides ongoing support for the global WHO surveillance network, laboratory testing, training, and other actions.

(Reference Performance Detail Section/Detail of Performance Analysis for Infectious Diseases: Goal 2, Performance Measure 2)

Improving Global Disease Detection (GDD) Efforts Worldwide –The GDD program works with international partners to protect Americans from infectious threats. This is accomplished through efforts to ensure rapid and accurate detection, diagnosis and verification of global emerging infectious diseases and bioterrorist threats, as well as the control of infectious diseases at their origin to prevent international spread. The initial focus of the GDD

program has been strengthening the global influenza surveillance network through bilateral support to 12 countries and enhanced communications and laboratory capabilities in strategic countries (Thailand, Kenya, and Guatemala). In addition, robust GDD response centers have already been established in Kenya and Thailand.

(Reference Performance Detail Section/Detail of Performance Analysis for Infectious Diseases: Goal 2, Performance Measure 2)

Engaging in Post-Tsunami Disaster Response in Indonesia and Thailand– Personnel at CDC mobilized as part of the worldwide recovery effort to ease suffering caused by the Indian Ocean earthquake and subsequent Tsunami. In addition, in Thailand, CDC collaborated with the Ministry of Public Health and the department of Psychiatry to conduct mental health surveys among Tsunami survivors. The results of the survey were used to guide mental health relief programs.

(Reference Performance Detail Section/Detail of Performance Analysis for Environmental Health: Goal 2, Performance Measure 3)

Working with the Hardest Hit Countries to Address HIV/AIDS and Reducing HIV Infections Among Infants– CDC provided counseling and testing to approximately 300,000 individuals through the Global AIDS Program and Preventing Mother-and-Child HIV Transmission (PMTCT) services to over 550,000 pregnant women residing in the ten countries in FY 2004. In total, 125,000 HIV-positive women received short-course antiretroviral prophylaxis in PMTCT settings, resulting in aversion of an estimated 24,000 infant infections. In 2005, CDC continued to play a vital role implementing the President's Emergency Plan for AIDS Relief in 15 of the hardest hit countries in Africa, Asia, Latin America, and the Caribbean. With other USG partners, CDC supported antiretroviral treatment (ART) for over 400,000 patients and provided PMTCT services for almost two million pregnant women in the 15 focus countries in FY 2005. Approximately 125,000 HIV-positive women received short-course antiretroviral (ARV) prophylaxis in PMTCT settings, which resulted in an estimated 23,000 infant infections being averted.

(Reference Performance Detail Section/Detail of Performance Analysis for Global Health: Goal 2, Performance Measures 4, 6, 7, 8)

PERFORMANCE APPROACH

CDC's FY 2007 HHS Performance Budget contains 136 performance measures: 60 outcome measures, 57 output measures and 20 efficiency measures. Of these measures, 64 were developed through the Program Assessment Rating Tool (PART) process. Through this process, CDC continues to refine its measures to become more outcome-oriented and efficient.

As of January 2006, CDC reported on 100 of 116 measures in its FY 2004 Performance Report. Of these reported measures for FY 2004, CDC met or exceeded 73 percent of its targets. Additionally, CDC reported on 130 of 134 measures in its FY 2003 Performance Report. Of these reported measures for FY 2003, CDC met or exceeded 74 percent of its targets. Finally, CDC reported on 176 of 178 measures in its FY 2002 Performance Report. Of these reported measures for FY 2002, CDC met or exceeded 77 percent of its targets. Measures with outstanding data will be reported as soon as results become available.

Many of CDC's performance measures and goals support CDC's overarching domestic strategic goals, as well as Healthy People 2010, the HHS Strategic Plan, the Secretary's 500-Day Plan, and the President's Management Agenda (PMA). Links from the performance measures to these initiatives are indicated in the Detail of Performance Analysis sections.

Healthy People 2010 goals serve as a foundation for several of CDC's performance measures. Although CDC has lead responsibility for many of the objectives in Healthy People 2010, achievement of these objectives represents a national effort in which CDC works closely with other federal, state, local, and community partners. CDC further supports Healthy People 2010 by providing the underlying data infrastructure to set targets and track progress in meeting health objectives.

The PMA and the related HHS Secretary's Management Objectives have guided improvements in CDC's management and operations. The components of the PMA are (1) Human Capital, (2) Competitive Sourcing, (3) Financial Management, (4) E-Government, and (5) Budget and Performance Integration. Please refer to the PMA section of this document for additional information.

OVERVIEW OF BUDGET REQUEST

The FY 2007 President's Budget supports the Administration's highest priorities and CDC's strategic imperatives by reflecting a request that is responsible, reflects targeted growth in a time of national budgetary constraints, and that focuses on fulfilling the mission of CDC and the health protection of the nation.

Overall, CDC's FY 2007 President's Budget reflects a total proposed law funding level of \$8.2 billion, a decrease of \$178.6 million below the FY 2006 Enacted level of \$8.4 billion. This includes \$367.1 million in reductions to CDC's direct budget authority, increased funding of \$188.5 million for the Vaccines for Children (VFC) program, and an increase of \$0.1 million for ATSDR. Funding involves a variety of changes from the FY 2006 Enacted level such as program reductions and increases, program eliminations, and administrative savings.

Pandemic Influenza Preparedness

The most significant priority reflected in the FY 2007 President's Budget for CDC is to continue preparing the nation to prevent, detect, and respond to a potential influenza pandemic. As a part of the National Strategy for Pandemic Influenza Preparedness and Response, CDC will invest new resources in several specific areas. In addition to ongoing annual and pandemic influenza planning activities at CDC, investments of \$188 million in FY 2007 will be made as follows:

- Develop an Ongoing Repository of Pandemic Virus Reference Strains for Manufacturing (+\$19.8 million): An increased investment in FY 2007 will allow CDC to increase laboratory and analytical capabilities for genetic and antigenic analysis of influenza viruses.
- Increase Stock of Diagnostic Reagents for Influenza (+\$14.9 million): With increased resources in FY 2007, CDC will provide for the acquisition, storage, shipping, and support of a newly acquired inventory of reagents either internally or through a commercial vendor. CDC will also work with the manufacturer to work toward more stringent quality assurance and control by instituting control protocols to ensure reagents are used properly. Finally, CDC will provide incentives for the manufacturer to make reagents available when needed.
- Fund States to Increase Demand for Influenza Vaccine (+\$19.8 million): With increased funding, CDC will increase the demand for annual influenza vaccine, particularly to accommodate high-risk populations, thereby stimulating vaccine manufacturers to produce additional vaccine and increasing the nation's preparedness for a pandemic. CDC will also assist state and local health departments with the integration of existing information systems to increase interoperability between them and adult immunization provider-based systems to improve coverage assessment and inventory management.
- Develop Vaccine Registry to Monitor Vaccine Use (Safety/Efficacy) and Distribution (+\$29.7 million): In FY 2007, CDC will develop and deploy national capabilities to track and manage the distribution of influenza vaccine and other countermeasures through government purchase, stockpile, or commercial purchase from the point of manufacture through their delivery. CDC will also integrate such information with adverse event monitoring and surveillance tracking.
- Real Time Assessment and Evaluation of Interventions (+\$9.9 million): With increased funding in FY 2007, CDC will improve decision makers' ability to understand the current disease burden, develop predictions, and integrate key surveillance data by enhancing system capabilities by: 1) collecting and collating all suitable existing influenza-related surveillance data from various databases and systems to develop a population-based analysis of disease impact and evaluation of interventions; 2) designing and implementing robust models that will use these data to provide frequently updated population-based estimates of disease burden and impact of interventions; and, 3) creating decision tools based on these data and usable by decision makers at local, state, and national levels.
- Rapid outbreak response for high priority countries (+\$2.8 million): When a potential pandemic flu strain is identified, swift and decisive action can make the difference in whether the strain is contained or spreads globally. Based on the available epidemiologic information, CDC will continue to identify countries as high risk for the emergence of a potential pandemic and in need of current and potentially future monitoring efforts and help develop in-country response teams. Increased funding in FY 2007 will allow CDC to enhance activities undertaken with funding in FY 2006 to ensure the target countries are monitored and safeguarded from disease spread that could elevate to pandemic levels.
- Human-Animal Interface Studies (+\$1.0 million): To complement NIH epidemiological studies, CDC will enhance FY 2006 activities by continuing to support studies that examine the risk and frequency of human infections with animal influenza A viruses with pandemic potential. CDC will analyze epidemiologic case control studies of risk factors for severe disease and cross sectional seroprevalence studies of antibodies of

H5N1 virus in different risk populations that may include people with occupational exposure to poultry and persons living in rural areas with, or in close contact with, poultry and pigs.

- International surveillance, diagnosis, and epidemic investigations (-\$2.5 million): With increased resources in FY 2006 and continued funding in FY 2007, CDC will enhance its efforts to address preparedness gaps in high priority countries through increasing laboratory capacity and technical support at local levels; assisting in the development of surveillance, diagnosis, and epidemic investigations; and assisting the WHO in creating and maintaining proper coordinating and monitoring infrastructure in high risk countries.
- BioSense (-\$15.2 million): The BioSense initiative improves the nation's capabilities for near real-time disease detection by using data from existing health-related databases without identifying information to enable early detection in all major metropolitan areas. Increased funding in FY 2006 will expand the total number of metropolitan areas in the system from 10 to 41 and will extend the number of clinical care sites and sentinel hospitals in major metropolitan areas that are streaming real-time information to BioSense. In FY 2007, activities conducted through increased BioSense funding in FY 2006 can be maintained with fewer funds, thus requiring decreased resources to continue utilizing BioSense for the highest quality real time data.
- Fund Enhancements and Completion of 35 U.S. Quarantine Stations (-\$15.1 million): In FY 2007, CDC will complete its latest expansion of U.S. quarantine stations, funded with additional funding in FY 2006, to up to 35 in major U.S. ports of entry (POE). With FY 2006 and FY 2007 funding, CDC will also develop comprehensive quarantine and isolation approaches that involve detection and prevention of transmission at POE, in-transit, and at points-of-exit from other countries.

These investments, combined with increased funding in FY 2006, will make the nation and the world more prepared and capable of combating influenza viruses with pandemic potential.

Increased Investments

Strategic National Stockpile: (+\$69.2 million)

The mission of the SNS has expanded dramatically since the creation of the program in 1999. From an initial small cache of pharmaceuticals, the SNS is now poised to help respond to a potential pandemic of influenza, catastrophic natural disasters such as Hurricane Katrina, and biological, chemical, radiological, or nuclear terrorist attacks. Increased funding in FY 2007 will allow the SNS to continue to purchase and store needed countermeasures, vaccines, and treatments. CDC will meet the expanded need for pediatric dosing requirements and unit of use bottling for quicker pharmaceutical distribution. Additionally, CDC will purchase antivirals and medical supplies to prepare for a pandemic. Of the total increase, a portion will be used for the Federal Medical Stations program, which will allow CDC to procure and manage shelters and supplies for a mass casualty event. FY 2007 funding will also be used to expand CDC's storage capacity to ensure CDC can manage the increasing inventory of the SNS. This increase does not include an IT reduction for the SNS.

Botulinum Toxin Research: (+\$3.0 million)

With additional funding in FY 2007, CDC will expand its new mass spectrometry method for detecting botulinum toxin and its seven subtypes to detect anthrax lethal factor, ricin, and other toxins used as bioweapons. Increased funds will allow CDC to improve the speed of analysis to up to 1,000 samples per day and simplify the method for use by external laboratories. This method will also be developed as a cost-effective method for preventive screening of milk samples and used in "toxin fingerprinting," whereby the method detects minor variations that will help identify the source of the toxin, provide identifying forensic information, and assist epidemiologists investigating the cause and pathways of disease. Overall, these breakthrough advances will improve early detection and help ensure prompt, appropriate treatment and prevention of additional exposure.

Domestic HIV/AIDS Initiative (+\$93.0 million)

A key challenge in the United States for reducing the burden of HIV/AIDS is to stop the spread of HIV by detecting the approximately 250,000 persons who are undiagnosed and preventing new infections. The FY 2007 President's Budget Request includes an increase of \$93 million to significantly increase testing in medical settings, make voluntary testing a routine part of medical care, and create new testing guidelines, models, and best practices. This initiative would directly facilitate the testing of more than three million additional Americans, emphasizing regions with the highest numbers of new cases as well as focusing on incarcerated persons and injecting drug users.

Vaccines for Children (+\$48.5 million plus a net increase of \$40.0 million under the proposed law)

Program increases in FY 2007 for VFC program reflect estimated price increases for vaccines and the addition of meningococcal conjugate vaccine (MCV) and a larger target of Hepatitis A Vaccine into the pediatric vaccine stockpile. MCV and wider usage of Hepatitis A vaccine was recommended for inclusion in the VFC program in 2005.

Currently, underinsured children can receive vaccines purchased with VFC program funds only at community health centers and federally qualified health centers. A proposed change to VFC legislation proposes allowing these children to receive VFC vaccine at a state or local public health clinic. Amending the VFC authorizing legislation to expand access points for these children will increase vaccine purchase needs for VFC by an estimated \$140 million, ensuring these children have rapid access to new vaccines such as PCV.

Amending the VFC authorizing legislation to expand access points for these children could decrease the amount of discretionary vaccine purchase appropriations needed by \$100 million. Also, the proposed legislation would ensure these children have rapid access to new vaccines such as PCV. This reduction in the amount of discretionary funding needed would be contingent upon passage of the proposed amendment to the VFC legislation.

Service and Supply Fund, Unified Financial Management System, and Rent (+\$3.4 million)

Additional funding for the Unified Financial Management System (UFMS) and the Service and Supply Fund will support increasing needs for existing activities through FY 2007. The President's Budget also includes funds to cover projected FY 2007 increases in funding needs for rent.

Pay Raise (+\$14.9 million)

The request includes funds to support the projected FY 2007 pay increase.

Program Decreases and Eliminations

West Nile Virus (-\$9.9 million)

WNV funding has built infrastructure and led to the enhancement of state-based programs to make states better able to prevent, detect, and respond to the threat of WNV. The establishment of this national program has also enhanced viral laboratory capacity, veterinarian epidemiology capacity, and surveillance of disease. A reduction in funding will decrease funding proportionally in every state and local health department, although CDC will make every attempt to distribute funds according to the profile of the epidemic. This requires states to leverage existing funding for future activities. CDC will also discontinue funding for training grants and other studies as identified.

Bulk Monovalent (-\$29.7 million)

The FY 2006 appropriation contained \$29.7 million in no-year funding for CDC to enter into back-end sales guarantee contracts with vaccine manufacturers to maintain a more stable influenza vaccine supply. As these funds can be utilized in future years, additional funds will not be necessary in FY 2007. Additionally, bulk monovalent vaccine purchased in FY 2006 may be used for the 2007/2008 season should the strain remain the same.

Program Reductions (-\$46.3 million)

The FY 2007 President's Budget proposes reductions to activities that are outside the scope of CDC's mission to focus on primary prevention. Included in this reduction are CDC's Epilepsy, Alzheimer's Disease, Lupus, Attention-Deficit Hyperactivity Disorder, Cooley's Anemia, Paralysis, Tourette Syndrome, and Pfiesteria programs. The budget also proposes reductions to fund base activities at FY 2006 President's Budget levels.

Anthrax (-\$13.9 million)

In FY 2007, CDC proposes to eliminate funding for the anthrax research study. With the completion of the anthrax vaccine clinical trial interim safety analysis, CDC has presented the results to key stakeholders and has submitted the final report detailing all findings from the safety analysis to the Food and Drug Administration. This brings the long running anthrax study near its conclusion. The information gleaned over the course of this study will not be compromised due to the cessation in funding, and the expected benefits will have been gained by the time of the project's completion.

Preventive Health and Health Services Block Grant (PHHSBG) (-\$99.0 million)

The FY 2007 President's Budget reflects the elimination of the PHHSBG. At the same time, new appropriations language is proposed that provides authorization for states to utilize funds within categorical grant programs for purposes related to those conducted with PHHSBG funds to allow for a source of flexible funding in the absence of PHHSBG funds.

Buildings and Facilities (-\$128.7 million)

In FY 2006, CDC will continue funding its East Campus Consolidated Laboratory Project with increased funds provided by Congress as well as completing funding for the infectious diseases facility in Ft. Collins, Colorado. With the FY 2006 President's Budget level of \$29.7 million in FY 2007, CDC will fund its nationwide repairs and improvements, continuing to protect the nation's investment in current facilities at CDC.

Program Decreases Related to One-Time Costs and Completed Projects

World Trade Center (-\$75.0 million)

The FY 2006 appropriation provided \$75.0 million for the continuation of World Trade Center Health Registry, which began as a result of the September 11, 2001 terrorist attacks. This registry, a collaboration between CDC/ATSDR and the New York City Department of Health and Mental Hygiene, has identified and tracked the long-term health effects of the tens of thousands of workers and community members who were the most directly exposed to smoke, dust, and debris from the World Trade Center collapse. The additional funds provided in FY 2006 will allow for continued analysis and interpretation of the data collected since the program's inception in 2003 to ensure the health needs of all those exposed are understood and can be addressed. These funds will be used over several years to complete all necessary follow-up.

Pandemic Influenza Planning (-\$77.0 million)

In FY 2006, CDC received funding of \$77 million for to develop better and more rapid antigen detection tests and conduct enhanced laboratory capacity activities related to pandemic influenza planning. As these funds are sufficient to move CDC toward greater capacities in these areas for the future, no new funds are requested in FY 2007 and FY 2006 funds are not maintained.

Administrative and Information Technology Savings (-\$36.3 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

Overall, the FY 2007 President's Budget for CDC includes investments in critical areas that will assist CDC in accomplishing its mission and increasing its preparedness and response capacity within the agency, across the nation, and around the world.

PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE

(Dollars in Millions)

PART PROGRAM	FY 2006 ENACTED	FY 2007 REQUEST	FY 2007 +/- FY 2006	NARRATIVE RATING
FY 2004 PART Programs				
317 Immunization Program ¹	\$519.9	\$407.4	(\$112.5)	Adequate
Breast and Cervical Cancer	\$202.4	\$201.0	(\$1.4)	Adequate
Diabetes	\$63.1	\$62.4	(\$0.7)	Adequate
Domestic HIV/ AIDS Prevention	\$651.1	\$739.6	\$88.5	Results Not Demonstrated
Health Alert Network ²	N/A	N/A	N/A	N/A
FY 2005 PART Programs				
State and Local Preparedness ³	\$823.7	\$823.7	\$0	Results Not Demonstrated
FY 2006 PART Programs				
Buildings and Facilities	\$158.4	\$29.7	(\$128.7)	Adequate
Epidemic Services and Response ²	N/A	N/A	N/A	N/A
Occupational Safety and Health ⁴	\$255.3	\$250.2	(\$5.1)	Adequate
Infectious Diseases	\$226.8	\$245.3	\$18.5	Adequate
Sexually Transmitted Diseases / Tuberculosis	\$295.5	\$293.4	(\$2.1)	Adequate
FY 2007 PART Programs				
Environmental Health	\$150.0	\$141.1	(\$8.9)	Adequate
Global AIDS Program ⁵	\$122.6	\$122.0	(\$0.6)	<u>Focus Countries</u> - Moderately Effective; <u>Other Bilateral</u> - Adequate
Global Immunization	\$145.0	\$144.3	(\$0.7)	Effective
Health Statistics	\$109.0	\$109.0	\$0	Moderately Effective
Strategic National Stockpile	\$524.7	\$592.6	\$67.9	Moderately Effective

¹The FY 2006 President's Budget and FY 2007 Estimate reflect the Proposed Law transfer of \$100 million from the discretionary Section 317 Program to the mandatory Vaccines for Children program.

²Health Alert Network and Epidemic Services and Response will no longer be tracked for the purposes of PART. Health Alerting is no longer a separate function within CDC. Instead, it is an element of State and Local Preparedness within the Terrorism program. Under CDC's new budget structure, the Epidemic Services and Response budget activity no longer exists. Accordingly, the activities that took place under this former budget activity are now dispersed across the Agency within Health Information and Services, Global Health and Public Health Improvement and Leadership.

³Funding levels for State and Local Preparedness reflect the entire Upgrading State and Local Capacity line.

⁴The FY 2007 Estimate carries forward the proposal in the FY 2006 House and Senate language to move management and administrative costs (\$34.8 million) from Occupational Safety and Health to the Business Services Support budget activity line. As a result, the funding level for the FY 2006 President's Budget is shown on a comparable basis.

⁵Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$441.6 million to date in FY 2005), as part of the President's Emergency Plan for AIDS Relief.

Funding requested for FY 2007 will allow CDC's PART programs to continue working towards their long-term and annual performance goals and measures, as well as actions to enhance program performance. Progress toward these goals and measures are reported in the Detail of Performance Analysis in the Performance Detail section.

For those programs with a Results Not Demonstrated (RND) rating, including Domestic HIV/AIDS Prevention and State and Local Preparedness, CDC recommends that funding be continued at requested levels because of the significant progress being made toward the programs' PART Recommendations. Further, both programs anticipate undergoing a comprehensive PART re-review during the FY 2009 budget cycle.

For the FY 2007 cycle, CDC had five programs undergo the PART process: Environmental Health, the Global AIDS Program (in conjunction with the President's Emergency Plan for AIDS Relief), Global Immunizations, Health Statistics, and the Strategic National Stockpile. A brief overview of PART review findings and recommendations is provided below for these programs, as well as those CDC programs that have been assessed through PART in FY 2004 – FY 2006. Further detail may be found at www.ExpectMore.gov.

FY 2004 Programs

317 Immunization

Assessment findings include:

- The 317 Immunization program was, and continues to be, successful in improving immunization coverage rates among children.
- There were no comprehensive evaluations analyzing current program operations, management, or the program structure.
- The program generally had strong management practices, but did not have processes in place to measure or improve efficiency.

Actions taken to improve program performance include:

- Conducting an evaluation and working with grantees to better measure outcomes and allocate resources based on more clear criteria.
- Reviewing administrative functions to determine how improvements in program operations and efficiency can be made.
- Improving the link between the program's budget for state immunization program operations activities to program performance.

Breast and Cervical Cancer

Assessment findings include:

- The program provided, and continues to provide, important health screenings to a population that would otherwise not receive these services.
- The program lacked long-term health outcome goals such as reduced morbidity/mortality through early detection.
- While Federal managers are accountable for cost and schedule, all program managers were not held accountable for achieving the program's stated performance goals.

Actions taken to improve program performance include:

- Developing outcome-oriented long-term measures and more ambitious long-term goals.
- Moving to performance-based employee evaluation plans.

Diabetes

Assessment findings include:

- The program adopted a long-term measure on diabetes-associated lower extremity amputations and is also working to develop a way to project the number of cases of blindness, amputations and kidney disease in order to develop scientifically credible performance targets.
- The program has made progress in improving efficiency and cost effectiveness in achieving program goals.

- The program was in the process of establishing performance-based contracts for senior program managers.

Actions taken to improve program performance include:

- Developing the program's long-term health outcome goals.
- Demonstrating improved efficiencies and cost effectiveness in achieving program goals.
- Collecting performance data on an annual basis and making it available to the public in a transparent and meaningful manner.

Domestic HIV/AIDS Prevention

Assessment findings include:

- The program had made progress on reducing new infections from 120,000 in the late 1980's to 40,000 in the mid-1990's, but this level has not changed for several years.
- The program had taken steps to improve the efficiency of Federal operations, but did not have incentives and procedures to make gains more broadly or ways of measuring annual improvements.
- CDC had comprehensive evaluations at regular intervals to inform program improvements.

Actions taken to improve program performance include:

- Holding managers accountable by linking achievement of target levels to employee performance plans and improving oversight of grantee activities through the Program Evaluation Monitoring System.
- Developing incentives and procedures to measure and achieve efficiencies and cost-effectiveness in program execution.
- Collecting data on program performance and making it available publicly.

FY 2005 Programs

State and Local Preparedness

Assessment findings include:

- While the purpose and importance of the program's effort were clear, results had not yet been demonstrated. In large part, this is due to the fact that the program was relatively new, and to the inherent difficulty of measuring preparedness against an event that does not regularly occur.
- This effort is well coordinated with other Federal preparedness efforts including the Health Resources and Services Administration Hospital Preparedness grants. The programs have joint grant announcements and are cross referenced in cooperative agreements with grantees.
- The formula for distribution of grants may not be optimal since it does not address varying threat levels or states of preparedness.

Actions taken to improve program performance include:

- Developing and conducting independent program evaluations.
- Working with grantees to ensure that performance data will be available to determine when acceptable preparedness has been demonstrated, and targeting assistance for areas not adequately prepared.

ATSDR: Please refer to ATSDR's FY 2007 Congressional Justification for details of PART findings and follow-up actions.

FY 2006 Programs

Buildings and Facilities

Assessment findings include:

- Buildings and Facilities lacked performance measures. The program adopted a new outcome measure that will track changes in areas such as the productivity and expansion of laboratory research and techniques resulting from new facilities.
- The program uses a master plan of CDC headquarters construction projects to target resources.
- The program has a clear purpose and is well managed, but lacked a comprehensive evaluation to track its impact.

Actions taken to improve program performance include:

- Refining the newly adopted long-term measure and developing ambitious targets and timeframes.
- Tying budget requests to the accomplishment of goals in an explicit manner and presenting resource needs more completely and transparently.

Infectious Diseases

Assessment findings include:

- The Infectious Diseases program addresses infectious disease outbreaks, a continuing threat to our nation's health that can have huge medical and economic consequences. Its focus is on both newly emerging infections such as West Nile Virus and SARS, as well as ongoing challenges such as influenza.
- The program has been the subject of multiple reports from the Government Accountability Office and has had targeted evaluations to help fill in gaps in performance information. In general, these reports have highlighted areas of needed improvement, but document the program's positive impact on controlling diseases.
- The program adopted long-term measures focused on food-borne pathogens, bloodstream infections, illness from bacterial pneumonia, and hepatitis A. It also measures progress in global influenza surveillance and detection as one key indicator of the U.S.'s preparedness for a pandemic influenza outbreak.

Actions taken to improve program performance include:

- Enhancing budget and performance integration to identify changes in program outcomes associated with resource levels.
- Tracking progress on performance measures.
- Making grantee performance data available to the public in a more transparent and meaningful way.

National Institute of Occupational Safety and Health

Assessment findings include:

- The program works to address and prevent occupational hazards that result in disabling injuries, disease and/or death. Well managed overall, it lacked strong performance measures to evaluate its impact on reducing workplace illness and injuries.
- It has a well-established mechanism for setting priorities to guide budget requests and funding decisions. The National Occupational Research Agenda will invest up to \$99 million in 21 priority areas of research this year

Actions taken to improve program performance include:

- Tracking performance on the percent of firefighters/first responders with access to respirators and reductions in respirable coal dust overexposure and road construction fatalities and injuries.
- Advancing work with the National Academy of Sciences to develop a standard method of measuring the impact of their research on the occupational safety and health field.
- Using performance information from its research efforts to help improve program direction, allocate resources and develop annual budgets.

Sexually Transmitted Diseases and Tuberculosis

Assessment findings include:

- Both the STD and TB activities have a clear purpose and address specific and ongoing problems.
- The programs have strong performance measures that focus on outcomes. For example, goals include the elimination of syphilis by 2008 and the reduction of the number of persons per 100,000 population with TB among US-born persons, foreign-born persons, and overall to 1.2, 19.3, and 2.9, respectively, by 2010.
- The STD program distributes its main grant awards to states based on historical distributions and does not target the majority of funds based on current need.

Actions taken to improve program performance include:

- Developing methods to effectively target the STD and TB programs so that resources directly address the programs' purposes.
- Conducting independent evaluations of sufficient scope and quality to support program improvements and evaluate effectiveness and relevance to the need.
- Tracking performance on the new long-term and annual performance measures and developing a measure to track its efficiency.

FY 2007 Programs

Environmental Health

Assessment findings include:

- The program addresses the specific need to reduce and mitigate human exposure to a variety of toxic substances and hazardous environmental conditions.
- The program has established annual and long-term performance measures and is able to show progress in achieving yearly targets. The program has already made progress in reducing the number of children under age 6 with elevated blood lead levels, with a goal of zero children with elevated blood lead levels by 2010.
- The program has had independent evaluations. The Government Accountability Office has reviewed the majority of environmental health programs, and the findings helped the program better focus its public health efforts. The program's Board of Scientific Counselors is scheduled to review all of the National Center for Environmental Health's activities over a five-year period (FY 2004 - 2009).

Actions taken to improve program performance include:

- Tying budget requests to the accomplishment of annual and long-term goals, and presenting resource needs in a complete and transparent manner.
- Demonstrating adequate progress in achieving the program's long-term performance goals.
- Continuing program improvements so that future independent evaluations indicate that the program is effective and achieving results.

Global AIDS Program (in conjunction with the President's Emergency Plan for AIDS Relief)

Focus Countries:

Assessment findings include:

- The Emergency Plan demonstrated measurable progress towards long-term goals. The FY 2005 goal for care was exceeded and the treatment goal was missed by approximately 70,000 people.
- Several evaluations were conducted of the program, completed early in the program's implementation. These evaluations did not seek to provide information on the program's performance. A performance study is being conducted by the Institute of Medicine. A plan for the evaluation was issued in fall 2005 and the completed study is scheduled for fall of 2006.

- The implementing agencies have mechanisms for financial accountability and control, but they do not yet meet the standards for strong financial management practices. A new financial management system has been put in place at HHS/CDC to eliminate this weakness. USAID is also rolling out a new financial management system both overseas and in headquarters.

Actions taken to improve program performance include:

- Implementing a system to capture expenditures by country.
- The Office of the Global AIDS coordinator is urged to undertake an internal review of budget allocations to focus countries based on performance data and pipeline capacity.

Other Bilateral Countries:

Assessment findings include:

- The strength of existing programs operated by CDC and USAID enabled the Emergency Plan to rapidly improve existing mechanisms, grant structures and relationships already established on the ground. In addition, the Government Accountability Office has noted that the CDC is the single greatest source of technical expertise and resources for international disease surveillance.
- While there have been performance measures for HIV/AIDS programs in the other bilateral countries, these measures were not consistent across agencies and did not, in all cases, include baseline and target information. Beginning in FY 2006, countries will report on a set of indicators standardized for use across countries that receive \$1 million or more in U.S. government HIV/AIDS funding in FY 2005.
- The implementing agencies have mechanisms for financial accountability and control, but they do not yet meet the standards for strong financial management practices. However, CDC has implemented a new financial management system designed to eliminate preciously identified weaknesses and USAID is also rolling out a new financial management system both overseas and in headquarters.

Actions taken to improve program performance include:

- Completing implementation of USAID's new financial management systems.

Global Immunizations

Assessment findings include:

- The program has a clear purpose: to eliminate or reduce vaccine-preventable diseases overseas. These efforts protect American children from diseases imported to the US or acquired abroad and against the medical costs of morbidity and mortality associated with these diseases.
- The program has well-established annual and long-term performance measures, consistent with its global partners. Performance data indicates that global polio incidence has declined by more than 99 percent from 1988 to 2004.
- The program is meeting its efficiency goals of minimizing headquarters expenses and overhead. At least 90 percent of program funds are in direct support of field work to accomplish the long-term outcome of ending vaccine-preventable illness.

Actions taken to improve program performance include:

- Tying budget requests to the accomplishment of annual and long-term goals, and presenting resource needs in a complete and transparent manner.
- Reviewing opportunities to conduct an evaluation of management of Global Immunizations measles activities at domestic headquarters in Atlanta, Georgia.

Health Statistics

Assessment findings include:

- The program provides statistical information on health, illness and disability, the effects of health hazards, management of medical conditions, health care costs and financing, family size and make-up, and birth and death. Without these data, researchers and policymakers would not have the information they need to monitor public health, design and manage programs, and allocate resources.
- The program has established annual and long-term performance measures and is able to show progress in achieving its goals. Considerable progress has been made on Health Statistics' annual measures.

- The program has established an efficiency measure. Additionally, administrative savings have been achieved through a reduction in the number of administrative management and support staff and an improved supervisory ratio.

Actions taken to improve program performance include:

- Tying budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.
- Monitoring progress on new long-term outcome measures to drive program improvements.

Strategic National Stockpile

Assessment findings include:

- The Strategic National Stockpile has a focused and well-defined mission and is generally well managed, but improvement is needed in the process for identifying procurement priorities.
- The program is evaluated regularly to fill gaps in performance information and highlight areas of potential improvement. Follow-up reviews by the Government Accountability Office and HHS' Office of Inspector General determined improvement has been made in implementing recommendations to correct internal weaknesses involving security and environmental controls.
- The program has developed new annual and long-term performance measures and is able to demonstrate significant progress in its ability to treat the public for the appropriate response to known threats. The program has also established an efficiency measure which captures cost reductions made by extending the shelf life of products.

Actions taken to improve program performance include:

- Tying budget requests to the accomplishment of annual and long-term goals, and presenting resource needs in a complete and transparent manner.
- Analyzing trade-offs between cost, schedule, risk and performance goals to guide future activity.
- Maintaining clearly defined deliverables and appropriate, credible cost and schedule goals.

BUDGET EXHIBITS

APPROPRIATION LANGUAGE

DISEASE CONTROL, RESEARCH, AND TRAINING

To carry out titles II, III, VII, XI, XV, XVII, XIX, XXI, and XXVI of the Public Health Service Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act of 1977, sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, and for expenses necessary to support activities related to countering potential biological, disease, 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, [\$5,884,934,000] \$5,833,952,000 of which [\$160,000,000] \$29,700,000 shall remain available until expended for equipment, construction, and renovation of facilities; [of which \$30,000,000 of the amounts available for immunization activities shall remain available until expended;] of which [\$530,000,000] \$592,648,000 shall remain available until expended for the Strategic National Stockpile; and of which [\$123,883,000] \$121,952,000 for international HIV/AIDS shall remain available until September 30, [2007] 2008. In addition, such sums as may be derived from authorized user fees, which shall be credited to this account: *Provided*, That in addition to amounts provided herein, the following amounts shall be available from amounts available under section 241 of the Public Health Service Act: (1) \$12,794,000 to carry out the National Immunization Surveys; (2) \$109,021,000 to carry out the National Center for Health Statistics surveys; (3) \$24,751,000 to carry out information systems standards development and architecture and applications-based research used at local public health levels; (4) \$463,000 for Health Marketing evaluations; (5) \$31,000,000 to carry out Public Health Research; and (6) \$87,071,000 to carry out research activities within the National Occupational Research Agenda: *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 up to \$31,800,000 shall be made available until expended for Individual Learning Accounts for full-time equivalent employees of the Centers for Disease Control and Prevention: *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 Congress is to be notified promptly of any such transfer: *Provided further*, That not to exceed \$12,500,000 may be available for making grants under section 1509 of the Public Health Service Act to not more than 15 States, tribes, or tribal organizations: [*Provided further*, That notwithstanding any other provision of law, a single contract or related contracts for development and construction of facilities may be employed which collectively include the full scope of the project: *Provided further*, That the solicitation and contract shall contain the clause "availability of funds" found at 48 CFR 52.232-18;] *Provided further*, That of the funds awarded to a state, a state may reallocate up to five percent

of such funds to be used for the purposes designated in section 1904 of the Public Health Service Act, provided that such reallocations do not exceed a five percent reduction to any grant: Provided further, that no State may reallocate grants awarded under Section 319C-1of the Public Health Service Act: Provided further, That a State must notify the Director of the Centers for Disease Control and Prevention within 10 days of implementing such a reallocation: Provided further, That of the funds appropriated, \$10,000 is 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 Public Health Service Act, 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.

Footnote on New Language:

“....That of the funds awarded to a State, a State may reallocate up to five percent of such funds to be used for the purposes designated in section 1904 of the Public Health Service Act, provided that such reallocations do not exceed a five percent reduction to...”

The FY 2007 President’s Budget eliminates the Public Health and Social Services Block Grant (PHHSBG). This new language provides authorization for states to utilize funds within categorical grant programs for purposes related to those conducted with PHHSBG funds to allow for a source of flexible funding in the absence of PHHSBG funds.

CENTERS FOR DISEASE CONTROL AND PREVENTION LANGUAGE ANALYSIS

LANGUAGE ANALYSIS

PURCHASE AND LANGUAGE PROVISION	EXPLANATION
<i>"...including purchase and insurance of official motor vehicles in foreign countries..."</i>	No specific authorization exists for the provision regarding insurance; however, experience of the Centers for Disease Control and Prevention (CDC) in stationing Public Health Service officials overseas and at the Mexican Border indicates that this provision is essential. Unless adequate automobile insurance is provided, Public Health Service officials could be subject to arbitrary arrest if they were involved in an accident.
<i>"...and purchase, hire, maintenance, and operation of aircraft..."</i>	CDC must maintain the ability to purchase or hire aircraft for deployment of the Strategic National Stockpile or other emergency response operations; testing of new insecticides and formulations; and for applying the insecticides when outbreaks of mosquito-borne disease, such as encephalitis, occur in populous areas where no other method can be used to control the spread of the disease.
<i>"...of which [\$160,000,000] \$29,700,000 shall remain available until expended for equipment, construction, on-going maintenance, and renovation of facilities ..."</i>	Provides specific authorization for CDC to fund the construction, maintenance, and improvement of CDC buildings and facilities.
<i>["...of which \$30,000,000 of the amounts available for immunization activities shall remain available until expended..."]</i>	Congress provided no-year funding in FY 2006 for CDC to enter into back-end sales guarantees with manufacturers for the purchase of influenza vaccine to increase production capacity and ameliorate fluctuations in influenza vaccine supply. Funding for this activity is not requested in the FY 2007 President's Budget. As such, this language is no longer required.
<i>"...such sums as may be derived from authorized user fees, which shall be credited to this account."</i>	Provides specific authorization to allow all funds collected as user fees to be deposited to this appropriation.
<i>"...\$87,071,000 to carry out [Research Tools and Approaches] research activities within the National Occupational Research Agenda..."</i>	Allows CDC to utilize Section 317 funding to conduct all research activities related to the National Occupational Research Agenda rather than limiting use of these funds to Research Tools and Approaches.
<i>".....That of the funds awarded to a State, a state may reallocate up to five percent of such funds to be used for the purposes designated in section 1904 of the Public Health Service Act, provided that such reallocations do not exceed a five percent reduction to any grant: Provided further, that no State may reallocate grants awarded under Section 319C-1of the Public Health Service Act: Provided further, That a State must notify the Director of the Centers for Disease Control and Prevention within 10 days of implementing such a reallocation"</i>	The FY 2007 President's Budget eliminates the Public Health and Social Services Block Grant (PHHSBG). This new language provides authorization for states to utilize funds within categorical grant programs for purposes related to those conducted with PHHSBG funds to allow for a source of flexible funding in the absence of PHHSBG funds.

AMOUNTS AVAILABLE FOR OBLIGATION

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DISEASE, CONTROL, RESEARCH AND TRAINING AMOUNTS AVAILABLE FOR OBLIGATION ¹ (\$ IN 000)			
	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate ²
Appropriation:			
Annual	4,533,911,000	5,884,934,000	5,733,952,000
Rescission	(36,256,000)	(58,848,000)	
HHS Reduction Pursuant to HR2673	(1,944,000)		
Subtotal, adjusted Appropriation³	4,495,711,000	5,826,086,000	5,733,952,000
Transfers from Other Accounts (Office of the Secretary)	58,000,000		
Transfers from Other Accounts (Department of State)	15,000,000		
Subtotal, adjusted Budget Authority	4,568,711,000	5,826,086,000	5,733,952,000
Receipts from CRADA	959,000	1,000,000	1,000,000
Recovery of prior year Obligations	12,485,000		
Unobligated balance start of year	219,335,952	(297,347,270)	(298,000,000)
Unobligated balance expiring	(2,853,538)		
Unobligated balance end of year	297,347,270	298,000,000	299,000,000
Total obligations	5,095,984,684	5,827,738,730	5,735,952,000

¹ Excludes the following amounts for reimbursements: FY 2005 \$574,983,000; FY 2006 \$597,983,000; and FY 2007 \$610,540,000.

² FY 2007 estimate is based on the proposed law transfer of \$100,000,000 from the Section 317 account of the Public Health Service Act to the Vaccines for Children program.

³ Beginning in FY 2006, the Terrorism budget activity was appropriated to CDC as part of its Budget Authority. As a result, FY 2006 and FY 2007 funding levels are significantly higher than FY 2005.

SUMMARY OF CHANGES

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF CHANGES (DOLLARS IN THOUSANDS)				
	Dollars		FTEs	
FY 2007 Estimate (Budget Authority)	\$5,733,952		9,041	
FY 2006 Appropriation (Budget Authority)	\$5,826,086		8,992	
Net Change	(\$92,134)		49	
	FY 2006 Appropriation		FY 2007 Estimate Change from Base	
	FTE	Base Funding	FTE	Proposed Level
Increases:				
A: Built-In/Mandatory Costs:				
1. January 2007 Pay Raise/Locality Pay.....	---	---	---	11,146
2. Annualization of FY 2006 Pay Increase.....	---	---	---	4,027
3. Within-Grade Increases.....	---	---	---	12,159
4. Rental Payments to GSA and Others.....	---	---	---	165
5. HHS Service & Supply Fund.....	---	---	---	1,889
6. Vaccine Price Increase.....	---	---	---	10,542
7. Inflation Costs on Other Objects.....	---	---	---	35,550
8. Restoration of FY 2006 Government-wide Rescission.....	---	---	---	58,848
9. Removal of FY 2006 Government-wide Rescission in FY 2007.....	---	---	---	(56,982)
Subtotal, Built-In/Mandatory Increases	8,563	5,826,086	49	77,344
B: Program Increases:				
1. Pay raise		---		\$14,835
2. Domestic HIV/AIDS Initiative		---		\$93,000
3. Service and Supply Fund, UFMS, Rent		---		\$3,333
4. Biosurveillance		\$78,431		\$49,500
5. Strategic National Stockpile		\$524,700		\$69,300
6. Botulinum Toxin Research		---		\$2,970
7. Pandemic Influenza		---		\$188,100
Subtotal, Program Increases	N/A	N/A	0	\$421,038
Total Increases (Budget Authority)	8,563	\$5,826,086	49	\$498,383
Decreases:				
A. Built-In:				
1. Absorption of Current Services				(\$77,344)
Subtotal, Built-In/Mandatory Decreases				(\$77,344)
B. Program Decreases:				
1. West Nile virus		\$37,298		(\$9,953)
2. Bulk Monovalent Influenza Vaccine		\$29,700		(\$29,700)
3. Program Eliminations for Non-Primary Prevention Programs		\$29,168		(\$29,168)
4. Preventive Health & Health Services Block Grant		\$99,000		(\$99,000)
5. Buildings and Facilities		\$158,400		(\$128,700)
6. IT Reduction		---		(\$7,399)
7. FY 2006 President's Budget Policy		---		(\$18,166)
8. Administrative Reduction		---		(\$29,502)
9. Section 317 Immunization Program (proposed law)		---		(\$100,000)
10. Anthrax Research Program		\$13,860		(\$13,860)
11. FY 2006 Rescission carried forward into FY 2007		---		(\$47,724)
Subtotal, Program Decreases	N/A	N/A	0	(\$513,172)
Total Decreases (Budget Authority)	N/A	N/A	0	(\$590,517)
NET CHANGE - L/HHS/ED BUDGET AUTHORITY	8,563	\$5,826,086	49	(\$92,134)
Program Level Changes				
1. Vaccines for Children (Proposed Law)		\$1,957,963		\$188,482
2. ATSDR	429	\$74,905		\$99
3. PHS Evaluation Transfers		265,100		\$0
4. Department of Defense		275,000		(275,000)
5. User Fees		\$2,226		\$0
Total - Program Level Net Increase	429	\$2,300,194	0	(\$86,419)
NET CHANGE: BUDGET AUTHORITY & PROGRAM LEVEL	8,992	8,401,280	49	(\$178,553)

BUDGET AUTHORITY BY ACTIVITY (ALL PURPOSE TABLE)

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION ALL-PURPOSE TABLE (DOLLARS IN THOUSANDS)				
Budget Activity	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Infectious Diseases (Current Law)				
Budget Authority	\$1,666,538	\$1,680,423	\$1,772,890	\$92,467
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Infectious Diseases (Current Law) -	\$1,679,332	\$1,693,217	\$1,785,684	\$92,467
Infectious Diseases (Proposed Law)²				
Budget Authority	\$1,666,538	\$1,680,423	\$1,672,890	(\$7,533)
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Infectious Diseases (Proposed Law)² -	\$1,679,332	\$1,693,217	\$1,685,684	(\$7,533)
Health Promotion¹	\$1,024,204	\$963,426	\$929,208	(\$34,218)
Health Information and Service				
Budget Authority	\$94,439	\$88,668	\$127,439	\$38,771
PHS Evaluation Transfers	\$134,235	\$134,235	\$134,235	\$0
Subtotal, Health Information and Service -	\$228,674	\$222,903	\$261,674	\$38,771
Environmental Health and Injury Prevention¹	\$289,432	\$289,021	\$279,309	(\$9,712)
Occupational Safety and Health³				
Budget Authority	\$164,170	\$168,201	\$163,123	(\$5,078)
PHS Evaluation Transfers	\$87,071	\$87,071	\$87,071	\$0
Subtotal, Occupational Safety and Health -	\$251,241	\$255,272	\$250,194	(\$5,078)
Global Health^{1,4}				
Budget Authority	\$317,153	\$313,251	\$381,103	\$67,852
Department of Defense Appropriation	\$0	\$68,000	\$0	(\$68,000)
Subtotal, Global Health -	\$317,153	\$381,251	\$381,103	(\$148)
Public Health Research (PHS Evaluation Transfers)	\$31,000	\$31,000	\$31,000	\$0
Public Health Improvement and Leadership (PHIL)¹				
Budget Authority	\$247,389	\$189,823	\$190,165	\$342
Department of Defense Appropriation	\$0	\$75,000	\$0	(\$75,000)
Subtotal, PHIL -	\$247,389	\$264,823	\$190,165	(\$74,658)
Prev. Health & Health Services Block Grant (PHHSBG)	\$118,526	\$99,000	\$0	(\$99,000)
Buildings and Facilities	\$269,708	\$158,400	\$29,700	(\$128,700)
Business Services Support^{1,3}	\$319,152	\$298,616	\$303,854	\$5,238
Terrorism				
Budget Authority	\$1,622,757	\$1,577,257	\$1,657,161	\$79,904
Department of Defense Appropriation	\$0	\$55,000	\$0	(\$55,000)
Subtotal, Terrorism -	\$1,622,757	\$1,632,257	\$1,657,161	\$24,904
FY 2006 Pandemic Influenza One-Time Funding - Department of Defense⁵	\$0	\$77,000	\$0	(\$77,000)
CDC-wide HIV/AIDS (non-add) -	\$855,535	\$842,360	\$929,653	\$87,293
Total, L/HHS/ED (Current Law)⁵ -	\$6,133,468	\$5,826,086	\$5,833,952	\$7,866
Total, L/HHS/ED (Proposed Law)^{2,5} -	\$6,133,468	\$5,826,086	\$5,733,952	(\$92,134)
Total, L/HHS/ED (inc. PHS and DoD) (Current Law)⁵ -	\$6,398,568	\$6,366,186	\$6,099,052	(\$267,134)
Total, L/HHS/ED (inc. PHS and DoD) (Proposed Law)^{2,5} -	\$6,398,568	\$6,366,186	\$5,999,052	(\$367,134)
PHS Evaluation Transfer (non-add)	\$265,100	\$265,100	\$265,100	\$0
Department of Defense Appropriation (non-add)	\$0	\$275,000	\$0	(\$275,000)
Agency for Toxic Substances and Disease Registry⁶	\$76,041	\$74,905	\$75,004	\$99
Vaccines for Children (Current Law)⁷	\$1,503,127	\$1,957,963	\$2,006,445	\$48,482
Vaccines for Children (Proposed Law)^{2,7}	\$1,503,127	\$1,957,963	\$2,146,445	\$188,482
User Fees	\$2,226	\$2,226	\$2,226	\$0
Total, CDC/ATSDR Program Level (Current Law) -	\$7,979,962	\$8,401,280	\$8,182,727	(\$218,553)
Total, CDC/ATSDR Program Level (Proposed Law)² -	\$7,979,962	\$8,401,280	\$8,222,727	(\$178,553)
Full-Time Equivalents (FTEs) -	8,657	8,992	9,041	49

¹FY 2005 funding levels reflect a technical reprogramming among several budget activities, shown comparably in FY 2006 and FY 2007.
²FY 2007 reflects the Proposed Law transfer of \$100 million from the Section 317 Program to the Vaccines for Children program.
³The FY 2007 Estimate carries forward FY 2006 Conference language to move management and administrative costs (\$34.8 million) from Occupational Safety and Health to Business Services Support. Funding for FY 2005 is shown on a comparable basis.
⁴Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$439.0 million in FY 2005), as part of the President's Emergency Plan for AIDS Relief.
⁵The FY 2006 Appropriation includes a 1.0% across-the-board rescission for all relevant programs, projects, and activities. FY 2006 funding also reflects \$77 million in one-time costs related to pandemic influenza planning that are not carried forward into FY 2007.
⁶FY 2006 funding for ATSDR includes a rescission of 0.476% for Interior, Environment, and Related Agencies.
⁷Funding for VFC in FY 2005 reflects obligations. FY 2006 funding includes carryover of \$60 million from FY 2005.

BUDGET AUTHORITY BY OBJECT

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION OBJECT CLASSIFICATION - DIRECT OBLIGATIONS (DOLLARS IN THOUSANDS)			
	FY 2006 Appropriation	FY 2007 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent(11.1)	401,796	417,968	16,172
Other than Full-Time Permanent (11.3)	42,576	44,290	1,714
Other Personnel Comp. (11.5)	25,482	26,508	1,026
Military Personnel (11.7)	41,160	42,899	1,739
Special Personal Service Comp. (11.8)	1,012	1,225	213
Total Personnel Compensation	512,026	532,890	20,864
Civilian personnel Benefits (12.1)	134,374	139,783	5,409
Military Personnel Benefits (12.2)	30,126	31,399	1,273
Benefits to Former Personnel (13.0)	4,959	5,058	99
SubTotal Pay Costs	681,485	709,130	27,645
Travel (21.0)	37,787	34,334	(3,453)
Transportation of Things (22.0)	8,813	8,108	(705)
Rental Payments to GSA (23.1)	7,864	7,167	(697)
Rental Payments to Others (23.2)	1,257	1,132	(125)
Communications, Utilities, and Misc. Charges (23.3)	36,143	32,461	(3,682)
Printing and Reproduction (24.0)	6,501	6,060	(441)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	327,774	301,716	(26,058)
Other Services (25.2)	159,752	143,575	(16,177)
Purchases from Government Accounts (25.3)	551,576	494,154	(57,422)
Operation and Maintenance of Facilities (25.4)	41,761	37,612	(4,149)
Research and Development Contracts (25.5)	195,303	194,320	(983)
Medical Services (25.6)	787	474	(313)
Operation and Maintenance of Equipment (25.7)	37,402	33,487	(3,915)
Subsistence and Support of Persons (25.8)	125	112	(13)
Subtotal Other Contractual Services	1,314,480	1,205,450	(109,030)
Supplies and Materials (26.0)	140,945	128,592	(12,353)
Equipment (31.0)	69,985	63,544	(6,441)
Land and Structures (32.0)	147,419	129,601	(17,818)
Investments and Loans (33.0)	0	0	0
Grants, Subsidies, and Contributions (41.0)	3,373,407	3,508,373	134,966
Insurance Claims and Indemnities (42.0)	0	0	0
Interest and Dividends (43.0)	0	0	0
Refunds (44.0)	0	0	0
Subtotal Non-Pay Costs	5,144,601	5,124,822	(19,779)
Total Budget Authority	5,826,086	5,833,952	7,866

SALARIES AND EXPENSES

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SALARIES AND EXPENSES (DOLLARS IN THOUSANDS)			
	FY 2006 Appropriation	FY 2007 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent(11.1)	401,796	417,968	16,172
Other than Full-Time Permanent (11.3)	42,576	44,290	1,714
Other Personnel Comp. (11.5)	25,482	26,508	1,026
Military Personnel (11.7)	41,160	42,899	1,739
Special Personal Service Comp. (11.8)	1,012	1,225	213
Total Personnel Compensation	512,026	532,890	20,864
Civilian personnel Benefits (12.1)	134,374	139,783	5,409
Military Personnel Benefits (12.2)	30,126	31,399	1,273
Benefits to Former Personnel (13.0)	4,959	5,058	99
SubTotal Pay Costs	681,485	709,130	27,645
Travel (21.0)	37,787	34,334	(3,453)
Transportation of Things (22.0)	8,813	8,108	(705)
Rental Payments to Others (23.2)	1,257	1,132	(125)
Communications, Utilities, and Misc. Charges (23.3)	36,143	32,461	(3,682)
Printing and Reproduction (24.0)	6,501	6,060	(441)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	58,999	54,309	(4,690)
Other Services (25.2)	159,752	143,575	(16,177)
Purchases from Government Accounts (25.3)	33,095	29,649	(3,446)
Operation and Maintenance of Facilities (25.4)	29,233	26,328	(2,905)
Medical Services (25.6)	787	474	(313)
Operation and Maintenance of Equipment (25.7)	37,402	33,487	(3,915)
Subsistence and Support of Persons (25.8)	125	112	(13)
Subtotal Other Contractual Services	319,393	287,934	(31,459)
Supplies and Materials (26.0)	140,945	128,592	(12,353)
Subtotal Non-Pay Costs	550,839	498,621	(52,218)
Total Budget Authority	1,232,324	1,207,751	(24,573)

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – HOUSE

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2007 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
HOUSE REPORT NO. 109-143
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Botulinum Neurotoxin Research – The Committee understands that botulinum neurotoxin is one of the most toxic substances known to mankind and that a recent technological breakthrough, using fluorescent sensors, may for the first time enable the detection of neurotoxin activity in a person's body and in living cells on a near real-time basis. The Committee encourages CDC to evaluate, develop, and validate the fluorescence resonance energy transfer assay for the detection of botulinum toxins to meet its mission requirements, and to incorporate it into its bioterrorism preparedness program. The Committee also encourages CDC to continue to investigate new and advanced methods for measuring botulinum toxins and other toxins using mass spectrometry. (Page 36)

Action taken or to be taken

CDC agrees that botulinum toxin is one of the most toxic substances known and is of significant concern because of its potential use by terrorists. Major public health decisions about detecting, treating, and preventing illness or death from botulinum toxin and other toxins rely on sensitive, specific, high-quality, and timely laboratory information about the presence of toxin-forming organisms and the toxins they produce. CDC's Environmental Health Laboratory utilizes the mass spectrometry method for detecting botulinum toxin and its seven subtypes in people. CDC plans on using this method, including its utility in detecting anthrax lethal factor, ricin, and other toxins used as bioweapons. This method provides for improved speed of analysis [up to 1000 samples per day]; simplification of the method for use by external laboratories; as a cost-effective method for preventive screening of milk samples; and its use in "toxin fingerprinting," whereby the method identifies the amino acid sequence of the protein toxin that will allow scientists to detect minor variations that will help identify the source of the toxin, provide identifying forensic information, and assist epidemiologists investigating the cause and pathways of disease. Overall, these breakthrough advances based on mass spectrometry techniques to detect and measure botulinum and other toxins will improve early detection and help ensure prompt, appropriate treatment and prevention of additional exposure. CDC is open to further discussions on concepts and principles about the fluorescence resonance energy transfer technology.

Item

Hepatitis – ...The Committee is concerned that more than 75% of the 4 million HCV positive individuals are unaware of their condition and therefore urges a public education campaign to urge appropriate screening and medical follow up of target populations. The Committee also is concerned with increasing rates of adult infections of Hepatitis A & B and urges an expanded vaccination program be launched in response to this critical public health issue. Finally, CDC is encouraged to focus on education and awareness programs targeted at specific populations where there is a high prevalence of hepatitis B and where therapeutic interventions are increasingly effective. (Page 36)

Action taken or to be taken

During FY 2005, CDC funded 12 organizations to develop, evaluate, and distribute educational materials for health professionals, patients and the concerned public. These and other informational materials are also available on line; in 2005, approximately 600,000 persons used the Internet to access information about viral hepatitis. Awareness has increased significantly from the 1990s when only 25% of infected persons had knowledge of their infection. However, approximately half of HCV positive individuals remain unaware of their infection status. To address adult infections of hepatitis A and B, some states use a small portion of the immunization funds provided under Section 317 of the PHS Act to offer hepatitis A and B vaccines in public health venues to persons at high risk. However, there currently is no national adult immunization program to support hepatitis B vaccination of adults. CDC works with the National Viral Hepatitis Roundtable, many of whose member organizations have developed educational materials and campaigns that can be coordinated through the Roundtable for increased effectiveness and impact. For example, both the Immunization Action Coalition and the Jade Ribbon Campaign produce and provide culturally appropriate educational materials for a variety of ethnic populations at increased risk for hepatitis B.

Also, in 2005, CDC launched a program to increase vaccination of adolescents in juvenile detention facilities; a population at high risk for hepatitis B. The detention period provides an opportunity to immunize at-risk and medically underserved youth. In this setting, two common barriers to vaccination—cost and availability of healthcare providers—are overcome because juvenile residential facilities can receive vaccines at no cost through the Vaccines for Children (VFC) program and most facilities have staff available to administer vaccines. Currently many detention facilities do not take advantage of the VFC program. This project attempts to increase vaccination against all recommended vaccines, including hepatitis B, among youth in juvenile residential facilities and increase awareness among detention center staff of the availability of VFC vaccines.

Item

Meningococcal Disease – Meningococcal disease is one of the few diseases that can be fatal or severely debilitating to a victim within a matter of hours of initial onset and yet is vaccine-preventable in most cases. The Committee is aware of the recent improvements in the meningitis vaccine and of recent CDC efforts to increase the availability and focus of information on meningococcal disease and ways to prevent it so that the general public will be better educated on the symptoms and prevention methods. The Committee encourages the CDC to improve meningococcal education and adolescent immunization programs, including giving consideration to partnering with relevant professional and voluntary health associations to ensure that all families, especially those with adolescents and young adults, are effectively educated on this disease, vaccine availability, and all methods of prevention. (Page 36)

Action taken or to be taken

CDC continues to educate the public and providers about the availability of adolescent vaccines including meningococcal. In April 2005, CDC held a net conference for clinicians titled "Current Issues in Immunization" that included a focus on the new meningococcal vaccine recommendations. Also, CDC's website also offers an adolescent area entitled "Vaccines for Teens: Vaccinate before You Graduate" available at www.cdc.gov/nip/recs/teen-schedule.htm. The site includes information about vaccines recommended for teenagers and provides links to information about vaccines for adults and children.

A 2-day Adolescent Stakeholders meeting sponsored by CDC and the National Vaccine Advisory Committee (NVAC) was held in Washington in June 2005. The meeting included over 140 key stakeholders with an interest in adolescent immunization. The objectives for this meeting were to identify issues expected to arise with the licensing of new vaccines for this age group, and identify approaches that will most effectively increase adolescent vaccination. Adolescent vaccines, including meningococcal vaccine were also discussed at this meeting. A series of white papers summarizing findings from this meeting will be published in *Pediatrics*.

Item

Sepsis –...The Committee applauds the CDC's ongoing demonstration program to reduce hospital-based transmission of sepsis and other infections, but recognizes that significant reductions in morbidity and mortality could be achieved through improved, timely diagnosis and treatment. Within the funds provided, the Committee encourages CDC to consider establishing an education program to train critical care nurses, emergency room physicians, and infectious disease specialists, especially those in rural and traditionally underserved areas, in use of the new protocol to identify sepsis and improve patient outcomes. The Committee encourages CDC to work towards this end in collaboration with the relevant voluntary health organizations, such as the American Sepsis Alliance. (Page 37)

Action taken or to be taken

CDC has implemented several successful interventions to prevent bloodstream infections, including educating clinicians on the appropriate use of intravenous catheters and other strategies to prevent infections that lead to sepsis.

CDC's collaborative project to decrease bloodstream infections (BSI) in the greater Pittsburgh area (Pittsburgh Regional Health Initiative) has resulted in a nearly 70% region-wide decline in BSI.

CDC has funded five states to conduct state-wide educational initiatives for clinicians on the prevention strategies outlined in CDC's *Campaign to Prevent Antimicrobial Resistance in Healthcare Settings*. BSI are a central focus of the Campaign.

CDC serves as a scientific partner and its guidelines have been used as a foundation for the Institute for Healthcare Improvement *100K Lives Campaign*. One of the Campaign's six goals is to reduce bloodstream infections (BSI).

- Through its collaboration with the Society for Hospital Medicine (SHM), CDC has conducted a series of educational workshops in four major US cities to educate Hospitals about strategies for prevention and appropriate diagnosis and management of BSIs. This collaboration also resulted in the development of an evidence-based toolkit for dissemination to all SHM members.
- CDC will continue to work with organizations such as the American Sepsis Alliance to expand its interventions to prevent healthcare-associated sepsis.

Item

Partner Notification – The Committee supports CDC's efforts to require state, territorial, and municipal grantees of HIV/AIDS prevention programs to conduct partner counseling and referral services of newly diagnosed individuals, with strong linkages to prevention and care services. The Committee understands that all States, territories, and large cities with HIV/AIDS prevention cooperative agreements with CDC must provide partner notification and counseling services. The Committee encourages CDC to ensure that all grantees are in compliance with this requirement. (Page 38)

Action taken or to be taken

CDC supports HIV partner counseling and referral services (PCRS) as part of a comprehensive HIV care program and has emphasized to funded-grantees PCRS as an important strategy for reducing HIV transmission in the United States. CDC has issued guidelines on the provision of PCRS and has emphasized the importance of PCRS to its state partners through venues such as sessions at national grantee meetings and conferences.

Item

Tuberculosis – The Committee understands that the CDC plans to undertake a new initiative, the Intensified Support and Activities to Accelerate Control (ISAAC). ISAAC targets tuberculosis in African Americans, tuberculosis along the U.S./Mexico border, allows for universal genotyping of all culture positive TB cases, and expands clinical trials for new tools for the diagnosis and treatment of TB. The Committee encourages the CDC to implement ISAAC to enhance and maximize strategies to accelerate the control and elimination of TB. (Page 38)

Action taken or to be taken

In FY 2004, the National Coalition for the Elimination of Tuberculosis proposed a new initiative: Intensified Support and Activities to Accelerate Control (ISAAC). The initiative aims to sustain the momentum of the past 10 years and accelerate the control and elimination of tuberculosis in the United States. CDC has completed some activities that are supportive of the strategies outlined in ISAAC. In 2005 CDC completed a four year demonstration project to intensify TB prevention, control, and elimination activities in African-American communities in the United States. These projects examined social and cultural dimensions of health-seeking behaviors, beliefs, and values in order to develop targeted interventions. CDC also requires programs reporting more than 50 cases of TB in African Americans to develop specific performance measures related to the reduction of TB in African Americans. Findings will be translated into interventions for use in other areas of the country where there are disproportionate rates of TB in black, non-Hispanic persons.

Along the border, CDC works closely with the World Health Organization (WHO), the Pan American Health Organization (PAHO), Mexico, the U.S.-Mexico Border Health Commission, and the four U.S. Border States of California, Arizona, New Mexico, and Texas to conduct case management, administer directly observed therapy, follow-up on persons exposed to TB disease, and provide support for laboratory services for diagnosis. CDC has just completed a successful four year demonstration project, the Binational Card, to improve communication on both sides of the border to ensure continuity of care and thus avoid interruptions that lead to the emergence of drug resistance. This project could serve as a model for all states who are working with immigrants from Mexico.

To provide universal genotyping, CDC is working to provide laboratory capacity to state health departments that allows every culture-positive TB patient to have his or her TB isolate genotyped. This project has yielded a great deal of useful epidemiologic data and could serve as an early warning system for nascent outbreaks.

Finally, CDC is analyzing data on recently developed tools for rapidly diagnosing TB. In 2005 CDC issued guidelines for using one such tool – the TB QuantiFERON TB Gold test in public health practice. These were among three sets of guidelines CDC issued in 2005 to improve TB control in the U.S. Other guidelines addressed contacts of persons with TB and preventing infections among health care workers, patients and their families.

Item

Tuberculosis – Tuberculosis is an enormous public health crisis in the developing world, killing millions of people in the prime of their lives every year. To help stem this growing pandemic, the Committee encourages CDC to enhance ongoing efforts involving the TB vaccine research cooperative agreement. (Page 38)

Action taken or to be taken

In September 2004, the Centers for Disease Control and Prevention awarded a three-year cooperative agreement to the Aeras Global Tuberculosis Vaccine Foundation (Aeras). CDC has provided technical assistance including assisting in the development of laboratory capacity and referral systems to treat and cure patients with TB, developing protocols for epidemiologic studies, observational cohort studies, and refine information on TB prevalence and incidence in neonatal and adolescent cohorts in the trials site.

Item

Immunization Safety – The committee commends the CDC for moving the Immunization Safety Branch (ISB) out from under the National Immunization Program (NIP) to the office of the Director of Science. This is a positive step. The committee urges the CDC to carefully review and implement the recommendations in the Institute of Medicine report: Vaccine Safety Research, Data Access and Public Trust. The Committee is particularly interested in the CDC prioritizing IOM recommendations that the CDC (1) establish an independent oversight board to review CDC's vaccine safety research agenda, study protocols, and changes in study protocols, and (2) initiate conversations with Managed Care Organizations involved in the Vaccine Safety Datalink to ensure that independent researchers have access to all VSD data, particularly post-2000 data through the National Center for Health Statistics. (Page 38)

Action taken or to be taken

The recommendations outlined in the IOM's report entitled Vaccine Safety Research, Data Access and Public Trust are currently under review by both CDC and the Department of Health and Human Services (HHS). CDC is planning to implement many of the recommendations outlined in report. Discussions surrounding establishing a independent oversight board for review of CDC's vaccine safety research agenda, study protocols, and changes in study protocols have been initiated with the National Vaccine Program Office (NVPO) and the National Vaccine Advisory Committee (NVAC). CDC has also been discussing with the Managed Care Organizations involved in the Vaccine Safety Datalink (VSD) Project additional options for ensuring that independent researchers have access to VSD data.

Item

Vaccine Safety Research – The Committee recognizes the importance of directing additional funding toward vaccine safety research, specifically funding to develop better screening methods for children at risk for serious adverse reactions. The Committee recommendation includes \$3,000,000 above the request for the CDC to expand funding for vaccine safety research, particularly with respect to investigator initiated, peer-reviewed, extramural research. Furthermore, the Committee urges that this funding be used for non-epidemiology research, to better understand risk factors for serious adverse reactions, to develop screening tools to eliminate from vaccination those children at greater risk for such reactions, and to develop effective treatments and interventions for children suffering severe adverse reactions. (Page 39)

Action taken or to be taken

CDC will assess the current vaccine safety portfolio and determine what additional research would be useful to help further answer the important research questions related to this issue. In addition, CDC will be actively engaged with its partners to decide the direction of the additional funding of \$1,494,000, awarded by the LHHS House Conference Committee. A competitive process will be created so that investigator initiated, peer-reviewed, extramural research can be conducted. CDC will collaborate with the grantees to assure that the funding is used for non-epidemiology research, to better understand risk factors for serious adverse reactions, to develop screening tools to eliminate from vaccination those children who are at greater risk for adverse reaction, and to develop effective treatments and intervention for children suffering severe adverse reactions.

Item

State-based model programs and research – The National Center for Chronic Disease Prevention and Health Promotion at CDC supports research and programs to prevent the leading causes of death and disability (e.g., heart disease and stroke, cancer, diabetes, and arthritis) that are among the most prevalent, costly, and preventable of all health problems. CDC plays a leadership role in coordinating and catalyzing the efforts of numerous public and private partners, which allows CDC to substantially extend its effectiveness in reaching people at highest risk for chronic disease. The Committee recognizes the essential infrastructure that CDC has built in State health departments and encourages CDC to expand its State-based leadership in surveillance, public health education, communications and model programs and research. The Committee urges the CDC to examine ways of maximizing the federal investments in prevention, such as incorporating performance measures into State and local health

department cooperative agreements where they may not currently exist, including incentives or requirements for state and local matches of federal funds, and/or streamlining funding mechanisms to focus on common risk factors among the leading chronic conditions. (Page 39)

Action taken or to be taken

CDC appreciates the Committees support for its research and state-based programs to prevent chronic disease. CDC will continue to expand its leadership role in coordinating and catalyzing the efforts of numerous public and private partners to prevent chronic disease. CDC's Prevention Research Centers is the National Center for Chronic Disease Prevention and Health Promotion's largest extramural research program. It has a long history of collaboration with state-based programs to ensure that research findings are reaching people at highest risk for chronic disease.

CDC provides extensive technical assistance and training to its state-based programs, and convenes the states in a network of programs all working on the same disease or risk factor for training and information sharing on how to achieve success. States are encouraged to identify and leverage opportunities that can enhance efforts to address related chronic diseases or risk factors. This may include cost sharing of positions, joint planning activities, joint funding of complementary activities, coalition alliances, and joint public health education. Furthermore, CDC also encourages combined development and implementation of environmental and policy activities, systems, and community interventions and other cost sharing activities that cut across chronic disease programs.

All state-based programs are required to evaluate the impact of their activities and report on program outcomes. Performance measures must be objective and quantitative and measure the intended outcome of the program. The evaluation measures provide an opportunity for CDC to work with states and make programmatic adjustments as needed to improve program effectiveness. CDC also reaches out to other organizations to leverage their efforts to prevent a disease or risk factor in collaboration with states and CDC programs. The synergy of these efforts captures national attention (e.g. to cancer, heart disease, diabetes, obesity, or tobacco use) and is a major force in getting important health messages out to families, communities, and individuals.

Item

Adolescent Health – The Committee encourages the CDC to maintain a focus on public health issues confronting adolescents, including maintaining support of the National Network of State Adolescent Health Coordinators (NNSAHC) Annual Meeting, which brings together specific expertise on the health issues that face adolescents and on the special programmatic considerations for this population. (Page 40)

Action taken or to be taken

CDC recognizes that adolescence is a transitional life stage between childhood and adulthood and many risks to adolescent health begin during earlier life stages. By the time children reach adolescence, they have already developed many of the risk factors that will have a health impact later in adulthood. CDC recognizes the need to develop stronger adolescent health programs to begin to address some of the most serious and costly problems threatening the health of our nation's youth.

CDC recognizes the critical role played by the State Adolescent Health Coordinators in addressing the health needs of our nation's young people. CDC is currently soliciting proposals under a new national non-governmental program announcement. This announcement will enable organizations such as the National Network of State Adolescent Health Coordinators (NNSAHC) to apply for funding to support public health issues confronting adolescents.

Item

Alzheimer's disease – A growing body of evidence suggests that many of the same strategies that preserve overall health may also help prevent or delay the onset of Alzheimer's disease and dementia. In fiscal year 2005, CDC, in cooperation with the Alzheimer's Association, launched a new program aimed at educating the general public and health professionals on ways to reduce the risks of developing Alzheimer's disease by maintaining a healthy lifestyle. The Committee supports this initiative and urges CDC to consider expanding it within the funds made available for fiscal year 2006. (Page 40)

Action taken or to be taken

CDC and the Alzheimer's Association are collaborating on a multi-faceted approach to promote brain health through the adoption and maintenance of healthy lifestyles. This collaboration presents a unique and much welcomed opportunity for both organizations to identify public health opportunities and develop a needed roadmap of recommended public health strategies to address brain health, a critical health issue for all Americans. CDC has created a new Alzheimer's segment of the Healthy Aging Program, which works to educate the public and health professionals about healthy lifestyles and general brain health. As part of this collaboration, the Alzheimer's Association is launching a community-based demonstration project to promote a brain-healthy lifestyle. A key

component of this project will be the Alzheimer's Association's Maintain Your Brain™ workshop, and other educational resources to support the adoption of brain-healthy lifestyles.

CDC and the Alzheimer's Association are developing a national public health action plan to address brain health that will be released in 2007. As part of this effort, CDC and the Alzheimer's Association have convened a Steering Committee to provide guidance and coordination for the development of the national action plan, including representatives from the National Institutes of Health, Administration on Aging, and other public health and aging organizations.

Item

Breast and Cervical Cancer Screening – The Committee commends the CDC for creating partnerships to address the early detection of breast cancer, particularly in historically underserved communities, including the Native American, Hispanic and African American populations. As part of this initiative, the Committee is very interested in the innovative approach of the Men Against Breast Cancer Partners In Survival Program focusing on the role of the male support-giver as an integral component of the early detection, patient care and survivorship of breast cancer. The Committee encourages CDC's continued support of programs of this type that might also have secondary benefits, such as greater participation of the male support-giver in their own health management, including early-detection and health screening activities. (Page 40)

Action taken or to be taken

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) currently provides breast and cervical cancer screening and diagnostic support in all 50 states, the District of Columbia, 4 U. S. Territories, and 13 tribes and tribal organizations. The NBCCEDP supports an array of strategies that include public education and outreach; professional development; screening; tracking; follow-up; case management services; and partnerships. Since its inception in 1991, the national screening program has provided more than six million screening tests to nearly three million women. The program has diagnosed more than 22,000 breast cancers, approximately 77,000 precancerous cervical lesions, and over 1,500 cases of invasive cervical cancer.

CDC agrees that the success of the NBCCEDP has historically depended upon the complimentary efforts of national, state, and local partnerships that provide a variety of education and outreach services to diverse populations. CDC continues to support and foster partnerships with other national organizations like the Men Against Breast Cancer, the Patient Advocate Foundation, the Asian and Pacific Islander American Health Forum, and others to deliver cancer education and awareness activities and increase cancer survivorship for individuals who may be underserved, uninsured or underinsured, at risk, or of various racial and ethnic minorities.

Item

Colorectal Cancer – The Committee is pleased with the leadership of CDC's National Colorectal Cancer Roundtable in promoting the availability and advisability of screening to both health care providers and the general public. The Committee encourages the CDC to continue to expand its partnerships with state health departments, professional and patient organizations, and private industry to combat this devastating disease. (Page 41)

Action taken or to be taken

In the fall of 2005, CDC awarded \$2.1 million to establish a new colorectal cancer screening demonstration program to increase screening among Americans, aged 50 years or older. Five program sites have been selected to participate in this 3-year program. Each site will focus efforts on screening low-income men and women who have inadequate or no health insurance coverage for colorectal cancer screening.

CDC will continue to support and promote national colorectal cancer screening by educating health care providers and the public about the benefits of screening, the availability of screening procedures, and screening guidelines. CDC also works with partners like the American Cancer Society to support the National Colorectal Cancer Roundtable, a coalition of organizations that educate medical providers and the public about the importance of colorectal cancer screening. In addition, CDC funds comprehensive cancer control programs to integrate the full range of cancer control activities to better maximize resources, improve community-based education and health promotion, share expertise, and effectively reach at-risk populations.

CDC funds various research and surveillance activities to expand the knowledge base, analyze data, and fund prevention and intervention research projects related to colorectal cancer. The results of these efforts allow CDC to focus its policies, programs, and efforts toward the goals of increasing screening rates and reducing deaths from colorectal cancer in the U.S. population.

Item

Cancer Survivorship – The Committee supports the ongoing partnership between CDC and the Lance Armstrong Foundation (LAF) to address the needs of the nearly 10 million cancer survivors. The Committee encourages CDC to

enhance support for the Live Strong, National Cancer Survivorship Resource Center, to serve cancer survivors and their families across the country. (Page 41)

Action taken or to be taken

CDC continues to work with the Lance Armstrong Foundation to address the needs of cancer survivors, their family members, friends, and caregivers. In fiscal year 2005, CDC funded the LAF for a five-year LIVESTRONG cooperative agreement grant to support the National Cancer Survivorship Resource Center. This funding assistance to LAF has enhanced a previously established resource center that assists individuals' understanding of some of the physical, emotional and practical issues that may be apart of dealing with the disease.

CDC and LAF have partnered to create, implement, and evaluate the LIVESTRONG™ Resource for Cancer Survivors. The LIVESTRONG™ Web site at www.livestrong.org provides information about the physical, emotional, and practical issues of people living with cancer often face. This interactive Web resource is designed for people living with cancer, their families and friends, their caregivers, and their healthcare team. The LIVESTRONG™ Survivorship Notebook can help organize and guide someone's cancer experience. This portable, three-ring binder contains a variety of information covering a full range of physical, emotional and practical survivorship topics, survivorship tools, and selected stories to assist cancer survivors in understanding long-term effects of cancer.

As part of the CDC/LAF relationship, LAF will be embarking on a systematic evaluation to assess the impact the program has in improving the quality-of-life for participants.

Item

Diabetes – The Committee commends CDC for implementation of SEARCH, a pilot study to determine the incidence and prevalence of diabetes in youth under the age of 20 years in six locations around the United States. The Committee encourages the CDC to consider developing a plan to use the information gathered from SEARCH to create a national registry of patients afflicted with juvenile diabetes. In addition, the Committee urges the CDC to examine the feasibility of collecting information about the standard of care available to people with diabetes nationwide and consider making samples from this study available to the research community. CDC should be prepared to report to the Committee on these issues during the fiscal year 2007 budget hearings. (Page 41)

Action taken or to be taken

One of the primary goals of the CDC's SEARCH project is to estimate the number of new (incidence) and existing (prevalence) childhood diabetes cases by type, age of the child, sex, and racial or ethnic group. In time, the SEARCH study will also describe the clinical characteristics of different types of diabetes in youth and how these types evolved and the complications of diabetes and the quality of life of children and adolescents with diabetes, and it will develop a uniform classification of types of childhood diabetes.

The sentinel sites involved in the SEARCH study will provide reliable data that can be used to calculate national incidence and prevalence data using synthetic estimates. These synthetic national estimates will provide useful information for public health policy formulation, research, and program planning. Rather than establishing state or national registries for diabetes surveillance, CDC recommends the use of the synthetic national estimates as a cost effective, efficient and adequate means to monitor the burden of childhood diabetes. In general, registries are difficult and expensive to develop and maintain. Also, registries require intensive monitoring to ensure accurate disease reporting. Additionally, registries present complex and on-going issues related to privacy and protection against discrimination.

CDC is actively engaged in monitoring the standard of care available to people with diabetes. CDC published A Diabetes Report Card for the United States: *Quality of care in the 1990s* (Annals of Internal Medicine, 2002) and will publish an updated report in 2006 to document the quality of diabetes care. CDC and other federal agencies also publish articles and reports and make presentations at national meetings (e.g. Annual Meeting of the American Diabetes Association) that provide the most current information relative to diabetes standards of care. To help share the reports with the general public, CDC also posts the information on the CDC diabetes program website.

Item

Epilepsy – The Committee provides \$8,000,000 for Epilepsy activities, which is \$440,000 above fiscal year 2005. The Committee supports the CDC's epilepsy program and applauds the collaboration the Agency developed with the Epilepsy Foundation in crafting the recommendations of Living Well With Epilepsy II. The Committee encourages CDC to maintain support for ongoing epilepsy public health programs as well to begin implementation of the new recommendations from Living Well With Epilepsy II as funds become available. It is also expected that CDC be prepared to report on the current results on implementation of those recommendations and future plans, including those involving coordination with other agencies, during the fiscal year 2007 budget hearings. (Page 41)

Action taken or to be taken

In partnership with the National Epilepsy Foundation, CDC has built a highly successful public health response to epilepsy. CDC's Epilepsy Program has been on the forefront of establishing partnerships, utilizing an existing infrastructure (the National Epilepsy Foundation and local affiliates) and delivering direct public education.

CDC and the Epilepsy Foundation convened two highly visible national forums, "Living Well with Epilepsy" and "Living Well with Epilepsy II" to provide input and direction to public health's response to epilepsy. Recommendations from those forums have shaped public health's response to epilepsy and continue to inform CDC's work in this area.

The recommendations from the Living Well with Epilepsy forums informed CDC activities in 2005 and 2006. These activities include the continuing national epilepsy awareness campaign. Following the release of a toolkit for teens with epilepsy and a toolkit for parents of teens with epilepsy, CDC in partnership with the Epilepsy Foundation is now implementing a new phase of the national epilepsy campaign focused on Hispanic communities. This phase is being implemented through such national and local partnerships as the Hispanic Radio Network, the National Council of La Raza and the Lay Health Workers National Network.

In addition to the new focus on the Hispanic community, Epilepsy campaign activities will include training high school and middle school students using a curriculum pilot tested in 2005; training school nurses in collaboration with the National Association of School Nurses; continuing a grant program to support local community education and awareness initiatives by affiliates of the Epilepsy Foundation; developing a curriculum for first responders; analyzing and disseminating information from the 2005 Behavioral Risk Factor Surveillance Survey data; and pilot testing a toolkit for parents of teens with epilepsy.

Intramural and extramural research activities will continue to better understand the epidemiology of epilepsy, specifically, the incidence and prevalence of epilepsy in diverse populations in the U.S., including potentially underserved communities; risk factors and severity of epilepsy in these communities; health disparities and factors contributing to health disparities among people with epilepsy; and process and outcome measures that may be used to define optimum care in epilepsy. CDC will continue to work with Prevention Research Centers to evaluate self-management programs for adolescents and adults with epilepsy.

Item

Genomic Medicine – The Committee understands that steps need to be taken now to prepare the public health system for the expected widespread future use of genetic technologies in healthcare. The Committee encourages CDC to move forward aggressively with the creation and implementation of partnerships with industry and the nonprofit sector to achieve the widest benefits from the coming era of genomic medicine. (Page 41)

Action taken or to be taken

CDC agrees that aggressive steps are needed to prepare for the proper use of genomic technologies to prevent disease and improve health. CDC is ready to create and implement partnerships with industry and the nonprofit sector to achieve the broadest public health impact across the lifespan. In 2006, CDC's Office of Genomics and Disease Prevention plans to continue work in three major focus areas: family history, evaluation of genetic tests, and describing the distribution of relevant genetic markers in the population.

Family health history is a low-cost, low-tech "genomic" tool that can be used today in disease prevention and health promotion. CDC has created a web-based tool called Family Healthware™, which collects information about a person's family history for six diseases – heart disease, stroke, diabetes, and colorectal, breast, and ovarian cancer. Three research centers are currently conducting a clinical trial of the family history tool. A pending patent will also make the tool available for use by industry and nonprofit organizations.

New genomic technologies, such as genetic tests, are developing rapidly and are already being marketed to health care professionals and directly to the general public. However, evidence for their validity and usefulness is often insufficient to inform decision-making. Recognizing this information need, CDC launched the Evaluation of Genomic Applications in Practice and Prevention (EGAPP) project in FY2005. An independent panel of experts will commission reviews of the analytic and clinical validity and the clinical utility of important genetic tests. This information will be disseminated widely to physicians, health insurers, managed care organizations, industry, nonprofit organizations, public health agencies and the general public.

Information on the population distribution of relevant genetic markers is needed to design and interpret the clinical trials fundamental to development of genomic medicine. CDC is collaborating with the National Cancer Institute to measure population variation in selected genes using stored DNA samples collected during the National Health and Nutrition Examination Survey (NHANES) III. The results--which will be made available to researchers, industry and the public--will provide an important basis for estimating the proportions and numbers of people who could benefit from particular genotype-based screening or diagnostic tests, drugs, or other preventive or therapeutic interventions.

Item

Heart Disease and Stroke – The Committee understands that the CDC is creating a Heart Disease and Stroke Division to consolidate and elevate its efforts to prevent and control heart disease, stroke and other cardiovascular diseases and is supportive of this effort. The Committee supports the goal of implementing statewide heart disease and stroke prevention programs and urges the CDC to maintain and expand its support for these activities within the funds provided for fiscal year 2006. (Page 41)

Action taken or to be taken

In July 2005, CDC announced the formation of a new Division for Heart Disease and Stroke Prevention, which will substantially advance CDC's work to prevent and control heart disease and stroke, the principal components of cardiovascular disease, and our nation's first and third leading causes of death. Over the coming months, CDC will be establishing the new division during the transition phase and putting into place a leadership team.

CDC remains committed to supporting statewide heart disease and stroke prevention programs. Over the past three years, CDC has expanded funding to 32 states and the District of Columbia for heart disease and stroke prevention programs – including 18 states and DC for initial capacity building and 14 states for basic program implementation. CDC also funds four statewide Paul Coverdell Stroke National Acute Stroke Registries and three regional stroke networks at the state level, and three statewide cardiovascular health examination surveys. These programs are producing results. For example, among participating health plans in Wisconsin, the percentage of patients who had high blood pressure controlled increased by nearly 21% from 2000 to 2003.

Item

Infertility Prevention – The Committee understands that there are other causes of infertility beyond sexually transmitted diseases, such as delayed child bearing, smoking, low or excessive body weight, exposure to hazardous environmental toxins, drug and alcohol abuse and, particularly for men, exposure to high temperatures. The Committee encourages CDC to consider expanding the scope of the Agency's efforts regarding the prevention of infertility and to providing greater support to public education on the broader risks to fertility. (Page 42)

Action taken or to be taken

CDC monitors success rates of Assisted Reproductive Technology (ART) clinics and uses these data to help analyze factors related to reduced fertility and infertility, and the safety of ART procedures. More than 1% of US births are now ART-related, representing more than 48,000 births in the most recent year (2003). In collaboration with Massachusetts, CDC is linking ART surveillance data with birth and death records for infants born to Massachusetts resident mothers. This data set will allow for more detailed analyses of maternal and infant health outcomes.

CDC's Pregnancy Risk Monitoring System (PRAMS) provides the foundation for improving maternal and child health programs across the country and in measuring success of those programs. In FY 05, PRAMS expanded to cover more than three quarters of U. S. births. Through PRAMS, states are able to monitor trends and improve the health of women and infants. PRAMS data track health indicator and behavior issues such as smoking during pregnancy, pre-pregnancy weight, alcohol consumption, and other factors affecting pregnancy and birth outcomes. These data are used in implementing the Maternal and Child Health Block Grant program, funded by the Health Resources and Services Administration.

In addition, recent CDC studies include findings that gestational diabetes mellitus has been associated with adverse maternal and infant outcomes, including high blood pressure and high birth weight. Cigarette smoking has been associated with increased insulin resistance, showing an association between smoking and gestational diabetes mellitus.

Item

Inflammatory Bowel Disease – In fiscal year 2005, the Committee provided funds to continue a national IBD epidemiology program established through a partnership between CDC and the Crohn's and Colitis Foundation of America. The Committee encourages the CDC to continue this initiative in fiscal year 2006. (Page 42)

Action taken or to be taken

CDC has collaborated with the Crohn's and Colitis Foundation of America (CCFA) to estimate the incidence and prevalence of Crohn's Disease and Ulcerative Colitis. With fiscal year 2006 funds, CDC and CCFA will progress to the next phase of the research project and collaborate with a large single health care plan to examine the diagnosis and treatment of IBD. The project will use direct access to a patient population to understand patient and disease characteristics such as patient demographics, type and severity of IBD and co-morbid conditions. Because there is little understanding of the consistency and quality of treatment given to IBD patients in the community setting, the research project will examine adherence to current practice guidelines and barriers to implementing guidelines in community practice.

Item

Interstitial Cystitis (IC) – The Committee is pleased by the establishment of a cooperative agreement between the CDC and the Interstitial Cystitis Association and has provided sufficient funds to continue the campaign to educate the public and professional community about IC. (Page 42)

Action taken or to be taken

CDC has developed a cooperative agreement with the Interstitial Cystitis Association (ICA) to enhance awareness and educate the public and health care providers about interstitial cystitis. An initial meeting of key stakeholders was held in September, 2005 which included representatives from the ICA, CDC, the National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK), and the American Urology Association (AUA). Campaign target audiences, priorities of the campaign, and immediate tasks to be completed were developed from this meeting. An IC Awareness Advisory Council (AAC) was developed which includes representatives from the ICA, CDC, NIDDK, and AUA. This advisory council convenes monthly to provide guidance and coordination and to track progress made in developing the health communications campaign. Stakeholder interview scripts and questions regarding physician knowledge about IC were drafted and finalized for health care providers. Interviews with health care providers will commence in early 2006. A communications audit and analysis of existing health communications materials for interstitial cystitis was conducted to develop recommendations to enhance existing IC messages to the public and health care providers. A web site analysis of the ICA website will be conducted in early 2006 and recommendations made to make necessary web site improvements to enhance usability. An IC awareness and information page will also be developed on the CDC web site in 2006. IC awareness messages and educational materials for health care providers and the general public will be developed and market-tested in 2006 with customer feedback solicited. Outreach to underserved populations such as, Native Americans, African Americans, Hispanics, etc. will be highlighted.

Item

Kidney Disease – The Committee urges the CDC to develop the capacity and infrastructure for a kidney disease surveillance, epidemiology, and health outcomes program, including awarding grants to support several state-based demonstration projects for chronic kidney disease prevention and control. Furthermore, the Committee urges CDC, in partnership with the relevant national voluntary health organization, or organizations, convene a consensus conference of experts in the area of kidney disease and other stakeholders to lay the groundwork for a formal Public Health Kidney Disease Action Plan for prevention and control of kidney disease. (Page 42)

Action taken or to be taken

CDC shares the Committee's concern regarding chronic kidney disease and will work quickly to establish a program with the new funding received in fiscal year 2006. CDC will initiate vital public health surveillance and epidemiologic research activities which will inform policy decisions and program planning for chronic kidney disease prevention and control. CDC will also work with key public and voluntary organization partners to bring together experts and stakeholders in the kidney disease arena to develop a National Public Health Kidney Disease Action Plan. These activities will lay the groundwork CDC needs to launch state-based demonstration projects for chronic kidney disease prevention and control.

Item

Oral Health – The Committee is concerned about the rising obesity rate among America's youth. Some eating habits can adversely affect not only body weight but also oral health. The Committee understands that the dental community has developed some instructional materials and encourages the CDC to work with the American Dental Association in producing an instructional video for school-aged children on the harmful effects of excessive consumption of high sugar products, such as soda. (Page 42)

Action taken or to be taken

CDC is convening experts in the areas of oral health, nutrition, and school health to assess the evidence regarding: harmful effects of excessive consumption of high sugar products and beverages, such as soda; current knowledge, attitudes and behaviors of school-age children and adolescents related to dietary practices; and the effectiveness of interventions, including instructional videos. After this review is completed, CDC will work with the American Dental Association to develop appropriate interventions, which may include promoting policy changes in schools to promote healthier dietary practices and the production of appropriate instructional materials for children.

Item

Obesity Prevention – The multiple factors contributing to the overweight and obesity epidemic took years to develop. Reversing the epidemic will require a long-term, well-coordinated, concerted approach to reach Americans where they live, work, play, and pray. Effective collaboration among the public, voluntary, and private sectors is critical to reshape the social and physical environment of our Nation's communities and provide the necessary support,

information, tools, and realistic strategies needed to reverse the current obesity trends nationwide. To reduce consumer confusion about the myriad of health messages about obesity, diabetes, and cardiovascular disease, the Committee strongly urges CDC to design and develop mechanisms for fast-tracked translation of research into reasoned guidance for the American public. In addition, the Committee urges CDC to develop evidenced-based recommendations on body fat measurement to be used in the evaluation of obesity prevention programs. (Page 42)

Action taken or to be taken

CDC agrees that reversing the obesity epidemic will require a long-term, coordinated, and comprehensive approach to reach Americans in all aspects of their lives. Addressing obesity requires understanding the many factors that influence health behavior and then creating targeted action across a socio-ecologic model to affect social change. CDC's portfolio of programs reflects this approach to drive social change and impact health. As examples:

VERB: This 5-year pilot mass media campaign demonstrated the effectiveness of a social marketing approach featuring extensive consumer research, state-of-the-art creative production, and high levels of exposure. Evaluation results showed that the pilot campaign led to increased physical activity levels among 9-13 year olds and stopped the decline in physical activity with age.

Goals and Evaluation Indicators: CDC has recently developed health goals, logic models, and performance indicators specifically for obesity. In the spring we will co-host a meeting with the Robert Wood Johnson Foundation, IOM, Kellogg, and the American Council for Fitness and Nutrition to review this work and to identify suitable indicators for evaluating programs and monitoring progress.

Community Guide: Based on systematic reviews of the scientific literature, CDC's Community Guide presents recommendations for increasing physical activity, promoting healthy nutrition, and reducing overweight and obesity. Interventions include approaches such as community-wide campaigns, behavioral and social approaches such as physical education in the schools, and environmental and policy approaches such as urban design and land use.

Prevention Research Centers: This national network of academic, public health, and community partners focus on linking science and practice. A number of CDC-funded projects focus on innovative approaches to preventing overweight and obesity. For example, investigators at Harvard University are assessing selected neighborhoods in Chicago to determine the impact of neighborhood design and the quality of public transportation on physical activity levels and BMI measurements in youths and young adults. Another Harvard team is exploring how dietary patterns relate to weight gain and the development of obesity among adolescents.

CDC also agrees with the Committee that evaluation of obesity prevention programs through the measurement of changes in body fat, as well as changes in physical activity and dietary behaviors, are essential to document and disseminate effective programs and services. CDC acknowledges that there are a number of accepted methods to measure and/or estimate body fat (i.e., adiposity), such as skin folds, waist circumference, and DEXA (Dual Energy X-ray Absortometry). Each of these methods has varying degrees of validity, reliability and sensitivity that have been established through a number of published studies. Determining which method should be used for evaluation of obesity prevention programs will be based on these measurement characteristics, as well as the acceptability, feasibility, and cost of each method. Currently, body mass index (BMI, defined as weight in kilograms divided by height in meters squared) is commonly used to estimate adiposity because it is a widely accepted, minimally invasive (can be done simply with height and weight measurement), and a low-cost method.

Item

Obesity and diabetes – The Committee also is very concerned about the adverse health toll that the twin epidemics of diabetes and obesity are taking on the health of minorities. The Committee encourages CDC to collaborate with organizations directed by and serving individuals from communities with disproportionate diabetes and obesity rates to ensure that the Agency's prevention efforts effectively reach all communities. (Page 43)

Action taken or to be taken

CDC shares the Committee's concerns regarding the disproportionate impact of diabetes and obesity on racial and ethnic minorities. CDC's efforts include several strategies to address the disproportionate diabetes and obesity rates:

The National Diabetes Education Program (NDEP) has provided competitive funding and technical assistance to national minority organizations (NMOs) to promote culturally appropriate diabetes prevention and control resources and strategies in their communities since 1999. Initially, NDEP funded four NMOs for three years; in fiscal year 2005 CDC awarded eight organizations for five years to promote diabetes education strategies in minority communities.

The newly funded organizations and their strategies are:

- The Association of American Indian Physicians will work to improve knowledge, attitudes, beliefs and behaviors related to the prevention, early detection and control of diabetes.
- The Black Women's Health Imperative's will focus on improving diabetes awareness and education in a total of 48 church congregations across 12 states.
- The Khmer's National Cambodian American Diabetes Project will promote diabetes awareness and deliver education messages, interventions and products to Cambodian communities nationwide.
- The National Alliance for Hispanic Health's "Juntos Contra la Diabetes" program (JCD-United Against Diabetes) will design and implement local Hispanic diabetes action plans with culturally appropriate diabetes education and community outreach resources.
- The National Association of School Nurses will work in six large urban school districts that are at high risk for diabetes and being overweight. They will provide positive messages about the management of type 1 and the prevention of type 2 diabetes for primarily African American students in the 4th and 5th grade.
- The National Latina Health Network will implement an innovative peer-education program in Spanish and English.
- The National Medical Association will increase awareness of diabetes prevention and control strategies and promote diabetes education, diet, nutrition, and exercise programs.
- Papa Ola Lokahi will identify diabetes awareness and education priorities in Hawaiian and Pacific Islander communities.

CDC has made substantial strides in reducing racial and ethnic disparities in health by working in partnership with local communities through CDC's Racial and Ethnic Approaches to Community Health (REACH) 2010 program. REACH 2010 supports community coalitions in the design, implementation, and evaluation of unique community-driven strategies to eliminate health disparities. REACH 2010 addresses racial and ethnic disparities in infant mortality, breast and cervical cancer, cardiovascular diseases (CVD), diabetes, HIV/AIDS and immunizations. The communities served by REACH 2010 include: African Americans, American Indians, Hispanic Americans, Asian Americans, Pacific Islanders and Alaska Natives. CDC currently funds 40 communities, five are tribes and tribal organizations under the American Indian/Alaska Native Core Capacity Building program. Of these 40 communities, 13 communities are addressing diabetes specifically and another 7 are addressing it as a co-morbidity.

In addition, CDC is funding the YMCA for a four-year Steps to a HealthierUS cooperative agreement grant to support the Steps Communities in addressing the obesity and diabetes epidemics. The YMCA's strong presence in the community, with local chapters nationwide, provides an ideal opportunity to build strong partnerships and increase the capacity and impact of Steps communities in efforts related to obesity, diabetes and asthma.

Item

Obesity education for children – To prevent unhealthy weight gain and maintain healthy weight among children and adolescents, CDC is urged to work with the U.S. Department of Education to issue a report with recommendations about reintroducing school physical education into the school day. (Page 43)

Action taken or to be taken

CDC works closely with the U.S. Department of Education in addressing efforts to reduce and prevent overweight and obesity in children and adolescents. CDC consistently seeks input and review from the U.S. Department of Education on physical and health education materials. In February 2006, CDC will release the Physical Education Curriculum Analysis Tool (PECAT). The PECAT is an innovative, practical tool that will enable the Nation's physical educators to assess the quality of school physical education curricula and revise those aspects of their curricula that do not align with national physical education standards. In addition, CDC is currently revising the Guidelines for Schools to Promote Lifelong Physical Activity and Healthy Eating for Health Promotion and Obesity Prevention among Young People. The new Guidelines will include a new section on obesity.

Furthermore, CDC funds 28 states to prevent obesity and other chronic diseases through science-based interventions addressing both poor nutrition and inadequate physical activity. Through these efforts, the Division of Nutrition and Physical Activity works closely with CDC's Division of Adolescent and School Health to ensure cooperative agreement grants and other related efforts through schools are coordinated through the appropriate education agencies and staff.

Item

Obesity in abused children – Finally, the Committee supports research into the link between disadvantaged or physically and sexually abused youth, and obesity programs that target the physical health of children who have been abused and are in treatment programs. The CDC is encouraged to partner with organizations that treat or otherwise serve youth who have been abused in efforts to identify links between abuse and obesity and programs to address childhood obesity among this population. (Page 43)

Action taken or to be taken

CDC's Adverse Childhood Experiences (ACE) Study has demonstrated that the number of adverse childhood experiences has a strong relationship to health-related behaviors and outcomes during adolescence and adulthood. These behaviors and outcomes include early initiation of smoking, sexual activity, illicit drug use, suicide attempts, and the development of adult chronic diseases, including obesity.

Data published from the ACE Study in the International Journal of Obesity found that abuse (sexual, verbal, and physical) during childhood was associated to increased body weight and higher risk of obesity in adulthood. In addition, obesity risk increased with the number and severity of each type of abuse examined. Another study released in the June 2005 issue of American Journal of Preventive Medicine found that sexual abuse among both male and female survivors was associated with long-term social, behavioral, and mental health outcomes.

In fiscal year 2006, CDC will continue to analyze and publish peer-reviewed articles by using the ACE study baseline database and data from the prospective arm of the study, which will include an examination of the impact ACEs have on health care utilization and specific disease outcomes. One study that is scheduled for release in 2006 in the Journal of Adolescent Health examines the association of adverse childhood experiences to initiation of alcohol use during adolescence. Another study scheduled for release in 2006 in the European Archives of Psychiatry and Neurosciences provides a brief review of the neurobiology of childhood trauma and presents the ACE Study as an epidemiological "case example" of the effects of childhood trauma on changes in brain structure and function and stress-responsive neurobiological systems. The Department of Defense is currently working on a Collaborative ACE Study at the request of the Assistant Secretary of Defense for Health Affairs, to examine applications within the military. In February of 2006, an expert review panel will convene to properly examine how the military might address adverse childhood experiences and to review previous studies conducted within the military.

Item

Osteoporosis – The Committee is aware of the report issued by the Surgeon General on Bone Health and Osteoporosis requested in the fiscal year 2002 Appropriations bill. In the report, the Surgeon General calls for a national action plan for bone health. The Committee urges the CDC to consider supporting the development of an action plan and to ensure that all relevant federal agencies and public and private stakeholders, including the National Osteoporosis Foundation, be involved in the development of any such plan. (Page 43)

Action taken or to be taken

CDC played an active role in developing the Surgeon General's Report on Bone Health and Osteoporosis, which include recommendations for a systems-based approach to bone health that draws upon the entirety of the health care delivery system and a coordinated public health approach that brings together a variety of stakeholders to improve bone health that starts in childhood. CDC has conducted partnership meetings in 2004-2005 with representatives from Federal agencies, state and non-profit organizations (in particular, the National Osteoporosis Foundation) to inform them of the National Bone Health Campaign and to discuss collaborative projects.

CDC is currently developing a draft 5-year social marketing plan for bone health and will leverage this plan with the Surgeon General's Report. The plan will include an audience-based campaign and an evaluation program. The major goals in 2005 were to plan, design, and develop a social marketing pilot study to be executed in 2006; solidify partnership and stakeholder opportunities and secure Memorandums of Understanding with faith and community based organizations, the private sector, academics, and non-profit organizations, to include the National Osteoporosis Foundation.

Item

Pulmonary Hypertension – The Committee continues to be interested in pulmonary hypertension (PH), a rare, progressive and fatal disease that predominantly affects women, regardless of age or race. Because early detection of PH is critical to a patient's survival and quality of life, the Committee continues to encourage CDC to work in partnership with the pulmonary hypertension community to foster greater awareness of the disease. (page 43)

Action taken or to be taken

Because early diagnosis and aggressive treatment are critical to improve the prognosis of those with pulmonary hypertension, increased public and health care provider awareness of the signs and symptoms of pulmonary

hypertension is important. In fiscal year 2004, CDC funded the Pulmonary Hypertension Association to create a DVD to educate physicians on the symptoms and diagnosis of pulmonary hypertension. The initial target audience is clinicians who are most likely to receive referrals from primary care physicians – cardiologists, pulmonologists and rheumatologists.

CDC is also exploring opportunities to work on collaborative studies and surveillance reports with the Pulmonary Hypertension Association and other partners such as the American Heart Association and the National Heart Lung and Blood Institute. In November of 2005, CDC published a surveillance summary on pulmonary hypertension, which found that the numbers of deaths and hospitalizations rates have increased for persons with pulmonary hypertension, particularly among women, blacks, and older adults. Two distinct geographic clusters were observed for the highest hospitalization rates in the Medicare population and the highest death rates for pulmonary hypertension, in the western United States and in the Appalachian region. These increases in deaths and hospitalizations may reflect increased physician awareness and changes in diagnosing and reporting this chronic disease. In fiscal year 2006, CDC will continue to work with the Pulmonary Hypertension Association to foster greater awareness of pulmonary hypertension.

Item

School Health – The Committee urges the CDC to prioritize obesity prevention in proportion to its burden on childhood and adolescent health through the Division of Adolescent School Health (DASH). CDC should urge states to use existing program funds to address this critical epidemic. (Page 43)

Action taken or to be taken

Addressing obesity requires an understanding of the many factors that influence health behavior and then creating targeted action model to affect social change. CDC's programs reflect a comprehensive approach to address obesity including state- and community-based efforts, school-based programs, and health communication programs. CDC recognizes that many patterns of behavior are set at an early age.

CDC is investing substantial resources to address obesity prevention in childhood and adolescents. CDC's Comprehensive School Health program promotes the use of a coordinated approach that combines quality education, services, and environments that support healthy eating and physical activity among young people. CDC continues to fund 23 states to implement a coordinated school health program. These states are encouraged to implement CDC's 10 strategies for helping schools to prevent obesity <http://www.cdc.gov/HealthyYouth/KeyStrategies>.

Furthermore, CDC funds 28 states to prevent obesity and other chronic diseases through science-based interventions addressing both poor nutrition and inadequate physical activity. Through these efforts, the Division of Nutrition and Physical Activity works closely with CDC's Division of Adolescent and School Health to ensure cooperative agreement grants and other related efforts through schools are coordinated through the appropriate education agencies and staff.

Item

Sleep Disorders – The Committee remains concerned about the prevalence of sleep disorders and recognizes the need for enhanced public and professional awareness on sleep and sleep disorders. The Committee encourages CDC to work with other agencies, such as the National Center on Sleep Disorders Research, and voluntary health organizations, such as the National Sleep Foundation, to support the development of a sleep education and public awareness initiative. (Page 43)

Action taken or to be taken

Surveillance conducted at CDC has previously indicated that sleep insufficiency is associated with impairments in both quality of life and self-reported general health, and, notably that the strength of these associations varies inversely with age. CDC plans to analyze data from a new Behavioral Risk Factor Surveillance System (BRFSS) module specifically assessing depressive disorders, which will better enable researchers to address the complex interrelationship widely reported between sleep and depressive disorders. CDC continues to participate in the Frontiers in Knowledge in Sleep and Sleep Disorders program and the State-of-the-Science Conference of Manifestations and Management of Chronic Insomnia in Adults, both sponsored by the National Institutes of Health (NIH). CDC also serves in an advisory capacity as an ex-officio member of the Sleep Disorders Research Advisory Board coordinated by the National Heart, Lung, and Blood Institute within NIH.

Item

Vision Screening and Education – The Committee commends CDC for its partnership with a leading voluntary health association dedicated to fighting blindness and saving sight, to improve education and early detection of potentially blinding eye diseases and encourages CDC to continue and expand this partnership. Despite the fact that half of all blindness can be prevented through education, early detection and treatment, it is estimated that the number of blind and visually impaired people will double by 2030 if nothing is done to curb vision problems. To

address this growing public health problem, the Committee provides \$2,500,000 to enhance the CDC national vision screening and education program and the CDC partnership with Prevent Blindness America. (Page 44)

Action taken or to be taken

CDC is pleased with the progress that the National Vision Program (NVP) is making. CDC continues to work with national voluntary partner organizations including Prevent Blindness America to achieve the following goals: developing and maintaining initiatives for adult vision screening, developing a national data collection system, and building capacity for adult vision projects. CDC is expanding its partnerships and sharing information with the public by presenting at national conferences and the Administration on Aging's White House Council on Aging forum, and publishing articles. CDC was also invited to present to the Congressional Vision Caucus. The NVP surveillance accomplishments include establishing a Vision module for use in the national Behavioral Risk Factor Surveillance System Survey. Five states used the module in 2005 and it is anticipated that as many as 10 will use the module in 2006. CDC also included visual field testing in the National Health and Nutrition Examination Survey, through collaboration with the National Eye Institute. Over the next year the NVP will publish two economic studies—one on the cost of vision loss and eye diseases, and the other on the cost effectiveness of vitamin therapy and screening for age-related macular degeneration. CDC will convene a strategic planning meeting in April 2006 in Atlanta. The meeting will involve approximately 15 – 20 vision health experts to assist in the development of a National Vision strategic plan.

Item

Alpha-1 Antitrypsin Deficiency – The Committee is aware that Alpha-1 Antitrypsin Deficiency (Alpha-1) is the major genetic risk factor for Chronic Obstructive Pulmonary Disease (COPD) and cryptogenic liver disease. Early detection allows individuals to engage in preventative health measures and receive appropriate therapies that significantly improve their health status. The Committee encourages CDC to consider collaborating with appropriate patient and professional organizations, such as the Alpha-1 Foundation, to actively support Alpha-1 targeted detection efforts that utilize public and professional education regarding obstructive lung disease, both genetic and tobacco related. (Page 44)

Action taken or to be taken

CDC shares the Committee's concern regarding Alpha-1 Antitrypsin Deficiency (Alpha-1) as a major genetic risk factor for Chronic Obstructive Pulmonary Disease (COPD) and cryptogenic liver disease. CDC looks forward to meeting with representatives from the affected community to discuss ways in which we can work together to address the impact of Alpha-1 Antitrypsin Deficiency.

Item

Birth Defects Surveillance, Research and Prevention – The Committee commends the CDC's work in the area of birth defects surveillance, research and prevention and encourages the CDC to continue its support for birth defects related programs. (Page 45)

Action taken or to be taken

CDC appreciates the recognition of our important work in birth defects surveillance, research, and prevention. We remain committed to support birth defects programs. We currently fund birth defects surveillance and prevention activities in 15 states, birth defects research activities in 8 states, and work with the National Birth Defects Prevention Network to collect birth defects surveillance data from a total of 35 states.

Item

Cooley's Anemia – The Committee is pleased with the progress that CDC has made with regard to the establishment of a blood safety surveillance program for Cooley's anemia patients, who are the largest consumers of red blood cells. Six treatment centers throughout the nation handle the medical monitoring and treatment; the Cooley's Anemia Foundation provides education and awareness, patient recruitment, and other services; and, CDC has created an archive of tested and analyzed blood samples. As the program moves forward and start-up costs are met, the Committee expects CDC to direct an increasing amount of the funds available to education and awareness, patient recruitment and other services. (Page 45)

Action taken or to be taken

CDC remains committed to monitor blood safety and reduce complications among persons with thalassemia, using the successful CDC National Hemophilia Program as a model. In doing so CDC works to increase access to prevention services for persons with thalassemia by supporting prevention education and outreach activities. CDC has expanded the blood safety surveillance program in thalassemia to collect information on other complication risk factors. This program reached several milestones recently including having the data collection form finalized with input from collaborators, IRB approval obtained, and the finalizing of web based data entry programming.

Item

Down Syndrome – The Committee understands that CDC has undertaken a study to estimate the number of people in the United States living with Down syndrome and identify them by age and ethnic group and that it is expected to have preliminary estimates of prevalence of Down syndrome among children and adolescents by the end of fiscal year 2005. The Committee further understands that a second study, to document the onset and course of secondary and related developmental and mental disorders in individuals with Down syndrome, will be initiated by the end of this fiscal year. The Committee recognizes the importance of this research and has provided sufficient funding to further develop the study relating to the onset of secondary and related developmental mental disorders in fiscal year 2006. (Page 45)

Action taken or to be taken

CDC shares the Committee's commitment to increasing understanding of the prevalence of Down syndrome in the United States. Towards this goal, CDC is utilizing data collected through its Atlanta-based birth defects program to determine the number of cases of Down syndrome in the metropolitan Atlanta area by race and age group. These data, along with vital status data, will allow the agency to determine prevalence estimates for children and adolescents in the Atlanta area. As Atlanta may not be representative of other regions in the United States, CDC is also working with other regions of the country to perform similar analyses. These efforts, taken together, will allow for the establishment of national prevalence estimates for Down syndrome among children and adolescents. Obtaining prevalence data on older adults is more difficult due to the limited availability of vital status data prior to the late-1970s. CDC has also begun planning activities regarding the second study, to document the onset and course of secondary and related developmental and mental disorders among individuals with Down syndrome. Current activities include exploring a methodology for assessing the co-occurrence of autism among children with Down syndrome. Planning efforts are also underway to further document other little-understood secondary and coexisting conditions among this population.

Item

Early Hearing Detection and Intervention – ...The Committee is concerned that about one-third of the babies who are referred from hearing screening programs do not receive diagnostic evaluations by the time they are 3 months of age. Moreover, only about half of the infants and toddlers diagnosed with hearing loss are enrolled in appropriate early intervention programs by 6 months of age. The Committee believes that increased funding is required to ensure that States develop appropriate surveillance and tracking systems to provide timely and appropriate diagnostic and intervention services to infants and toddlers. (Page 46)

Action taken or to be taken

Through competitive cooperative agreements awarded in Fiscal Year 2005, CDC provided assistance to 30 states and territories to (1) develop or enhance a sustainable state-based EHDI tracking and surveillance system capable of accurately capturing each birth and tracking each subsequent step throughout the EHDI process, and (2) integrate the EHDI system with other State/territorial screening, tracking, and surveillance programs that identify children with special health care needs. Successful awardees were directed to:

- establish or improve a surveillance and tracking system to document the initial results of hearing screenings and to ensure that, when indicated, infants receive additional screening, diagnostic testing, and early intervention for hearing loss.
- develop or improve integrated reporting systems (e.g. with immunization or birth defects registries) to minimize infants lost to follow-up
- outline an analytic plan to use State/territorial level unduplicated individual EHDI data in order to determine or identify (1) number/percent of infants screened, referred, evaluated, and enrolled in intervention programs; (2) unexpected clusters of infants with hearing loss in particular regions at particular times; (3) unexpected differences in EHDI screening performance between birthing hospitals, racial ethnic subpopulations, gender and geographic location (urban vs. rural); false positive rates; (4) loss to follow-up rates; (5) most favorable developmental indicators such as language scores, socioemotional levels, achievement scores, and or intelligence quotients.

Item

Newborn hearing screening – Funding may also be used to support applied research projects related to increasing the accuracy of newborn hearing screening, improving the effectiveness of tracking and surveillance programs, determining the etiology and epidemiology of childhood hearing loss, and analyzing the costs and benefits of such programs. The Committee encourages CDC to assist States in clarifying how EHDI surveillance, tracking, and data management programs are affected by the Health Insurance Portability and Accountability Act and the Family Education Rights and Privacy Act. (Page 46)

Action taken or to be taken

In FY 2005, CDC provided funding used to support extramural applied research activities to:

- The University of Washington for evaluating the efficacy and accuracy of hospital reporting as well as compliance of primary care monitoring using for late onset hearing loss
- The Children's Hospital of Philadelphia to survey current audiologic practice patterns used for the assessment and management of infants and young children with unilateral and mild hearing loss across the US, determine whether hearing screening targeted in the preschool setting can detect young children at risk for unilateral and mild hearing loss; and study various audiologic management strategies for infants and young children with confirmed unilateral hearing loss.
- The Utah State University to investigate the potential use of integrated child health information systems to improve the follow-up screening rate for infants who fail their initial newborn hearing test and do not return for needed follow-up screenings.

CDC continues to provide technical assistance to EHDI programs to ensure that these programs comply with the privacy protections codified by the Health Insurance Portability and Accountability Act.

Item

Coordination – To avoid duplication and interference, the Committee urges CDC to coordinate projects funded with this appropriation with EHDI projects conducted by the Health Resources Services Administration, the National Institute on Deafness and Other Communication Disorders, the National Institute on Disability and Rehabilitation Research, and the Office of Special Education and Rehabilitative Services. (Page 46)

Action taken or to be taken

Through the National Center on Birth Defects and Developmental Disabilities (NCBDDD) CDC is collaborating with the Health Resources Services Administration, the National Institute on Deafness and Other Communication Disorders and the National Institute on Disability and Rehabilitation Research as well as the Office of Special Education and Rehabilitation Services/ Rehabilitation Services Administration and the Office of Special Education Programs. In particular, CDC has worked with the Office of Special Education Programs to ensure that all state-based EHDI systems are working with Part C Early Intervention Programs so that all children with hearing loss are referred for Part C/ Early Intervention services.

Item

Fetal Alcohol – The Committee is concerned about the prevalence of Fetal Alcohol Syndrome (FAS) in the United States and notes that drinking during pregnancy is the nation's leading known preventable cause of mental retardation and birth defects. The Committee commends the U.S. Surgeon General for releasing an updated advisory in February, 2005, on alcohol use in pregnancy, urging women who are pregnant or who may become pregnant to abstain from alcohol. The Committee urges CDC to work with partner organizations, such as the National Organization on Fetal Alcohol Syndrome, to generate awareness of the Surgeon General's new FAS prevention advisory, especially among high-risk communities. (Page 46)

Action taken or to be taken

CDC shares the committee's concern regarding the prevalence of FAS and is committed to continuing efforts to leverage the visibility raised by the release of an updated advisory from the U.S. Surgeon General. Since its release, CDC has disseminated approximately 15,000 copies of the Surgeon General's advisory as part of its education and outreach activities. In this and other efforts, CDC continues to work closely with FAS prevention colleagues within and outside the government, including the National Organization on Fetal Alcohol Syndrome, to reach women at highest risk for an alcohol-exposed pregnancy.

Item

Folic Acid – The Committee provides \$2,400,000 to support and expand the folic acid educational campaign, which is \$212,000 above fiscal year 2005. The Committee is pleased since fortification of U.S. grain products with folic acid, the rate of neural tube defects has decreased by 26% and encourages CDC to enhance the national campaign to increase the number of women taking folic acid daily. The Committee also encourages CDC to continue to support collaboration among the States on issues related to surveillance, research and prevention through support of the National Birth Defects Prevention Network. (Page 47)

Action taken or to be taken

CDC is also pleased that the rate of the neural tube defects (spina bifida and anencephaly) have decreased since fortification of the US food supply with the B vitamin folic acid. A recent CDC study provided race-specific data on

this decline and found that while the prevalence of these birth defects decreased after fortification among all racial and ethnic groups, the data revealed that the prevalence remains highest among Hispanics. CDC shares the committee's view of the urgency of reaching groups at higher risk for folic-acid preventable birth defects and will work to reach such populations through pursuing manufacturers' voluntary fortification of ethnic foods and through targeted health and marketing programs. Collaboration with CDC-funded and other state and local birth defects programs participating in the National Birth Defects Prevention Network remain a critical part of efforts to identify additional causes of birth defects and to implement effective prevention strategies where known.

Item

Hemophilia – The Committee supports CDC's efforts, in collaboration with the National Hemophilia Foundation, to carry out needed education, prevention, blood safety surveillance, and outreach programs for the millions of people in the United States affected by bleeding and clotting disorders, including hemophilia, women's bleeding disorders, and thrombophilia. The Committee recognizes the strain these additional efforts place on the national hemophilia treatment center network. Within the resources provided, the Committee urges CDC to enhance its support where possible of the network to ensure continued access to this comprehensive chronic care model for all persons with bleeding and clotting disorders. (Page 47)

Action taken or to be taken

CDC will continue to support the Hemophilia Regional Network of Hemophilia Treatment Centers (HTCs) throughout the United States and its territories to monitor blood safety and reduce complications of bleeding disorders through a comprehensive program to provide surveillance, outreach, education and care to individuals seen in HTCs. Through a public/private partnership, including the National Hemophilia Foundation, a pilot program to determine the occurrence of inhibitors among the hemophilia population has been initiated. The CDC will work to design and expand a surveillance program to gather information on rare bleeding disorders.

Item

Hereditary Hemorrhagic Telangiectasia (HHT) – The Committee is aware of interest in the establishment of an HHT National Resource Center through a partnership between the CDC and the national voluntary agency representing HHT families. The Committee encourages the CDC to examine carefully proposals to establish such a center and give every appropriate consideration to supporting it within the funds provided. (Page 47)

Action taken or to be taken

Early in 2006 CDC will be meeting with representatives from the agency representing HHT families. At that time we will discuss proposals and explore opportunities to create an HHT National Resource Center.

Item

Limb Loss Information Center – The Committee recognizes that one of the greatest challenges facing individuals with limb loss is access to necessary health and rehabilitative services. The Committee applauds CDC for its partnerships with governmental, academic and voluntary health organizations, such as the Amputee Coalition of America, to advance the quality of life through research and support programs for people living with limb loss. The Committee continues to strongly support the CDC's resource and information center which assist individuals living with disabilities, and their families, in need of information on medical, physical, and emotional needs, and resources and support to reintegrate socially and economically into society. The Committee urges CDC to continue its support of the Center at no less than the fiscal year 2005 level. (Page 47)

Action taken or to be taken

The CDC provides funds to the Amputee Coalition of America (ACA) in order to support the National Limb Loss Information Center (NLLIC). The NLLIC continues to provide education and psychosocial support for people with limb loss. One primary focus is reaching out to multicultural groups at high risk for diabetes and amputation. In addition, an ongoing partnership between the NLLIC and the Department of Defense concentrates on educating military amputees and their healthcare providers. As the ACA pursues access to appropriate technology and rehabilitative care, the NLLIC's public health initiative seeks to reduce the incidence of primary amputations, through education, and promote better health practices among those with limb loss.

Item

Spina Bifida – The Committee provides \$5,300,000, which is \$475,000 above fiscal year 2005 for the National Spina Bifida Program in coordination with its external partners, such as the Spina Bifida Association of America. The Committee continues to support the partnerships CDC has developed and encourages CDC to allocate a portion of the increase provided for the maintenance and expansion of the National Spina Bifida Clearinghouse and Resource Center. In addition, the Committee supports the Memorandum of Understanding between CDC and the Agency for Healthcare Research and Quality to examine clinical treatment of Spina Bifida and improve quality of life. (Page 47)

Action taken or to be taken

CDC through the National Spina Bifida program in coordination with its partners, continues to support research efforts to reduce secondary conditions, to maintain functional independence and to improve the overall quality of life for individuals with spina bifida. For example, CDC has completed a survey of 240 adolescents and young adults in Arkansas with spina bifida for development of secondary conditions. Results will be compared with survey of same individuals in 1993 to determine if and how obesity, depression and other conditions developed. CDC continues to explore the best means to not only maintain, but expand the National Spina Bifida Clearinghouse and Resource Center. The National Spina Bifida Clearinghouse and Resource Center aims to prevent the recurrence of pregnancies affected by neural tube defects, expand local programs via state spina bifida associations, promote research projects, and expand information resources for those with spina bifida.

Item

Tuberous Sclerosis Complex .– Tuberous sclerosis complex (TSC) is a genetic disorder that causes uncontrollable tumor growth. Because this disorder can affect multiple organs of the body, it is difficult to diagnose, track and properly treat. The Committee is aware of interest in developing a joint initiative between the CDC and a relevant voluntary health organization, such as the Tuberous Sclerosis Alliance, to collect and analyze data from the nationwide network of TSC clinics; support surveillance and epidemiological studies; and to educate health care professionals and teachers who come into contact with TSC patients. The Committee encourages the CDC to examine the feasibility of undertaking this initiative from within the funds provided. (Page 48)

Action taken or to be taken

In FY05, CDC awarded funds to the Saint Louis Children's Hospital to develop a Tuberous Sclerosis Natural History Database for use by clinicians and researchers across the nation. The project staff at SLCH work closely with the Tuberous Sclerosis Alliance. CDC will continue to support the growing project within the funds provided.

Item

Chronic Obstructive Pulmonary Disease – Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in the United States and the only one of the top ten causes of death that is on the increase. The Committee urges the CDC to expand its data collection efforts on COPD. Specifically, the Committee encourages the CDC to include question on COPD in the National Health and Nutrition Examination Survey, the National Health Interview Study and the Behavioral Risk Factor Surveillance Survey that asks about COPD by name. (Page 49)

Action taken or to be taken

CDC collects data on Chronic Obstructive Pulmonary Disease (COPD) through the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES). Both of these surveys obtain data on the three major components of COPD (chronic bronchitis, asthma, and emphysema). Questions asked of survey participants generally name these conditions specifically - as opposed to using the term "COPD" - because survey participants are more familiar with the specific conditions.

CDC's NHANES will add special lung function tests (spirometry) beginning in 2007, re-instituting a test conducted on NHANES participants from 1988-94. This expanded data collection will help improve the completeness of COPD data, and will also allow analysis of change from the previous measure. In 2007-08 NHANES will also include a major focus on asthma.

The content of the Behavioral Risk Factor surveillance System (BRFSS) questionnaire is determined each year by state BRFSS coordinators in consultation with CDC based on proposals submitted prior to the annual BRFSS conference. The American Lung Association has submitted a proposal for a question to be added to the BRFSS questionnaire which asks respondents if they have ever been told that they have COPD, emphysema, or chronic bronchitis. The proposal will be voted on at the BRFSS conference in March 2006. If approved, this question would be asked on the 2007 questionnaire.

Item

Nontuberculous Mycobacteria – The Committee is concerned that Nontuberculous Mycobacteria [NTM] incidence continues to rise. Mycobacteria are environmental organisms found in both water and soil that cause significant respiratory damage. The Committee encourages NCHS to include questions regarding NTM testing in ongoing surveys to gain a better understanding of the epidemiology of this emergent disease. (Page 49)

Action taken or to be taken

Testing for nontuberculous mycobacteria (NTM) is not part of standard clinical practice, so individuals are unlikely to be aware of possible exposure to NTM. As part of CDC's National Health and Nutrition Examination Survey, however, skin tests for NTM were conducted in the early 1970s and in 1999-2000. The resulting data, which reveal

possible exposure to antigens and cannot be used to determine whether a person is ill due to a particular disease, were released on public use files for analysis by interested researchers.

Item

Asthma – The Committee is pleased with the work that the CDC has done to address the increasing prevalence of asthma. However, the increase in asthma among children remains alarming. The Committee urges CDC to expand its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. To further facilitate this effort, CDC is urged to partner with relevant voluntary health organizations, such as the American Lung Association, to support program activity consistent with the CDC's efforts to fund community-based interventions that apply effective approaches demonstrated in research projects within the scientific and public health community. (Page 49)

Action taken or to be taken

CDC's National Asthma Control Program is further expanding its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. This year, through its National Asthma Health Education Enhancement effort, CDC/EHHE has funded voluntary health organizations such as the Allergy and Asthma Network/Mothers of Asthmatics, American Lung Association, and Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers. CDC/EHHE also has created a Web site for state and local public health organizations and others called "Effective Interventions for Asthma Control" (<http://www.cdc.gov/nceh/airpollution/asthma/interventions/interventions.htm>) to help them know "what works" and provide access to materials to adapt and implement the interventions.

CDC's Division of Adolescent and School Health (DASH) is funding seven urban school districts with at least 50% minority population (Albuquerque, Baltimore, Charlotte, Detroit, Los Angeles, Memphis, Philadelphia) and one state education agency (Oregon) to implement strategies to reduce asthma-related illnesses and absences. Activities include providing health services and education for students with asthma; disseminating asthma management guides and education curricula to schools; and professional development for school nurses, teachers, physical education teachers, and coaches in asthma management.

CDC/DASH is also currently funding six national nongovernmental organizations (American Lung Association, Asthma and Allergy Foundation of America, Starlight Starbright Children's Foundation, National Association of School Nurses, American Academy of Pediatrics, and American Association of School Administrators) to assist in building the capacity of state and local health and education agencies in addressing asthma in schools. Activities range from developing an asthma toolkit for community members to assist with addressing asthma in schools to providing asthma education for children and teens with asthma, school administrators, school nurses and pediatricians. Funding for these NGOs will end in 2006. They and other NGOs will be eligible to apply for a new 5-year cooperative agreement. From 2006-2011, CDC/DASH will fund two or three NGOs to provide capacity building assistance to faith-based institutions, youth service providers, or parent organizations interested in addressing asthma in schools.

All of CDC/DASH's asthma funded partners are using CDC's research-based document, *Strategies for Addressing Asthma Within a Coordinated School Health Program*, released in Fall 2002, to guide their programs. CDC/DASH just released a new version of its popular *School Health Index: A Self-Assessment and Planning Guide* which now includes asthma content and should also prove helpful in guiding funded partners to use research-based strategies to address asthma in schools.

Item

Biomonitoring – The CDC's National Report on Human Exposure to Environmental Chemicals is a significant new exposure tool that provides invaluable information for setting research priorities and for tracking trends in human exposures over time. Accordingly, the Committee continues to support the CDC environmental health laboratory's efforts to provide exposure information about environmental chemicals. In addition, the Committee encourages CDC to consider devoting a greater proportion of program resources to develop the necessary methods to interpret human biomonitoring concentrations in the context of potential health risks. The Committee applauds the CDC's biomonitoring efforts and encourages the agency to continue this program and as well as improve its efforts to communicate these results in context. (Page 50)

Action Taken or To Be Taken

CDC agrees that having unique information about the exposure of the U.S. population to environmental chemicals is a key to understanding the relation between exposure and disease. Research studies are needed to determine which levels of a chemical may cause health effects and which are not a significant health concern. Currently, CDC conducts or provides measurements for 50-65 studies each year and is working to increase number of these studies to 70-80 that examine the relation of exposure to particular chemicals and the occurrence of health effects. In

addition, CDC's Environmental Health Laboratory is exploring the possibility of collaborating on exposure studies in animals at levels typically found in the U.S. population that are described in CDC's National Report on Human Exposure to Environmental Chemicals. CDC strives to communicate in all of its printed documents, press statements, interviews, and other media and educational materials that the toxicity of a chemical is related to its dose or concentration as well as to a person's individual susceptibility and that just because people have an environmental chemical in their blood or urine does not mean that the chemical causes disease.

Item

Dioxin Emission Reduction – The Committee encourages the CDC to establish a public health awareness effort to inform the public of dioxin emissions that may originate from non-point sources and methods and/or techniques that the public can use to reduce the emissions of non-point source dioxins to the environment. (Page 50)

Action taken or to be taken

The Environmental Protection Agency (EPA) already has a Dioxin Exposure Initiative (<http://cfpub.epa.gov/ncea/cfm/recordisplay.cfm?deid=15239>) that addresses non-point sources of dioxin and how people can avoid exposures. Information on EPA's other dioxin activities is available at <http://cfpub2.epa.gov/ncea/cfm/recordisplay.cfm?deid=55264>. CDC plans to work with EPA in their efforts on this issue.

Item

Pandemic Preparedness and Avian Flu – The Committee understands antiviral treatments have repeatedly been shown to reduce the duration and severity of symptoms when given in the first 48 hours of influenza symptoms. Although there are gaps in knowledge about the efficacy of antivirals in a pandemic, it appears that these gaps should not be used as a reason for inaction. The Committee urges the Department to undertake an analysis to define optimal antiviral use, potential health impacts and cost-effectiveness of antiviral drugs in the setting of a pandemic and directs the Secretary to be prepared to report on the findings during the Committee hearings on the fiscal year 2007 budget request. (Page 53)

Action Taken or to be Taken

Because of recent findings that resistance has been developed to antivirals, CDC monitors the susceptibility of avian and other potential pandemic influenza viruses to available antiviral agents on a continuous basis. The resistance patterns of influenza viruses, the dosing and adverse effects profiles of the antivirals, and current and future production capacities for these agents are being considered as plans are made to stockpile additional antiviral courses in CDC's Strategic National Stockpile. CDC agrees that it is important to monitor clinical effectiveness, cost effectiveness and safety of antivirals during a pandemic and is working with WHO to monitor results on human cases of avian influenza that have been treated with antivirals to better understand outcomes.

Item

Pandemic Preparedness and Avian Flu – The Committee urges CDC to review and approve state pandemic influenza plans in order to ensure nationwide preparedness standards and to facilitate regional coordination. Further, CDC should recommend that States make approved plans publicly available. . . . the Committee urges CDC to develop and implement a public education campaign about pandemic influenza and preparedness, including information concerning the potential need for general vaccination and personal precautionary measures. CDC should also develop a strategy for communicating with the business community to provide information about the economic disruptions and community needs that may arise during a pandemic period. (Page 54)

Action Taken or to be Taken

CDC has reviewed each State's current pandemic influenza plans and provided feedback. Any future guidance will include recommendations that the states work together regionally to foster pandemic influenza planning. Updates to plans will be reviewed and approved in conjunction with pandemic influenza supplemental funding. CDC will recommend - but not require - that States make plans publicly available.

In the event of an influenza pandemic and given the likely surge in demand for healthcare, public communications must include instruction in assessing true emergencies, in providing essential home care for routine cases, and basic infection control advice. CDC provides the health-care and public health communities with timely notice of important trends or details necessary to support robust domestic surveillance. We also provide guidance for public messages through the news media, Internet sites, public forums, presentations, and responses to direct inquiries.

CDC agrees that in the event of pandemic influenza, businesses will play a key role in protecting employees' health and safety as well as limiting the negative impact to the economy and society. CDC has conducted a needs assessment with key businesses and business influentials to assess the requirements for business pandemic influenza planning. Using information from this assessment, HHS and CDC have developed a tool (Business

Pandemic Influenza Planning Checklist) for large businesses and are currently producing an accompanying Business Pandemic Influenza Planning Toolkit. These tools identify important, specific activities large businesses can do now to prepare for pandemic influenza and other health emergencies. Currently, activities are underway to develop similar tools for small- to mid-sized businesses. Strategies for communicating with the business community to provide accurate and timely information about an influenza pandemic are in the planning stages. Further information on the checklist for businesses and on CDC's other communications activities can be found at www.pandemicflu.gov and www.cdc.gov/business.

Item

Risk factors associated with obesity - The multiple factors contributing to the overweight and obesity epidemic took years to develop. Reversing the epidemic will require a long-term, well-coordinated, concerted approach to reach Americans where they live, work, play, and pray. Effective collaboration among the public, voluntary, and private sectors is critical to reshape the social and physical environment of our Nation's communities and provide the necessary support, information, tools, and realistic strategies needed to reverse the current obesity trends nationwide. To reduce consumer confusion about the myriad of health messages about obesity, diabetes, and cardiovascular disease, the Committee encourages CDC to design and develop mechanisms for fast-tracked translation of research into reasoned guidance for the American public. To prevent unhealthy weight gain and maintain healthy weight among children and adolescents, CDC is encouraged to work with the U.S. Department of Education to issue a report with recommendations about reintroducing physical education into the school day.

Action taken or to be taken

CDC agrees that reversing the obesity epidemic will require a long-term, coordinated, and comprehensive approach to reach Americans in all aspects of their lives. Addressing obesity requires understanding the many factors that influence health behavior and then creating targeted action across a socio-ecologic model to affect social change. CDC's portfolio of programs reflects this approach to drive social change and impact health. As examples:

VERB: This 5-year pilot mass media campaign demonstrated the effectiveness of a social marketing approach featuring extensive consumer research, state-of-the-art creative production, and high levels of exposure. Evaluation results showed that the pilot campaign led to increased physical activity levels among 9-13 year olds and stopped the decline in physical activity with age.

Goals and Evaluation Indicators: CDC has recently developed health goals, logic models, and performance indicators specifically for obesity. In the spring we will co-host a meeting with the Robert Wood Johnson Foundation, IOM, Kellogg, and the American Council for Fitness and Nutrition to review this work and to identify suitable indicators for evaluating programs and monitoring progress.

Community Guide: Based on systematic reviews of the scientific literature, CDC's Community Guide presents recommendations for increasing physical activity, promoting healthy nutrition, and reducing overweight and obesity. Interventions include approaches such as community-wide campaigns, behavioral and social approaches such as physical education in the schools, and environmental and policy approaches such as urban design and land use.

Prevention Research Centers: This national network of academic, public health, and community partners focus on linking science and practice. A number of CDC-funded projects focus on innovative approaches to preventing overweight and obesity. For example, investigators at Harvard University are assessing selected neighborhoods in Chicago to determine the impact of neighborhood design and the quality of public transportation on physical activity levels and BMI measurements in youths and young adults. Another Harvard team is exploring how dietary patterns relate to weight gain and the development of obesity among adolescents.

CDC works closely with the U.S. Department of Education in addressing efforts to reduce and prevent overweight and obesity in children and adolescents. CDC consistently seeks input and review from the U.S. Department of Education on physical and health education materials. In February 2006, CDC will release the Physical Education Curriculum Analysis Tool (PECAT). The PECAT is an innovative, practical tool that will enable the Nation's physical educators to assess the quality of school physical education curricula and revise those aspects of their curricula that do not align with national physical education standards. In addition, CDC is currently revising the *Guidelines for Schools to Promote Lifelong Physical Activity and Healthy Eating for Health Promotion and Obesity Prevention among Young People*. The new Guidelines will include a new section on obesity.

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – SENATE

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2007 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
SENATE REPORT NO. 109-103
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Collaboration with Asia – The Committee recognizes that strong collaborative ties with Asian countries are among the mechanisms which may contribute to the stability of the Asia/Pacific region. The multiethnic and multicultural population of Hawaii and its geographic location provide an ideal pathway for a CDC-supported initiative with a focus on emerging infections and chronic disease problems in Asia. The Committee also recognizes this has the potential for providing frontline protection for the United States mainland from emerging diseases, as well as assisting Asian countries with treatment for such diseases. The Committee encourages CDC to explore collaboration and joint funding of projects with Asian governments, such as Korea, to study immigrants in Hawaii as a mechanism for addressing both infectious and chronic disease burden and treatment in the Pacific. (Page 59)

Action taken or to be taken

CDC agrees that strong ties with Asian countries will contribute to both the stability and quality of public health in the Asia/Pacific region, as well as afford the United States a measure of protection from emerging diseases. CDC will conduct an assessment of potential opportunities of having resources in Hawaii to focus on emerging infections and chronic disease. CDC is also working to establish 18 Global Disease Detection and Response Centers, several of which will be in Asia (locations to be determined), to quickly identify and respond to emerging threats before they can reach the United States.

Item

Hepatitis – The Committee is concerned that more than 75 percent of the 4 million people with hepatitis C are unaware of their condition. The Committee encourages CDC to collaborate with national voluntary health organizations to raise awareness of appropriate screening and medical follow up of target populations. The Committee is also aware of increasing rates of hepatitis A and B infections among select adult populations, as well as the alarming rate of individuals co-infected with both hepatitis C and HIV. The Committee encourages CDC to help increase hepatitis screening initiatives in the States. In addition, The Committee encourages CDC to consider focusing on education and awareness programs targeted at specific populations where there is a high prevalence of hepatitis B and where therapeutic interventions are increasingly effective. (Page 59)

Action taken or to be taken

CDC continues to work with voluntary health organizations, notably through the National Viral Hepatitis Roundtable, to raise awareness about hepatitis issues. Hepatitis C Coordinators funded by CDC in 48 states and 3 large metropolitan areas have also helped to lead state efforts to implement the integration of immunization, screening, and other hepatitis prevention services into existing public health programs. The Division collaborates with other CDC programs and external partners to characterize, monitor, and prevent HIV and other co-factors that accelerate the progression of chronic hepatitis. Awareness has increased significantly from the 1990s when only 25% of infected persons had knowledge of their infection. However, approximately half of HCV positive individuals remain unaware of their infection status. Similarly, collaboration with such CDC partners as the Immunization Action Coalition and the Jade Ribbon Campaign help to provide culturally appropriate educational materials for more and more specific populations at increased risk for hepatitis B.

Item

Liver Wellness – The Committee continues to be concerned about the prevalence of hepatitis and encourages CDC to consider working with voluntary health organizations and professional societies to promote liver wellness with increased attention toward education and prevention. (Page 59)

Action Taken or to be Taken

CDC continues to work with the National Viral Hepatitis Roundtable, whose member organizations include those devoted to health care professionals, voluntary health, and patient advocacy, to develop and distribute effective

educational materials about hepatitis and liver wellness both for patients and for physicians and other health professionals.

Item

Meningococcal Disease – Meningococcal disease is one of the few diseases that can be fatal or severely debilitating to a victim within a matter of hours of initial onset and yet is vaccine-preventable in most cases. The Committee is aware of the recent improvements in the meningitis vaccine and of recent CDC efforts to increase the availability and focus of information on Meningococcal disease and ways to prevent it so that the general public will be better educated on the symptoms and prevention methods. The Committee encourages the CDC to improve meningococcal education and adolescent immunization programs through partnerships with associations, such as the National Meningitis Association, to ensure that all families, especially those with adolescents and young adults, are effectively educated on this disease, vaccine availability, and all methods of prevention. (Page 59)

Action taken or to be taken

CDC continues to educate the public and providers about the availability of adolescent vaccines including meningococcal. In April 2005, CDC held a net conference for clinicians titled "Current Issues in Immunization" that included a focus on the new meningococcal vaccine recommendations. Also, CDC's website also offers an adolescent area entitled "Vaccines for Teens: Vaccinate before You Graduate" available at www.cdc.gov/nip/recs/teen-schedule.htm. The site includes information about vaccines recommended for teenagers and provides links to information about vaccines for adults and children.

A 2-day Adolescent Stakeholders meeting sponsored by CDC and the National Vaccine Advisory Committee (NVAC) was held in Washington in June 2005. The meeting included over 140 key stakeholders with an interest in adolescent immunization. The objectives for this meeting were to identify issues expected to arise with the licensing of new vaccines for this age group, and identify approaches that will most effectively increase adolescent vaccination. Adolescent vaccines, including meningococcal vaccine was also discussed at this meeting. A series of white papers summarizing findings from this meeting will be published in *Pediatrics*.

Item

Prevention Epicenter Program – The Committee applauds CDC's support for the Prevention Epicenter Program and encourages CDC to continue and expand this program to address patient safety issues. (Page 59)

Action taken or to be taken

CDC continues to support the Prevention Epicenters Program as a means of addressing important patient safety issues. A new group of Epicenters investigators will be awarded a 5-year cycle of funding beginning in February 2006. The purpose of the awards is to promote collaborative research to improve detection, reporting, and prevention of healthcare-associated infections, antimicrobial resistance, and other adverse events in all types of healthcare facilities in the United States. The new awards are designed to facilitate research among investigators affiliated with multiple healthcare facilities in a healthcare system (such as those that may be affiliated with an academic medical center). Participation by multiple facilities will allow for more robust validation of findings and innovations than is possible in a single facility, and will enhance the project's ability to produce patient safety advances applicable to a wide spectrum of US healthcare facilities

Item

Sepsis – The Committee is aware that sepsis, an overwhelming systemic response to infection that leads to organ dysfunction and death, kills more than 215,000 Americans every year. The Committee understands that new treatments have been developed which significantly improve prognosis when sepsis is diagnosed in a timely fashion. In addition, new guidelines have been developed to aid health care professionals in identifying the syndrome. Unfortunately, too few medical personnel know how to properly diagnose sepsis. To improve patient outcomes, the Committee encourages CDC to develop a sepsis education program to train infectious disease physicians, emergency room doctors, and critical care nurses in the proper identification of sepsis. (Page 60)

Action taken or to be taken

CDC has implemented several successful interventions to prevent bloodstream infections, including educating clinicians on the appropriate use of intravenous catheters and other strategies to prevent infections that lead to sepsis.

CDC's collaborative project to decrease bloodstream infections (BSI) in the greater Pittsburgh area (Pittsburgh Regional Health Initiative) has resulted in a nearly 70% region-wide decline in BSI.

CDC has funded five states to conduct state-wide educational initiatives for clinicians on the prevention strategies outlined in CDC's *Campaign to Prevent Antimicrobial Resistance in Healthcare Settings*. BSI are a central focus of the Campaign.

CDC serves as a scientific partner and its guidelines have been used as a foundation for the Institute for Healthcare Improvement *100K Lives* Campaign. One of the Campaign's six goals is to reduce bloodstream infections (BSI).

Through its collaboration with the Society for Hospital Medicine (SHM), CDC has conducted a series of educational workshops in four major US cities to educate Hospitals about strategies for prevention and appropriate diagnosis and management of BSIs. This collaboration also resulted in the development of an evidence-based toolkit for dissemination to all SHM members.

CDC will continue to work with organizations such as the American Sepsis Alliance to expand its interventions to prevent healthcare-associated sepsis.

Item

Infertility Prevention – The Committee notes that CDC is charged legislatively with instituting programs to help prevent infertility. CDC's current program activities in this matter are undertaken by the division of HIV/STD/TB and are limited to the prevention of venereal diseases. The Committee understands that there are numerous additional causes of infertility beyond sexually transmitted diseases, such as delayed child bearing, smoking, low or excessive body weight, exposure to hazardous environmental toxins, drug and alcohol abuse and, particularly for men, exposure to high temperatures. The Committee encourages CDC to consider expanding the scope of this program and provide greater support to public education on the risks to fertility. (Page 60)

Action taken or to be taken

CDC monitors success rates of Assisted Reproductive Technology (ART) clinics and uses these data to help analyze factors related to reduced fertility and infertility, and the safety of ART procedures. More than 1% of US births are now ART-related, more than 48,000 births in the most recent year (2003). In collaboration with Massachusetts, CDC is linking ART surveillance data with birth and death records for infants born to Massachusetts resident mothers. This data set will allow for more detailed analyses of maternal and infant health outcomes.

CDC's Pregnancy Risk Monitoring System (PRAMS) provides the foundation for improving maternal and child health programs across the country and in measuring success of those programs. In fiscal year 2005, PRAMS was expanded to cover more than three quarters of US births. Through PRAMS, states are able to monitor trends and improve the health of women and infants. PRAMS data track health indicator and behavior issues such as smoking during pregnancy, pre-pregnancy weight, alcohol consumption, and other factors affecting pregnancy and birth outcomes. These data are used in implementing the Maternal and Child Health Block Grant program, funded by the Health Resources and Services Administration.

In addition, recent CDC studies include findings that gestational diabetes mellitus has been associated with adverse maternal and infant outcomes, including high blood pressure and high birth weight. Cigarette smoking has been associated with increased insulin resistance, showing an association between smoking and gestational diabetes mellitus.

Item

Oral Fluid Rapid HIV Tests – The Committee is supportive of CDC's use of the oral fluid rapid HIV test in its HIV/AIDS activities. The Committee strongly encourages CDC to move forward as quickly as possible with the purchase of additional tests to sustain and expand these successful efforts. (Page 60)

Action taken or to be taken

CDC is strongly encouraging recipients for CDC HIV funds to use HIV prevention funds to purchase rapid HIV tests. CDC directly funded community-based organizations are already directly procuring rapid HIV tests for use in non-clinical settings. State and local health departments which receive the majority of CDC's HIV prevention funds are also encouraged to use their grant funds to procure rapid HIV tests.

Item

Tuberculosis - vaccine research cooperative agreement – ...The Committee understands that TB is an enormous health crisis in the developing world, killing 2 million people every year. In recent years, several new vaccine candidates for TB have been developed and have shown promising results when tested in animals. The Committee strongly encourages CDC to continue and, if possible, expand the existing TB vaccine research cooperative agreement. (Page 61)

Action taken or to be taken

In September 2004, the Centers for Disease Control and Prevention awarded a three-year cooperative agreement to the Aeras Global Tuberculosis Vaccine Foundation (Aeras). CDC has provided technical assistance including assisting in the development of laboratory capacity and referral systems to treat and cure patients with TB, developing protocols for epidemiologic studies, observational cohort studies, and refine information on TB prevalence and incidence in neonatal and adolescent cohorts in the trials site.

Item

Tuberculosis - funding for refugees – The Committee is aware that refugees entering the United States with TB pose a serious public health threat. In particular, multidrug resistant TB cases pose the deadliest and costliest risk. The Committee recognizes that over the past year an outbreak of TB has occurred among Hmong refugees from Thailand who have resettled in the United States, mainly in California, Minnesota and Wisconsin. In California alone, local health departments have detected 25 TB cases among 3,400 Hmong refugees from Thailand in the last 10 months, four of which are multidrug resistant. The Committee urges CDC to make resources available to States facing TB outbreaks among their refugee population. (Page 61)

Action taken or to be taken

In FY2005, CDC conducted an epi-aid investigation to provide recommendations for the screening and treatment of Hmong refugees in Thailand prior to their resettlement in the US. These recommendations guided the resettlement of additional refugees. In addition to the epi-aid DTBE provided patient and provider education, communication and outreach activities in communities where refugees had resettled in the U.S. For example, CDC staff traveled to refugee communities in Fresno and Sacramento to recommend a communications strategy for the refugees. Since many refugees were not literate, CDC produced a flip book with pictures and a video with Hmong voiceover describing TB screening, prevention and treatment.

CDC, along with the State of California, county health departments, and members of the Hmong community continue to work together for continued TB prevention. In addition, CDC and its partners are examining strategies for preparing for the resettlement of other refugees with needs similar to those of the Hmong.

Item

Tuberculosis-Intensified Support and Activities to Accelerate Control – The Committee understands that the CDC plans to undertake a new initiative, the Intensified Support and Activities to Accelerate Control [ISAAC]. ISAAC targets tuberculosis in African Americans, tuberculosis along the U.S./Mexico border, allows for universal genotyping of all culture positive TB cases, and expands clinical trials for new tools for the diagnosis and treatment of TB. The Committee encourages the CDC to implement ISAAC to enhance and maximize strategies to accelerate the control and elimination of TB. (Page 61)

Action taken or to be taken

In FY 2004, the National Coalition for the Elimination of Tuberculosis proposed a new initiative: Intensified Support and Activities to Accelerate Control (ISAAC). The initiative aims to sustain the momentum of the past 10 years and accelerate the control and elimination of tuberculosis in the United States. CDC has completed some activities that are supportive of the strategies outlined in ISAAC. In 2005 CDC completed a four year demonstration project to intensify TB prevention, control, and elimination activities in African-American communities in the United States. These projects examined social and cultural dimensions of health-seeking behaviors, beliefs, and values in order to develop targeted interventions. CDC also requires programs reporting more than 50 cases of TB in African Americans to develop specific performance measures related to the reduction of TB in African Americans. Findings will be translated into interventions for use in other areas of the country where there are disproportionate rates of TB in black, non-Hispanic persons.

Along the border, CDC works closely with the World Health Organization (WHO), the Pan American Health Organization (PAHO), Mexico, the U.S.-Mexico Border Health Commission, and the four U.S. Border States of California, Arizona, New Mexico, and Texas to conduct case management, administer directly observed therapy, follow-up on persons exposed to TB disease, and provide support for laboratory services for diagnosis. CDC has just completed a successful four year demonstration project, the Binational Card, to improve communication on both sides of the border to ensure continuity of care and thus avoid interruptions that lead to the emergence of drug resistance. This project could serve as a model for all states who are working with immigrants from Mexico.

To provide universal genotyping, CDC is working to provide laboratory capacity to state health departments that allows every culture-positive TB patient to have his or her TB isolate genotyped. This project has yielded a great deal of useful epidemiologic data and could serve as an early warning system for nascent outbreaks.

Finally, CDC is analyzing data on recently developed tools for rapidly diagnosing TB. In 2005 CDC issued guidelines for using one such tool – the TB QuantiFERON TB Gold test in public health practice. These were among three sets of guidelines CDC issued in 2005 to improve TB control in the U.S. Other guidelines addressed contacts of persons with TB and preventing infections among health care workers, patients and their families.

Item

Section 317 grant support for Alaska – The Committee encourages CDC to increase section 317 grant support for infrastructure development and purchase of vaccines for the State of Alaska's universal immunization program. It has been brought to the Committee's attention that infrastructure costs of delivering vaccines to children in Alaska are substantially higher than in other areas of the country, because of the many small, remote communities which must be served primarily by air. The Committee encourages the agency to give careful consideration to Alaska's request for sufficient funding for the purchase of vaccines needed for 90 percent of Alaskan children and to provide infrastructure support needed to deliver these vaccines at the community level, including development of a statewide immunization registry to ensure that all children in Alaska are immunized. The Committee notes that failure to immunize children in remote areas of Alaska results in deaths each year from exposure to open sewage lagoons and contaminated water. (Page 62)

Action taken or to be taken

CDC provides Section 317 funding to support the purchase of vaccines, as well as the infrastructure used to help assure recommended doses are provided. The development of immunization information systems (registries) are also supported through these funds. Because CDC recognizes the increased costs associated with delivering vaccines to remote communities, the allocation of grant funds takes into consideration the needs of grantees that have a significant portion of their jurisdiction living in rural areas. To help improve and maintain high childhood vaccination coverage levels, eligible children -- including those who are uninsured, Medicaid recipients, Native Americans, and Alaska Natives -- benefit from the Vaccines for Children Program as well, which provides recommended vaccines to these children at no charge to their parents or providers. The VFC program also provides infrastructure funding to support the delivery of vaccines. Efforts to reduce the number of deaths due vaccine-preventable diseases, such as hepatitis A, have been successful. For example, Alaska has the highest hepatitis A vaccination coverage among 24-35 month olds of any state and has also implemented a school entry requirement.

Item

Autoimmune Diseases – The Committee encourages CDC to provide resources for the awareness and prevention of autoimmune diseases. (Page 64)

Action taken or to be taken

ATSDR continues to conduct several projects and studies related to autoimmune diseases including the development of a national surveillance strategy for autoimmune and neurological conditions. ATSDR has convened two expert panels on Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS) and other motor neuron diseases. The panels reviewed autoimmune diseases and are working to build upon the methodology and findings from previous ATSDR prevalence studies by developing a national surveillance strategy for select autoimmune and neurological diseases. To accomplish this, a working group consisting of researchers with experience in surveillance of autoimmune and neurological diseases from ATSDR, CDC (NCEH, NCCDPHP), NIEHS, state health departments and academia will be convened. Upon completion, ATSDR plans to establish a research consortium. This consortium will be composed of participants identified by the working group. The consortium will be responsible for reviewing and commenting on the draft proposal developed by the expert panel, discussing methods for developing a strategy for a national autoimmune and neurological disease surveillance system, and developing a consensus regarding research priorities, methods, and standardized data collection. Upon completion of these activities, a pilot test will be conducted of the national surveillance strategy for autoimmune/neurological conditions. In addition, the working group will be responsible for developing a website for researchers of autoimmune and neurological diseases to share information such as data collection instruments, protocols, and research findings.

ATSDR continues to conduct case control studies in Ohio, Texas and Missouri. These studies will examine the role of both environmental exposures and genetic factors in the development of multiple sclerosis. Although inherited genetic susceptibility is an important determinant of MS, environmental factors most certainly contribute to disease. This study will fill the epidemiologic gap regarding the role of genes and environment, as well as the interaction of the two. Additionally, ATSDR continues to fund a three year cooperative agreement project centered on waste sites that will determine the prevalence of neurological conditions for which there is little or no existing data.

Item

Chronic Kidney Disease – The Committee previously has expressed concern regarding the need to expand public health strategies to combat chronic kidney disease [CKD] given that many individuals are diagnosed too late to initiate treatment regimens that could reduce morbidity and mortality. Twenty million Americans have CKD, and

another 20 million are at risk of developing the disease. Individuals with diabetes or hypertension have especially high vulnerability. Kidney disease is the 9th leading cause of death in the United States, and death by cardiovascular disease is 10 to 30 times higher in kidney dialysis patients than in the general population. Further, the number of individuals with end stage renal disease [ESRD], irreversible kidney failure requiring either dialysis or a transplant to remain alive, is expected to increase from 372,000 patients in 2000 to over 660,000 by 2010. Therefore, the Committee has included an increase of \$1,800,000 for CKD to develop capacity and infrastructure at CDC for a kidney disease surveillance, epidemiology, and health outcomes program; award grants to support several State-based demonstration projects for CKD prevention and control; and under the leadership of a national voluntary health organization and in collaboration with CDC, convene a consensus conference of experts in the area of kidney disease and other stakeholders to lay the groundwork for a formal Public Health Kidney Disease Action Plan for prevention and control of kidney disease. (Page 64)

Action taken or to be taken

CDC shares the Committee's concern regarding chronic kidney disease and will work quickly to establish a program with the new funding received in fiscal year 2006. CDC will initiate vital public health surveillance and epidemiologic research activities which will inform policy decisions and program planning for chronic kidney disease prevention and control. CDC will also work with key public and voluntary organization partners to bring together experts and stakeholders in the kidney disease arena to develop a National Public Health Kidney Disease Action Plan. These activities will lay the groundwork CDC needs to launch state-based demonstration projects for chronic kidney disease prevention and control.

Item

Chronic Obstructive Pulmonary Disease – Chronic Obstructive Pulmonary Disease [COPD] is the fourth leading cause of death in the United States and the only one of the top 10 causes of death that is on the increase. The Committee urges the CDC to expand its data collection efforts on COPD. Specifically, the Committee encourages the CDC to include question on COPD in the National Health and Nutrition Examination Survey, the National Health Interview Study and the Behavioral Risk Factor Surveillance Survey that asks about COPD by name. (Page 65)

Action taken or to be taken

CDC collects data on Chronic Obstructive Pulmonary Disease (COPD) through the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES). Both of these surveys obtain data on the three major components of COPD (chronic bronchitis, asthma, and emphysema). Questions asked of survey participants generally name these conditions specifically - as opposed to using the term "COPD" - because survey participants are more familiar with the specific conditions.

CDC's NHANES will add special lung function tests (spirometry) beginning in 2007, re-instituting a test conducted on NHANES participants from 1988-94. This expanded data collection will help improve the completeness of COPD data, and will also allow analysis of change from the previous measure. In 2007-08 NHANES will also include a major focus on asthma.

The content of the Behavioral Risk Factor surveillance System (BRFSS) questionnaire is determined each year by state BRFSS coordinators in consultation with CDC based on proposals submitted prior to the annual BRFSS conference. The American Lung Association has submitted a proposal for a question to be added to the BRFSS questionnaire which asks respondents if they have ever been told that they have COPD, emphysema, or chronic bronchitis. The proposal will be voted on at the BRFSS conference in March 2006. If approved, this question would be asked on the 2007 questionnaire.

Item

Colorectal Cancer –...The Committee is pleased with the leadership of CDC's National Colorectal Cancer Roundtable in promoting the availability and advisability of screening to both health care providers and the general public. The Committee encourages the CDC to continue to expand its partnerships with State health departments, professional and patient organizations, and private industry to combat this devastating disease. (Page 65)

Action taken or to be taken

In the fall of 2005, CDC awarded \$2.1 million to establish a new colorectal cancer screening demonstration program to increase screening among Americans, aged 50 years or older. Five program sites have been selected to participate in this 3-year program. Each site will focus efforts on screening low-income men and women who have inadequate or no health insurance coverage for colorectal cancer screening.

CDC will continue to support and promote national colorectal cancer screening by educating health care providers and the public about the benefits of screening, the availability of screening procedures, and screening guidelines. CDC also works with partners like the American Cancer Society to support the National Colorectal Cancer Roundtable, a coalition of organizations that educate medical providers and the public about the importance of

colorectal cancer screening. In addition, CDC funds comprehensive cancer control programs to integrate the full range of cancer control activities to better maximize resources, improve community-based education and health promotion, share expertise, and effectively reach at-risk populations.

CDC funds various research and surveillance activities to expand the knowledge base, analyze data, and fund prevention and intervention research projects related to colorectal cancer. The results of these efforts allow CDC to focus its policies, programs, and efforts toward the goals of increasing screening rates and reducing deaths from colorectal cancer in the U.S. population.

Item

Juvenile Diabetes – The Committee commends CDC for implementation of SEARCH, a pilot study to determine the incidence and prevalence of diabetes in youth under the age of 20 years in six locations around the United States. The Committee encourages CDC to consider developing a plan to use the information gathered from SEARCH to create a national registry of patients afflicted with juvenile diabetes. In addition, the Committee encourages CDC to take advantage of the opportunity to also collect information about the standard of care available to people with diabetes nationwide. Samples from this study may represent a valuable scientific resource, and the Committee encourages CDC to consider making these samples and information available to the research community. (Page 66)

Action taken or to be taken

One of the primary goals of CDC's SEARCH project is to estimate the number of new (incidence) and existing (prevalence) childhood diabetes cases by type, age of the child, sex, and racial or ethnic group. In time, the SEARCH study will also: describe the clinical characteristics of different types of diabetes in youth and how these types evolved; describe the complications of diabetes and the quality of life of children and adolescents with diabetes; and, it will develop a uniform classification of types of childhood diabetes. These findings will be published and shared with the general public via the CDC diabetes program Web site.

The sentinel sites involved in the SEARCH study will provide reliable data that can be used to calculate national incidence and prevalence data using synthetic estimates. These synthetic national estimates will provide useful information for public health policy formulation, research, and program planning. Rather than establishing state or national registries for diabetes surveillance, CDC recommends the use of the synthetic national estimates as a cost effective and efficient means to monitoring the burden of childhood diabetes. In general, registries are difficult and expensive to develop and maintain. Also, registries require monitoring to ensure accurate disease reporting. Additionally, registries present complex and on-going issues related to privacy and protection against discrimination.

CDC is actively engaged in monitoring the standard of care available to people with diabetes. CDC published A Diabetes Report Card for the United States: Quality of care in the 1990s (Annuals of Internal Medicine, 2002) and will publish an updated report in the near future to document the quality of diabetes care. CDC and other federal agencies also publish articles and reports and make presentations at national meetings (e.g. Annual Meeting of the American Diabetes Association) that provide the most current information relative to diabetes standards of care. To help share the reports with the general public, CDC also posts the information on the CDC diabetes program website.

Item

Diabetes—measurement of C-peptide – The Committee encourages the CDC to continue and expand its efforts to standardize the measurement of C-peptide as a surrogate marker for pancreatic beta cell function. The development and validation of reliable, standard assays for C-peptide have the potential to significantly accelerate regulatory approval of new therapies to prevent or reverse autoimmune diabetes. (Page 66)

Action taken or to be taken

CDC recognizes the importance of having validated and reliable assays for the measurement of C-peptide as a surrogate marker for pancreatic beta cell function. Currently, CDC serves as the link between the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the University of Missouri on this activity. Thus far, several interlaboratory comparisons of methods have been conducted, reference materials are being developed, and at least three interlaboratory comparison studies are planned for fiscal year 2006.

Item

Diabetes and Obesity in Minority Populations – The Committee is concerned by the toll that the twin epidemics of diabetes and obesity are taking on the health of minorities. An effective culturally-sensitive response is urgently needed to address this escalating epidemic. The Committee encourages CDC to fund initiatives of national and community organizations that have the capacity to carry out coordinated health promotion programs that will focus on diabetes and obesity in minority communities. The Committee encourages CDC to seek out organizations directed by and serving individuals from communities with disproportionate diabetes and obesity rates. (Page 66)

Action taken or to be taken

CDC shares the Committee's concerns regarding the disproportionate impact of diabetes and obesity on racial and ethnic minorities. CDC's efforts include several strategies to address the disproportionate diabetes and obesity rates:

The National Diabetes Education Program (NDEP) has provided competitive funding and technical assistance to national minority organizations (NMOs) to promote culturally appropriate diabetes prevention and control resources and strategies in their communities since 1999. Initially, NDEP funded four NMOs for three years; in fiscal year 2005 CDC awarded eight organizations for five years to promote diabetes education strategies in minority communities.

The newly funded organizations and their strategies are:

- The Association of American Indian Physicians will work to improve knowledge, attitudes, beliefs and behaviors related to the prevention, early detection and control of diabetes.
- The Black Women's Health Imperative's will focus on improving diabetes awareness and education in a total of 48 church congregations across 12 states.
- The Khmer's National Cambodian American Diabetes Project will promote diabetes awareness and deliver education messages, interventions and products to Cambodian communities nationwide.
- The National Alliance for Hispanic Health's "Juntos Contra la Diabetes" program (JCD-United Against Diabetes) will design and implement local Hispanic diabetes action plans with culturally appropriate diabetes education and community outreach resources.
- The National Association of School Nurses will work in six large urban school districts that are at high risk for diabetes and being overweight. They will provide positive messages about the management of type 1 and the prevention of type 2 diabetes for primarily African American students in the 4th and 5th grade.
- The National Latina Health Network will implement an innovative peer-education program in Spanish and English.
- The National Medical Association will increase awareness of diabetes prevention and control strategies and promote diabetes education, diet, nutrition, and exercise programs.
- Papa Ola Lokahi will identify diabetes awareness and education priorities in Hawaiian and Pacific Islander communities.

CDC has made substantial strides in reducing racial and ethnic disparities in health by working in partnership with local communities through CDC's Racial and Ethnical Approaches to Community Health (REACH) 2010 program. REACH 2010 supports community coalitions in the design, implementation, and evaluation of unique community-driven strategies to eliminate health disparities. REACH 2010 addresses racial and ethnic disparities in infant mortality, breast and cervical cancer, cardiovascular diseases (CVD), diabetes, HIV/AIDS and immunizations. The communities served by REACH 2010 include: African Americans, American Indians, Hispanic Americans, Asian Americans, Pacific Islanders and Alaska Natives. CDC currently funds 40 communities, five are tribes and tribal organizations under the American Indian/Alaska Native Core Capacity Building program. Of these 40 communities, 13 communities are addressing diabetes specifically and another 7 are addressing it as a co-morbidity.

In addition, CDC is funding the YMCA for a four-year Steps to a HealthierUS cooperative agreement grant to support the Steps Communities in addressing the obesity and diabetes epidemics. The YMCA's strong presence in the community, with local chapters nationwide, provides an ideal opportunity to build strong partnerships and increase the capacity and impact of Steps communities in efforts related to obesity, diabetes and asthma.

Item

Diabetes among Native American, Native Alaskan, and Native Hawaiian populations – 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, in particular, to assist the leadership of Native Hawaiian and Pacific Basin Islander communities. It is important to incorporate traditional healing concepts and to develop partnerships with community health centers. The Committee encourages CDC to build on all its historical efforts in this regard. (Page 66)

Action taken or to be taken

CDC will continue to address the needs of Native American, Native Alaskan, and Native Hawaiian communities to prevent and reduce the burden of diabetes and its complications. In 2005, the CDC National Diabetes Education Program (NDEP) awarded eight organizations with competitive funding for five years to promote diabetes education strategies in minority communities. Two of the national organizations will promote culturally appropriate diabetes

prevention and control resources and strategies in Native American and Native Hawaiian and Pacific Islander communities. The national organizations and their activities include:

Papa Ola Lokahi will identify diabetes awareness and education priorities in Hawaiian and Pacific Islander communities. They plan to establish a minimum of 20 community based coalitions/partnerships in Hawaii and in the Pacific Jurisdictions to promote diabetes awareness and deliver diabetes education messages, interventions and products to targeted populations in selected communities; use community-based intervention strategies to improve lifestyles through knowledge, skills, attitudes and behaviors for the prevention, control and management of diabetes complications or; strengthen relationships with local health care providers.

The Association of American Indian Physicians (AAIP) will aim to improve knowledge, attitudes, beliefs and behaviors related to the prevention, early detection and control of diabetes in American Indians/Alaskan Native (AIAN) communities. They will work with healthcare providers to assist them in providing culturally appropriate diabetes education and support to AI/communities.

The CDC's National Native Diabetes Wellness Program (Wellness Program) will work with communities, tribes, and other partners to eliminate the gaps in health equity in American Native and American Indian communities. The Wellness Program incorporates traditional healing concepts in their strategies.

Item

Genomic Medicine – The Committee is aware that steps need to be taken today to prepare the public health system for the coming widespread use of genetic technologies in healthcare. Failing to do so may exacerbate existing health disparities and seriously limit progress generated by the Human Genome Project. The Committee urges CDC to move forward aggressively with the creation and implementation of partnerships with industry and the nonprofit sector to achieve the widest benefits from the coming era of genomic medicine. (Page 66)

Action taken or to be taken

CDC agrees that aggressive steps are needed to prepare for the proper use of genomic technologies to prevent disease and improve health. CDC is ready to create and implement partnerships with industry and the nonprofit sector to achieve the broadest public health impact across the lifespan. In 2006, CDC's Office of Genomics and Disease Prevention plans to continue work in three major focus areas: family history, evaluation of genetic tests, and describing the distribution of relevant genetic markers in the population.

Family health history is a low-cost, low-tech "genomic" tool that can be used today in disease prevention and health promotion. CDC has created a web-based tool called Family Healthware™, which collects information about a person's family history for six diseases – heart disease, stroke, diabetes, and colorectal, breast, and ovarian cancer. Three research centers are currently conducting a clinical trial of the family history tool. A pending patent will also make the tool available for use by industry and nonprofit organizations.

New genomic technologies, such as genetic tests, are developing rapidly and are already being marketed to health care professionals and directly to the general public. However, evidence for their validity and usefulness is often insufficient to inform decision-making. Recognizing this information need, CDC launched the Evaluation of Genomic Applications in Practice and Prevention (EGAPP) project in FY2005. An independent panel of experts will commission reviews of the analytic and clinical validity and the clinical utility of important genetic tests. This information will be disseminated widely to physicians, health insurers, managed care organizations, industry, nonprofit organizations, public health agencies and the general public.

Information on the population distribution of relevant genetic markers is needed to design and interpret the clinical trials fundamental to development of genomic medicine. CDC is collaborating with the National Cancer Institute to measure population variation in selected genes using stored DNA samples collected during the National Health and Nutrition Examination Survey (NHANES) III. The results--which will be made available to researchers, industry and the public--will provide an important basis for estimating the proportions and numbers of people who could benefit from particular genotype-based screening or diagnostic tests, drugs, or other preventive or therapeutic interventions.

Item

Geraldine Ferraro Cancer Education Program – In fiscal year 2004, Congress provided funding to initiate the Geraldine Ferraro Cancer Education Program, as authorized by the Hematological Cancer Research Investment and Education Act of 2002. The Committee is pleased that CDC has established a cooperative agreement program with national health organizations to develop strategies to provide information and education for patients, their family members, friends, and caregivers with respect to hematologic cancers. The Committee expects CDC to increase efforts to address hematologic cancer survivorship issues and improve quality of national hematologic data. With the additional funds provided, the Committee strongly encourages CDC to support activities related to the development of interactive web based education for health care providers on the signs, symptoms and current treatment of blood cancer by comprehensive cancer centers. (Page 67)

Action taken or to be taken

CDC has continued to broaden efforts in hematologic cancers by initiating and awarding a fiscal year 2005 cooperative agreement grant to the University of Colorado Cancer Center (UCCC), Hematological Cancer Healthcare Providers Education Program. The UCCC is a NCI-designated Comprehensive Cancer Center located at the University of Colorado at Denver and Health Sciences Center's Fitzsimons campus in Aurora, Colorado. This effort will result in the dissemination of hematological cancer education to healthcare providers, including primary care physicians, hematologists, oncologist and allied healthcare workers.

Item

Inflammatory Bowel Disease – The Committee understands that an estimated 1 million people in the United States may suffer from Crohn's disease or ulcerative colitis, collectively known as inflammatory bowel disease [IBD]. In fiscal year 2005, the Committee provided funds to continue a national IBD epidemiology program established through a partnership between CDC and the Crohn's and Colitis Foundation of America. The Committee encourages the CDC to continue this important initiative and has provided sufficient resources to do so. (Page 67)

Action taken or to be taken

CDC has collaborated with the Crohn's and Colitis Foundation of America (CCFA) to estimate the incidence and prevalence of Crohn's Disease and Ulcerative Colitis. With fiscal year 2006 funds, CDC and CCFA will progress to the next phase of the research project and collaborate with a large single health care plan organization to examine the diagnosis and treatment of IBD. The project will use direct access to a patient population to understand patient and disease characteristics such as patient demographics, type and severity of IBD and co-morbid conditions. Because there is little understanding of the consistency and quality of treatment given to IBD patients in the community setting, the research project will examine adherence to current practice guidelines and barriers to implementing guidelines in community practice.

Item

Lung Disease – The Committee encourages the CDC to consider supporting efforts to validate the importance of spirometry screenings in early detection of lung disease. Such efforts include further research and development of projects to facilitate the translation of new scientific knowledge into spirometry public health screening programs. The Committee urges the CDC to coordinate with the National Heart, Lung and Blood Institute in translating the results of these efforts into guidance for public health programs, including vital signs and screening programs. (Page 68)

Action taken or to be taken

CDC is a member of the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program and continues to work with NHLBI specifically related to asthma. In addition, CDC's National Asthma Control Program has funded Dr. James Stout, University of Washington, to develop a training CD on spirometry. The goal of this CD is to train providers how to administer, interpret, and ensure the quality of pulmonary function testing in their office. The CD is currently under development. In addition, CDC's NHANES study will add spirometry tests beginning in 2007, re-instituting a test conducted on NHANES participants from 1988-94.

Item

Lupus – The Committee recognizes that lupus is a serious, complex, debilitating chronic autoimmune disease that can cause inflammation and tissue damage to virtually any organ system in the body and impacts between 1.5 and 2 million individuals. The Committee is concerned by the lack of reliable epidemiological data on the incidence and prevalence of all forms of lupus among various ethnic and racial groups. The Committee encourages CDC to consider modifying the National Lupus Patient Registry to create a common data entry and management system across all study sites, to collaborate with a consortium of academic health centers with an expertise in lupus epidemiology, and to ensure that study sites represent different geographic regions of the United States that have a sufficient number of individuals of all racial and ethnic backgrounds disproportionately affected by Lupus, including Hispanics, Asians, Native Americans, and African Americans. (Page 68)

Action taken or to be taken

Systemic lupus erythematosus (SLE) is a rheumatic condition with serious disability, pain, compromised quality of life, and premature death. The condition is most common among women, and the burden is more severe for African American women. Because of concern over the morbidity and early mortality that lupus can cause, Congress directed CDC in 2003 to initiate a registry to provide the public health and medical communities with a better understanding of lupus, including incidence and prevalence of the disease.

Because lupus is difficult to diagnose, its broad spectrum of severity and corresponding burden on society has been extremely difficult to estimate. There is consensus that science needs to be improved in this area. CDC's registry is a first major step forward in improving this science. CDC has initiated two carefully designed and focused, population-

based lupus registries in Michigan and Georgia. Both pilot registries are in localities with large African American populations, a group disproportionately impacted by lupus. These registries will provide important information about lupus to both the public health and clinical communities. Ideally data collection would need to expand to new sites to address epidemiological gaps among Hispanics, Asians, and Native Americans to explore cultural and geographic differences in lupus.

Item

Vision Loss – The Committee is aware of interest in the creation of a National Information Center on Vision Loss to address the need for appropriate public health information to prevent further impairment and disability among individuals who are blind or who have low vision. The Committee encourages CDC to consider this proposal, including partnering with a national non-profit organization that is recognized for leadership in providing information to persons who are blind or visually impaired, including published resource guides, directories of services for consumers in the field, scholarly journals on blindness and vision loss, assistive technology magazines, and talking books. (Page 68)

Action to be taken

CDC concurs with the need for appropriate public health information dissemination to prevent further impairment and disability among individuals who are blind or who have low vision. CDC has prepared a concept paper to identify potential health concerns and health disparities among people with vision loss. For example, people with vision impairment may have a greater likelihood of medical errors because they cannot read pharmaceutical instructions and they may have greater rates of auto pedestrian injury because they cannot see automobiles. CDC is currently working with the American Foundation for the Blind, a private blindness organization, to help support the publication of a special issue of the Journal of Visual Impairment and Blindness on the public health of vision loss. This publication will serve to create the intellectual foundation for this important area of public health inquiry for people who are blind and visually impaired.

Item

Oral health - health care disparities – The Committee recognizes that to effectively reduce disparities in oral disease will require improvements at the State and local levels. The Committee has provided additional funding to States to strengthen their capacities to assess the prevalence of oral diseases, to target interventions, such as additional water fluoridation and school-linked sealant programs, and resources to the underserved, and to evaluate changes in policies, programs and disease burden. The Committee encourages the CDC to advance efforts to reduce the disparities and health burden from oral cancers that are closely linked to chronic diseases such as diabetes and heart disease. (Page 69)

Action taken or to be taken

CDC is working with 12 states and one territory to build capacity for effective oral health prevention programs and to reduce disparities among disadvantaged populations. This effort includes working with states to develop school-based or school-linked programs to reach children at high risk of oral disease with proven and effective education and prevention services, such as dental sealants. CDC also works with states to expand the fluoridation of community water systems and operates a fluoridation training and quality assurance program. In addition, CDC will expand its efforts to assess the extent of oral diseases, target prevention programs and resources to those at greatest risk, fund prevention research, and evaluate changes in policies and programs to reduce disparities. CDC will continue to develop methods to identify and reach adults at greatest risk of oral diseases associated with other chronic diseases (e.g., diabetes and heart disease) and their risk factors.

Item

Oral health and the effects of soft drinks – The Committee is concerned about the rising obesity rate among American's youth. Some eating habits can adversely affect not only body weight but also oral health. The Committee has provided \$50,000 above the fiscal year 2005 level for the CDC Division of Oral Health to develop an instructional video for school age children on the harmful effects of excessive consumption of soft drinks. The Committee understands that the dental community has already developed some instructional materials and urges CDC to work with the American Dental Association in producing the video. (Page 69)

Action taken or to be taken

CDC is convening experts from the areas of oral health, nutrition, and school health to assess the evidence regarding: harmful effects of excessive consumption of high sugar products and beverages, such as soda; current knowledge, attitudes and behaviors of school-age children and adolescents related to dietary practices; and the effectiveness of interventions, including instructional videos. After this review is completed, CDC will work with the American Dental Association to develop appropriate interventions, which may include promoting policy changes in schools to promote healthier dietary practices and the production of appropriate instructional materials for children.

Item

Osteoporosis and Bone Health Action Plan – The Committee is aware of the Surgeon General's report on Bone Health and Osteoporosis. The Surgeon General calls for a national action plan for bone health. The Committee encourages CDC to collaborate with a leading national voluntary health organization focused on osteoporosis and bone health to confer with other relevant Federal agencies and public and private stakeholders to develop a National Action Plan on Bone Health and Osteoporosis. (Page 69)

Action taken or to be taken

CDC played an active role in developing the Surgeon General's Report on Bone Health and Osteoporosis, which include recommendations for a systems-based approach to bone health that draws upon the entirety of the health care delivery system and a coordinated public health approach that brings together a variety of stakeholders to improve bone health that starts in childhood. CDC has conducted partnership meetings in 2004-2005 with representatives from Federal agencies, state and non-profit organizations (in particular, the National Osteoporosis Foundation) to inform them of the National Bone Health Campaign and to discuss collaborative projects.

CDC is currently developing a draft 5-year social marketing plan for bone health and will leverage this plan with the Surgeon General's Report. The plan will include an audience-based campaign and an evaluation program. The major goals in 2005 were to plan, design, and develop a social marketing pilot study to be executed in 2006; solidify partnership and stakeholder opportunities and secure Memorandums of Understanding with faith and community based organizations, the private sector, academics, and non-profit organizations, to include the National Osteoporosis Foundation.

Item

Prostatitis – The Committee understands that up to 10 percent of the male population worldwide may benefit from better methods to diagnose and prevent prostatitis. The Committee encourages CDC to consider expanding its investigation of the etiology of prostatitis. (Page 70)

Action Taken or to be Taken

Results from a pilot study of prostate tissue biopsies from men with chronic prostatitis that was finished this year could not establish that bacterial biofilms cause chronic prostatitis in the patients studied. However, the newer tissue staining methods developed in this study may provide a clearer future understanding of chronic prostatitis and a better understanding of chronic infections unrelated to prostatitis. CDC will continue to pursue researching the possible etiologies of this disease.

Item

Psoriasis – The Committee urges CDC to consider working with a national organization to develop a surveillance program to ascertain and monitor psoriasis and psoriatic arthritis prevalence and comorbidities. (Page 70)

Action taken or to be taken

CDC does not currently have any activities addressing dermatologic conditions such as psoriasis, however, CDC will work with existing partners to explore ways to incorporate attention to this disease when appropriate. Psoriatic arthritis is a low prevalence rheumatic condition. Although prevalence estimates of this condition vary, it is reported as approximately 0.1% of the population. A recent study, based on self-reported psoriatic arthritis, estimated an adult population prevalence of 0.25% (11% of persons with psoriasis). Based on these estimates, approximately 520,000 adults in the U.S. live with psoriatic arthritis.

Item

Pulmonary Hypertension – The Committee continues to be interested in pulmonary hypertension [PH], a rare, progressive and fatal disease that predominantly affects women, regardless of age or race. PH causes deadly deterioration of the heart and lungs and is a secondary condition in many other serious disorders such as scleroderma and lupus. Because early detection of PH is critical to a patient's survival and quality of life, the Committee encourages CDC to consider supporting a cooperative agreement with the pulmonary hypertension community to foster greater awareness of the disease. (Page 70)

Action taken or to be taken

Because early diagnosis and aggressive treatment are critical to improve the prognosis of those with pulmonary hypertension, increased public and health care provider awareness of the signs and symptoms of pulmonary hypertension is important. In fiscal year 2004, CDC funded the Pulmonary Hypertension Association to create a DVD to educate physicians on the symptoms and diagnosis of pulmonary hypertension. The initial target audience is clinicians who are most likely to receive referrals from primary care physicians – cardiologists, pulmonologists and rheumatologists.

CDC is also exploring opportunities to work on collaborative studies and surveillance reports with the Pulmonary Hypertension Association and other partners such as the American Heart Association and the National Heart Lung and Blood Institute. In November of 2005, CDC published a surveillance summary on pulmonary hypertension, which found that the numbers of deaths and hospitalizations rates have increased for persons with pulmonary hypertension, particularly among women, blacks, and older adults. Two distinct geographic clusters were observed for the highest hospitalization rates in the Medicare population and the highest death rates for pulmonary hypertension, in the western United States and in the Appalachian region. These increases in deaths and hospitalizations may reflect increased physician awareness and changes in diagnosing and reporting this chronic disease. In fiscal year 2006, CDC will continue to work with the Pulmonary Hypertension Association to foster greater awareness of pulmonary hypertension.

Item

Reorganization – The Committee understands that the CDC is considering the reorganization of programs under the Coordinating Center on Health Promotion, particularly programs under the National Center on Chronic Disease Prevention and Health Promotion. The Committee encourages the Director to work closely with external partners to adopt changes that will streamline administrative functions, improve and strengthen collaboration among programs, and increase public awareness of these serious illnesses. (Page 70)

Action taken or to be taken

Like other coordinating centers at CDC, the Coordinating Center for Health Promotion (CoCHP) was created to improve public health outcomes through increased efficiencies, integration of similar programs, and support for cross-cutting public health activities. CoCHP maintains ultimate responsibility for CDC's health promotion efforts, particularly related to wellness, chronic disease prevention, genomics and population health, disabilities, birth defects and other reproductive outcomes, and adverse consequences of hereditary conditions. CoCHP has the lead for working with key partners and external constituents to garner support for a public health agenda that moves from a disease specific focus to the advancement of health promotion in a broader, more systematic way.

Whereas the National Centers within CoCHP will retain their identities and specific partner relationships, CoCHP is exploring innovations to advance health promotion efforts – including the oversight for four of CDC goal areas (healthy schools, older adults, adults and infants/toddlers), the establishment of an external committee to CDC in the areas of wellness and health promotion, and the definition and implementation of a national health promotion agenda. CoCHP will forge new partnerships, while enhancing certain existing ones, by looking at ways partners can further these innovations. In addition, CoCHP is working with partners on the first national CDC health promotion conference, *Innovations in Health Promotion, New Avenues for Collaboration*, scheduled for September 2006 to discuss and advance the innovations described.

Item

Sleep Disorders – The Committee continues to be concerned about the prevalence of sleep disorders and recognizes the need for enhanced public and professional awareness on sleep and sleep disorders. The Committee encourages CDC to consider working with other agencies and voluntary health organizations to support the development of a sleep education and public awareness initiative. (Page 71)

Action taken or to be taken

Surveillance conducted at CDC has previously indicated that sleep insufficiency is associated with impairments in both quality of life and self-reported general health, and, notably that the strength of these associations varies inversely with age. CDC plans to analyze data from a new Behavioral Risk Factor Surveillance System (BRFSS) module specifically assessing depressive disorders, which will better enable researchers to address the complex interrelationship widely reported between sleep and depressive disorders. CDC continues to participate in the Frontiers in Knowledge in Sleep and Sleep Disorders program and the State-of-the-Science Conference of Manifestations and Management of Chronic Insomnia in Adults, both sponsored by the National Institutes of Health (NIH). CDC also serves in an advisory capacity as an ex-officio member of the Sleep Disorders Research Advisory Board coordinated by the National Heart, Lung, and Blood Institute within NIH.

Item

Steps to a Healthier United States – The Committee applauds the Department's continued commitment to tackling the problems of obesity, diabetes, and asthma. The Committee agrees that these are three of the most critical chronic conditions afflicting Americans. The Committee is concerned that existing programs that address these problems have not yet been implemented in all of the States. The Committee has provided sufficient resources to continue this initiative and existing programs within CDC that are aimed at obesity, diabetes, and asthma. The Committee strongly urges CDC to coordinate the efforts of these programs such that the best possible outcome is achieved using these funds. (Page 71)

Action taken or to be taken

Through the Steps Program, CDC is enhancing the tremendous efforts being done at the local, state, and national level by adding connections, building on existing infrastructure, coordinating best practices, and leveraging resources to create an integrated approach to public health promotion and chronic disease prevention. The Steps cooperative agreement program, however, cannot exist without the support, infrastructure, and resources established and maintained by the existing state-based categorical chronic disease programs at CDC and within the communities. The Steps program has been established as an extension of these programs to enhance, expand, and create an integrated approach to address the collective goals of chronic disease prevention. The overarching design of the Steps program emphasizes well-integrated programs at the national, state, and local levels; connecting categorical programs to maximize limited resources and accelerate progress toward important outcomes; and basing programs on sound scientific evidence and practice-based knowledge and lessons. The Steps program will continue to coordinate activities at the national, state and community level through shared and integrated staffing, technical assistance and evaluation activities.

Item

Thrombosis – The Committee understands that thrombosis is a serious public health problem and that there is a great need to increase public awareness of thrombosis and thrombophilia among the public and the medical community. Information on the basic epidemiology of thrombosis and thrombophilia remains to be collected. The Committee encourages CDC to expand its efforts by partnering with a volunteer health organization to expand its outreach and education programs regarding thrombosis and thrombophilia. (Page 71)

Action taken or to be taken

CDC continues a pilot program to expand the scope of the hemophilia treatment network to integrate services for persons with thrombophilia by providing support to eight Hemostasis and Thrombosis Center sites. The sites, in collaboration with CDC have developed a data collection study to determine the genetic and environmental factors that cause or trigger activation of abnormal blood clotting. The sites are continuing to explore models of care for secondary prevention and management of thrombosis. As evidenced in the development of these sites, CDC has focused on encouraging collaboration between the specialized health-care network and community-based organizations to enhance outreach and education. In moving forward, CDC will evaluate the effectiveness of the specialized health-care system to improve health outcomes and quality-of-life measures for persons with thrombophilia, develop educational materials for patients and health-care providers, develop rapid screening methods to detect risk factors for thrombosis and continue to conduct studies to determine risk factors and describe potential interventions to prevent thrombosis.

Item

Centers for Birth Defects Research and Prevention – The Committee encourages CDC to consider expanding the promising research being conducted by the regional Centers for Birth Defects Research and Prevention and maintain assistance to States to implement and expand community-based birth defects tracking systems, programs to prevent birth defects, and activities to improve access to health services for children with birth defects. The Committee also encourages CDC to continue to support collaboration among the States on issues related to surveillance, research and prevention through support of the National Birth Defects Prevention Network. (Page 72)

Action taken or to be taken

CDC appreciates the Committee's recognition of the Centers for Birth Defects Research and Prevention and of state- and community-based surveillance programs. CDC is proud to support these programs and committed to continuing to support individual programs and foster collaboration among programs through the National Birth Defects Prevention Network. A recent example of the fruits of such collaboration is the annual Congenital Malformations Surveillance Report, a compendium providing critical state-specific data on rates and trends of birth defects in the United States. An important example of the recent work of the Centers for Birth Defects Research and Prevention is a recent publication showing a strong association between maternal progesterin intake and the occurrence of hypospadias, a defect of the penis.

Item

Christopher and Dana Reeve Paralysis Resource Center – The Committee understands the growing demand for information, resources, and public health services by individuals with paralysis. The Committee has included \$500,000 above the fiscal year 2005 level for the Paralysis Resource Center and the associated rehabilitation therapy program. The Committee encourages CDC to evaluate the public health effectiveness of the paralysis programs and explore the feasibility of health care system-wide implementation of new rehabilitation programs. (Page 72)

Action taken or to be taken

As part of its mission to strategically develop programs to translate basic science findings to the clinic, the Christopher Reeve Foundation (CRF) is deploying specialized centers primed to deliver intensive activity-based rehabilitation treatments to people with spinal cord injury and other select neurological disorders. The goal of these centers is to improve the overall health and well-being of people living with paralysis as well as promote functional recovery. All treatments are based on continually evolving scientific and clinical evidence. The network of specialized centers is expanding from existing locations in Louisville, KY, and Philadelphia, PA, to Atlanta, GA, and Houston, TX, with a fifth center in Florida under review. CRF is also developing a marketing campaign aimed at prospective consumers of the network.

Item

Fragile X – The Committee is encouraged by the CDC's progress in establishing a Fragile X public health program to expand surveillance and epidemiological research of Fragile X, as well as provide patient and provider outreach on Fragile X and other developmental disabilities. The Committee has provided sufficient resources to continue these activities. (Page 73)

Action taken or to be taken

In FY05, CDC funded three projects related to Fragile X Syndrome (FXS). First, CDC is working with the University of California at Davis to draft protocols for Fragile X family testing and genetic counseling. The CDC expects to present the protocols to the public in the fall of 2006. Secondly, CDC funded Emory University to conduct feasibility testing of a novel DNA testing procedure of FXS using anonymous newborn screening bloodspots. In addition, the project will provide estimates of allele frequencies in the FXS gene in different racial and ethnic groups. Finally, CDC is working with the Genetic Alliance to develop a resource center for single gene disorders. The project includes development and dissemination of provider education materials related to the diagnosis and care of children with FXS. FY06 funds will be used to continue activities at Emory and with the Genetic Alliance. The resource center will be used to augment the dissemination of the genetic testing and counseling protocols. In addition, FY06 funds will be used to fund a national FXS family needs assessment.

Item

Hemophilia – The Committee supports CDC's continued efforts with the National Hemophilia Foundation to carry out needed education, prevention, blood safety surveillance, and outreach programs for the millions of people in the United States affected by bleeding and clotting disorders, including hemophilia, women's bleeding disorders, and thrombophilia. The Committee encourages CDC to consider enhancing its support of the network to ensure continued access to this comprehensive chronic care model for all persons with bleeding and clotting disorders. (Page 74)

Action taken or to be taken

CDC has implemented a pilot study aimed at determining the best methodology to collect information to determine the occurrence of and risk factors for inhibitors. In the year ahead, CDC will be providing technical assistance in aiding efforts to attain the goal of having 60% of hemophilia treatment centers trained and submitting Universal Data Collection (UDC) data via electronic submission. CDC will also be engaging in an effort to determine baseline of quality of life among persons participating in the UDC surveillance program

Item

Hemophilia organizations – The Committee recognizes the important work of all voluntary organizations concerned with hemophilia, and encourages CDC to take steps to ensure that additional patient-based organizations can participate in its hemophilia grant program on an annual basis. (Page 74)

Action taken or to be taken

CDC's success in hemophilia is predicated on its relationships with organizations concerned with hemophilia and will continue to take steps to ensure that additional patient-based organizations can participate in its hemophilia grant program when appropriate.

Item

Hereditary Hemorrhagic Telangiectasia – The Committee is aware of interest in the establishment of a Hereditary Hemorrhagic Telangiectasia [HHT] National Resource Center through a partnership between the CDC and the national voluntary agency representing HHT families. The Committee encourages the CDC to examine carefully proposals to establish such a center and give appropriate consideration to supporting it within the funds provided. (Page 74)

Action taken or to be taken

Early in 2006 CDC will be meeting with representatives from the agency representing HHT families. At that time we will discuss proposals and explore opportunities to create an HHT National Resource Center.

Item

Genomic Medicine – The Committee is aware that steps need to be taken today to prepare the public health system for the coming widespread use of genetic technologies in healthcare. Failing to do so may exacerbate existing health disparities and seriously limit progress generated by the Human Genome Project. The Committee urges CDC to move forward aggressively with the creation and implementation of partnerships with industry and the nonprofit sector to achieve the widest benefits from the coming era of genomic medicine. (Page 75)

Action taken or to be taken

CDC agrees that aggressive steps are needed to prepare for the proper use of genomic technologies to prevent disease and improve health. CDC is ready to create and implement partnerships with industry and the nonprofit sector to achieve the broadest public health impact across the lifespan. In 2006, CDC's Office of Genomics and Disease Prevention plans to continue work in three major focus areas: family history, evaluation of genetic tests, and describing the distribution of relevant genetic markers in the population.

Family health history is a low-cost, low-tech "genomic" tool that can be used today in disease prevention and health promotion. CDC has created a web-based tool called Family Healthware™, which collects information about a person's family history for six diseases – heart disease, stroke, diabetes, and colorectal, breast, and ovarian cancer. Three research centers are currently conducting a clinical trial of the family history tool. A pending patent will also make the tool available for use by industry and nonprofit organizations.

New genomic technologies, such as genetic tests, are developing rapidly and are already being marketed to health care professionals and directly to the general public. However, evidence for their validity and usefulness is often insufficient to inform decision-making. Recognizing this information need, CDC launched the Evaluation of Genomic Applications in Practice and Prevention (EGAPP) project in FY2005. An independent panel of experts will commission reviews of the analytic and clinical validity and the clinical utility of important genetic tests. This information will be disseminated widely to physicians, health insurers, managed care organizations, industry, nonprofit organizations, public health agencies and the general public.

Information on the population distribution of relevant genetic markers is needed to design and interpret the clinical trials fundamental to development of genomic medicine. CDC is collaborating with the National Cancer Institute to measure population variation in selected genes using stored DNA samples collected during the National Health and Nutrition Examination Survey (NHANES) III. The results--which will be made available to researchers, industry and the public--will provide an important basis for estimating the proportions and numbers of people who could benefit from particular genotype-based screening or diagnostic tests, drugs, or other preventive or therapeutic interventions.

Item

Eating Disorders – The Committee is concerned about the growing incidence and health consequences of eating disorders among the population. The extent of the problem while estimated by several long-term outcome studies as being high remains unknown. The Committee urges the CDC to research the incidence and morbidity and mortality rates of eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified across age, race, and sex. (Page 76)

Action taken or to be taken

CDC is similarly concerned about the increase and consequences of eating disorders among the population, and understands that NIH and SAMHSA take a leadership role in the United States for researching the extent of the problem, its causes, and effective treatment strategies. CDC currently does not collect data about the prevalence of eating disorders; however, through several of our ongoing data collection/surveillance systems (e.g., YRBSS, NHANES, NHIS) we collect data periodically about unhealthy dieting and eating behaviors, such as fasting, taking diet pills, vomiting, and reducing caloric intake.

Item

Asthma – The Committee is pleased with the work that the CDC has done to address the increasing prevalence of asthma. However, the increase in asthma among children remains alarming. The Committee urges CDC to expand its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. To further facilitate this effort, CDC is encouraged to partner with voluntary health organizations to support program activity consistent with the CDC's efforts to fund community-based interventions that apply effective approaches demonstrated in research projects within the scientific and public health community. (Page 77)

Action taken or to be taken

CDC's National Asthma Control Program (based in the Division of Environmental Hazards and Health Effects or EHHE) is further expanding its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. This year, through its National Asthma Health Education Enhancement effort, CDC/EHHE has funded voluntary health organizations such as the Allergy and Asthma Network/Mothers of Asthmatics, American Lung Association, and Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers. CDC/EHHE also has created a Web site for state and local public health organizations and others called "Effective Interventions for Asthma Control" to help them know "what works" and provide access to materials to adapt and implement the interventions (<http://www.cdc.gov/nceh/airpollution/asthma/interventions/interventions.htm>).

CDC's Division of Adolescent and School Health (DASH) is funding seven urban school districts with at least 50% minority population (Albuquerque, Baltimore, Charlotte, Detroit, Los Angeles, Memphis, Philadelphia) and one state education agency (Oregon) to implement strategies to reduce asthma-related illnesses and absences. Activities include providing health services and education for students with asthma; disseminating asthma management guides and education curricula to schools; and professional development for school nurses, teachers, physical education teachers, and coaches in asthma management.

CDC/DASH is also currently funding six national nongovernmental organizations (American Lung Association, Asthma and Allergy Foundation of America, Starlight Starbright Children's Foundation, National Association of School Nurses, American Academy of Pediatrics, and American Association of School Administrators) to assist in building the capacity of state and local health and education agencies in addressing asthma in schools. Activities range from developing an asthma toolkit for community members to assist with addressing asthma in schools to providing asthma education for children and teens with asthma, school administrators, school nurses and pediatricians. Funding for these NGOs will end in 2006. They and other NGOs will be eligible to apply for a new 5-year cooperative agreement. From 2006-2011, CDC/DASH will fund two or three NGOs to provide capacity building assistance to faith-based institutions, youth service providers, or parent organizations interested in addressing asthma in schools.

All of CDC/DASH's asthma funded partners are using CDC's research-based document, Strategies for Addressing Asthma Within a Coordinated School Health Program, released in Fall 2002, to guide their programs. CDC/DASH just released a new version of its popular School Health Index: A Self-Assessment and Planning Guide which now includes asthma content and should also prove helpful in guiding funded partners to use research-based strategies to address asthma in schools.

Item

Biomonitoring – The CDC's National Report on Human Exposure to Environmental Chemicals is a significant new exposure tool that provides invaluable information for setting research priorities and for tracking trends in human exposures over time. The Committee continues to support the CDC environmental health laboratory's efforts to provide exposure information about environmental chemicals. The Committee understands that for most chemicals it is currently difficult to interpret biomonitoring information in a health risk context. Therefore, the Committee encourages CDC to develop the necessary methods to better interpret human biomonitoring concentrations in the context of potential health risks. The Committee applauds the CDC's biomonitoring efforts and encourages the Agency to continue this program and continue to improve its efforts to communicate these results in context. (Page 77)

Action taken or to be taken

CDC agrees that having unique information about the exposure of the U.S. population to environmental chemicals is a key to understanding the relation between exposure and disease and that the ability to interpret biomonitoring information in a health-risk context is important. Clearly, research studies are needed to determine which levels of a chemical may cause health effects and which are not a significant health concern. Currently, CDC conducts or provides measurements for 50-65 studies each year in collaboration and is working to increase number of these studies to 70-80 in order to examine the relation of exposure to particular chemicals and the occurrence of health effects. In addition, CDC's Environmental Health Laboratory is exploring the possibility of collaborating on exposure studies in animals at levels typically found in the U.S. population and that are described in CDC's National Report on Human Exposure to Environmental Chemicals. CDC strives to communicate in all of its printed documents, press statements, interviews, and other media and educational materials that the toxicity of a chemical is related to its dose or concentration as well as to a person's individual susceptibility and that just because people have an environmental chemical in their blood or urine does not mean that the chemical causes disease.

Item

Volcanic Emission and Asthma – The problem of asthma in Hawaii remains a serious health threat and challenge, especially among the medically underserved. In particular, the problem of volcanic emissions in Hawaii contributes to this and other respiratory problems. The Committee encourages CDC to consider potential interventions that may be helpful. (Page 78)

Action taken or to be taken

Since 1998, CDC's National Asthma Control Program has been funding the Hawaii State Department of Health (HDOH) to address the problem of asthma among medically-underserved populations in the state. HDOH is currently conducting an assessment of the health effects that may be associated with potentially toxic volcanic emissions from an active volcano in the state. The purpose of the program is for HDOH to conduct necessary surveys and data analyses to determine the association between volcanic gases and human health effects among Hawaiian residents and visitors.

CDC also is funding the HDOH to oversee a "Childhood Rural Asthma Project." The Childhood Rural Asthma Project builds the capacity of five rural community health centers to effectively identify, treat, and educate pediatric asthma sufferers and their families on the islands of Kauai, Oahu, and Hawaii.

This project focuses on improving the health, quality of life, and functional status of Hawaii's low income children living in medically-underserved communities served by Hawaii's five rural health centers. With funding and technical assistance from CDC, the HDOH has developed the Hawaii State Asthma Control Program (HSACP). This program through the Hawaii Asthma Initiative is currently engaging in planning activities with community partners, developing and enhancing surveillance activities, and implementing interventions to build the state's capacity to address asthma. The seven phases of the HSACP are to (1) conduct an epidemiological analysis of secondary mortality and morbidity data and service provision data related to asthma, (2) identify current and existing resources and services, (3) identify the gaps and needs of resources and services in the state, (4) prioritize the identified needs and gaps in services, (5) develop a strategic plan to address asthma in the state, (6) identify and initiate various implementation/intervention activities based on surveillance data, and (7) monitor and evaluate the accomplishments in reducing the burden of asthma in the population.

Item

National Violent Death Reporting System – The Committee is supportive of the National Violent Death Reporting System, which is a State-based system that collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. The information can be used to develop, inform, and evaluate violence prevention programs. The Committee has provided sufficient resources to continue this program with at least the fiscal year 2005 level of funding. The Committee urges the CDC to continue to work with private health and education agencies as well as State agencies in the development and implementation of an injury reporting system. (Page 78)

Action taken or to be taken

Established by the CDC in Fiscal Year 2002, the National Violent Death Reporting System (NVDRS) allows states and communities to develop a system to collect timely, complete, and accurate information about violent deaths. In FY 05, CDC funded 17 states to implement NVDRS. Through a national violent death reporting system, states can quickly see how their problems compare with others across the nation and work to address the violence in their communities. CDC continues to work with state health departments, academic institutions, health care providers, national organizations, and others regarding the system's development and implementation.

Item

Violence Against Women – The Committee urges CDC to increase 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, and other affected populations. (Page 79)

Action taken or to be taken

CDC conducts intramural and extramural research to address the psychological consequences of violence against women. For example, CDC funded Emory University to evaluate a randomized controlled trial on suicidal ideation in abused women. This study focuses on low income, African American women and utilizes culturally-competent assessments and interventions. CDC is also investigating the psychological influences that perpetuate violence against women, by examining the extent to which batterers and non-batterers can be distinguished on the basis of issues surrounding power and control in response to violence.

CDC is funding the development and pilot testing of a family-based program, *Families for Safe Dates*, that will be designed to address multiple types of dating violence (psychological, physical, and sexual), victimization and

perpetration, and violence directed at peers. The content of Families for Safe Dates will draw heavily from Safe Dates, a school-based dating violence prevention program that was shown to be effective. The premises and structure will model a program called Family Matters that was developed and evaluated by the investigators in a national randomized trial, and found to be successful in reducing the prevalence of adolescent substance use.

CDC also supports four sites to conduct efficacy and effectiveness trials of interventions to prevent intimate partner violence and/or its negative consequences for at-risk or underserved populations. Additionally, CDC funds two organizations to assist racial or ethnic minority communities to assess and prevent sexual and intimate partner violence.

Item

Youth Violence – The Committee has included \$2,500,000 above the fiscal year 2005 level for CDC's youth violence prevention activities. The Committee notes that the level of youth violence in cities around the Nation is troubling. The city of Philadelphia, in particular, has experienced a spike in youth violence. The Committee encourages CDC to use some of the increase to address the growing number and seriousness of violent acts committed by youth in urban areas such as Philadelphia. (Page 79)

Action taken or to be taken

CDC supports programs and research to better understand and address youth violence, because of the significant burden of youth violence in the United States. CDC funds 8 National Academic Centers of Excellence on Youth Violence to foster joint efforts between university researchers and communities to address youth violence. The Centers focus on developing and implementing community response plans, training health care professionals and conducting research projects to evaluate effective strategies for preventing youth violence. In addition, the University of Pittsburgh's CDC funded Center for Injury Research and Control is conducting a study to determine if early identification of at-risk youth and timely referral to community-based programs can reduce injury recidivism and the number of violent events in the area. CDC also supports the University of Wisconsin-Milwaukee to examine the effectiveness of a violence prevention program aimed at reducing aggressive behavior in assaulted urban youth. In FY06, CDC will expand its existing portfolio to support additional activities to prevent youth violence in urban areas.

Item

Miners' Choice Health Screening Program – The Committee is concerned that sufficient resources were not allocated to implement the Miners' Choice Health Screening Program in fiscal year 2005. The Committee urges NIOSH to implement this program in fiscal year 2006. This program was initiated to encourage all miners to obtain free and confidential chest x-rays to obtain more data on the prevalence of Coal Workers' Pneumoniosis in support of development of new respirable coal dust rules. The Committee is strongly supportive of these efforts and urges NIOSH to work to improve this health screening program thereby helping to protect the health and safety our Nation's miners. (Page 81)

Action taken or to be taken

NIOSH agrees that the Miners' Choice Health Screening Program is very important. NIOSH plans to begin implementation of a program in FY 2006 that will serve two targeted regional areas per year. Each year, the planned program will focus on screening miners from different regions of the country identified by surveillance data as areas of high prevalence.

Item

Global HIV/AIDS – The Committee notes that funding for continuation of the International Mother and Child HIV Prevention Initiative [MTCT] has been requested in the budget for the Department of State under the jurisdiction of the Foreign Operations Appropriations Subcommittee. Therefore, the Committee does not provide any funding for the program in the CDC, however, the Committee remains supportive of this critical program. The Committee encourages CDC to ensure that funds provided to the MTCT program, the CDC GAP initiative, and the Global Fund for HIV/AIDS, Tuberculosis, and Malaria are used in a coordinated and complementary fashion. (Page 82)

Action taken or to be taken

Preventing childhood infections through prevention of mother-to-child HIV transmission (PMTCT) programs has been a high priority of the U.S. Government (USG) in the fight against AIDS. The President's International Mother and Child HIV Prevention Initiative launched some of the first programs in this critical area, and provided the foundation for current work under the President's Emergency Plan for AIDS Relief (the Emergency Plan). As a partner in the Emergency Plan, HHS/CDC GAP worked closely with other USG agencies to provide PMTCT services for almost 2 million pregnant women in the 15 focus countries in FY 2005. Approximately 125,000 HIV-positive women received short-course antiretroviral (ARV) prophylaxis in PMTCT settings, which resulted in the prevention of an estimated 23,000 infant infections. In addition to assisting host governments to strengthen the capacity to operate PMTCT programs, the USG supported training or retraining of over 28,000 people in the provision of PMTCT services, and

supported approximately 2,500 service outlets that provide PMTCT services in the 15 focus countries. HHS/CDC GAP provided PMTCT services to more than 272,788 women who reside in the ten countries receiving other bilateral support in FY 2005. In addition, HHS/CDC GAP collaborates closely with the Country Coordinating Mechanisms of the Global Fund for HIV/AIDS, Tuberculosis, and Malaria in the GAP countries and 31 other countries served by GAP regional offices.

Item

Alternative Therapies – As more and more Americans use alternative and complementary therapies to maintain and improve their health, there is a growing need for better consumer information about these therapies. The Committee encourages CDC to consider expanding their efforts in this area. Practice-based assessments and the identification and study of promising and heavily used complementary and alternative therapies and practices should be undertaken and results published. The Committee urges CDC to collaborate with the National Center for Complementary and Alternative Medicine [NCCAM] to assure that its efforts complement efforts by NCCAM. (Page 83)

Action taken to be taken

CDC supports complementary and alternative medicine's role in traditional health care practice through collaborating and funding a multi-level project on the mechanisms and therapeutic effects of the relaxation response with the Mind/Body Medical Institute at Harvard Medical School. The relaxation response is a physiologic response opposite to that of the fight-or-flight or stress response. Physiology of the relaxation response and its clinical usage has been accurately described over the last 30 years. It is a recognized, successful treatment in diseases caused or made worse by stress—diseases that comprise more than 60% of visits to health care professionals. Yet better understanding of the relaxation response is necessary to ensure its proper and perhaps expanded usage. New technologies now allow such progress. The project has four components: Component 1 uses cutting-edge technology (functional magnetic resonance imaging) to identify specific brain regions that become active (or less active) as experienced meditators elicit the relaxation response. Researches have successfully scanned 10 experienced meditators of Kundalini tradition, 18 experienced meditators of Vipassana tradition and approximately 20 aged matched controls. Component 2 is a laboratory-based experiment which studies the protective role that the relaxation response plays in counteracting the effects of acute stress in health subjects (ages 18-45). In the first cohort of subjects (n=38), initial analysis indicates that the changes in exhaled nitric oxide are associated with decreases in oxygen consumption—a characteristic of successful elicitation of the relaxation response. Also, decreases in oxygen consumption are associated with reduction in the stress hormone cortisol over 8 weeks of training. Component 3 is a randomized controlled trial to examine whether 8 weeks of relaxation response training reduces blood pressure in hypertensive patients and whether 16 weeks of relaxation response training allows for these patients to reduce their anti-hypertensive medications. Data from 90 subjects (83% of the study group) has been completed. Component 4 is a new laboratory-based experiment and is a follow-up study on the success of Project 2. Specifically, this project examines changes in the genetic expression from the relaxation response in healthy individuals (aged 18-30).

Item

Food Marketing – The Committee commends the CDC for its role and participation in the Food Marketing and the Diets and Health of Children and Youth study done in partnership with the Institute of Medicine through the Food and Nutrition Board and the Board on Children, Youth, and Families. The Committee encourages CDC to continue its efforts to identify the causes of obesity, particularly the science-based effects of food marketing on the diets and health of children and youth in the United States. (Page 84)

Action taken or to be taken

CDC continues to pursue research and analysis activities that will illuminate causes of obesity, including the effects of food marketing on the diets and health of children and youth in the United States. In partnership with CDC, Institute of Medicine recently released a report entitled "Food Marketing to Children and Youth: Threat or Opportunity." The report offers the most comprehensive review to date of the scientific evidence on the influence of food marketing on diets of children and youth. The committee assessed hundreds of relevant studies and rigorously reviewed evidence from more than 120 of the best designed to determine what effects marketing may have on children's diets and health. The committee found strong evidence that television advertising influences the food and beverage preferences and purchase requests of children ages 2 through 11 years old and affects their consumption habits, at least over the short term. Most advertising geared toward children promotes high-calorie, low-nutrient foods, beverages, and meals, which, the committee concluded, influences children to request and choose these products.

There is not enough evidence to determine the extent to which marketing influences the preferences and consumption habits of 12- to 18-year-olds as too few studies focused on this cohort. In addition, the evidence on whether television advertising directly affects children's long-term dietary patterns is limited and less conclusive. However, nutrition studies show that America's children and youth are consuming too many calories and too much

added sugar, fat, and salt. Moreover, they are consuming less-than-recommended amounts of many key nutrients, including calcium, vitamin E, and fiber. Available studies are too limited to determine whether television advertising is a direct cause of obesity among children. However, the statistical association between ad viewing and obesity is strong.

Item

Poor Diet and Inactivity – Hundreds of thousands of people die prematurely each year from heart attack, stroke, and diabetes, and scientists agree that poor diet, physical inactivity, and being obese puts one at greater risk for those conditions. The Committee is concerned that the recent controversy regarding the estimates of the number of deaths due to obesity has resulted in public confusion and ignores other diet and physical inactivity disease rates, related deaths and health care costs. The Committee urges the CDC to conduct a study to estimate the number of premature deaths, diseases, and costs due to poor diet and physical inactivity. The study should include diet- and inactivity-related deaths, diseases, and costs due to heart disease, cancer, stroke, diabetes, and other diseases and those due to a range of dietary factors. The number of diet- and inactivity-related deaths, diseases, and costs should be compared to other leading causes including tobacco, alcohol, infectious diseases, etc. (Page 84)

Action taken or to be taken

As the nation's prevention agency, CDC is charged with protecting the nation's health. Seven of the 10 leading causes of death in the United States are chronic diseases, the top two being heart disease and cancer. Because so many chronic diseases are affected by obesity, and because mortality (deaths) is an important indicator of the severity of a public health problem, estimating deaths from obesity helps us better understand one aspect of the burden of obesity.

Because obesity has so many different effects on so many diseases, it is extremely difficult for doctors to identify obesity-related deaths reliably on death certificates. As a result, scientists use complex modeling techniques to estimate deaths related to obesity. CDC is supporting research to improve these methods. This research is part of CDC's follow-up to a December 2004 Institute of Medicine (IOM) workshop, "Estimating the Contribution of Lifestyle-Related Factors to Preventable Death." To this end, CDC is convening a meeting of experts on May 17-18, 2006 to discuss the complex scientific issues related to estimating the burden of disease from lifestyle risk factors. The CDC meeting will focus on overweight and obesity but have broader application to other lifestyle risk factors including poor diet and physical inactivity. The meeting, moderated by IOM president Dr. Harvey Fineberg, will bring together leading subject matter experts and methodology experts from around the world. This meeting will lay the foundation for further work at CDC and elsewhere to estimate the burden of disease and costs related to poor diet and physical inactivity. During this meeting, experts will discuss what factors are most likely to alter the relationship between health outcomes and obesity and therefore need to be statistically controlled in some way and what are the best methods to control these factors. For example, whether people smoke or not needs to be considered when trying to learn the health effects of obesity because smoking alters the relationship between being obese and illness. What are the best measures of obesity? For example, most scientists have used a measure called body mass index as a measure of obesity. Other measures such as the distribution of body fat may be useful. What are the effects of using self-reported weight rather than actually measuring weight? For example, some evidence shows that people will report that they weigh less than they actually do which would alter the study results and make this method less valid.

It is important to widen the scope of the concept of estimating health burden beyond the number that we call attributable fraction whether for deaths or other outcomes. This number was reported in the two articles that appeared in 2004-2005. Using this metric for smoking can be justified because the exposure (smoking) can theoretically be removed (or, in reality reduced) and numbers of deaths/illnesses attributable to smoking calculated. This is not necessarily the case for life-style factors such as obesity or nutrition. Experts will discuss research needed to reduce the health burden of obesity and other life-style risk factors.

Item

Clinician Update Service – The conferees are aware of the Clinician Update Service, which the CDC has begun with World Medical Leaders to disseminate news, information, and alerts to physicians who are on the front lines in the effort to recognize biological, chemical, and radiological events. The Committee encourages CDC to consider supporting the completion of Phase II of the project. (Page 86)

Action taken or to be taken

The Clinician Update Service project with World Medical Leaders resulted in a development of a technical prototype of a "clinician update service" application. Focus groups were conducted in three large metropolitan cities (New York, Chicago and Los Angeles) with small groups of clinicians to review the prototype and determine whether the "clinician update service" would be of use and interest to them. While many clinicians noted that the "clinician update service" was conceptually useful, additional evaluation research with this target population would need to be conducted to ensure it would actually be used as intended. Finding of note included that clinicians and other healthcare providers

get information through many channels and from many information providers. Prior to seeking further funding for additional phases of this initiative, an evaluation to determine whether this is the best "niche" for CDC information delivery would need to be conducted.

Item

Pandemic Influenza – The Committee notes that several outside organizations, including the Trust for America's Health, have made recommendations regarding pandemic preparedness. The Committee encourages CDC to consult with outside experts in its preparations for, and response to, a potential pandemic. (Page 87)

Action Taken or to be Taken

CDC has well-established and effective means of receiving input and advice from outside experts in pandemic preparedness through its advisory committee system. CDC programs also have individual outside experts who provide feedback to the CDC leadership in these arenas on an ongoing basis. Additionally, CDC has met with the Trust for America's Health and also collaborates regularly with other key external organizations, including the Association of Public Health Laboratories, the Council of State and Territorial Epidemiologists, and the National Association of City and County Health Officers. CDC considers these and other partners to be key constituents in issues related to influenza, and CDC continuously improves its operations on the basis of input from these organizations.

Item

Pandemic Influenza – The Committee is aware that the Department is developing a pandemic influenza response plan. The Committee recognizes that local public health departments, working with their States, play essential roles in responding to influenza outbreaks, including monitoring of local vaccine availability, distribution and redistribution of vaccines and antiviral medications to high priority populations, implementation of necessary epidemic containment measures, and communication to the public. Therefore, Committee encourages the Department to assure that all aspects of Federal pandemic influenza planning are consistent with operational realities at the local level and will have the intended public health results when implemented locally. The Committee further urges the Department to assure that Federal pandemic flu planning avoid duplication and inconsistency with other Federal directives concerning public health preparedness.

Action taken or to be taken

Most states have developed their pandemic influenza plans as components of an overall plan, and the relationship of state and local public health agencies are clarified. Pandemic influenza planning and preparedness activities have been part of CDC's Public Health Preparedness Cooperative Agreement funding. All guidance applies to pandemic influenza preparedness to assure planning consistency.

Item

State and Local Capacity – The Committee continues to recognize that bioterrorism events will occur at the local level and will require local capacity, preparedness and initial response. It is the Committee's intent that significant funding for State and local public health infrastructure be used to improve local public health capacity and meet the needs determined by local public health agencies. The Committee notes that HHS' cooperative agreement guidance now includes explicit requirements for local concurrence with State spending plans for public health emergency preparedness and urges CDC to monitor and enforce these requirements. (Page 87)

Action taken or to be taken

CDC is monitoring compliance with the concurrence language. Development and promulgation of guidance to states for pandemic influenza planning will strengthen this requirement.

Item

State and Local Capacity – The Committee also recognizes that HHS has incorporated the National Response Plan into the cooperative agreement guidance and established new CDC Preparedness Goals. The Committee urges the Department to assure that the performance metrics for the CDC Preparedness Goals, by which local health department preparedness will be measured, are fully consistent with all requirements in the Target Capabilities being developed under Homeland Security Presidential Directive 8 by the Department of Homeland Security. (Page 87)

Action taken or to be taken

In addition to ensuring that state and local public health agencies are performing activities that help them achieve the CDC public health Preparedness Goals, CDC has aligned all required public health capabilities and metrics to those developed and incorporated into the Department of Homeland Security's (DHS) Targeted Capabilities List (TCL). CDC and public health partners played key and active roles in developing the TCL in partnership with DHS. Activities

required of states in the terrorism cooperative agreement guidance have been cross-walked with the TCL to ensure consistency.

Item

Strategic National Stockpile – The Committee appreciates that planning and exercising plans for distribution of the Strategic National Stockpile is an integral aspect of overall local bioterrorism preparedness. The Committee urges CDC to assure that requirements for and evaluation of State and local activities with respect to the stockpile, including the Cities Readiness Initiative, are fully integrated into and consistent with requirements of the guidance for overall bioterrorism preparedness.

Action taken or to be taken

The CDC Strategic National Stockpile (SNS) provides technical assistance, education and training to improve the ability of states to receive, stage, store and distribute the SNS materiel. Homeland Security Presidential Directive 8 establishes the National Preparedness Goal which provides guidance for overall bioterrorism preparedness. For the past several months, CDC has been an active participant in the development of the Target Capabilities List (TCLs) as part of the development of the National Preparedness Goal led by the Department of Homeland Security. Specifically, the CDC provided input for the Mass Prophylaxis target capability, a national priority, to plan for a worse case scenario where significant resources would be needed to protect the public's health. This input includes capabilities that support the distribution of Strategic National Stockpile assets. These collaborative efforts will also help to ensure capacity building and funding at the state and local level are consistent with bioterrorism preparedness for the nation.

In addition, the FY 2006 Cooperative Agreement guidance for overall bioterrorism preparedness will be especially assertive in requiring State and local governments to assess ongoing readiness in detail. This includes evaluating the numerous capabilities required to manage and use deployed Strategic National Stockpile (SNS) materiel and evaluating proficiency at each participating organizational level. This focus will include the evaluation of the Cities Readiness Initiative (CRI) localities.

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – CONFERENCE

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2007 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
HOUSE CONFERENCE REPORT NO. 109-337
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Cancer prevention and control– Within the amount provided for Cancer Prevention and Control the conference agreement includes \$17,113,000 for comprehensive cancer activities, including \$100,000 for a national education campaign concerning gynecologic cancer. The conferees urge that the CDC coordinate this effort both with the Office of Women’s Health, within the Office of the Secretary, and qualified non-profit private sector organizations. (Page 68)

Action taken or to be taken

In fiscal year 2006, CDC will work with the Office of Women’s Health, within the office of the Secretary, and qualified non-profit private sector organizations to coordinate public education efforts targeting gynecologic cancer. CDC supports initiatives specifically designed to reduce the burden of certain gynecologic cancers. For many of these cancers, prevention and early detection are essential to survival. CDC’s efforts largely are directed towards surveillance; screening (where recommended); public education and awareness; health care provider education and awareness; and research. CDC continues to focus on risk reduction, early detection, surveillance, identifying and improving barriers to appropriate clinical practice, and enhanced survivorship.

Item

Obesity prevention program – The conferees encourage CDC to collaborate with the West Virginia Department of Health and Human Resources to develop a model obesity prevention program that could be replicated nationwide. (page 69)

Action taken or to be taken

The state of West Virginia has one the highest state obesity prevalence rates in the country. West Virginia is one of 28 state programs funded by CDC’s Nutrition and Physical Activity Program to Prevent Obesity and other Chronic Diseases through science-based interventions addressing both poor nutrition and inadequate physical activity. CDC recently collaborated with staff from state and local health departments in West Virginia to conduct assessments of environmental characteristics that support or inhibit healthy eating and good nutrition. Lessons learned from these assessments, as well as from assessment and program efforts in other funded states, will be disseminated among relevant programs and organizations at the national, state, and local levels.

Item

The National Folic Acid Education and Prevention Program and National Spina Bifida Program – The conferees strongly support the activities of both the National Folic Acid Education and Prevention Program and National Spina Bifida Program and believe the activities are complementary. The National Folic Acid Education Program’s goal is primary prevention through the promotion of the consumption of folic acid to prevent Spina Bifida and other neural tube defects. The National Spina Bifida Program works to improve the quality of life for individuals affected by Spina Bifida and reduce and prevent the occurrence of, and suffering from this birth defect. The conferees have provided \$7,400,000 for these activities. In order to achieve budget transparency, prevent any overlap of effort, ensure the continued proper balance between primary prevention and quality of life activities, and to maximize the effectiveness of these funds, the conferees request that CDC develop a comprehensive strategic plan whose goal is to establish a unified program to be housed in the Human Development and Disability Division and to be prepared to report on the feasibility of such a unified program during fiscal year 2007 budget hearings. (Page 70)

Action taken or to be taken

CDC remains committed to efforts both to prevent spina bifida through folic acid consumption and to improve the health and well-being of children and adults living with spina bifida. CDC agrees that these complementary activities need to be coordinated and will pursue the development of a strategic plan that includes an analysis of the most effective and efficient organization of program components.

Item

Muscular Dystrophy program – Within the amount for activities related to Duchenne and Becker Muscular Dystrophy, \$750,000 is to enhance the coordinated education and outreach initiative through the Parent Project Muscular Dystrophy. In addition, the conferees concur in the directive in the Senate report for CDC to develop and submit a strategic plan for the Duchenne and Becker Muscular Dystrophy program by May 1, 2006. (Page 70)

Action taken or to be taken

In FY05, CDC awarded a cooperative agreement to the Parent Project Muscular Dystrophy to develop and disseminate educational materials related to Duchenne muscular dystrophy (DMD). These activities are targeted to people who interact with children with DMD (such as teachers and fellow students) and the general public. In FY06, CDC staff will continue to work with PPMD on these outreach activities, and will coordinate the efforts of PPMD with those of other CDC-funded projects, such as the single gene disorder resource network.

A draft strategic plan has been developed, and it will be reviewed by external peer reviewers in February 2006. After review, it will be shared with partners for additional comments and submitted to Congress by May 1, 2006.

Item

Congressional Justification structure – The conferees also request that CDC continue to include at least the level of detail provided in past years in the Justification of Estimates for the Appropriations Committees, including the functional tables for each budget activity, the mechanism table by activity, and the crosswalks of funding between programs and CDC organizations. (Page 73)

Action taken or to be taken

The Centers for Disease Control and Prevention FY 2007 Justification of Estimates for Appropriations Committee will contain at least the same level of detail as FY 2006 and other previous years for financial and performance information. Examples of this detail include functional tables for each budget activity and mechanism tables by activity. Although the FY 2005 budget restructuring greatly simplified the funding stream between budget activity and program, all funding is explained, accounted for, and justified to ensure full understanding of what each budget activity comprises.

Item

Use of authority to charter aircraft – The conference agreement includes a new provision granting authority to the Secretary to use, at his discretion, charter aircraft under contract with the Centers for Disease Control and Prevention (CDC). The Secretary has significant operational responsibilities in times of emergencies and in the days following such emergencies. The Department is the primary agency for directing public health and medical services in response to significant events. Due to the unpredictable nature of such events, the conferees believe the Secretary must be in a posture to respond and communicate as an event is unfolding. Yet, existing travel limitations on the Secretary make this extremely difficult. The availability of CDC's charter aircraft will allow the Secretary to immediately return to Washington or rapidly move to another location as the situation dictates, at the same time being able to securely communicate with and direct the Department. The conference agreement also extends this authority to the Director of the Centers for Disease Control and Prevention. The conferees understand that, due to existing restrictions, the Director on a number of occasions has not been able to accompany employees of the Agency responding to public health emergencies. The conferees expect the Secretary and the Director of CDC to exercise this authority in an economical and judicious manner. The conferees request that the Secretary report to the Committees on Appropriations of the House and Senate regarding the use of this authority in the annual justification of estimates for the Appropriations Committees and at the end of the third quarter of each fiscal year. (Page 95)

Action taken or to be taken

CDC appreciates the committee's provision for the Director to use charter aircraft in times of public health emergencies, and will do so in an economical and judicious manner. The use of charter aircraft has been essential for CDC to reaching areas of need in a timely manner during emergencies. CDC welcomes the opportunity to extend use of its charter aircraft to the Secretary and will collaborate with the Department to report on the use of this authority at the end of the third quarter of each fiscal year.

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2007 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
DEFENSE CONFERENCE REPORT NO. 109-359
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Influenza laboratory capacity – The conference agreement includes bill language designating \$50,000,000 for laboratory capacity and research at the Centers for Disease control and Prevention (CDC). Section 8116 of the Senate bill included \$125,000,000 for this purpose. The conferees intend that a portion of these funds go to address a critical lack of influenza laboratory capacity, which has resulted in delays in processing influenza virus samples and the sharing of DNA sequence information with outside laboratories in a timely manner. The conferees also recognize that the proper laboratory and research assets are vital to definitively characterize virus strains and determine best practices among protective public health measures. Finally, the conferees encourage the development of an evidence base for the effectiveness of policies and technologies to reduce respiratory disease transmission, modeling means of social distancing, and accelerating the development of rapid field diagnostic tests suitable for both domestic and international use, particularly use in developing nations. (Page 523)

Action taken or to be taken

CDC is working on strategies to increase rapid diagnostic capacity and characterization of pandemic influenza strains as well as to increase state and local laboratory capacity to respond to anticipated surges in diagnostic needs. Potential avenues for enhanced capacity include applying advanced mass spectrometry techniques to examine structural changes in viral surface proteins to identify factors that alter the virulence of the influenza virus and applying mass spectrometry analysis to better characterize drifts and shifts in the influenza virus, including those that lead to new viral characteristics, such as human-to-human transmission.

Additionally, CDC is looking at enhancements for pandemic influenza in the Laboratory Response Network, including determining the potential for increasing stocks of diagnostic reagents for influenza as well and accelerating the research and development for diagnostic tests. CDC agrees that sharing of information is critical and is working with international partners to address critical issues such as timely sharing of data.

Item

Pandemic preparedness – The conferees encourage CDC to partner with industry to ensure it has the proper diagnostic surge capacity in place for both surveillance and pandemic response. The conferees also request that the Secretary be prepared to report on a plan for using diagnostics in early-stage clinical response to an emerging pandemic during the hearings on the fiscal year 2007 budget. (Page 524)

Action Taken or to be Taken

CDC is working with industry and other partners to develop a sensitive and specific rapid diagnostic test. Thus far, such technology has not been developed to the CDC standard of excellence. In the interim, CDC has trained nearly every state laboratory to conduct RT-PCR technology, the present standard, to make sure each state has the capacity to accurately identify avian influenza. CDC will continue to conduct training as needed and remains vigilant to update reagents as the viruses evolve so that timely global diagnosis of viruses that pose a threat to human health can be maintained.

Item

Avian influenza tracking – The conferees are aware of the key role migratory bird tracking has played in predicting the spread of avian influenza. The conferees encourage CDC to ensure that this important activity is part of its surveillance activities. (Page 524)

Action Taken or to be Taken

CDC agrees that it is important to coordinate surveillance between the human and animal health sectors in response to emerging zoonotic diseases of public health importance including avian influenza. CDC participates on an Interagency Working Group for the Coordination of Zoonotic Disease Surveillance (ZDWG). The ZDWG meets by teleconference monthly and consists of representatives from CDC, USDA, FDA, USGS (National Wildlife Health Center), the Southeast Cooperative Wildlife Disease Study, the National Assembly of State Animal Health Officials, and the National Association of State Public Health Veterinarians. This group is working to incorporate zoonotic

disease surveillance into existing systems which include the CDC Laboratory Response Network and the USDA National Animal Health Laboratory Network. In addition, CDC has established close working relationships with organizations such as the Wildlife Conservation Society, the American Zoological Association and the International Species Information System to ensure that migratory bird and captive bird species surveillance data can be shared in a timely and transparent manner to promote early detection of avian influenza.

Item

Assessment of role of smoking in influenza epidemics – The conferees understand that smoking substantially increases both the incidence and severity of influenza because it compromises the upper respiratory system. One study found that smoking more than doubles the risk of developing clinical influenza. The conferees encourage CDC to provide information about the link between smoking and an increased risk for influenza infection and severity of illness through existing quitlines and to collaborate with other countries to assess the role of smoking in flu epidemics. (Page 524)

Action taken or to be taken

CDC agrees that smoking increases a person's risk of developing certain respiratory infections, including influenza. As a result, CDC efforts to reduce influenza-associated illnesses and deaths include multiple strategies, such as immunization, appropriate use of antiviral medications, handwashing and others. CDC's website includes information on smoking and influenza and provides information on strategies for smoking cessation.

Item

Pandemic readiness B The conferees encourage HHS to procure the Strategic National Stockpile essential supplies that may be needed in the event of a pandemic including syringes, ventilators, respirators, diagnostic equipment, surgical masks, and gloves. (Page 524)

Action taken or to be taken

The CDC Strategic National Stockpile (SNS) is currently procuring critical assets that may be used in the event of an influenza pandemic. The decision to stockpile assets in the SNS is based on guidance from HHS with subject matter expert input from within CDC. All procurements by the CDC's SNS, in preparation for an influenza pandemic are continually reviewed by HHS. As of January 2006, SNS has purchased antivirals, masks and ventilators with additional procurements ongoing.

AUTHORIZING LEGISLATION

DOLLARS IN THOUSANDS	FY 2006 AMOUNT AUTHORIZED	FY 2006 APPROPRIATION	FY 2007 AMOUNT AUTHORIZED	FY 2007 BUDGET REQUEST
Infectious Diseases:				
Infectious Disease Control	Indefinite	\$226,768	Indefinite	\$245,346
PHSA §§ 301, 307, 310, 311, 317 ³ , 317N ³ , 317S ⁵ , 319, 319E ⁴ , 319F ⁴ , 319G ⁴ , 322, 325, 327, 352, 361-369, 1102 Immigration and Nationality Act §§ 212, 232				
HIV/AIDS, STD and TB Prevention	Indefinite	\$946,577	Indefinite	\$1,032,969
PHSA §§ 301, 307, 308(d), 310, 311, 317 3 , 317(a) 317E1, 317P, 3181, 318A1, 318B 2 , 322, 327, 352, 2315, 2320, 2341, 2625 3 , 25211- 2523 Provisions Concerning Pregnancy and Perinatal Transmission of HIV [2625(c)] 3 Tuskegee Health Benefits: P.L. 103-333 Ryan White CARE Act Amendments: § 502 of P.L. 106-345 3 International authorities: P.L. 109-149 sec. 215				
Immunization (Proposed Law)	Indefinite	\$519,872	Indefinite	\$407,369
Grants: PHSA §§ 317 (a), 317(j), 317(k)(1) ³ Prevention Activities: PHSA §§ 301, 307, 310, 311, 317 ³ , 327, 340C, 352, 2125, 2126 Title XXI, Subtitle 1—National Vaccine Program § 1928 of Social Security Act (42 U.S.C. § 1396s)				
Health Promotion:				
Birth Defects/Developmental Disabilities/Disabilities & Health	Indefinite	\$124,762	Indefinite	\$110,481
PHSA §§ 301,307,310,311,317 ³ , 317C ¹ , 317J ³ , 327, 352, 399M ¹ ,1102, 1108 ³ PHSA Title IV				
Chronic Disease Prevention, Health Promotion, and Genomics	Indefinite	\$838,664	Indefinite	\$818,727
General Authority: PHSA §§ 301, 307, 310, 311, 317 ³ , 317K ³ , 327, 340D, 352, 391, 1102, 1501-1510 ¹ , 1706 ¹ Public Health Cigarette Smoking Act of 1969 Comprehensive Smoking Education Act of 1984 Comprehensive Smokeless Tobacco Health Education Act of 1986 Fertility Clinic Success Rate and Certification Act of 1992 Asthmatic Schoolchildren's Treatment and				

DOLLARS IN THOUSANDS	FY 2006 AMOUNT AUTHORIZED	FY 2006 APPROPRIATION	FY 2007 AMOUNT AUTHORIZED	FY 2007 BUDGET REQUEST
Health Management Act of 2004 ⁷ Prostate cancer: PHSA § 317D ² Cancer registries: PHSA §§ 399B-399D ² , 399F ¹ Benign Brain Tumor Cancer Registries Amendment Act ⁵ Diabetes Among Children and Youth: PHSA § 317H ³ Safe Motherhood/Infant Health Promotion: PHSA §§ 317K(a) ³ , 317K(b) ³ , 317L ³ Childhood Obesity Prevention PHSA §§ 399W- 399Z ³ Oral Health Promotion: PHSA § 317M ³ Prevention centers: PHSA §§ 301, 310, 311, 317 ³ , 391, 1102, 1706 ¹ Supplemental Grants for Preventive Health Services (WISEWOMAN): 1509 ¹ Hematological Cancer Research Investment and Education: 419C Breast and cervical cancer prevention: PHSA §§ 301, 340D, 1501-1510 ¹ Breast and Cervical Cancer Mortality Prevention Act				
Health Information and Service:				
Health Statistics	Indefinite	\$109,021	Indefinite	\$109,021
PHSA §§ 301, 304, 306 ¹ 307, 308 1% Evaluation: PHSA § 241 (non-add) (Superseded in the FY 2002 Labor HHS Appropriations Act - Section 206)	Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary		Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary	
Public Health Informatics	Indefinite	\$70,641	Indefinite	\$109,193
§§ 301, 304, 306, 308, 307, 310, 311, 317 ³ , 318 ¹ , 319, 319A ⁴ , 319B ¹ , 319C ⁴ , 327, 352, 391, 1102, 2315, 2341 Clinical Laboratory Improvement Amendments of 1988, § 4				
Health Marketing	Indefinite	\$43,241	Indefinite	\$43,460
§§ 301, 304, 306, 308, 307, 310, 311, 317 ³ , 318 ¹ , 319, 319A ⁴ , 319B ¹ , 319C ⁴ , 327, 352, 391, 1102, 2315, 2341 Clinical Laboratory Improvement Amendments of 1988, § 4				

DOLLARS IN THOUSANDS	FY 2006 AMOUNT AUTHORIZED	FY 2006 APPROPRIATION	FY 2007 AMOUNT AUTHORIZED	FY 2007 BUDGET REQUEST
Environmental Health and Injury:				
Environmental Health:	Indefinite	\$149,985	Indefinite	\$141,095
PHSA §§ 301, 307, 310, 311, 317 ³ , 317A ³ , 317B, 317I ³ , 327, 352, 1102 Housing and Community Development Act, 1021 (15 U.S.C. 2685)				
Injury Prevention and Control:	Indefinite	\$139,036	Indefinite	\$138,214
PHSA §§ 301, 307, 310, 311, 317 ³ , 319, 327, 352, 391-394A ³ Use of Allotments for Rape Prevention Education (393B) Sec 413 of the Family Violence Prevention and Services Act of 2003 ⁶				
Occupational Safety and Health:				
Occupational Safety and Health	Indefinite	\$255,272	Indefinite	\$250,194
PHSA §§ 301, 304, 306 ¹ , 307, 310, 311, 317 ³ , 317A ³ , 317B, 327 Occupational Safety and Health Act of 1970 (P.L. 91-596), §§ 9, 20-22 (29 USC 657) Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164, §§ 101, 102, 103, 202, 203,204, 205, 206, 301, 501, 502, 508 and PL 95-239 § 19 (30 USC 904) Federal Fire Prevention and Control Act, § 209, (29U.S.C.671(a)) Radiation Exposure Compensation Act, §§ 6 and 12(42U.S.C.2210) Housing and Community Development Act of 1922 §1021 (15 U.S.C. 2685) Energy Employees Occupational Illness Compensation Program Act (2000) 42 U.S.C. 7384, et. Seq. (as amended) Floyd D. Spence National Defense Authorization Act §§ 3611, 3612, 3623, 3624, 3625, 3626 of P.L. 106-393 National Defense Authorization Act for Fiscal Year 2006, PL 109-163 Toxic Substances Control Act (15 USC 2682) Prohibition of Age Discrimination Act (29 USC 623)				
Global Health:				
Global Health	Indefinite	\$381,251	Indefinite	\$381,103
PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 361-369, 2315, 2341 Foreign Assistance Act of 1961 §§ 104, 627,628				

DOLLARS IN THOUSANDS	FY 2006 AMOUNT AUTHORIZED	FY 2006 APPROPRIATION	FY 2007 AMOUNT AUTHORIZED	FY 2007 BUDGET REQUEST
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 22 U.S.C. 3968 Foreign Employees Compensation Program 41 U.S.C. 253 International Competition Requirement Exception) P.L. 107-116 sec. 215 HR 5656 § 220 FY 2001 Appropriations Bill				
Public Health Research:				
Public Health Research	Indefinite	\$31,000	Indefinite	\$31,000
PHSA §§ 301, 304, 307, 310, 317, 327	Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary		Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary	
Public Health Improvement and Leadership:				
Public Health Improvement:	Indefinite	\$264,823	Indefinite	\$190,165
PHSA §§ 301, 304, 307, 310, 311, 319, 319A ⁴ , 319C ⁴ , 327, 352, 361, 362, 368, 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				
Preventive Health and Health Services Block Grant:				
Preventive Health and Health Services Block Grant	Indefinite	\$99,000	Indefinite	\$0
Grants: PHSA Title XIX ¹ Prevention Activities: PHSA §§ 214, 301, 304, 306 ¹ , 307, 308, 310, 311, 317 ³ , 327				
Buildings and Facilities:				
Buildings and Facilities	Indefinite	\$158,400	Indefinite	\$29,700
PHSA §§ 319D ⁸ , 321(a)				
Business Services Support:				
Business Services Support	Indefinite	\$298,616	Indefinite	\$303,854
PHSA §§ 301, 304, 307, 310, 317 ³ , 317F ¹ ,				

DOLLARS IN THOUSANDS	FY 2006 AMOUNT AUTHORIZED	FY 2006 APPROPRIATION	FY 2007 AMOUNT AUTHORIZED	FY 2007 BUDGET REQUEST
319, 327, 361, 362, 368, 399F ¹ Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517				
ATSDR:				
Agency for Toxic Substances and Disease Registry (ATSDR)	Indefinite	\$74,905	Indefinite	\$75,004
Comprehensive Environmental Response, Compensation, and Liability Act § 104(l) Resource Conservation and Recovery Act § 3001 Great Lakes Critical Programs Act of 1990 Clean Air Act of 1990 Housing and Community Development (Lead Abatement) Act of 1992 Defense Environmental Restoration Program				
Terrorism:				
Terrorism	Indefinite	\$1,632,257	Indefinite	\$1,657,161
PHSA §§ 301, 307, 311, 317 ³ , 319, 319A ⁴ , 319D ⁴ , 319F ⁴ , 319G ⁴ , 361-368 (42 U.S.C. 262 note), 2801-2811. Public Health Security and Bioterrorism Preparedness and Response Act of 2002				
Reimbursables: (non-add)				
PHSA §§ 301, 306(b)(4), 353 Clinical Laboratory Improvement Act User fee: Labor-HHS FY Appropriations	Indefinite		Indefinite	
Total Appropriation – Proposed Law		\$6,441,091		\$6,074,056

- 1 Expired.
- 2 Expires 2004.
- 3 Expires 2005.
- 4 Expires 2006.
- 5 Expires 2007.
- 6 Expires 2008.
- 7 Expires 2009.
- 8 Expires 2010.

APPROPRIATIONS HISTORY

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION' APPROPRIATION HISTORY TABLE DISEASE CONTROL, RESEARCH, AND TRAINING				
	Estimate	House Allowance	Senate Allowance	Appropriation
1997	2,229,900,000	2,187,018,000	2,209,950,000	2,302,168,000 ²
1998	2,316,317,000 ³	2,388,737,000	2,368,133,000	2,374,625,000 ⁴
1998 Supplemental	--	--	--	9,000,000 ⁵
1999	2,457,197,000	2,591,433,000	2,366,644,000 ⁶	2,609,520,000 ⁷
1999 Offset	--	--	--	(2,800,000) ⁸
1999 Resc./1% Transfer	--	--	--	(3,539,000)
2000	2,855,440,000 ⁹	2,810,476,000	2,802,838,000	2,961,761,000 ¹⁰
2000 Rescission	--	--	--	(16,810,000)
2001	3,239,487,000	3,290,369,000	3,204,496,000	3,868,027,000
2001 Rescission	--	--	--	(2,317,000)
2001 Sec's 1% Transfer	--	--	--	(2,936,000)
2002	3,878,530,000	4,077,060,000	4,418,910,000	4,293,151,000 ¹¹
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 ¹²	--	--	--	16,000,000
2004 ¹³	4,157,330,000	4,538,689,000	4,494,496,000	4,367,165,000
2005 ^{13 14}	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 ¹⁴	--	--	--	15,000,000
2006 ^{13 15}	3,910,963,000	5,945,991,000	6,064,115,000	5,884,934,000
2006 Rescission	--	--	--	(58,848,000)
2007 ^{13 15}	5,733,952,000	--	--	--

¹Does not include funding for ATSDR

²Includes \$32,000,000 for the transfer of the Bureau of Mines. Transfer occurred in FY 1997.

³Includes \$522,000 supplemental increase for ICASS activities.

⁴Includes \$509,000 supplemental increase for ICASS activities/transfer from Department of State and a \$4.436 million reduction due to the exercise of the Secretary's 1% Transfer Authority.

⁵This supplemental increase was provided for emergency Polio eradication efforts in Africa.

⁶Does not include emergency funding provided under the Public Health and Social Services Emergency Fund (PHSSEF) for \$228,400,000 or \$25,000,000 in interagency transfer from NIH for state tobacco control activities.

⁷Does not include \$156,600,000 in FY 1999 for emergency funding provided under the PHSSEF for Bioterrorism, Polio & Measles, and the Environmental Health Laboratory.

⁸This offset was used to fund Bioterrorism across the Department of Health and Human Services.

⁹Revised to include \$35,000,000 for Global HIV initiative. Does not include \$20,000,000 (\$18,040,000 with rescission of \$1,960,000) transferred from NIH for Anthrax.

¹⁰Does not include \$229,000,000 (\$228,680,000 with rescission of \$320,000) in FY 2000 for emergency funding provided under the PHSSEF for Bioterrorism, Global AIDS, Polio, Malaria, Micronutrient Malnutrition, and the Environmental Health Laboratory.

¹¹Includes Retirement accruals of +\$57,297,000; Management Reform Savings of -\$27,295,000

¹²Emergency Wartime Supplemental Appropriations Act, 2003 PL 108-11 for SARS

¹³FY 2004, FY 2005, and FY 2006 funding levels for the Estimate reflect the Proposed Law for Immunization.

¹⁴FY 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.

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION APPROPRIATION HISTORY TABLE TERRORISM FUNDING				
	Estimate	House Allowance	Senate Allowance	Appropriation
1999	---	43,000,000 ¹	81,000,000	123,600,000
2000	118,000,000	138,000,000	189,000,000	155,000,000
2000 Rescission	---	---	---	(320,000)
2001	148,500,000	182,000,000	148,500,000	180,919,000
2002	181,919,000	231,919,000	181,919,000	181,919,000
2002 PHSSEF ²				2,070,000,000
2002 Rescission ³	--	--	--	(396,000)
2003 ⁴	1,116,740,000	1,522,940,000	1,536,740,000	--
2003 Transfer ⁵	(400,000,000)	--	--	--
2004 ⁴	1,116,156,000	1,116,156,000	1,116,156,000	1,507,211,000
2004 Transfer ⁶	(400,584,000)	--	--	--
2005	1,509,571,000	1,637,760,000	1,639,571,000	1,577,612,000
2005 Labor/HHS Reduction				(271,000)
2005 Rescission				(12,584,000)
2005 Supplemental ⁷				58,000,000
2006 ^{8,9}	1,796,723,000			
2006 Rescission				
2007 ⁸				

¹This funding was an amendment to the original House mark, which did not include Bioterrorism.

²Public Health and Social Services Emergency Fund

³Administrative and Related Expenses Reduction.

⁴Funding will be provided through the Public Health and Social Services Emergency Fund (PHSSEF).

⁵\$300,000,000 for the National Pharmaceutical Stockpile and \$100,000,000 for Smallpox to the Department of Homeland Security.

⁶Same transfer as FY 2003 to the Department of Homeland Security, plus an additional \$584,000 for support/overhead.

⁷FY 2005 includes a one time supplemental of \$58,000,000 for avian influenza through the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005.

⁸Starting with the FY 2006 House Mark, Terrorism funds are directly appropriated to CDC instead of being appropriated to the Public Health and Social Service Emergency Fund (PHSSEF). As a result these funds are now included in CDC's appropriation history table.

⁹The FY 2006 President's Budget for Terrorism was amended after submission of the FY 2006 Justification of Estimates for Appropriations Committee to include an additional \$150,000,000 for influenza activities through the Strategic National Stockpile.

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NARRATIVE BY ACTIVITY

INFECTIOUS DISEASES

Infectious Diseases (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$1,666,538	\$1,680,423	\$1,672,890	(\$7,533)
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Total¹	\$1,679,332	\$1,693,217	\$1,685,684	(\$7,533)

¹The FY 2007 Estimate reflects the Proposed Law transfer of \$100 million from the Section 317 Program to the Vaccines for Children program.

INTRODUCTION

The Infectious Diseases budget activity unites three infectious disease programs to better align infectious disease services and science with CDC's goals and priorities. This activity includes infectious disease programs related to: 1) HIV/AIDS, STD, and TB Prevention; 2) Infectious Diseases Control; and 3) Immunization. The Infectious Diseases budget activity brings together CDC's engagement with some of public health's most critical, complicated, and urgent issues having national and international scope and impact.

CDC's Infectious Diseases activities include responsibilities for:

- Achieving public health goals specific to infectious diseases;
- Ensuring science and programs are of the highest quality and are meeting CDC's goals;
- Providing leadership, decision-making, and management to infectious disease programs;
- Identifying areas of synergy for collaboration within HIV/AIDS, STD, and TB Prevention, Infectious Diseases Control, and Immunization activities, and across the agency;
- Identifying opportunities for coordination and integration of programs across CDC to improve health outcomes.

In FY 2007, CDC will integrate science, program, epidemiology and laboratory activities as well as focus on enhancing cross-organizational activities to enhance efficiency and service. Continued infectious disease coordination will ensure infectious disease programs are based on the highest standards of quality, equity, and integrity as well as ensuring excellent service to CDC's customers.

INFECTIOUS DISEASES CONTROL

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 317N, 317S, 319, 319E, 319F, 319G, 322, 325, 327, 352, 361-369, 1102
 Immigration and Nationality Act §§ 212, 232

Infectious Diseases Control (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$225,589	\$226,768	\$245,346	\$18,578

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$245,346,000 for Infectious Diseases Control, an increase of \$18,578,000 above the FY 2006 Enacted level of \$226,768,000.

PROGRAM DESCRIPTION

Infectious diseases are a continuing threat to our nation's health. Although modern advances have conquered some diseases, the outbreaks of Severe Acute Respiratory Syndrome (SARS), avian influenza, West Nile virus (WNV), and monkeypox are recent reminders of the extraordinary ability of microbes to adapt and evolve. Earlier predictions of the elimination of infectious diseases often did not take into account changes in demographics and human behaviors and the ability of microbes to adapt, evolve, and develop resistance to drugs. SARS demonstrated that U.S. health and global health are inextricably linked and that fulfilling CDC's infectious diseases mission – to prevent illness, disability, and death caused by infectious diseases in the U.S. and around the world – requires global awareness and collaboration with international partners to prevent the emergence and spread of infectious diseases.

Infectious disease outbreaks can have huge medical and economic consequences. Modeling studies suggest that, in the absence of any control measures, a "medium-level" pandemic in the U.S. could result in an estimated 89,000 – 207,000 deaths, 314,000 – 734,000 hospitalizations, 18 – 42 million outpatient visits, and another 20 – 47 million people being sick if 15 – 35 percent of the U.S. population develops influenza. The associated economic impact on the U.S. could range from \$71 – \$167 billion. With the recent widespread outbreaks of avian influenza in poultry and wild migratory birds in Asia and Eastern Europe, and reported human deaths due to infections with avian A (H5N1) influenza, we must be vigilant in our surveillance for avian viruses that may adapt and become easily transmissible in humans. CDC is working throughout the world, in support of the President's National Strategy on pandemic influenza, the Health and Human Services Pandemic Influenza Plan, and other initiatives to ensure that the United States is prepared for an influenza pandemic.

Each year, 76 million U.S. citizens suffer from foodborne illnesses; 325,000 are hospitalized, approximately 5,000 die, and the economic burden is estimated to be greater than \$6 billion. Over 1000 foodborne disease outbreaks occur each year, each one making groups of people ill, and taking public health and food industry resources to investigate and control. Hepatitis C Virus (HCV) infection is the most common chronic bloodborne viral infection in the U.S. Based on data from the National Health and Nutrition Examination Survey from 1999-2002, CDC has estimated that there are approximately 4.1 million Americans who have ever been infected with HCV, and approximately 3.2 million currently infected. CDC provides leadership and coordination for the prevention and control of hepatitis virus infections, and their acute and chronic liver disease consequences, both in the U.S. and internationally.

Antimicrobial resistance is a growing concern around the world. Many important human infections are developing resistance to the antimicrobial drugs used to treat them. In the 1970s, virtually all *Streptococcus pneumoniae*, an organism which is a common cause of ear infections, meningitis, and pneumonia, were susceptible to preferred drugs. Now up to 34 percent found in some areas of the U.S. are no longer susceptible to penicillin, and multidrug resistance is common. *Staphylococcus aureus* is a common cause of skin and more serious infections and over 60 percent of infections acquired in U.S. intensive care units are now resistant to the class of beta-lactam antibiotics which includes penicillins and cephalosporin antibiotics. These are referred to as methicillin-resistant *Staphylococcus aureus* (MRSA). Some infections found among hospitalized patients are resistant to virtually all effective antimicrobial drugs available. In addition, community-associated MRSA are increasing. Data suggests that 8-20 percent of clinical MRSA isolates are community-associated. Resistance to the most effective antimicrobial drugs can require treatment with less effective and more expensive alternatives which may also be associated with a greater

risk for side effects. CDC is working with other government agencies to implement a Public Health Action Plan to Combat Antimicrobial Resistance.

An Institute of Medicine (IOM) report published in March 2003, *Microbial Threats to Health: Emergence, Detection, and Response*, recognizes that while we have made dramatic advances in the prevention and control of infectious diseases, the magnitude and urgency of these problems requires renewed concern and commitment. Going forward, CDC continues the partnerships to build domestic and global capacity for recognizing and responding to infectious diseases and protecting the health of Americans at home and abroad.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Infectious Diseases Control activity, the following performance measures have been selected as highlights of the program's performance plan:

Performance Goal	Results	Context
1. By 2010, enhance preparedness for pandemic influenza by establishing in-country influenza networks that are actively producing usable samples for testing as measured by geographic and population coverage.	CDC is progressing toward its FY 2006 target. Currently 12 networks are supported. All have expanded geographic coverage by 50% or greater and expanded population coverage by at least 70% on average per country network.	Infectious disease outbreaks, including influenza, can have huge medical and economic consequences. Collecting data domestically and internationally is essential for the early detection of an influenza pandemic and is effective in tracking its spread. Robust surveillance networks provide the critical information needed to improve vaccine decision-making and other preparedness actions.

Performance Goal	Results	Context
2. By 2010, reduce the incidence and infection with four key foodborne pathogens by 50 percent. <ul style="list-style-type: none"> • <i>Campylobacter</i> • <i>Escherichia Coli O157:H7</i> • <i>Listeria monocytogenes</i> • <i>Salmonella species</i> 	Annual data on the incidence rates of infection with <i>Campylobacter</i> species, <i>Escherichia coli</i> O157:H7, and listeria indicate that CDC is on track to meet its annual targets for 2006 in this area. <i>Salmonella</i> has been more of a challenge. CDC, USDA, and FDA are working together to reduce <i>Salmonella</i> cases.	Each year 76 million U. S. citizens suffer from foodborne illnesses; 325,000 are hospitalized; about 5,000 die; and the economic burden is estimated to be greater than \$6 billion. More than 1000 foodborne outbreaks, affecting groups of people, are investigated and reported each year. CDC is the lead federal agency for the foodborne disease surveillance which is essential to the prevention and control of foodborne disease and microbial threats.

Current Activities

- Continuing to build epidemiology and laboratory capacity in the U.S. by providing funds and technical assistance to 58 state, territorial, and local health departments. The funds are used to enhance national capacity to identify and monitor the occurrence of known infectious diseases of public health importance, detect new and emerging infectious disease threats, respond to disease outbreaks, and use public health data for priority setting.
- Conducting worldwide monitoring of influenza viruses to collect data that contributes to annual northern and southern hemisphere vaccine decisions.
- Building capacity domestically and internationally to improve systems for early detection of unusual increases in influenza activity and new influenza viruses.
- Providing leadership to the National Pandemic Influenza Preparedness and Response Task Force, created in May 2005 by the Secretary of HHS.

- Working with the Association of Public Health Laboratories and World Health Organization (WHO) on training workshops for state laboratories on the use of special laboratory (molecular) techniques to identify H5 viruses.
- Working with WHO to investigate influenza H5N1 among people (e.g., in Vietnam) and to provide help in laboratory diagnostics and training to local authorities.
- Acting as a global reference laboratory of influenza viruses including H5N1 and other novel viruses to understand characteristics and changes and to monitor antiviral resistance.
- Developing and distributing reagent kits domestically and globally to detect the currently circulating influenza A H5N1 viruses.
- Working closely with WHO and the National Institutes of Health (NIH) on safety testing of vaccine candidates and development of additional vaccine virus seed candidates for H5N1 and other subtypes of influenza A viruses.
- Advancing laboratory diagnostics and expanding laboratory networks for foodborne bacteria, viruses, parasites, and other contaminants.
- Conducting nationwide foodborne diseases outbreak surveillance and analyzing this data used to guide food safety programs.
- Translating research findings into community-based and health care-based prevention programs to promote appropriate antimicrobial use, infection control, vaccine use, and detection of drug-resistant infections.
- Educating health care and public health professionals to improve identification of persons at risk for chronic hepatitis C virus (HCV) infection; and ensuring appropriate counseling, diagnosis, management, and treatment.
- Conducting national surveillance for chronic hepatitis B virus and hepatitis C virus (HCV) infections, continuing to evaluate current routine nationwide surveillance activities, and implementing enhanced surveillance in selected states and counties. The goal of surveillance is to monitor who is getting infected with hepatitis B and HCV in order to ensure appropriate counseling and testing and medical management of infected persons.
- Conducting sentinel surveillance in companion animals and zoo animals which might suggest major threats to human health using the electronic veterinary databases a nationwide group of small animal clinics.
- Continuing to train young scientists in public health laboratory practice as part of the Emerging Infectious Diseases Laboratory fellowship. Since its inception in 1995, 265 scientists have participated in the program and have participated in over 120 disease outbreak investigations and co-authored 376 scientific publications.

Significant Accomplishments

- Worked with the HHS in a Department-wide initiative to develop the National Pandemic Preparedness Plan, which was publicly released in November 2005.
- Established 11 population-based Emerging Infections Programs (EIPs) in the U.S. to investigate emerging diseases. Much of the activity in the EIP network involves collaborative projects including: population-based surveillance for invasive bacterial pathogens including drug resistant pathogens; a population-based active surveillance network (FoodNet) to develop and evaluate food-borne disease prevention and control strategies; and systematic investigations to determine the causes of specific syndromes and serious illness in the U.S, including chronic liver disease, encephalitis, and respiratory diseases.
- Documented an ongoing, dramatic effect of pneumococcal vaccination (PCV) on disease in children <5 years and on unvaccinated adults by decreasing spread from children through CDC's EIP's Active Bacterial Core Surveillance for invasive pneumococcal disease. CDC demonstrated that conjugate vaccine is reducing the disparity in disease burden between whites and blacks in the U.S. In 2003, PCV use prevented 24,900 cases of invasive pneumococcal disease in the U.S.
- Established FoodNet, a network of ten sites within the EIP network that covers nearly 42 million persons and provides the most comprehensive information available on foodborne illness. FoodNet has demonstrated that in 2004 infections with *E.coli* O157 have declined 42 percent since 1996, *Listeria* by 40 percent, and *Campylobacter* by 31 percent. For the first time, the infection rate of *E. coli* O157 was below the 2010 Healthy People Objective.

NARRATIVE BY ACTIVITY
INFECTIOUS DISEASES
INFECTIOUS DISEASES CONTROL

- Enhanced national foodborne outbreak surveillance by implementing a new national web-based reporting system with advanced data security and management functions. This system collects extensive information on 1,200 to 1,500 foodborne outbreaks annually. This system has demonstrated a 90% decrease in outbreaks due to *Salmonella* in eggs between 1993 and 2003, although the proportion of outbreaks due to contaminated produce increased over the past three decades.
- Implemented PulseNet, an early warning system for foodborne illness outbreaks, in all 50 states. PulseNet detects outbreaks earlier by performing near real-time comparison of disease-causing bacteria isolated from people, even if they are geographically far apart. Provided training and protocols to Latin American countries interested in joining PulseNet Latin America, and for Asian and Pacific countries joining PulseNet Asia/Pacific Rim, and consulted with European colleagues forming PulseNet Europe. Signed a Memorandum of Understanding with the Government of Canada in 2005 to exchange surveillance information between PulseNet USA and PulseNet Canada, to enhance rapid detection of foodborne outbreaks affecting both countries.
- Provided onsite technical assistance and/or training to China, Vietnam, Thailand and Malaysia for the avian influenza outbreak, and technical assistance to South Korea and Taiwan through training at CDC, and regional training for more than 10 countries affiliated with the Western Pacific Regional Office of WHO.
- Provided support for influenza surveillance in Asia, Europe and Latin America to monitor for variant viruses that could circulate in the U.S. in the future.
- Development of an initiative to improve influenza surveillance, enhance epidemiology and laboratory capacity, improve pandemic preparedness in Asia including placement of staff in several locations internationally to coordinate activities and enhance technical assistance.
- Conducted key research on novel influenza viruses to understand pathogenesis, transmissibility and species host range to contribute to a better understanding of the risk that novel viruses pose.
- Established domestic and global sentinel surveillance networks linking health care providers in order to improve the ability to detect and monitor emerging diseases. These networks include: (1) sentinels along the U.S.-Mexico border; (2) sentinel physicians for influenza; (3) travel medicine clinics in the U.S. and other countries; (4) academic hospital emergency departments; and (5) infectious disease specialists throughout the U.S. These networks are uniquely capable of identifying and responding to newly emerging infections that require immediate attention.
- Enhanced surveillance for prion diseases in the U.S. through several surveillance mechanisms including:
 - Continued support for the National Prion Disease Pathology Surveillance Center at Case Western Reserve University, as part of CDC efforts to facilitate improved recognition and diagnoses of prion diseases in the United States and to increase the number of confirmatory autopsies on patients in whom this type of disease is clinically suspected or diagnosed;
 - Special support to state health departments, particularly to states where presence of bovine spongiform encephalopathy (BSE, commonly known as mad cow disease) has been documented, where there are large populations and many potential visitors to countries with major outbreaks of BSE, and where the presence of chronic wasting disease (CWD) in free-ranging deer and/or elk is a special concern;
 - Support of studies of the abnormal form of prion protein associated with CWD to identify potential diagnostic markers for possible human CWD, as well as transgenic mice experiments that assess the human species barrier to infection by the agent of CWD (initial results indicate a high degree of human resistance to this infection); and,
 - Support of special prion disease surveillance studies of persons in whom prion diseases are of special concern (e.g., recipients of blood donated by persons who subsequently develop Creutzfeldt-Jakob disease, recipients of pituitary-derived human growth hormone, persons who hunt and consume deer and/or elk in locations where CWD has been endemic for decades).
- Developed and implemented other strategies and protocols with other federal, private, and commercial partners that resulted in screening of the entire U.S. blood supply for WNV contamination beginning in 2003. Since 2003, over 15 million blood donations were screened for WNV. Since screening began, more than 1,400 presumptively viremic (infected, but asymptomatic) donors have been reported to CDC. CDC continues to work with partner agencies and organizations to identify the best approaches to use in the future to ensure the safety of the blood supply.
- Invited by the Pittsburgh Regional Healthcare Initiative in 2001 to provide technical assistance for a hospital-based intervention to prevent central line-associated blood stream infections (BSIs) among intensive care

unit (ICU) patients in southwestern Pennsylvania. The results of this collaboration were published in *Morbidity and Mortality Weekly Report (MMWR)* in October 2005. Between April 2001--March 2005, the pooled mean rate of central line--associated BSIs per 1,000 central line days in participating ICUs in 32 hospitals decreased by 68%, from 4.31 to 1.36 ($p < 0.001$). The results suggest that major reductions in BSI rates can be achieved and sustained through programs designed to improve adherence to existing CDC recommendations for preventing BSIs.

- Conducted laboratory research to evaluate the ability of bacteriophage-treated catheters in preventing biofilm formation. Significant reduction in biofilm formation by clinically-relevant microorganisms was observed, demonstrating the potential of this novel approach for reducing catheter-related infections.
- Identified and promoted health behaviors (e.g., hand hygiene, cough etiquette, and respiratory hygiene) that can prevent the spread of influenza and other respiratory infections through collaborations with state and local health departments, partner agencies and organizations, and healthcare professionals. The HHS pandemic influenza plan has been designed to use these and other means of limiting the impact of a possible influenza pandemic on the health of our population and the functioning of our communities. This is of particular importance, given the possible limitations of antiviral treatment and vaccine availability during a pandemic.
- Expanded CDC's National Hepatitis C Prevention Strategy by funding: hepatitis C coordinators in 52 jurisdictions, including state, territorial, and large metropolitan health departments and the Indian Health Service; state-based hepatitis C/viral hepatitis prevention plans in 24 states; five Viral Hepatitis Integration and Intervention Projects (VHIPS) to establish best practices for prevention of hepatitis C and other causes of viral hepatitis; and 12 Viral Hepatitis Education and Training Projects (VHETS) to develop and disseminate hepatitis C education and training materials.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$245,346,000 for Infectious Diseases Control, an increase of \$18,578,000 above the FY 2006 Enacted level of \$226,768,000.

Develop an Ongoing Library of Pandemic Virus Reference Strains for Manufacturing (+\$19.8 million)

The U.S. laboratory system lacks sufficient capacity to analyze large quantities of viral samples of circulating strains to identify suitable vaccine candidates. There is also a lack of dedicated facilities for development and evaluation of vaccine reference strains. Increased funding in FY 2007 will allow CDC to increase laboratory and analytical capabilities for genetic and antigenic analysis of influenza viruses.

Increase Stock of Diagnostic Reagents for Influenza (+14.9 million)

Capacity for molecular detection of H5N1avian influenza virus and other strains with pandemic potential is available at CDC and state reference laboratories but is not widely distributed and at levels needed to respond to pandemic and pre-pandemic situations. It is vital to develop, validate, and continuously update new rapid bedside detection assays with subtype specificity for use during a pandemic. The United States also requires investments in rapid test capacity for novel influenza viruses. With increased resources in FY 2007, CDC will provide for the acquisition, storage, shipping, and support of a newly acquired inventory either internally or through a commercial vendor. CDC will also work with the manufacturer to work toward more stringent quality assurance and control by instituting control protocols to ensure reagents are used properly. Finally, CDC will provide incentives for the manufacturer to make reagents available when needed.

Pay Raise (+\$0.5 million)

The request includes funds to cover the projected FY 2007 increase.

West Nile virus (-\$9.9 million)

In FY 2005, approximately \$19 million was awarded to 56 state and local public health agencies to assist in the development of comprehensive, long-term disease monitoring, prevention, and control programs for WNV. WNV funding has built infrastructure and led to the enhancement of state-based programs to make states better able to prevent, detect, and respond to the threat of WNV. The establishment of this national program has also enhanced viral laboratory capacity, veterinarian epidemiology capacity, and surveillance of disease.

NARRATIVE BY ACTIVITY
INFECTIOUS DISEASES
INFECTIOUS DISEASES CONTROL

A reduction to WNV activities in FY 2007 will decrease the amount of funds available in every state and local health department to respond to this nationwide epidemic, although CDC would make every attempt to distribute funds according to the profile of the epidemic. CDC funds have allowed states to develop and enhance their WNV activities, and reductions in FY 2007 will require states to leverage existing funding for future activities. CDC will also discontinue funding for training grants and other studies as identified.

Administrative and Information Technology (IT) Savings (-\$2.5 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

Program Reductions (-\$4.3 million)

The FY 2007 President's Budget proposes reductions to fund base program activities at the FY 2006 President's Budget level.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of domestic/global surveillance networks for emerging infectious diseases.	5	5	5	0
Number of EIP network sites	11	11	11	0
Number of national surveillance and response programs in states and large local health departments for WNV and other arboviruses	58	58	58	0
Number of state/local health departments, health care systems funded for surveillance, prevention, control of antimicrobial resistance	50	49	48	(1)
Number of grants for infectious disease research to academic institutions and states	40	40	40	0
Number of reporting domestic sentinel physician sites to improve influenza surveillance	1,000	1,300	1,300	0
Number of state/local health departments supported to build epidemiological and lab capacity for influenza	47	47	47	0
Number of sites in the National Health Care Safety Network to report health care based reporting of adverse health events and errors	300	300	500	200
Food Safety				
Number of countries receiving PulseNet training, protocols	10	11	12	1

NARRATIVE BY ACTIVITY
INFECTIOUS DISEASES
INFECTIOUS DISEASES CONTROL

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of public health laboratories capable of accessing CaliciNet to detect viral diseases	40	40	40	0
Number of public health laboratories using DPDx to detect parasitic diseases	51	58	62	4
Number of states reporting food-borne disease data to CDC electronically	46	53	54	1

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

FUNCTIONAL TABLE

Infectious Diseases Control Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Infectious Diseases	\$191,855	\$193,074	\$212,377	\$19,303
Food Safety	\$28,767	\$28,774	\$28,097	(\$677)
Chronic Fatigue Syndrome (CFS) ¹	\$4,967	\$4,920	\$4,872	(\$48)
Total -	\$225,589	\$226,768	\$245,346	\$18,578

¹CFS does not include funding for the CFS payback, which was completed in FY 2005. In FY 2005, the payback amounts to \$3.8 million, for a total FY 2005 funding level for CFS of \$8.7 million. The total payback amount is \$12.9 million.

HIV/AIDS, STD, AND TB PREVENTION

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 308(d), 310, 311, 317, 317(a) 317E, 317P, 318, 318A, 318B, 322, 327, 352, 2315, 2320, 2341, 2625, 2521- 2523. Provisions Concerning Pregnancy and Perinatal Transmission of HIV [2625(c)]. Tuskegee Health Benefits: P.L. 103-333. Ryan White CARE Act Amendments: § 502 of P.L. 106-345. International authorities: P.L. 109-149 sec. 215

HIV/AIDS, STD and TB Prevention (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$960,711	\$946,577	\$1,032,969	\$86,392

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$1,032,969,000 for HIV/AIDS, STD, and TB, Prevention an increase of \$86,392,000 over the FY 2006 Enacted level of \$946,577,000.

PROGRAM DESCRIPTION

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), sexually transmitted diseases (STDs), and tuberculosis (TB) are among the most prevalent infectious diseases in the U.S. and have a substantial impact globally as well. Approximately 1 million Americans have been infected with HIV, the virus that causes AIDS, each with an estimated lifetime cost of \$210,000 per person. One-quarter of those infected are unaware of their infection, yet persons who are aware of their infection are more likely to modify their behaviors to avoid transmission to others

In the United States, an estimated 18.9 million new cases of STDs (excluding HIV) occur each year, nearly half of them among persons aged 15-24 years. Untreated STDs can lead to potentially severe and costly health consequences. Annual direct medical costs of STDs among persons aged 15-24 years are estimated at \$6.5 billion. Chlamydia, for example, is the most commonly reported infectious disease in the U.S. When diagnosed, chlamydia, gonorrhea, and syphilis are curable and transmission to others is preventable. Actual transmission is thought to be much higher than reported as many infections are asymptomatic and undiagnosed.

TB afflicted over 14,000 Americans in 2004 and is a leading infectious cause of death worldwide, killing more than two million people in 2004, despite the availability of effective treatments and control programs.

Effective control of TB and STDs is necessary to protect the health of HIV-infected persons and to reduce HIV transmission. HIV infection disables the immune system, putting infected persons at higher risk for developing other infectious diseases. Care must be taken to avoid exposing HIV-infected persons to TB, and to treat those HIV-infected persons who also have latent TB, as they are much more likely to develop active disease. Chlamydia and syphilis have been shown to increase the risk of HIV transmission among adults at least three- to five-fold. Preventing STDs, therefore, is one effective way to prevent the spread of HIV.

Although these diseases affect all Americans, they often hit hardest those populations that are least able to respond – the poor, minorities, youth, immigrants, incarcerated persons, and other disenfranchised populations. Syphilis and gonorrhea are examples of racial disparities in health with blacks suffering at rates five to 19 times higher than whites. The highest chlamydia and gonorrhea rates occur among adolescents and young adults. The HIV epidemic continues to have a disproportionate impact on racial and ethnic minorities. Studies of incarcerated persons have found that this group is often disproportionately impacted by a variety of health problems, including HIV, STDs and TB.

CDC provides leadership in preventing and controlling HIV infection, other STDs, and TB. CDC works in collaboration with partners at community, state, national, and international levels applying well-integrated, multidisciplinary programs of research, surveillance, risk factor and disease intervention, and evaluation. CDC achieves its mission by:

- Developing, implementing, and evaluating effective science-based prevention programs for HIV, STDs, and TB.
- Developing high quality research and translating relevant findings into prevention policy and programs.
- Creating and strengthening strategic relationships and networks with individuals and organizations.
- Strengthening and promoting surveillance activities and findings for program planning, public health response, and evaluation.

CDC conducts surveillance as well as epidemiologic and behavioral research to monitor trends and risk behaviors related to HIV/AIDS to provide a basis for targeting prevention resources. CDC also provides financial and technical assistance for HIV prevention programs conducted by state, local, and territorial health departments, national organizations, community-based organizations (CBOs), faith-based organizations, and training agencies. Supporting these efforts are intervention and operations research and evaluation activities.

To prevent STDs, CDC provides national leadership through research, surveillance, policy development, and assistance to states, territories, and local health departments in the delivery of services to prevent and control transmission and related complications of STDs. Comprehensive STD Prevention Systems (CSPS) grants provide federal support for a community-wide, science-based, interdisciplinary "systems" approach to STD prevention as recommended by the Institute of Medicine (IOM) in its report: *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. National surveillance of syphilis, chlamydia, and gonorrhea is supported and sentinel surveillance strategies have been developed for Human Papillomavirus (HPV) and lymphogranuloma venereum (LGV). CDC conducts prevention research to improve methods and delivery of prevention services and to develop and refine interventions.

CDC provides leadership and assistance to domestic and international efforts to prevent, control and eliminate TB. CDC's national program provides grants to states and other entities for prevention and control services; researches the prevention and control of TB; funds demonstration projects; sponsors public information and education programs; and supports education, training, and clinical skills improvement activities to prevent, control, and eliminate TB. In 1989, CDC set a goal to eliminate TB in the U.S., with elimination defined as less than one case per 1,000,000 persons. This goal was reaffirmed in 1999 by the Advisory Council for the Elimination of Tuberculosis (ACET) and in 2000 by the IOM. Elimination of TB is a long-term goal that requires developing new tools and fully implementing the strategies recommended by the IOM.

Success in achieving this goal, and ultimately TB elimination depends on: (1) treating infectious patients quickly and completely; (2) treating them with drugs that work; (3) treating their close contacts; (4) treating persons with latent infection who are at high risk of developing the disease; (5) maintaining timely, complete local, state, and national TB information systems to monitor elimination efforts; and (6) helping to control the spread of TB globally.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the HIV/AIDS, STD, and TB Prevention activity, the following performance measures have been selected as highlights of the program's performance plan:

Performance Goal	Results	Context
1. Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 235 cases.	Surveillance data published through 2004 show sharply declining trends in perinatal AIDS cases since the mid-1990s. This decline was strongly associated with increasing zidovudine use in pregnant women who were aware of their HIV status. Improved treatment has also likely delayed onset of AIDS for HIV-infected children.	Pregnant women who are HIV-infected but whose status is unknown miss opportunities to reduce the risk of transmission to their infants and to receive life-saving treatments for themselves. CDC is working with partners to promote routine prenatal HIV testing, and has developed guidance for using rapid tests during labor and delivery or immediately post partum. In addition, CDC provides training in conducting prenatal testing, and monitoring the integration of routine prenatal testing into medical practice.

Performance Goal	Results	Context
2. Reduce the racial disparity of P&S syphilis by 63 percent (reported ratio is black:white).	In 2004, rates of syphilis among African Americans were 5.6 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. 2002 baseline ratio: 8:1.	Syphilis remains an example of racial disparity in health. Although syphilis and other STDs affect all Americans, they often disproportionately affect communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to health care. Effective control of syphilis is also necessary to protect the health of HIV-infected persons and to reduce HIV transmission, as syphilis has been shown to increase the risk of HIV transmission among adults at least 3-5 fold. As such, the control and eventual elimination of syphilis is crucial in protecting the health of U.S. citizens. CDC supports national surveillance of syphilis and conducts prevention research to improve prevention services and to develop and refine interventions. Implementation of CDC's National Plan to Eliminate Syphilis has directed resources to 39 high syphilis morbidity areas.

Current Activities

Core HIV Prevention Activities -- CDC's core set of HIV prevention activities includes surveillance, research, intervention, capacity building, and evaluation. These activities are highlighted below:

- HIV/AIDS Surveillance – CDC and state and local health departments use surveillance to track the epidemic and understand its dynamics. Surveillance provides demographic, laboratory, clinical, and behavioral data that are used to identify populations at greatest risk for HIV infection. These data also help CDC estimate the size and scope of the national epidemic. CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS case surveillance. CDC recommends that all states and territories conduct HIV surveillance using a confidential, name-based system. As of November 2005, 43 areas (38 states and five territories) were conducting HIV surveillance using confidential name-based methods. CDC supports projects in 34 areas to assess HIV incidence in conjunction with HIV case reporting. To better understand the dynamics of the epidemic, CDC also conducts specialized surveys of infected and high-risk persons.
- HIV Research - CDC conducts biomedical and behavioral research to better understand the complex factors that lead to HIV infection and to identify effective approaches to prevent infection. Priorities for HIV research include research related to diagnostic tests, microbicides, vaccines, and behavioral research focused on eliminating disparities. Prior to the approval of the OraQuick HIV rapid test, CDC was involved in studies of

the test's accuracy as well as how the test could be used in certain settings. Most recently, CDC has initiated trials of the safety and efficacy of the prophylactic use of tenofovir, an anti-retroviral medication for use in preventing HIV infection.

- **HIV Interventions** – Early in the epidemic, CDC recognized that the involvement of affected communities was a critical success factor in HIV/AIDS prevention programs. CDC uses several tools to involve communities in HIV prevention, including community planning, coordinated through health departments, and direct funding of Community-Based Organizations (CBOs). Through the HIV community planning process, communities tailor HIV prevention programs, supported by CDC funding to health departments, to local needs. Since 1989, CDC has provided funding directly to CBOs to conduct HIV prevention activities. Since 1999, CDC has received additional funding through the Minority AIDS Initiative to augment these existing efforts to address racial and ethnic disparities in HIV/AIDS.
- **Capacity-Building** – Underpinning intervention programs are capacity-building efforts. To build the capacity of its state and CBO partners to prevent HIV, CDC: (1) supports national meetings and satellite broadcasts as a forum for sharing new ideas and best practices; (2) funds nongovernmental organizations to provide training and materials; (3) provides direct technical assistance to CBOs; and (4) synthesizes and disseminates information on science-based interventions.

STD and TB Prevention Activities – CDC's activities include infertility, syphilis elimination, HPV, State TB programs, clinical epidemiologic research, and global partnership

- **Evaluation** – Key to this effort is CDC's work to evaluate its programs in order to monitor progress and refine efforts. The Program Evaluation and Monitoring System (PEMS) is used to collect common data elements on HIV prevention activities to monitor progress on core performance indicators. Because it is standardized, PEMS will improve the quality of data reported and allow for more extensive querying and analysis of HIV program data.
- **Infertility Prevention Program** – CDC and the HHS Office of Population Affairs (OPA) work with family planning, STD, and primary health care programs to implement infertility prevention activities for uninsured and underinsured women, primarily screening for chlamydia and gonorrhea. CDC conducts research to identify the biological and behavioral determinant of chlamydia transmission and assess the feasibility, acceptability, and cost-effectiveness of chlamydia screening for males. CDC supports screening programs in all 65 STD project areas.
- **Syphilis Elimination** – CDC is increasing its focus on preventing syphilis transmission among men who have sex with men (MSM) because of recent resurgence of syphilis among this population. These increases represent a challenge in the control and eventual elimination of syphilis. CDC supported the Eight Cities Project to develop and implement innovative strategies to stem the epidemic of syphilis among MSM in eight metropolitan areas in the U.S. While addressing the increase in syphilis among MSM, CDC strives to maintain momentum in the success among populations originally targeted by syphilis elimination, i.e., minority heterosexuals and infants. In 2005-2006, CDC is reviewing and updating its National Plan to Eliminate Syphilis to assess current efforts, to develop new strategies to reduce syphilis among MSM, and to further reduce syphilis overall in the U.S.
- **Human Papillomavirus (HPV) and other STDs**—CDC also supports sentinel surveillance, formative communications research, behavioral research, and provider surveys on HPV, as well as work developing recommendations for HPV vaccines and implementation issues pertinent to such vaccines. In addition, CDC supports special surveillance studies for HPV and HSV-2; (Herpes Simplex Virus 2) epidemiologic, behavioral, laboratory and health services research on a variety of STD; and program support, training and health communications for national STD prevention programs.
- **State TB Control programs** – CDC funds 68 cooperative agreements with state and local health departments for TB prevention and control (technical and financial assistance, laboratory support, model centers, and health care worker training). CDC works with 41 state and local TB advisory committees that represent patients and providers.
- **Applied Clinical and Epidemiologic TB Research** – CDC collaborates, through contracts and interagency agreements, with the Veterans Administration and other partners, to maintain a consortium for TB clinical trials research. CDC supports the Tuberculosis Epidemiologic Studies Consortium to strengthen TB epidemiological, behavioral, economic, laboratory, and operational research capacity within states, cities, and academic institutions.
- **Works with a global partnership to implement the World Health Organization's "Stop TB" Initiative.**

- TB Control Along the U.S.-Mexico Border – CDC, in collaboration with international partners, piloted the Binational TB Card in three U.S. states and five Mexican states to ensure continuity of care and completion of TB treatment for patients who migrate between the U.S. and Mexico; to coordinate the referral of patients between the health systems of both countries; and to prevent multi-drug resistant strains of TB. CDC is evaluating results to determine whether to expand the U.S.-Mexico Binational TB Referral and Case Management Project to other parts of the U.S. and Mexico.

Significant Accomplishments

- In 2005, demonstration projects supporting the Advancing HIV Prevention (AHP) initiative, launched in 2003, are in their last year of funding. Data collection systems are in place, and new data are being reported. CDC is collecting quantitative data and identifying lessons learned to disseminate best practices for AHP interventions. The information obtained from the demonstration projects will be used to improve national HIV prevention programs. In particular, the Social Network demonstration project has shown success. Under this project, CDC funded community-based organizations to demonstrate the feasibility of using social network strategies to reach and provide HIV counseling, testing, and referral services to persons at high risk for HIV infection. Preliminary findings published in June 2005 indicated that HIV prevalence in the social networks project is 5.7%, which is six times the rate of 0.9% in publicly funded clinics.
- Purchased and distributed over 700,000 OraQuick rapid HIV test kits from 2003 to 2005. The test kits have been used by 137 health departments and CBOs in settings lacking immediate access to clinical laboratory services. Test kits were distributed free of charge to CDC-funded demonstration projects associated with the AHP initiative and to other CDC grantees.
- Continued to publish HIV/AIDS surveillance data which is used across the federal government and by other organizations to guide HIV-related programs, including those of CDC, the Health Resources and Services Administration (HRSA) and the Department of Housing and Urban Development (HUD). In July, 2005, CDC formally recommended confidential, name-based HIV surveillance to all state and territories. In 2005, trend data from 35 areas (33 states, Guam, and the U.S. Virgin Islands) using confidential, name-based systems were reported, representing nearly two-thirds of the national HIV burden and providing a more accurate picture of the epidemic in the U.S.
- The number of children nationwide reported to have acquired AIDS perinatally declined to an estimated 48 in 2004, down from an estimated 247 in 1998.
- Between 1988 and 2004, screening programs in HHS Region X have demonstrated a decline in chlamydia positivity of 49 percent (from 15.1 percent to 7.7 percent) among 15-24 year old women in participating family planning clinics.
- Conducted a study with Kaiser Permanente demonstrating the feasibility and cost-effectiveness of chlamydia screening in young women in managed care settings.
- Reduced the reported rate of primary and secondary syphilis from 3.1 cases per 100,000 population in 1997 to 2.7 cases per 100,000 population in 2004.
- Increased the percentage of syphilis-free U.S. counties from 75 percent in 1997 to 79.3 percent in 2004.
- Decreased black: white syphilis reported ratio from 43:1 in 1997 to 5.6:1 in 2004.
- Conducted 36 comprehensive syphilis elimination program assessments in high syphilis morbidity areas. The information from these assessments was compiled into a monograph, *Lessons Learned and Emerging Best Practices from the National Syphilis Elimination Program Assessment*. Information in the monograph will be used to update the National Syphilis Elimination Plan.
- Developed HPV educational materials for health care providers, patients, and the general public. Launched a comprehensive HPV website and conducted a national Webcast targeted to health care providers.
- In the aftermath of Hurricane Katrina, 132 New Orleans area residents who had been receiving treatment to cure tuberculosis were relocated to unknown locations. CDC lead special teams of federal, state, and local public health workers to confidentially match patient names with rosters maintained by shelters, hospitals, the American Red Cross, incident and emergency command centers in Texas, the Federal Emergency Management Agency, and both local and national pharmacy databases. By mid-October, all 132 patients were located and back on TB medications.
- Since 1992, the most recent peak of the TB epidemic, reported cases of TB declined 45.6 percent. From 2003 to 2004, reported cases of TB in the U.S. declined 1.3 percent (from 14,858 to 14,511). This represents the twelfth consecutive year that TB cases have declined nationally.

NARRATIVE BY ACTIVITY
INFECTIOUS DISEASES
HIV/AIDS, STD, AND TB PREVENTION

- Continued to achieve declines in TB cases rates; the TB case rate in 2004 was 4.9 per 100,000 populations, down from 5.1 in 2003.
- Issued guidelines to improve TB control in the U.S. in 3 critical areas: the use of new diagnostic tools, investigating contacts of TB cases, and preventing infection among health care workers, patients and their families.
- Successfully identified and controlled an outbreak of TB among Hmong refugees from Thailand. Due to improved recognition measures, an estimated 345 cases were identified prior to their entry into the U.S. Of those who had already been infected, 341 were treated for infection.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$1,032,969,000 for HIV/AIDS, STD, and TB, Prevention an increase of \$86,392,000 over the FY 2006 Enacted level of \$946,577,000.

Domestic HIV/AIDS Initiative (+\$93.0 million)

A key challenge in the United States for reducing the burden of HIV/AIDS is to stop the spread of HIV by detecting the approximately 250,000 persons who are undiagnosed and preventing new infections. The FY 2007 President's Budget Request includes an increase of \$93 million to significantly increase testing in medical settings, make voluntary testing a routine part of medical care, and create new testing guidelines, models, and best practices. This initiative would directly facilitate the testing of more than three million additional Americans, emphasizing regions with the highest numbers of new cases as well as focusing on incarcerated persons and injecting drug users.

Pay Raise (+\$2.3 million)

The request includes funds to cover the projected FY 2007 increase.

Administrative and Information Technology (IT) Savings (-\$8.9 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
HIV Prevention				
Areas funded for HIV prevention	65	65	65	0
Areas funded for HIV/AIDS surveillance	65	65	65	0
No. of areas funded to estimate HIV incidence	34	34	34	0
No. of cities to conduct surveillance for behavioral risks for HIV infection in high-risk groups	24	24	24	0
No. of capacity building assistance providers supporting minority CBOs	31	31	31	0
Number of CBOs funded to support community level interventions**	162	162	162	0

NARRATIVE BY ACTIVITY
INFECTIOUS DISEASES
HIV/AIDS, STD, AND TB PREVENTION

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
No. of cities funded with enhanced testing activities	0	0	10	10
Minority postdoctoral fellowships	3	3	3	0
STD Prevention				
Technical and financial assistance to grantees for STD Prevention	65	65	65	0
Syphilis Elimination Programs Funded	35	38	38	0
Regional infertility programs funded	10	10	10	0
STD/HIV Regional Prevention Training Centers funded	10	10	10	0
Percent of syphilis elimination funds awarded to project areas to support organizations serving affected populations	30	30	30	0
TB Elimination				
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	0
Number of research consortia funded	2	2	2	0
Number of studies funded under the TB Clinical Trials Consortia	3	2	2	0
Number of task orders funded under the TB Epidemiologic Studies Consortia	9	6	3	(3)
Number of communications disseminated via CD-ROM	11,000	11,300	11,200	(100)
Number of state public health laboratories participating in the TB Genotyping Network	50	50	50	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

**Includes activities supported with HHS Minority AIDS funding

NARRATIVE BY ACTIVITY
 INFECTIOUS DISEASES
 HIV/AIDS, STD, AND TB PREVENTION

FUNCTIONAL TABLE

HIV/AIDS, STD, & TB Prevention Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
<u>HIV/AIDS, Research and Domestic</u>				
State & Local Health Departments	\$412,016	\$408,100	\$493,263	\$85,163
Community Planning Grants (non-add)	\$321,868	\$318,649	\$316,419	(\$2,230)
National/Regional/Other Organizations	\$177,901	\$171,355	\$170,155	(\$1,200)
CDC Research, Tech Asst & Prog. Supt	\$72,350	\$71,663	\$76,161	\$4,498
Subtotal, Research & Domestic -	\$662,267	\$651,118	\$739,579	\$88,461
Sexually Transmitted Diseases (STD)	\$159,633	\$158,036	\$156,929	(\$1,107)
Tuberculosis (TB)	\$138,811	\$137,423	\$136,461	(\$962)
Total -	\$960,711	\$946,577	\$1,032,969	\$86,392

IMMUNIZATION

AUTHORIZING LEGISLATION

Grants: PHS § 317(a), 317(j), 317(k)(1); Prevention activities: PHS § 301, 307, 310, 311, 317, 327, 340C, 352, 2125, 2126, Title XXI; Subtitle 1 – National Vaccine Program § 1928 of Social Security Act (42 U.S.C. § 1396s).

Immunization (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Discretionary Immunization Program, Current Law	\$480,238	\$507,078	\$494,575	(\$12,503)
<i>Section 241, PHS Evaluation Transfer</i>	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Discretionary Immunization Program (Current Law)	\$493,032	\$519,872	\$507,369	(\$12,503)
Proposed Law Changes ^{1,2}	\$0	\$0	(\$100,000)	(\$100,000)
Subtotal, Discretionary Immunization Program (Proposed Law)¹	\$493,032	\$519,872	\$407,369	(\$112,503)
Vaccines for Children (VFC) (Current Law)	\$1,503,127	\$1,957,963	\$2,006,445	\$48,482
Proposed Law Changes ^{1,2}	\$0	\$0	\$140,000	\$140,000
VFC (Proposed Law) ^{1,2}	\$1,503,127	\$1,957,963	\$2,146,445	\$188,482
Total Immunization (Current Law)	\$1,996,159	\$2,477,835	\$2,513,814	\$35,979
Total Immunization (Proposed Law)^{1,2}	\$1,996,159	\$2,477,835	\$2,553,814	\$75,979

¹The FY 2007 Estimate reflects the Proposed Law transfer of \$100 million from the Section 317 Program to the Vaccines for Children program.

²Funding for VFC in FY 2005 reflects obligations. FY 2006 funding includes carryover of \$60 million from FY 2005.

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total proposed law level of \$2,553,814,000 for Immunization, an increase of \$75,979,000 above the FY 2006 total funding level of \$2,477,835,000. The FY 2007 President's Budget reflects a total current law level of \$2,513,814,000, an increase of \$35,979,000 above the FY 2006 total funding level of \$2,477,835,000.

PROGRAM DESCRIPTION

The mission of CDC's Immunization program is to prevent disease, disability and death in children, adolescents and adults through vaccination. Many life-threatening and/or debilitating infectious diseases, including diphtheria, measles, mumps, and pertussis, were once common in this country. Now, widespread use of vaccines, particularly among children, has resulted in continuing low levels of these diseases.

Appropriate administration of safe and effective vaccines is one of the most successful and cost-effective public health tools for preventing disease, disability, and death and for reducing economic costs resulting from vaccine-preventable diseases. To maintain this success, CDC provides national leadership in the ongoing effort to protect children, adolescents and adults from vaccine-preventable diseases and to ensure the safety of vaccines. The responsibilities are many but focus on the goal of ensuring that every person, of every age, in every part of the country is protected from vaccine-preventable diseases.

CDC strives to ensure control of vaccine-preventable diseases by working with partners to develop national immunization policy, ensure high quality immunization services, increase community participation, education and partnerships, improve systems to monitor disease and vaccination coverage, and improve vaccines and vaccine use.

In carrying out its mission, CDC:

- Awards grants through the Section 317 of the Public Health Service Act and the Vaccines for Children (VFC) Program to assist state and local health departments in purchasing safe and effective vaccines and in planning, developing, and conducting childhood immunization programs.
 - The Section 317 program provides vaccines for children, adolescents and adults who primarily present at local health departments for immunization services but are not eligible for the VFC program. These populations are predominately underinsured (i.e., their insurance does not cover immunization), insured but they cannot afford high deductibles, or the working poor. Vaccines are provided to adolescents and adults, as funding allows, but to a much lesser extent than children.
 - The VFC program serves children without insurance, those eligible for Medicaid, American Indian/Alaska Native children, and children who are underinsured and receive care through Federally Qualified Health Clinics. Under the VFC program, federally purchased vaccines are distributed to public health clinics and enrolled private providers, enabling vaccination of all eligible children.
- Provides technical, epidemiological, educational, statistical and scientific assistance to state and local health departments.
- Collaborates with three advisory bodies to issue a single schedule of routine childhood immunizations: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The schedule is continually evaluated to ensure the highest level of effectiveness, efficiency, and safety in childhood immunizations. Upon recommendation by ACIP, CDC includes new vaccines in the Vaccines for Children Program so that they are available to all eligible children.
- Develops an Adult Immunization Schedule to offer a summary of immunization recommendations for adults. The schedule is endorsed by ACIP, AAFP, and the American Academy of Obstetricians and Gynecologists.
- Strives to ensure a six month supply of recommended vaccines will be available for all U.S. children through a national pediatric stockpile.
- Strives for vaccine safety by monitoring harmful effects, conducting scientific research to evaluate the safety of vaccines, communicating the benefits and risks of vaccines to the public.
- Conducts research and operational programs for the prevention and control of vaccine-preventable diseases.
- Supports a nationwide framework for effective surveillance of diseases for which effective immunizing agents are available.

Vaccines are one of the most successful and cost-effective public health tools for preventing disease and death.

COST-EFFECTIVENESS OF CHILDHOOD VACCINES	
For every \$1 spent on an individual vaccine:	
•	DTaP saves \$27
•	MMR saves \$26
•	Perinatal Hepatitis B saves \$14.70
•	Varicella saves \$5.40
For every \$1 spent:	
•	Inactivated Polio (IPV) saves \$5.45
•	Childhood Series (7 vaccines) saves \$16.50*

* (DTaP, Td, Hib, IPV, MMR, Hep B and Varicella)

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

Despite great success and achievements, there are challenges:

- Nearly one million two-year-olds in the United States have not received one or more of the recommended vaccines. Even though coverage levels for preschool immunization are high in many states, pockets of need, or areas within each state and major city where substantial numbers of under immunized children reside, continue to exist.

- Every day in the United States, approximately 11,000 babies are born who will need up to 25 vaccinations before they are two years old to be protected against 13 vaccine-preventable diseases. New vaccines, although greatly beneficial to public health, complicate an already complex immunization schedule and make it increasingly difficult to ensure complete immunization.
- The burden of vaccine-preventable diseases in adults in the United States is staggering. Approximately 43,000 U.S. adults die annually of vaccine-preventable diseases. Pneumonia and influenza were the fifth leading cause of death in all persons aged 65 and older based on 2000 national mortality data. One of the greatest challenges is extending the success in childhood immunization to the adult population.
- Vaccine production difficulties can have a great impact on immunization programs and policies. In the 2005-2006 influenza season, a delay and decreased vaccine production by one manufacturer resulted in a mismatch between supply and demand for influenza vaccine that left a number of providers, hospitals, long term care facilities, and vaccine distributors without sufficient vaccine. CDC works to influence influenza vaccine distribution and use through recommendations and guidelines and extensive collaborations; however, there are limits to what CDC can accomplish in this role because influenza vaccine distribution and administration is a mostly private sector enterprise. Challenges will continue as new groups are recommended for influenza vaccination and there is an increase in vaccine usage. CDC is committed to working closely with partners to develop strategies to address these challenges.
- Immunizations are subject to a higher standard of safety than other medical interventions because they are given to healthy people. Actively monitoring and assuring the safety of vaccines is essential for maintaining public confidence in immunizations, thereby preserving high coverage levels and preventing a resurgence of vaccine-preventable diseases.

CDC is committed to:

- Promoting immunization at every stage of life: CDC works with health care providers, partners, and state and local government agencies to ensure that childhood immunizations remain at high levels. As childhood immunization coverage continues to increase, the incidence of vaccine-preventable diseases declines significantly.
- Achieving high vaccination coverage rates for adolescents and adults: This includes working with private health care providers, state and local health departments and other partners to foster awareness of immunization recommendations and increase vaccine knowledge.
- Providing effective, proactive leadership on vaccines and immunization: CDC provides effective, proactive leadership in the immunization arena by fostering sound vaccine recommendations and policies, conducting quality research, developing and distributing educational material, and enlisting and engaging the contributions of a wide range of professional groups and other organizations.
- Strengthening immunization science and communicating the results: CDC undertakes and promotes a wide range of scientific activities, including tracking and monitoring diseases, disease outbreak investigations, evaluations of health care delivery methods and systems, and social and behavioral science research. Importantly, CDC works to translate research findings into actions and recommendations and to communicate these to the appropriate audiences.
- Fostering and establishing partnerships and collaboration: CDC works with local, state, and national partner organizations to increase awareness of immunization recommendations, foster the development and implementation of effective immunization programs, and achieve high immunization coverage levels. CDC also develops partnerships with community organizations and private health care providers to increase awareness of immunization recommendations and the use of "best practices."
- Providing effective, responsive immunization education and information. CDC helps health departments, physicians, nurses, and other health care providers attain the knowledge and skills needed to effectively implement immunization recommendations. Patient-education materials are also provided to assist health care providers in educating parents, adolescents and adults about the importance, benefits and risks of immunization recommendations.
- Assisting states as they further develop and refine their pandemic preparedness and emergency response plans and identifying innovative approaches to common problems.

Immunization has been cited as one of the top ten public health achievements of the 20th century. In the U.S., vaccine-preventable diseases are at or near record low levels. Beginning in 1962, when the first national effort to improve the immunization status of children was proposed by Congress, CDC has counted immunization among its most vital programs, recognizing it as a core public health activity and perhaps the best example of effective primary prevention.

Vaccines have reduced cases of all vaccine-preventable diseases by more than 97 percent from peak levels before vaccines were available, saving lives and treatment and hospitalization costs (see table below).

INDIGENOUS CASES OF VACCINE PREVENTABLE DISEASES IN THE U.S. FINAL REPORTS FOR 2002, 2003 AND 2004					
	Highest # of Cases	2002 ¹	2003 ¹	2004 ¹	2010 Goal
Diphtheria ²	206,939	0	0	0	0
Measles ³	894,134	26	32	11	0
Mumps ³	152,209	253	222	245	0
Pertussis ⁴	265,269	4,109	3,719	6,850	2,000
Polio ³ (paralytic, wild-type)	21,269	0	0	0	0
Rubella ³	57,686	10	7	7	0
Congenital Rubella Syndrome (CRS) ⁵	20,000	1	1	0	0
Tetanus ²	1,733*	6	6	6	0

¹ 2002-2004 cases correspond to Healthy People 2010 and GPRA age targets

² Persons under 35 years of age reported 2002-2004

³ All ages reported

⁴ Children under 7 years of age reported 2002-2004

⁵ Children under one year of age reported 2002-2004 Estimated

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Immunization activity, the following performance measure has been selected as a highlight of the program's performance plan:

Performance Goal	Results	Context
1. Achieve or sustain immunization coverage of at least 90 percent in children 19- to 35-months of age for: 4 + doses DTaP vaccine ¹ 3 + doses <i>Haemophilus influenzae</i> type B (Hib) vaccine 1 + dose MMR vaccine ² 3 + doses hepatitis B vaccine 3 + doses polio vaccine 1 + dose varicella vaccine 4 + doses pneumococcal conjugate vaccine (PCV7) ³	The target of 90 percent coverage was met in 2004 for most of the vaccines except varicella and four doses of DTaP. Varicella is the most recently introduced vaccine that has a measurable target. Varicella rates are rising, with coverage at only 43 percent in 1998 reaching 88 percent in 2004.	Appropriate administration of safe and effective vaccines is one of the most successful and cost effective public health tools in preventing disease, disability, and death and reducing the economic costs resulting from vaccine-preventable disease. Immunizing children by two years of age helps to accomplish the goal of reducing the number of indigenous cases of vaccine preventable disease.

¹ Due to a shortage to vaccine and temporary change in recommendations, reported by 3 doses from 2002-2003

² Includes any measles containing vaccine

³ Performance targets for newly recommended vaccines, such as pneumococcal conjugate vaccine and influenza vaccine are reported in GPRA 5 years after ACIP recommendations. Measures for PCV7 will begin in 2006 and influenza in 2009.

In 2004, the coverage rate for four doses of DTaP containing vaccine did not achieve the 90 percent goal. However, the coverage rate for the fourth dose has steadily increased since the change to a four dose schedule, as recommended by the ACIP in 1991. This goal continues to be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. Coverage rates are 96 percent for the first three DTaP doses. Although the first three doses are considered to be most critical, CDC and the ACIP feel strongly that the fourth and a fifth dose administered at four to six years of age are important for full vaccination protection. Varying state requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage.

Current Activities:

Awarding Grants to States for Vaccine Purchase: Vaccine grants support the purchase of ACIP recommended vaccines through CDC's consolidated vaccine purchase contracts available to state and local health departments.

Awarding Grants to States for Operations/Infrastructure activities including:

- Implementing the unprecedented number of new vaccine recommendations for children, adolescents and adults which were approved by ACIP in 2005. New vaccines and/or expanded recommendations include: 1) Use of Meningococcal Vaccine (MCV4) for adolescents and college freshmen to protect against meningococcal disease in adolescence and young adulthood. 2) Replacement of the Td booster with the more comprehensive Tetanus, diphtheria, and pertussis (Tdap) vaccine, to reduce the number of cases of pertussis (whooping cough) in infants, adolescents and adults. 3) Universal use of Hepatitis A vaccine and lowering the age indication for vaccine to 12 months of age. Previously, the Hepatitis A vaccine was recommended for use in only certain high risk groups and children living in states, communities or counties with high annual incidence of hepatitis A during 1987-1997. 4) Use of the combination Measles Mumps Rubella Varicella (MMRV) vaccine to protect children against these four vaccine preventable diseases.

Raising and sustaining vaccination coverage levels through the technical assistance CDC provides which is based on evidence-based immunization strategies that have been scientifically proven to sustain and raise vaccination coverage levels such as:

- Identifying and improving coverage in "pockets of need" (areas within each state and major city where substantial numbers of under-immunized children reside), where the risks of vaccine-preventable disease outbreaks are increased. The development and use of state-based registries will help identify high-risk and under-immunized populations.
- Using reminder and recall systems to improve immunization levels in children and adults (the development and use of state-based registries that include reminder/recall components provide critical information needed to improve and sustain coverage).
- Conducting Assessing vaccination coverage levels and practices in public and private provider settings, providing Feedback, encouraging Incentives for improved performance, and eXchange of information to stimulate competition between providers (AFIX).
- Operating vaccine distribution systems, processing vaccine orders from the states and from physicians in the private sector who participate in the VFC program, conducting provider recruitment and enrollment activities, conducting the AFIX strategy with VFC-enrolled private and public providers, and developing and implementing vaccine accountability and evaluation plans.

Conducting prevention activities, supported by cooperative agreements, contracts, in house research, technical assistance and consultation, and planning and evaluation in cooperation with states and local agencies. Prevention activities include:

- Collecting vaccination coverage data at the national, state, and local levels (with this information, the impact of national, state, and local policies and programs can be evaluated and monitored; the results provide an essential means of monitoring progress toward Healthy People 2010 objectives).
- Conducting operational research to develop new and improved immunization delivery strategies to raise or sustain coverage levels.
- Researching the occurrence and scientific basis for infrequent adverse events following vaccination.
- Conducting surveillance of vaccine preventable infectious diseases to detect and respond more rapidly to outbreaks and other changes in disease incidence.
- Assessing vaccination coverage levels in adults and conducting research to determine strategies for raising coverage levels.
- Increasing community participation, education, and partnerships through public information campaigns.
- Increasing education and training for providers and partnerships with community based and professional organizations, national minority organizations, and other federal agencies.

Creating and managing stockpiles and improving the vaccine purchase and distribution process:

- Leveraging commercial best practices to address all aspects of vaccine procurement, ordering, distribution and management and achieve cost savings and efficiencies, through the Vaccine Management Business Improvement Project (VMBIP). VMBIP is a comprehensive review and update of the public pediatric vaccine supply chain from the distribution of vaccine by the manufacturer to the point of administration (either public clinic or private provider's office).

- Maintaining a contractual mechanism for the consolidated purchase of vaccine for states and local agencies with their own supplemental funds as well as federal funds provided through grants.
- Ensuring that a six month national supply of all recommended childhood vaccines is available for use in case of supply disruptions or outbreaks of vaccine-preventable diseases. CDC has a legislative mandate to create this stockpile and since its inception in 1983, the pediatric vaccine stockpiles have been accessed as many as twelve times.
- Purchasing a strategic reserve of influenza vaccine in the event of a vaccine shortage or increased demand. This vaccine may be distributed to state health departments for distribution to providers serving VFC eligible children if demand warrants this use of the vaccine. Alternatively, this vaccine can be borrowed by the manufacturer for sale outside the VFC program, with repayment to CDC for all doses sold. CDC first received funding for this activity in FY 2004.

Continuous monitoring of vaccines and ongoing assessment of immunization benefits and risks is a vital component of sound immunization policies and recommendations affecting the health of our nation. As a national leader in vaccine safety, CDC conducts several vaccine safety activities including:

- Managing the Vaccine Adverse Event Reporting System (VAERS), in collaboration with the Food and Drug Administration, which serves as an early warning system to detect problems that may be related to vaccines.
- Supporting the Vaccine Safety Datalink (VSD) project, a large linked database containing comprehensive medical and immunization histories of approximately 5.5 million people annually to enable vaccine safety research studies comparing incidence of health problems between vaccinated and unvaccinated people.
- Providing in depth, standardized clinical evaluations for individuals with unusual or severe vaccine adverse events through the Clinical Immunization Safety Assessment (CISA) Network to
- Developing case definitions for adverse events following vaccination through the support of the Brighton Collaboration an international collaborative effort.
- Promoting safer, simpler, and swifter vaccine delivery technologies to overcome potential dangers and drawbacks of using needle-syringe to administer vaccine through the Vaccine Technology Development (VAXDEV) Activity.
- Determining perceptions and develops interventions that help individuals make informed decisions about vaccinations through the Vaccine Acceptance and Risk Perception Activity.

Significant Accomplishments:

- The nation's childhood immunization coverage rates are at record high levels for every vaccine and for all the vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. For example, during the 1990s, approximately 11,000 hospitalizations and 100 deaths occurred each year due to varicella. CDC has made great progress in educating health care providers and the public about the benefits of varicella vaccine. Coverage for varicella vaccine reached 88 percent in 2004 as opposed to only 43 percent in 1998.

VACCINATION COVERAGE LEVELS AMONG CHILDREN AGED 19 - 35 MONTHS, NATIONAL IMMUNIZATION SURVEY, U.S.								
Vaccine/ Dose	1998 (%)	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2010 Goal
DTP 4*+	84	83	82	82	82/95	85/96	86	90
Polio 3+	91	90	90	89	90	92	92	90
Hib 3+	93	94	93	93	93	94	94	90
MMR 1+	92	92	91	91	92	93	93	90
Hepatitis B 3+	87	88	90	89	90	92	92	90
Varicella	43	58	68	76	81	85	88	90

* In 2002 and 2003, CDC temporarily modified reporting on DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose.

- An economic evaluation of the impact of seven vaccines (DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella) routinely given as part of the childhood immunization schedule found that vaccines are tremendously cost effective. Routine childhood vaccination with these seven vaccines, which prevent over 14 million cases of disease and over 33,500 deaths over the lifetime of children born in any given year, resulted in annual cost saving of \$10 billion in direct medical cost and over \$40 billion in indirect societal costs. This study in the Archive of Pediatrics and Adolescent Medicine is the first time the seven vaccine series has been examined together with a common methodology.
- In March 2005, CDC announced a major public health milestone—the elimination of the rubella virus in the U.S. Once a common disease in this country, rubella is now a rare threat. This remarkable achievement is a tribute to having a safe and effective vaccine and a successful immunization program. The rubella virus is an infectious agent that causes birth defects known as congenital rubella syndrome if a woman becomes infected during pregnancy. Babies with CRS may suffer from blindness, deafness, heart defects and mental retardation. Implementation of rubella control programs in other countries in the Americas since the late 1990s likely decreased importations of rubella into the US and contributed to the decline in cases since 2001. In spite of the remarkable achievement, the US should continue its current efforts and vigilance against rubella and CRS to ensure that elimination of rubella is maintained.
- Despite the devastation caused by Hurricane Katrina, the Immunization Information Systems (IIS) in Louisiana, Alabama, and Mississippi remained operational to ensure stability and accessibility for other grantees needing immunization histories for displaced children. IISs are systems that record all shots on all children given by providers in a state or city catchment area. Many IISs also have functions and features needed by an immunization program (e.g. vaccine inventory management, adverse event reporting etc.) as well as interoperability with other health information systems including Electronic Medical Records (EMR). Because of these systems, schools or health agencies outside of the three Hurricane Katrina-impacted states were able to contact their own state or local immunization information system to access records of children displaced by the hurricane. The connections established by immunization information systems enabled many immunization histories to be retrieved thereby reducing or eliminating the need for costly re-vaccination of Hurricane Katrina displaced children.
- CDC's consolidated vaccine purchase contracts provide access to pediatric, adolescent and adult vaccines for state and local health departments to secure a uniform price for vaccines for the 64 state and local immunization programs (grantees) supported by federal, state and local tax dollars. Substantially reduced prices afforded by these consolidated contracts saved over \$885 million in 2005 when compared to what would have been paid at private sector vaccine prices. Purchases through CDC contracts accounted for approximately 54 percent of all childhood vaccine used in the United States in 2004.
- The VFC program enables children to receive vaccines at their physicians' offices where they receive regular care instead of being referred to the local health department. One study (*Fairbrother and Colleagues*) showed that VFC resulted in vaccination levels increasing by 23 percent in inner city New York.
- As part of a broad reorganization of CDC, the Immunization Safety Branch was renamed the Immunization Safety Office and moved from the National Immunization Program into CDC's Office of the Director, Office of the Chief Science Officer in 2005. The reorganization was undertaken as part of CDC's efforts to build a more robust immunization safety activity. The immunization safety office identifies possible vaccine side effects through a multi-faceted approach.
- In 2005 findings from the VAERS have resulted in educational efforts targeted to health care providers and changes to the newly licensed meningococcal conjugate vaccine (Menactra®) vaccine's recommendations and instructions for use.
- In response to the influenza vaccine shortfall and resulting prioritization of influenza vaccine in 2004-2005, the VSD conducted a rapid assessment of influenza vaccination coverage among HMO members in Northern California.
- The Clinical Immunization Safety Assessment Network began enrolling subjects in the newly established centralized registry of clinical data and repository of biological specimens, which will be important in increasing our understanding of virologic, immunologic and genetic markers for post-vaccination adverse events.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total proposed law level of \$2,553,814,000 for Immunization, an increase of \$75,979,000 above the FY 2006 total funding level of \$2,477,835,000. The FY 2007 President's Budget reflects a total current law level of \$2,513,814,000, an increase of \$35,979,000 above the FY 2006 total funding level of \$2,477,835,000.

SECTION 317 PROGRAM

CURRENT LAW

The FY 2007 discretionary immunization current law estimate of \$507,369,000 reflects a decrease of \$12,503,000 below the FY 2006 Enacted level of \$519,872,000.

Fund States to Increase Demand for Influenza Vaccine (+\$19.8 million)

Demand for influenza vaccine is variable and relatively low given the number of people who are at increased risk for complications from influenza. With increased funding of \$20 million, CDC will increase the demand for and uptake of annual influenza vaccine, particularly to accommodate high-risk populations. Increasing vaccine demand will stimulate vaccine manufacturers to produce additional vaccine, thereby increasing vaccine production capacity and helping the nation's preparedness for a pandemic.

Pay Raise (+\$1.2 million)

The request includes funds to cover the projected FY 2007 increase.

Bulk Monovalent Influenza Vaccine (-\$29.7 million)

The FY 2006 appropriation contained \$29.7 million in no-year funding for CDC to enter into back-end sales guarantee contracts with vaccine manufacturers to maintain a more stable influenza vaccine supply. As these funds can be utilized in future years, additional funds will not be necessary in FY 2007. Additionally, bulk monovalent vaccine purchased in FY 2006 may be used for the 2007/2008 influenza season should the strain remain the same.

Administrative and Information Technology (IT) Savings (-\$3.8 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

PROPOSED LAW:

The FY 2007 discretionary proposed law budget request of \$407,369,000 for Immunization represents a decrease of \$112,503,000 below the FY 2006 Enacted level of \$519,872,000. The proposed law request reflects a proposed law transfer of \$100,000,000 from the Section 317 program to the VFC program (described below) and a program decrease of \$12,503,000, as described previously.

Vaccine Purchase Grants (-\$100.0 million)

Currently, underinsured children can receive vaccines purchased with VFC program funds only at Community Health Centers and Federally Qualified Health Centers. The change to VFC legislation proposes allowing these children to receive VFC vaccine at a state or local public health clinic. Amending the VFC authorizing legislation to expand access points for these children could decrease the amount of discretionary vaccine purchase appropriations needed by \$100 million. Also, the proposed legislation would ensure these children have rapid access to new vaccines such as PCV. This reduction in the amount of discretionary funding needed would be contingent upon passage of the proposed amendment to the VFC legislation.

VFC PROGRAM

In FY 2007, CDC requests a total proposed law funding level of \$2,146,445,000 for the VFC program. The request represents an increase of \$188,482,000 over the FY 2006 estimate of \$1,957,963,000.

CURRENT LAW:

The FY 2007 current law estimate for VFC is \$2,006,445,000. This reflects an increase of \$48,482,000 above the FY 2006 estimate of \$1,957,963,000.

Increased VFC Need (+\$48.5 million)

Increases in FY 2007 over FY 2006 reflect estimated price increases for vaccines and the addition of MCV and a larger target of Hepatitis A Vaccine into the pediatric vaccine stockpile. MCV and wider usage of Hepatitis A vaccine was recommended for inclusion in the VFC program in 2005. Due to the addition of these vaccines, more funds are necessary for anticipated stockpile purchases.

PROPOSED LAW:

The FY 2006 proposed law estimate of \$2,146,445,000 represents an increase of \$188,482,000 over the current law request. The proposed law request reflects a proposed law increase of \$140,000,000 to the VFC program offset by \$100,000,000 in savings from the Section 317 program, as well as a program increase of \$48,482,000, as described previously.

VFC Vaccine Purchase (+\$140.0 million)

Currently, underinsured children can receive vaccines purchased with VFC program funds only at Community Health Centers and Federally Qualified Health Centers. The change to VFC legislation proposed allowing these children to receive VFC vaccine at a state or local public health clinic. Amending the VFC authorizing legislation to expand access points for these children could increase the amount of VFC vaccine purchase funds available by \$140 million. Also, the proposed legislation would ensure these children have rapid access to new vaccines such as PCV.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
317 Vaccine Purchase Grants				
# of PCV doses purchased ¹	1.1M	1.1M	1.1M	0
# of routine influenza doses purchased ¹	1.6M	1.6M	1.6M	0
State Operations/Infrastructure Grants				
Number of states with 90 percent or greater coverage for 3+ Hib	50	50	50	0
Number of states with 90 percent or greater coverage for 1+ MMR	50	50	50	0
Prevention Activities				
Support clinical evaluations to study newly hypothesized or alleged vaccine related syndromes	80	80	80	0
Registries participating in safety monitoring with VAERS	17	17	17	0
Case reports submitted by immunization registries	275	275	275	0
CISA centers in operation	7	7	7	0

NARRATIVE BY ACTIVITY
INFECTIOUS DISEASES
IMMUNIZATION

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
VFC Vaccine				
Number of PCV doses purchased ¹	8.3M	9.5M	9.1M ²	(.4M)
Number of influenza vaccine doses purchased for routine administration ¹	5.0M	9.8M	9.8M	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

¹ Based on Current Law

² The total number of PCV doses purchased declined due to a smaller catch-up cohort in 2007, than 2006.

FUNCTIONAL TABLE

Immunization Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
<u>317 Immunization Program</u>				
Vaccine Purchase Grants (Current Law)	\$234,897	\$263,023	\$232,456	(\$30,567)
Vaccine Purchase Grants (Proposed Law) ¹	\$234,897	\$263,023	\$132,456	(\$130,567)
State Operations/Infrastructure Grants	\$195,798	\$193,840	\$192,480	(\$1,360)
Subtotal, 317 Immunization Program (Current Law) -	\$430,695	\$456,863	\$424,936	(\$31,927)
Subtotal, 317 Immunization Program (Proposed Law)¹ -	\$430,695	\$456,863	\$324,936	(\$131,927)
<u>Program Operations</u>				
Vaccine Tracking	\$4,960	\$4,910	\$4,876	(\$34)
Prevention Activities	\$57,377	\$58,099	\$77,557	\$19,458
Subtotal, Program Operations -	\$62,337	\$63,009	\$82,433	\$19,424
Total (Current Law) -	\$493,032	\$519,872	\$507,369	(\$12,503)
Total (Proposed Law)¹ -	\$493,032	\$519,872	\$407,369	(\$112,503)

¹The FY 2007 Estimate reflects the Proposed Law transfer of \$100 million from the Section 317 Program to the Vaccines for Children program.

HEALTH PROMOTION

Health Promotion (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$1,024,204	\$963,426	\$929,208	(\$34,218)

INTRODUCTION

The Health Promotion budget activity reflects CDC’s work to enhance the potential for full, satisfying, and productive living across the lifespan for all people in all communities. This is accomplished by promoting improved public health through increased efficiencies, fostering strong collaborations, and integrating synergistic programs and messages. The programs within the Health Promotion budget activity carry out multifaceted missions. Overall, this budget activity maintains ultimate responsibility for CDC’s health promotion efforts, particularly related to wellness, chronic disease prevention, genomics and population health, disabilities, birth defects and other reproductive outcomes, and adverse consequences of hereditary conditions.

CDC’s Health Promotion budget activity is home to Chronic Disease Prevention, Health Promotion, and Genomics and Disease Prevention as well as Birth Defects, Developmental Disabilities, Disability and Health activities. Through these programs, CDC works to prevent death and disability from chronic diseases; promote maternal; infant, and adolescent health; promote healthy personal behaviors; and integrate genomics into public health research, policy, and programs. Chronic diseases—such as cardiovascular disease (primarily heart disease and stroke), cancer, and diabetes—are among the most prevalent, costly, and preventable of all health problems. CDC also promotes the health of babies, children, and adults, and enhances the potential for full, productive living. Work includes identifying the causes of birth defects and developmental disabilities, helping children to develop and reach their full potential, and promoting health and well-being among people of all ages with disabilities.

The Chronic Disease Prevention and Health Promotion and Birth Defects, Developmental Disabilities, Disability and Health components work closely on a number of issues, ranging from premature births to preventing complications of disabling conditions caused by chronic conditions. In addition, CDC is now working to use public health genomics, including family history, to improve health across the lifespan. Our genes play a major role in health, and CDC is beginning to use this knowledge to develop targeted interventions that can prevent chronic and infectious diseases and reach occupational and environmental health protection goals.

The coordination of these activities in the health promotion budget activity will assure the efficient and seamless interaction among its component programs and other CDC programs on cross-cutting health issues. For example, CDC’s support of the Surgeon General’s Family History Initiative draws on the expertise of chronic disease, genomics, and birth defects and promotes the health of the public through each of these areas. The new budget and organizational structure at CDC assists with the centralization of functions that can obviate duplication of efforts among CDC components. For example, the acute delivery of information to stakeholders, e.g. Congress, and response to immediate information needs should not evoke simultaneous, duplicative efforts by various CDC components but is centralized within the communication function of the coordinating center. This allows the communications function of CDC’s components to focus on the longer-term development of effective health promotion messages in their respective areas of expertise.

All activities within the Health Promotion budget activity will work together to foster cross-cutting health promotion programs.

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

AUTHORIZING LEGISLATION

General Authority: PHSA §§ 301, 307, 310, 311, 317, 317K, 327, 340D, 352, 391, 1102, 1501-1510, 1706; Public Health Cigarette Smoking Act of 1969; Comprehensive Smoking Education Act of 1984; Comprehensive Smokeless Tobacco Health Education Act of 1986; Fertility Clinic Success Rate and Certification Act of 1992; Prostate Cancer: PHSA § 317D; Cancer Registries: PHSA §§ 399B-399D, 399F2; Diabetes Among Children and Youth: PHSA § 317H; Safe Motherhood/Infant Health Promotion: PHSA §§ 317K(a), 317K(b), 317L; Childhood Obesity Prevention PHSA §§ 399W-399Z; Oral Health Promotion: PHSA § 317M; Prevention Centers: PHSA §§ 301, 310, 311, 317, 391, 1102, 1706; Supplemental Grants for Preventive Health Services (WISEWOMAN): 1509; Hematological Cancer Research Investment and Education: PHSA 419C; Breast and Cervical Cancer Prevention: PHSA §§ 301, 340D, 1501-1510; Breast and Cervical Cancer Mortality Prevention Act; Asthmatic School Children’s Treatment and Health Management Act of 2004; Benign Brain Tumor Causes Registries Amendment Act.

Chronic Disease Prevention, Health Promotion, and Genomics (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$899,628	\$838,664	\$818,727	(\$19,937)

STATEMENT OF THE BUDGET

The FY 2007 President’s Budget reflects a total funding level of \$818,727,000 for Chronic Disease Prevention and Health Promotion, a decrease of \$19,937,000 below the FY 2006 Enacted level of \$838,664,000.

PROGRAM DESCRIPTION

More than 1.7 million Americans die of a chronic disease each year, accounting for about 70 percent of all deaths in the United States. In addition, the prolonged course of illness and disability from diseases such as heart disease and stroke, cancer, diabetes, and arthritis results in pain and suffering, poor quality of life, and disability for millions of Americans.

Cardiovascular disease (CVD) (including heart disease and stroke) alone is the leading cause of death in the U.S., affecting over 70 million Americans and costing the nation more than \$403 billion in direct and indirect health care costs per year. Much of the national burden could be prevented but effective preventive measures are currently underused.

Cancer is the second leading cause of death in the U.S. In 2004, the direct and indirect costs of cancer in the U.S. totaled \$189 billion. Screening tests for breast, cervical, and colorectal cancer reduce the number of deaths from these diseases. Over 20 million Americans have diabetes, and the number of new cases is increasing steadily. Diabetes costs the nation nearly \$132 billion a year and can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, and amputation of the leg, foot, and toe.

Deaths alone, however, fail to convey the full picture of the toll of chronic disease. More than 125 million Americans live with chronic conditions. Chronic, disabling conditions cause major limitations in activity for one in 10 Americans. Arthritis is the number one cause of disability. Stroke has left over one million Americans with disabilities, and diabetes is the leading cause of kidney failure and of new blindness in adults. These serious diseases are often treatable but not always curable. Thus, an even greater burden befalls Americans from the disability and diminished quality of life resulting from chronic disease.

There are continuing disparities in the burden of chronic disease illness and death experienced by African Americans, Hispanics, American Indians, Alaska Natives, Asian Americans, and Pacific Islanders compared to the U.S. population as a whole. For example, rates of death from diseases of the heart are 30 percent higher among African Americans than among whites and rates of death from stroke are 41 percent higher. The prevalence of diabetes is about 1.6 times higher among African Americans and 1.5 times higher among Hispanics than among non-Hispanic white Americans of similar age. African Americans are more likely to die of cancer than people of any other racial or ethnic group.

NARRATIVE BY ACTIVITY
HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

In the last ten years, obesity rates have increased by more than 60 percent in adults. Since 1980, rates have doubled in children and tripled in adolescents. Thirty-one percent of the adult population in the U.S. is obese and 16 percent of our children and adolescents are overweight. Obesity in the U.S. is truly epidemic.

Medical care for people with chronic diseases accounts for more than 75 percent of the \$1.4 trillion spent as a nation on medical care. Furthermore, if disease patterns stay the same, by the year 2030 the health care system will have to spend an additional \$300 to \$400 billion per year, excluding inflation, to treat the chronic diseases of an aging population. This expense means increased costs of \$1,500 per year per person in the United States just to help support the care of our older citizens.

In addition, maternal mortality has not decreased in the U.S. in the last 20 years. About one in four women, or one million per year, will have serious complications during labor. For every 100,000 infants born in the U.S., approximately 12 women will die of pregnancy-related causes or complications. African-American women continue to have four times the risk of dying from pregnancy complications than Caucasian women. CDC is working to reduce the incidence of pregnancy-related illness and death and promote optimal reproductive and infant health for mothers and their infants.

In general, chronic diseases are caused by behaviors that are preventable; for example, tobacco use is the single most preventable cause of death and disease, with poor diet and sedentary behavior close behind and on the rise. CDC works to prevent the occurrence and progression of chronic diseases by reducing or eliminating behavioral risk factors, by increasing the prevalence of health promotion practices, and by detecting and managing chronic disease early to avoid complications.

Today's most serious and expensive health and social problems are caused, in large part, by behaviors established during youth – tobacco use, diets high in fat and sugar, inadequate physical activity, drug and alcohol use, and risky sexual behaviors. These behaviors place young people at significantly increased risk for severe health problems, both now and in the future. CDC's prevention and intervention activities for this life stage are aligned with the Secretary's 500-Day Plan which supports the First Lady's initiatives on Helping America's Youth.

CDC's strategy for preventing the leading causes of death in the U.S. is a crosscutting approach: support for state and community programs, surveillance, prevention research, evaluation, and health promotion. CDC's efforts focus on the use of early detection practices for cancer, diabetes, and heart disease; school health education programs, supportive environments for physical activity and healthy eating in communities, and established standards for preventive care practices. CDC accomplishes this through funding and technical consultation to public health programs at the state, local community, and national levels. These programs place a strong emphasis on the aging population, adolescents, and those at highest risk for diseases. CDC's chronic disease programs include state-based disease prevention and health promotion programs as well as community-based programs such as Racial and Ethnic Approaches to Community Health (REACH) 2010 and Steps to a *HealthierUS*. CDC also conducts research in community settings to translate effective policy interventions that benefit individuals and their families. Through translation research, promising research findings are translated into practical, cost-effective prevention programs in communities. Translation research is one type of research CDC's PRC Program conducts.

Underpinning all of these efforts is surveillance (health tracking). Surveillance provides the information necessary to define the disease burden, identify populations at highest risk, and guide and evaluate disease prevention efforts at national, state, and local levels. CDC's Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system for measuring critical health problems and a wide range of health-related behaviors in the U.S. adult population at the state level. Active in all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands, BRFSS is the primary source of information on major health risk behaviors of American adults. BRFSS provides timely and ongoing data collection that is flexible in order to meet individual state needs. CDC provides funding, consults with state staff, and assists states with editing and processing data. BRFSS data are the source for important public health messages, such as the obesity and diabetes epidemic trend maps.

To support these programs, CDC provides technical consultation in planning, establishing, maintaining, and evaluating prevention and control strategies for selected chronic disease and health promotion activities. CDC also plays a leadership role in coordinating and catalyzing the efforts of numerous public and private partners such as other government agencies, professional organizations, voluntary organizations, academic institutions, community organizations, private organizations, and businesses. The expertise, experience, and outreach capabilities of these partners substantially extend CDC's effectiveness in reaching people at highest risk for chronic diseases.

CDC provides national leadership for the translation of genomic research into opportunities for public health and preventive medicine while building partnerships with other federal agencies, public health organizations, professional groups, and the private sector. The mission of OGDG is to integrate genomics into public health research, policy, and programs and to improve population health and prevent disease through the application of genomic information. Top priorities for genomics include: integrating genomics into public health research; assessing the value of family history

and utilizing family history of disease to improve health; assessing the value of genomic tests for population health for translation from research to practice.

Genomics is a new science arising from the discoveries of the human genome project. Although the terms genetics and genomics are sometimes used interchangeably, genetics is the study of inheritance, or the way traits are passed down from one generation to another, whereas genomics is a newer term that describes the study of all the genes in a person, as well as interactions of those genes with each other and with that person's environment. Genetics usually refers to the study of single genes, while genomics refers to the study of all the genes in a person or organism.

Genomics plays a part in nine of the ten leading causes of death in the United States such as heart disease, cancer, stroke, chronic lower respiratory diseases, diabetes, and Alzheimer's disease among others. All human beings are 99.9 percent identical in genetic makeup, but differences in the remaining 0.1 percent may hold important clues about the causes of 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. Better understanding of the interactions between genes and the environment will help us find better ways to improve health and prevent diseases.

CDC's chronic disease prevention and intervention activities align with several of the sub-priorities of the Secretary's 500-Day Plan, including:

- Wellness and prevention are sought as rigorously as treatment.
- Comprehensive, novel early prevention and detection strategies increase healthy life potential such that:
 - Cancer is more preventable and curable,
 - Obesity and its consequences, such as diabetes and heart and vascular diseases, are greatly reduced, and
 - Causes of mental, neurological and behavioral diseases are better understood and managed.
- Implementing a comprehensive plan for obesity research that will maximize collaboration among HHS stakeholders.
- CDC's efforts in genomics aligns with the Secretary's 500-Day Plan with respect to broad scientific advances measurably reduce the burden of all chronic diseases.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Chronic Disease Prevention and Health Promotion activity, the following performance measures have been selected as highlights of the program's performance plan.

Performance Goal	Results	Context
1. Increase the number of women screened. Breast: mammogram or Clinical Breast Examination (CBE) Cervical: Pap Smear	CDC continues to increase the number of women screened through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). In 2004, 558,846 women were screened for breast cancer (3.9% increase over 2003); and 329,645 women were screened for cervical cancer (8.3% increase over 2003).	Studies show that early detection of breast and cervical cancers saves lives. Except for skin cancer, breast cancer is the most commonly diagnosed cancer among American women. It is second to lung cancer as the leading cause of cancer-related deaths among women. In 2005, an estimated 211,240 new cases of invasive breast cancer and 10,370 new cases of cervical cancer will be diagnosed among women, with an estimated 40,870 deaths due to breast cancer and 3,710 due to cervical cancer. Timely mammography screening among women aged 40 years or older could reduce breast cancer mortality by approximately 16 percent compared with women who are not screened. Pap tests can find cervical cancer at an early stage when it is most curable or even prevent the disease if precancerous lesions found during the test are treated.

NARRATIVE BY ACTIVITY
HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

Performance Goal	Results	Context
2. Reduce the percentage of youth (grades 9-12) who smoke.	The percentage of youth who smoke has declined from a high of 36.4% in 1997 to 21.9% in 2003. The lowest level since national data has been available.	Tobacco use is the single most preventable cause of death and disease in the U.S.; it is responsible for approximately 440,000 deaths each year and more than \$167 billion annually in medical care costs and lost productivity. Every day, more than 6,000 young people try cigarettes for the first time. If current smoking trends continue, it is anticipated that one-third of these young smokers will die from a smoking-related disease. By 2030, the global tobacco epidemic will become the leading cause of preventable and premature death worldwide.

Current Activities

- Improving CVD disease health and reducing ethnic and racial disparities by funding 33 state-based Heart Disease and Stroke Prevention programs. Eighteen states and the District of Columbia receive grants for planning and capacity-building, which prepares them for program implementation. Fourteen states receive grants for basic program implementation that:
 - Prevent and control high blood pressure and high blood cholesterol, major risk factors for heart disease and stroke;
 - Improve quality of care to prevent and manage high blood pressure, stroke, and heart disease;
 - Improve access to appropriate and often life-saving emergency care quickly by educating the public about the signs and symptoms of heart attack and stroke and improving emergency care services, such as 911 coverage and emergency stroke therapy.
 - CDC also continues to support specific state- and local-based research projects.
- Developing and implementing evidence-based nutrition and physical activity interventions through the National Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases:
 - Funds seven states at the basic implementation level to conduct nutrition and physical activity interventions through population-based strategies, such as policy-level change, environmental change, and social marketing. Funds 21 states at the capacity-building level to form state-wide coalitions, develop state plans, and pilot test interventions in priority populations.
 - Conducts prevention research and health monitoring. CDC drafted recommendations for preventing and controlling obesity in the *Guide to Community Preventive Services*. Also, CDC is examining the role of fruit and vegetable consumption in weight loss and management.
- Reducing chronic disease risk factors such as poor eating habits, physical inactivity, and tobacco use through School Health programs funded in 23 states. CDC provides tools to states that strengthen and improve local school health programs. Through monitoring of youth risk behaviors and school health programs, science-based guidance, and support of program implementation and evaluation, CDC contributes to improvements in the quality of school health programs and policies.
- Providing young people with skills and information to avoid behaviors that put them at risk for HIV infection through school health programs in 48 states, seven territories, and 18 large city education agencies. CDC supports state and local education agencies in their efforts to help schools build the capacity required to provide effective HIV prevention education programs. Adolescents and young adults, particularly youth of minority races and ethnicities, are at persistent risk for HIV infection.
- Promoting access to quality diabetes care and services for people with diabetes by supporting 59 diabetes prevention and control programs in states, the District of Columbia, and U.S. territories through the National Diabetes Prevention and Control Program (DPCP). Twenty two states and the District of Columbia are funded at a capacity-building level. Twenty-eight states are funded at a basic implementation level. Basic implementation programs develop and promote diabetes care standards for adoption in health care delivery settings; help state Medicaid programs develop and monitor quality outcome measures for diabetes care; launch public and physician education campaigns to promote improved understanding and regular use of tests to determine average blood sugar levels; and involve communities in diabetes control activities, such

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as walking programs. In FY 2005, CDC funded five new state-based pilot programs for the primary prevention of diabetes in states funded at the basic implementation level and increased two states to the basic implementation level. In FY 2005, CDC also awarded eight American Indian communities with funding to promote diabetes prevention projects.

- Researching topics such as, nutrition and physical activity in preventing obesity, diabetes, and heart disease; promoting healthy aging; healthy youth development, including prevention of violence and substance abuse, strengthening family and community relationships to support healthy lifestyles; controlling cancer risk and other health disparities through the PRC. PRCs are a network of academic centers, public health agencies, and community partners researching strategies for preventing and controlling chronic disease. CDC funds 33 PRCs in 26 states that conduct about 500 research projects.
- Implementing chronic disease prevention efforts focused on reducing the burden of diabetes, overweight, obesity, and asthma by addressing three related risk factors – physical inactivity, poor nutrition, and tobacco use through Steps to a *HealthierUS* program. Forty communities, cities, and tribal entities are implementing community action plans that build on existing local, state, and federal efforts related to obesity, diabetes, asthma and their risk factors and include a special focus on populations with disproportionate burden of disease and disparities in preventive services. Through the Steps program, organized community, environmental, educational, media, and policy interventions are being implemented in school, community, health care and workplace settings.
- Establishing broad-based Comprehensive Cancer Control (CCC) coalitions, assessing the burden of cancer, determining priorities for cancer prevention and control, and developing and implementing comprehensive cancer control plans, in collaboration with public health agencies through CDC's CCC program. CDC Supports 63 Comprehensive Cancer Control programs (CCC) across the U.S., including 50 states, the District of Columbia, six tribes and tribal organizations and six U.S. Associated Pacific Islands/territories.
- Conducting breast and cervical cancer screening and early detection programs through NBCCEDP in all 50 states, four territories, the District of Columbia, and 13 American Indian/Alaska Native tribal organizations. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave states the option to choose to extend Medicaid coverage to women screened in the NBCCEDP, and diagnosed with cancer for the duration of their treatment. To date, 50 states and the District of Columbia have received approval. In addition, CDC works with grantees to ensure treatment for women who are not eligible to enroll in the Medicaid option. Several new activities have been identified as priorities for CDC, including advancing the use of geographic information technologies and implementing evidence-based recruitment interventions. CDC is also refining the program's strategic and evaluation plans.
- Directing and evaluating cancer prevention and control program activities through essential state cancer registry data. CDC supports 45 states, three territories, and the District of Columbia for cancer registries through the National Program of Cancer Registries. For example, cancer registry information can be used to target specific populations for breast, colorectal, and cervical cancer screening.
- Educating the public about the benefits of screening, the availability of screening procedures, and screening guidelines through the national colorectal cancer screening program. To this end, CDC educates Americans aged 50 years or older about the importance of colorectal cancer screening with its national colorectal cancer action campaign, *Screen for Life*. Additionally, CDC works with national partners and organizations to educate medical providers and the public about the importance of colorectal cancer screening. Further, CDC supports epidemiological, behavioral science, and surveillance research efforts to gather and analyze data, as well as fund prevention and intervention research projects and investigations related to colorectal cancer.
- Increasing colorectal cancer screening among low income adults, aged 50 years and older who have little or no health insurance coverage for regular screenings through five colorectal cancer screening demonstration programs. These programs will provide screening for colorectal cancer, as well as provide medical follow-up services, conduct public education and outreach, and evaluate the effectiveness of the demonstration program.
- Implementing activities in state action plans to improve the quality of life of people with arthritis, promoting key public health messages, and providing evidence-based interventions to high need populations with partner organizations in 36 states funded to enhance public health activities for arthritis. CDC developed and rolled-out a health communications campaign, *Physical Activity. The Arthritis Pain Reliever*, which targets low income African-American and Caucasian people age 45-64, and is used by 35 of the 36 funded states and many local chapters of the Arthritis Foundation. A Hispanic version of this campaign will be released 2006.

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- Promoting oral health nationwide, monitoring oral health status and behaviors, providing guidance on safer office infection control practice, and fostering applied research to document the effectiveness of community-based programs and provide tools that can assist programs in CDC supported state and community oral disease prevention programs. CDC funds 12 states and one territory for capacity building activities aimed at strengthening their oral health programs and reducing inequalities in the oral health of their residents. Additional funds are provided to some of these states to build capacity for two proven disease prevention strategies, community water fluoridation and school-based or linked dental sealant programs.
- Funds tobacco control programs in all 50 states, the District of Columbia, and seven U.S. territories. CDC also supports 15 organizations with access to diverse populations, including seven tribal organizations and eight national organizations.
- Established a national network of smoking cessation quitlines to provide smokers access to the support and latest information to help them quit, a new initiative in FY 2005. These funds were provided for this activity in addition to awards from CDC's Comprehensive State-Based Tobacco Use Prevention and Control Program. Forty-nine states, the District of Columbia, and five U.S. Territories are establishing state quitlines or enhancing existing quitlines within their states. A key component of the national network of quitlines is the establishment of a single, toll-free national number (1-800-QUIT NOW) that serves as a portal, linking callers to their state's telephone cessation services.
- Designing, implementing, and evaluating community-driven strategies that will contribute to the elimination of health disparities in racial and ethnic minority communities through CDC's REACH 2010 program. REACH 2010 focuses on six target health areas: diabetes, infant mortality, breast and cervical cancer screening and management, CVD, HIV infection and AIDS, and child and adult immunizations. Target populations are African-Americans, American Indians, Hispanic-Americans, Asian-Americans, Pacific Islanders, and Alaska Natives. Current funds support 40 communities (including four elderly projects) to carry out community action plans for the implementation and evaluation of REACH 2010. Five American Indian and Alaska Native communities are funded through capacity-building grants. CDC will continue to provide qualitative and quantitative assessments of the REACH 2010 program.
- Funds 29 states and New York City to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS), representing 62 percent of U.S. births. PRAMS collects information on pregnancy-related morbidity, access to and use of prenatal care, physical violence during pregnancy, obstetric history and nutrition, alcohol and tobacco use during pregnancy, infant health care, infant sleeping position, and economic status of the mother.
- Revised the 1996 Guidelines for Death Scene Investigation of Sudden Unexplained Infant Deaths (SIDS) and the SIDS Investigation Report Form, to provide consistent information across the country regarding SIDS deaths. Consistent information will enable preventive measures for SIDS to be developed and implemented.
- Collaborates with NIH to evaluate whether family history information can be used to assess risk for common diseases and influence early detection and prevention strategies. The Family History Public Health Initiative developed an evaluation framework for assessing the analytic validity (how accurately disease among relatives is reported), clinical validity (ability of family history to predict future disease), clinical utility (risks and benefits of the approach), and the ethical, legal and social implications of collecting and using family history information. Ongoing work includes pilot studies to further refine the family history tool, development of algorithms to assess risk, development of a resource manual for primary care providers, and design and funding of studies to evaluate the validity and utility of the approach. CDC's Family Healthware, a Web-based prototype family history tool created for the Family History Public Health Initiative will be pilot-tested in a variety of public health and preventive medicine settings. CDC is currently funding three research centers—the University of Michigan School of Medicine, Evanston Northwestern Healthcare Research Institute, and Case Western Reserve University School of Medicine—to conduct a collaborative study set in primary care clinics. The study will determine whether family history risk assessment, classification, and personalized prevention messages influence health behaviors and the use of preventive medical services.
- CDC's Evaluation of Genomic Applications in Practice and Prevention (EGAPP) is a three-year model project developed by CDC to support the first phases of a coordinated process for evaluating genetic tests and other genomic applications that are in transition from research to clinical and public health practice. EGAPP aims to draw on existing recommendations for action in the United States as well as knowledge gained from previous CDC initiatives. EGAPP will also integrate knowledge from existing processes for evaluation and appraisal (e.g., Agency for Healthcare Research and Quality (AHRQ) / U.S. Preventive Services Task Force, CDC's Task Force on Community Preventive Services) and the international health technology assessment experience to establish and evaluate a systematic mechanism for evaluation of genomic applications in health practice in the United States.

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- Conducts analyses of human genomic data in acute public health investigations (APHIs) to enhance our ability to assess the effectiveness and side effects of therapeutics and vaccines; characterize environmental exposure more accurately; understand variation in disease outcomes; and refine public health interventions such as vaccination, chemoprophylaxis, exposure reduction, behavior modification, and education. A CDC-wide team is collaborating with NIH to measure population variation in selected genes using stored DNA samples collected during the third National Health and Nutrition Examination Survey (NHANES). This collaboration will help develop genotype prevalence estimates based on a nationally representative sample of the U.S. population. Data collected from NHANES by the end of 2005 will add another dimension to the analysis of clinical, physical, and lifestyle information by creating a resource for analysis of genotype-phenotype correlations and gene-environment interactions.
- CDC-funded Centers for Genomics and Public Health at Schools of Public Health at the University of Michigan and the University of Washington serve as regional hubs of expertise in genomics and public health with a focus on translating genomic information into useable public health knowledge, providing technical assistance to state and community public health agencies and integrating genomics into programs and practice. The Centers are also working collaboratively with CDC's Office of Genomics and Disease Prevention on several key projects, such as the EGAPP Project.
- Established the Human Genome Epidemiology Network (HuGeNet), a global collaboration of 400 individuals and 17 organizations committed to assessing the role of human genome variation in population health and the potential of genomics for improving health and preventing disease. HuGeNet is promoting publication of systematic reviews of population-based data on genotype prevalence, gene-disease associations, and gene-environment interactions.
- Sponsors the National Children's Study (NCS) in collaboration with, the National Institute of Child Health and Human Development at NIH, and the Environmental Protection Agency. As a NCS sponsor, CDC has provided funding and agency-wide scientific input to the study: the Office of Genomics and Disease Prevention staff has helped provide leadership to the Gene-Environment Working Group.
- Funds the Jeffrey Modell Foundation (JMF) to support awareness campaigns related to primary immune deficiencies through dissemination of materials and provision of educational sessions. This campaign aims to prevent chronic problems or death arising from the inability to fight off common childhood infections often not diagnosed in time. Primary immune diseases affect 500,000 persons and often have the greatest impact in children.

Significant Accomplishments

- In six state trauma regions, the Kansas Heart Disease and Stroke Prevention Program implemented policies standardizing training for emergency medical dispatchers (EMDs). Training helps EMDs recognize signs and symptoms of heart attack and stroke and better manage services to the victim. Over 300 EMDs have been trained.
- Positively impacting the lives of underserved women and improving women's cardiovascular health profile through WISEWOMAN by doubling the number of women served each of the five years preceding 2005. WISEWOMAN provides screening and lifestyle interventions that can reduce risks for heart disease and other chronic diseases. During the first six months of 2005, 12,000 were screened for a total of 69,925 served since program inception. WISEWOMAN has provided more than 96,000 lifestyle interventions. For women who entered the program from 2000-2004, cholesterol levels dropped after one year from 212 milligrams per deciliter to 208, and their estimated risk of heart attack in the next five years decreased.
- The proportion of fully tobacco free secondary schools increased from 37 percent in 1994 to 46 percent in 2000 and a large and growing number of schools have recently improved the nutritional quality of food and beverage items sold in vending machines. School health policies and programs have contributed to recent decreases in health risk behaviors among high school students, including the decline in cigarette smoking rates from 36 percent in 1997 to 21.9 percent in 2003.
- Showed success of the VERB campaign with two years of evaluation data completed. After two years, a high awareness of VERB has been maintained across the targeted 9-13 year age group. Physical activity levels during the previous week were higher among children who reported seeing the campaign than those who did not see it. Also, children with awareness of VERB reported being significantly more active on the day before the survey than children unaware of VERB (61 percent vs. 46 percent). Although children typically become less physically active as they get older, this decline did not occur among children who saw VERB campaign messages. Data from year three of VERB are currently being analyzed and evaluation activities will conclude during FY 2006.

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- Provided nearly six million screening tests to almost three million women through the NBCCEDP. The program has diagnosed 22,878 breast cancers, 76,921 precancerous cervical lesions, and over 1,500 cases of invasive cervical cancer.
- Collaboration between two CDC-supported state programs, the Illinois Breast and Cervical Cancer Program and the Illinois Cancer Registry, led to an increase in the percentage of women diagnosed at the earliest stages of breast cancer. In counties that participated in the program for at least five years, the percentage of breast cancer cases diagnosed at the earliest stage increased 110 percent. Counties not participating in the program did not experience such an increase.
- The Louisiana Diabetes Prevention and Control Program partnered with the City of New Orleans Health Department's Healthcare for the Homeless Clinic to improve the clinic's ability to provide diabetes education to patients. The program seeks to improve patient compliance with treatment regimens. In June 2004, 99 percent of patients had at least one A1C (blood sugar) check, and 54 percent had at least two A1C checks in the past year, compared with 15.75 percent and 25.5 percent in September 2001. By June 2004, 99.4 percent of patients had met diabetes self management goals compared with 94.1 percent in September 2001. This program is a successful example of how state programs can promote healthy behaviors and reduce needless disease and economic burden for homeless people with, or at risk for, diabetes.
- The PRCs continue on the path to discovering effective and adoptable interventions. The University of Michigan PRC is finding through its Fathers and Sons Project, which brings African American boys and their nonresident fathers together for sessions on communication and behavioral skills, that such meaningful contact can reduce the boys' intentions toward violence, substance use, sexual initiation, and other health risk behaviors. A dissemination plan is in design for testing in four communities. The PRC at Columbia University is partnering with community organizations in Harlem to evaluate the impact of an asthma intervention on children in the area. Preliminary results show significant reductions in school absenteeism, emergency department and unscheduled physician visits, and hospitalization for children with asthma.
- As many states continued to cut funding for tobacco control due to fiscal crises, a study released in September 2003 found double the decrease in cigarette sales among states that spent more on comprehensive tobacco control programs than in the United States as a whole. Between 1990 and 2000, sales fell an average of 43 percent in four key states with large program expenditures – Arizona, California, Massachusetts, and Oregon – compared with 20 percent for all states. Program funding levels accounted for a substantial portion of the difference, above and beyond the effect of cigarette excise tax hikes, with increasing expenditures producing bigger and faster declines in cigarette sales.
- REACH 2010 continued to build healthy communities and reduce minority health disparities. Between 2001 and 2004, new data from the REACH 2010 risk factor survey show that in REACH communities: The proportion of Hispanics having cholesterol checks increased by 40 percent versus no change in the general U.S. population. The proportion of hypertensive American Indians on medication increased by ten percent versus a 6 percent increase nationally and cigarette smoking among Asian American men decreased by more than 30 percent versus a four percent decline nationally.
- CDC completed development of a web-based tool, Family Healthware™, that collects information about health behaviors, screening tests, and a person's family history for six diseases: coronary heart disease, stroke, diabetes, and colorectal, breast, and ovarian cancer. CDC funded three research centers to conduct a clinical trial of Family Healthware™. The study, consisting of approximately 8,400 patients who attend primary care practices, will measure whether family history risk assessment, stratification, and personal prevention messages influence health behaviors and use of medical services. CDC's also collaborated with the U.S. Surgeon General, Dr. Richard Carmona and other HHS agencies on the Surgeon General's Family History Initiative, which is a national campaign that marked Thanksgiving as National Family History Day. This initiative also included the development of a web-based tool called "My Family Health Portrait", which is a simplified version of CDC's Family Healthware™ tool, and organizes family health information into a printout that the public can take to health care professionals to help determine whether they are at a higher risk for certain diseases. In FY 2005, the tool was downloaded more than 360,000 times and a print-based version also available was distributed to more than 85,000 nationwide. Since its launch in November 2004, this national initiative has been highlighted in more than 1,000 media stories. In addition, CDC was responsible for creating and developing packets of family history resource materials that will be delivered in FY 2006 to chronic disease and genetic experts in state health departments of every U.S. state and territory.
- The EGAPP initiative has established a 13 member independent, non-federal Working Group that is charged with identifying, reviewing and prioritizing potential topics for review, specifying methods for evidence reviews and outcomes to be considered, and developing conclusions and recommendations based on the evidence developed. Three topics are currently under review by AHRQ Evidence-based Practice Centers; a

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fourth is beginning using another mechanism. A primary goal is to provide a clear linkage between the scientific evidence and the Working Group recommendations on the use of a genomic application in clinical and public health practice.

- CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to form a multidisciplinary APHI working group to outline key research priorities for incorporating genomics into APHIs at the state and federal levels. Next steps include assessing and developing public health genomics capacity, addressing laboratory, analytical, informatics, DNA specimen banking, and ethical, legal, and social issues.
- In collaboration with CDC, the Centers for Genomics and Public Health completed two web-based training programs for public health professionals. The first is a 45-minute introductory presentation called Genomics for Public Health Practitioners that describes the application of genomics to public health, dispel myths, and identify challenges in public health genomics. A more in depth series, Six Weeks to Genomics Awareness, includes six presentations designed to help public health professionals understand how genomic advances are relevant to public health,
- With CDC support, the Jeffrey Modell Foundation has: increased outreach measured by an increase in telephone hotline calls and nearly 700,000 website hits per month; reached 92.4 million American households with a 30 minute educational program on Primary Immunodeficiency (PI) aired nationally; provided 38,000 school nurses with an information kit; and secured \$10.5 million worth of donated media time for Public Service Announcements.

RATIONALE FOR THE BUDGET

The FY 2007 President’s Budget reflects a total funding level of \$818,727,000 for Chronic Disease Prevention and Health Promotion, a decrease of \$19,937,000 below the FY 2006 Enacted level of \$838,664,000.

Pay Raise (+\$1.7 million)

The request includes funds to cover the projected FY 2007 increase.

Program Reductions (-\$15.2 million)

The FY 2007 President’s Budget proposes reductions to activities that are outside the scope of CDC’s mission to focus on primary prevention. Included in this reduction are CDC’s Epilepsy, Alzheimer’s Disease, and Lupus programs. The budget also proposes reductions to fund base activities at FY 2006 President’s Budget levels.

Administrative and Information Technology (IT) Savings (-\$6.4 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC’s budget lines. The FY 2007 President’s Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Heart Disease and Stroke				
States funded for capacity-building CVD prevention programs (includes D.C.)	19	19	19	0
States funded for basic implementation CVD prevention programs	14	14	14	0

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OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Surveillance and research studies describing the CVD burden and developing effective intervention strategies	21	21	21	0
State health departments funded for ongoing state stroke registries to assess stroke treatment and improve the quality of care for acute stroke patients	4	4	4	0
Cancer Prevention and Control				
States funded for Comprehensive Cancer Control (includes 6 tribes and tribal organizations, the District of Columbia and 6 U.S. Associated Pacific Islands/territories)	63	63	63	0
Cancer Registry states/territories with capacity-building programs	3	3	3	0
Cancer Registry states/territories with basic implementation programs	46	46	46	0
Cancer Registry Programs submitting data to the NPCR Cancer Surveillance System	48	48	48	0
Education campaign to promote colorectal cancer screening	1	1	1	0
Number of breast and cervical cancer screening programs	68	68	68	0
Number of states, territories, AI/AN tribes provided consultation and scientific expertise to support screening programs	68	68	68	0
Number of cooperative agreements to national partners and professional societies to promote cancer prevention	17	17	17	0
Diabetes				
Number of state-based Diabetes Prevention & Control Programs: Capacity-building (including DC)	23	23	23	0

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OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of state-based Diabetes Control Programs: Basic Implementation	28	28	28	0
Number of territories/jurisdictions funded for capacity-building Diabetes Control Programs	8	8	8	0
Health education programs/ community interventions targeting minority populations	5	5	5	0
Number of childhood diabetes surveillance systems	6	6	6	0
Number of state-based pilot projects for the primary prevention of diabetes	5	5	5	0
Health Promotion				
Number of state tobacco prevention and control programs (includes DC)	51	51	51	0
Tobacco Cessation Quitlines – States/Territories/Tribes funded to implement quitlines	19	19	19	0
Tobacco Cessation Quitlines – States/Territories/Tribes funded to enhance existing quitlines	36	36	36	0
Number of cooperative agreements for tobacco prevention with key organizations with access to diverse population	15	16	15	(1)
Scientific, technical, and public inquiry response on tobacco use	50,000	50,000	50,000	0
Total state health departments and other organizations (e.g., local health departments) requesting advertising campaign materials through the Media Campaign Resource Center	250	250	250	0
New methods to measure constituents in tobacco or tobacco smoke	4	4	4	0
Countries in which Global Youth Tobacco Survey have been implemented	163	163	163	0

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OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of states implementing intervention programs for nutrition/PA/obesity	28	28	28	0
Number of state and tribal WISEWOMAN programs	15	15	15	0
Projects funded to conduct PRAMS	30	35	35	0
States with Maternal and Child Health (MCH) epidemiologist	16	16	16	0
Research projects in MCH	2	2	2	0
States funded for capacity-building arthritis programs	36	36	36	0
Number of population-based registries to define and monitor the incidence and prevalence of lupus	2	2	0	(2)
States/territories receiving support for capacity-building oral health prevention programs (e.g., fluoridation, sealants)	13	13	13	0
Number of vision screening initiatives	1	1	1	0
School Health Programs				
State education agencies working with state health departments to integrate prevention activities targeting tobacco use, sedentary lifestyles, poor eating habits into school health programs	23	23	23	0
Interventions identified to prevent HIV & chronic disease risk factors among youth	5	5	5	0
State, territory, and city education agencies working with state health departments to implement HIV education prevention in schools	73	73	73	0
Prevention Centers				
Prevention Research Centers with formal collaborative relationships with state and local agencies	33	33	33	0
Youth Media Campaign				
Maintain an interactive Web site for teens	1	0	0	0

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OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Direct interaction with 2 million tweens (9-13 years) across the nation to undertake physical activity as a result of promotional programs	1	0	0	0
Number of paid print media advertisements insertions	35	0	0	0
Number of paid TV spots	1,300	0	0	0
Number of targeted marketing and communications activities in communities with high percentages of racial and ethnic minority populations	25	0	0	0
Number of programs in schools and through community organizations to increase physical activities among teens	4	0	0	0
<i>Steps to a HealthierUS</i>				
Number of local health depts. to fund large city and urban communities	12	12	12	0
Number of state health depts. to fund state-coordinated small city and rural communities (each state funds an average of 4 communities)	7	7	7	0
Number of tribal organizations	3	3	3	0
National Organizations	1	1	1	0
REACH 2010				
Implementation and evaluation phase projects in minority communities	31	31	31	0
REACH elderly projects	4	4	4	0
American Indian/Alaska Native communities participating in REACH	5	5	5	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

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FUNCTIONAL TABLES

Chronic Disease Prevention, Health Promotion, and Genomics				
Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Heart Disease and Stroke	\$44,618	\$44,469	\$43,888	(\$581)
Diabetes Prevention and Control	\$63,457	\$63,119	\$62,420	(\$699)
Cancer Prevention and Control	\$309,704	\$307,913	\$304,690	(\$3,223)
Arthritis and Other Chronic Diseases	\$22,487	\$22,467	\$13,757	(\$8,710)
Tobacco	\$104,345	\$104,799	\$102,685	(\$2,114)
Nutrition, Physical Activity, and Obesity	\$41,930	\$41,520	\$41,477	(\$43)
Health Promotion	\$26,146	\$27,443	\$24,160	(\$3,283)
School Health	\$56,746	\$56,192	\$55,820	(\$372)
Safe Motherhood/Infant Health	\$44,738	\$44,292	\$44,009	(\$283)
Oral Health	\$11,204	\$11,682	\$11,022	(\$660)
Prevention Research Centers	\$29,690	\$29,700	\$29,206	(\$494)
Youth Media Campaign	\$58,795	\$0	\$0	\$0
Steps to a Healthier U.S.	\$44,276	\$43,857	\$45,255	\$1,398
Racial and Ethnic Approach to Community Health	\$34,505	\$34,259	\$33,942	(\$317)
Genomics	\$6,987	\$6,952	\$6,396	(\$556)
Total -	\$899,628	\$838,664	\$818,727	(\$19,937)

Consolidated Grant Categories				
Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Heart Disease and Stroke	\$44,618	\$44,469	\$43,888	(\$581)
Diabetes Prevention and Control	\$63,457	\$63,119	\$62,420	(\$699)
Cancer Prevention and Control	\$309,704	\$307,913	\$304,690	(\$3,223)
Tobacco	\$104,345	\$104,799	\$102,685	(\$2,114)
Health Promotion	\$187,997	\$188,615	\$174,763	(\$13,852)
School Health	\$56,746	\$56,192	\$55,820	(\$372)
Prevention Research Centers	\$29,690	\$29,700	\$29,206	(\$494)
Youth Media Campaign	\$58,795	\$0	\$0	\$0
Steps to a Healthier U.S.	\$44,276	\$43,857	\$45,255	\$1,398
Total -	\$899,628	\$838,664	\$818,727	(\$19,937)

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 317C, 317J, 327, 352, 399M, 1102, 1108.

Birth Defects, Developmental Disabilities, Disability and Health (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$124,576	\$124,762	\$110,481	(\$14,281)

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$110,481,000 for Birth Defects, Developmental Disabilities, Disability and Health, a decrease of \$14,281,000 below the FY 2006 Enacted level of \$124,762,000.

PROGRAM DESCRIPTION

The mission of CDC's Birth Defects, Developmental Disabilities, Disability and Health activity is to improve the health of children and adults by preventing birth defects and developmental disabilities, and complications of hereditary blood disorders; promoting optimal child development; and promote health and wellness among children and adults living with disabilities.

Birth defects are the leading cause of infant death in the U.S., with more than 120,000 infants born with birth defects each year. The 17 most common birth defects cost approximately \$6 billion per year. With medical advances, many babies with serious birth defects survive. An estimated 54 million people in the U.S currently live with a disability, and 17 percent of U.S. children under the age of 18 have some type of developmental disability. Direct and indirect costs associated with disability exceed \$300 billion, or four percent of the gross domestic product.

In response to these public health challenges, CDC seeks to promote the health of babies, children and adults to enhance the potential for full, productive living. This is accomplished through monitoring the rates of birth defects and disabilities, performing research to identify the causes of birth defects and developmental disabilities, designing interventions to help children develop and reach their full potential and promoting health and well-being among people of all ages with disabilities. To facilitate this work and to measure performance over time, CDC supports monitoring programs for birth defects and developmental disabilities and assures disability status to be included in all major health surveys.

Individuals with disabilities experience negative medical, social, emotional, family and community problems at higher rates than others. Increasing our understanding of these problems yields promising prevention approaches, thereby improving the quality of life for individuals with disabilities. Specific activities include monitoring health status, conducting research on cost-effectiveness, identifying risk and protective factors, and implementing health promotion strategies.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Birth Defects, Developmental Disabilities, Disability and Health activity, the following performance measure has been selected as a highlight of the program's performance plan:

Performance Goal	Results	Context
1. Reduce by one percent per year the number of children born with spina bifida and anencephaly through promotion of folic acid consumption by women of reproductive age.	CDC is working to capitalize on progress already made in this area by targeting Hispanic women, as this population has the highest rates of neural tube defects. The baseline for this measure is 1,709 cases.	Spina bifida and anencephaly are serious birth defects that occur when the neural tube fails to close properly during fetal development. Anencephaly is a lethal defect, and spina bifida results in serious long-term morbidity and disability. Before folic acid fortification, approximately 4,000 pregnancies resulted in 2,500--3,000 births in the United States each year affected by one of these two neural tube defects. Fortification of the food supply with folic acid has allowed major reductions in the rates of these serious birth defects. However, more reductions are possible if all women of reproductive age consume adequate amounts of folic acid before and during pregnancy.

Current Activities

- Monitoring birth defects: CDC offers technical and financial support to 15 state and territory programs to develop or enhance birth defects surveillance as well as implement prevention and referral activities to ensure that children with birth defects are referred to appropriate services. In addition, CDC provides technical assistance to other states and territories that are planning or have operational birth defects surveillance programs.
- Researching the causes of birth defects: CDC funds eight Centers for Birth Defects Research and Prevention to 1) participate in the National Birth Defects Prevention Study (NBDPS), one of the largest studies on birth defects ever conducted, 2) conduct center-specific research projects, and 3) enhance their state birth defect surveillance systems. The centers conduct genetic and environmental epidemiological studies to identify specific causes and risk factors for birth defects, such as maternal obesity, smoking and diet, genetic variation, maternal health conditions, and gene-environment interactions.
- Metropolitan Atlanta Congenital Defects Program (MACDP): CDC conducts a model birth defects monitoring program in the Metropolitan Atlanta area to collect, analyze, and interpret birth defects data. Since its inception in 1967, the program has collected information on more than 40,000 infants and fetuses with birth defects from among approximately 50,000 annual births in a population of about 2.9 million. MACDP serves as a model for many state-based programs and as a resource for the development of uniform methods and new approaches to birth defect surveillance, including incorporation of prenatal diagnosis, estimation of defect prevalences at different ages, linkage of geocoded data with environmental monitoring, and development of electronic data management. MACDP is being expanded to conduct surveillance of all stillbirths to provide the capacity to examine causes of fetal deaths.
- Estimating Prevalence of Spina Bifida and Down Syndrome in Childhood and Adolescence: Survival of children with birth defects has improved over the years, but there are currently no known prevalence estimates beyond infancy. CDC has developed a novel methodology to estimate the survival probabilities and the prevalence of spina bifida and Down syndrome among children and adolescents in Atlanta using data from MACDP, using vital status data derived from linkages with the National Death Index and denominator data estimates from the U.S. Census. CDC plans to replicate this study to estimate survival probabilities, predictors of survival, and prevalence in 10 other states.
- Medication Use During Pregnancy: CDC is working with partners to develop a comprehensive, coordinated plan to generate and interpret information about the effects of medications used during pregnancy, and to communicate that information to women and health care providers.
- Diabetes During Pregnancy and Birth Defects: CDC is conducting focus groups of women with diabetes during pregnancy to learn about their knowledge of diabetes during pregnancy and pregnancy outcomes, management of diabetes during pregnancy, and potential barriers to such management.
- Folic acid educational campaign: CDC provides educational materials to programs in states, managed care organizations and community-based organizations designed to increase consumption of folic acid to prevent spina bifida and anencephaly. CDC data have shown that Hispanic women are more likely to have a

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

pregnancy affected by these neural tube defects. CDC is continuing a targeted campaign to reach Hispanic women with the folic acid message. If preliminary successful results bear out, CDC will work to increase the reach of the campaign to the top U.S. Hispanic media markets.

- Folic acid: In collaboration with the CDC Foundation, Healthy Mothers, Healthy Babies, CDC has developed the Optimal Nutrition Project, a campaign focusing on vitamin supplementation for women of childbearing age to prevent adverse pregnancy outcomes.
- Fetal Alcohol Syndrome (FAS): CDC funds programs designed to build statewide capacity in FAS prevention and monitoring; a collaborative research consortium for identifying, developing, and evaluating effective strategies for intervening with children and/or adolescents with FAS and related conditions; research programs to identify and test new FAS prevention and management methods; regional training centers to increase health care providers' knowledge about how to identify and prevent FAS; and the development of prevention and education materials for parents, educators, students, professionals, and the public at-large. In addition, CDC provides support to all 50 states to monitor alcohol consumption levels, and supports targeted outreach to American Indian/Alaskan native populations.
- Awareness Campaign: CDC and its partners successfully launched "Learn the Signs. Act Early," a campaign to promote early identification and intervention for children with autism and other developmental disabilities. The campaign activities have included the creation and distribution of healthcare professional as well as parent resource kits, public service announcements, maintenance of a call center and widespread new media coverage in national outlets.
- Autism and Developmental Disabilities Tracking and Research: CDC operates a model tracking and research program to determine the prevalence of autism and other common developmental disabilities (including mental retardation, cerebral palsy, vision impairment, and hearing loss, and to conduct research on the causes of these conditions. In addition, CDC supports autism monitoring and research in other parts of the country. Including CDC's program, a total of 17 states are now tracking rates of autism and other developmental disabilities in children, with seven of these programs also conducting public health research on autism.
- CDC has finalized a report to Congress outlining methods used by the CDC and its grantees to monitor autism and will make recommendations on how to resolve data access challenges in a way that both protects the privacy of school children and provides critical information on the prevalence and trends of autism and other childhood-onset disabilities.
- CDC funds research grants to identify promising approaches to promoting health and wellness, and preventing secondary conditions among people with disabilities, as well as finances cooperative agreements with state health departments to build capacity in addressing the public health needs of people with disabilities.
- CDC supports 30 states and territories in their efforts to develop surveillance and tracking systems to ensure all newborns are screened for hearing loss and that, when necessary, infants receive appropriate follow up testing and services.
- CDC funds research projects investigating a wide range of topics such as risks factors for late-onset hearing loss in children, prevalence and effects of early intervention children with unilateral hearing loss, and the use of birth certificate information to improve lost to follow-up rates. The results of these studies will provide essential data needed to help make informed policy decisions.
- CDC supports activities of the American Academy of Pediatrics to increase the awareness and involvement of physicians with newborn hearing screening and intervention programs. These activities include providing educational opportunities to primary care providers; assisting state coordinators to access hospitals, individual physicians and other state agencies; providing medical expertise; and reviewing educational materials for providers and parents.
- CDC and researchers continue activities of conducting qualitative research on female Duchenne and Becker Muscular Dystrophy (DBMD) carriers' knowledge, beliefs and behaviors of preventive cardiac health care. This project will use a large-scale self-completed survey to collect information about what female DBMD carriers know or believe about cardiac health care and they act based on this information. CDC has conducted 18 key informant interviews and three focus groups of female carriers of DBMD to identify factors that may influence female carriers' preventive health care behaviors.

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- Attention-deficit/hyperactivity disorder (ADHD): Working with a national advocacy organization, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), CDC supports the National Resource Center on AD/HD. A two-site, community-based research study was also initiated and is ongoing, which will result in estimates of the prevalence of ADHD and treatment, rate of commonly co-occurring disorders, and health status and health risk behaviors in children with ADHD.
- *Legacy for Children™*: Ongoing research program to decrease developmental delays or problems in children at-risk for poor developmental outcomes. This set of long-term, randomized studies examines the potential for improving child health and well-being through programs designed to influence parenting behavior. *Legacy for Children™* works with low-income mothers and focuses on increasing their beliefs that they can have a positive impact on their child's development; using parent groups to facilitate positive parenting behaviors; and increasing the amount of time and energy these women invest in their child's development. The study is fully enrolled and ongoing in the Miami and Los Angeles metropolitan areas.
- Tourette Syndrome: CDC has established a partnership with the Tourette Syndrome Association (TSA) in support of a Tourette Syndrome Education and Outreach to Service Providers. Through this cooperative agreement, CDC has been working with TSA to bolster provider education and intensive training for health care professionals on how to identify, diagnosis, and treat Tourette Syndrome. To further understand the prevalence, risk factors, and comorbidities of TSA, CDC in collaboration with investigators from the University of Oklahoma Health Sciences Center has initiated a pilot epidemiology study of Tourette Syndrome and tics in school-age children. Results from this pilot study are expected by late 2006. Additionally, CDC is supporting extramural research that will identify factors contributing to the quality of life of persons with Tourette Syndrome.
- CDC has funded Swope Health Services of Kansas City, Missouri to implement the Healthy Steps for Young Children pediatric practice model in Swope's pediatric clinic. The model will be assessed for its effectiveness in increasing the number of children who receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and developmental screening in particular, to ensure that their physical and psychosocial developmental needs are being met. This project is supportive of CDC's interest in developing and evaluating an effective model for improving developmental screening practices for young children that will lead to an increase in the early identification and appropriate referrals of children at risk for or with developmental delays or disabilities.
- CDC maintains the Universal Data Collection system (UDC) to monitor blood safety and conduct research on health-care outcomes for persons with bleeding disorders.
- CDC performs epidemiology and laboratory research to develop new prevention techniques to lessen the impact of bleeding and clotting disorders as well as other inherited blood cell diseases.

Significant Accomplishments

- Through the National Birth Defects Prevention Study, 21,000 maternal interviews have been conducted. CDC has established a state-of-the-art central biologics laboratory for processing and long-term storage of DNA samples for genetic and gene-environment research studies, developed a comprehensive research agenda using NBDPS data with over 200 projects, and released an analytic database that included calculated variables to improve consistency and quality of analyses across centers. All of these have helped CDC develop capacity to respond to public health concerns and to critically analyze potential risk factors such as maternal smoking, fertility treatments, and scientific conferences, and the use of medications such as loratadine or herbal products.
- In 2005, CDC conducted two workshops with experts to review and discuss challenges in the development and implementation of a surveillance system of fetal deaths and possible pilot studies. Participants included scientists from the National Institute of Child Health and Human Development (NICHD) Stillbirth Network, academia, and MACDP partners.
- In collaboration with the American Heart Association, CDC prepared a synthesis of the literature on non-genetic risk factors for congenital heart defects. This report highlights established risk factors in need of translational research such as diabetes and knowledge gaps in need of further etiologic research. This report has been submitted for publication.

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- The 2005 Congenital Malformations Surveillance Report—a compendium of birth defects prevalence data by state—was published in October 2005. This report, a collaboration of CDC-funded birth defects surveillance programs and the National Birth Defects Prevention Network provides critical state-specific data on rates and trends of birth defects in the United States. The report also includes critical analyses of these data, such as an article that found that fortification of the U.S. food supply with folic acid – long known to prevent spina bifida and other birth defects of the neural tube – may also prevent a serious heart defect, certain oral clefts, and upper limb reduction defects.
- An additional important accomplishment is the publication of studies utilizing collaborative data from those programs participating in the National Birth Defects Prevention Study, one of the largest studies on the causes of birth defects ever conducted. Two studies assessed maternal smoking and maternal progesterin exposure as potential risk factors for the birth defect hypospadias. A third paper described the frequency of an emerging and important exposure during pregnancy – over-the-counter medications.
- In addition, a CDC study published in September 2005 provided race-specific rates of the birth defects spina bifida and anencephaly prior to and following fortification of U.S. cereal grains with folic acid. The prevalence of these birth defects decreased after fortification among all racial and ethnic groups. However, the data also revealed that the prevalence of these defects remains highest among Hispanics. More studies are required to determine why this is the case and to identify and implement effective strategies to increase folic acid intake specifically among Hispanic women of childbearing age. CDC has ongoing folic acid education efforts targeting Hispanic women and is also exploring the feasibility of additional systems-level changes, such as working with manufacturers to increase availability of products fortified with folic acid.
- CDC in collaboration with researchers at the Children's National Medical Center in Washington, D.C., developed a survey of parents of children with DBMD in the United States and Puerto Rico. The National Initiative for Families with Duchenne (NIFD) survey will include a large number of families from many backgrounds, and the results will help state health departments improve services for families with DBMD.
- In February 2005, the U.S. Surgeon General released an updated Surgeon General's Advisory on Alcohol Use in Pregnancy. CDC and other federal agencies and members of the National Task Force on FAS and Fetal Alcohol Effect (which is housed at CDC) worked together to craft the advisory, which is updated to reflect scientific knowledge amassed since the first advisory in 1981. The updated advisory helps stress to prospective parents, health care practitioners, and with childbearing-aged women, especially those who are pregnant, the importance of not drinking alcohol if a woman is pregnant or considering becoming pregnant. This is supported as part of the Surgeon General's "Year of the Healthy Child" along with other critical child health initiatives.
- In FY 2005, after being tested through multiple trainings and found to be effective, four FAS educational curricula became available. These curricula are designed to teach various audiences about FAS and related conditions and about how to access appropriate services for children with FAS and their families.
- In collaboration with partners, January 24-30, 2005 marked the first ever National Folic Acid Awareness Week. The U.S. Surgeon General endorsed this effort to improve the health and reduce the risk of birth defects as part of his year-long initiative, Year of the Healthy Child.
- In May 2005, an autism study funded in part by CDC was published. The study, conducted in Denmark, showed that both adverse events in pregnancy and parental history of psychiatric illness increased the risk for autism. Epidemiologic studies supported by CDC – such as this one – and the upcoming multi-site collaborative study planned by CDC and its Centers for Autism and Developmental Disabilities Research and Epidemiology, address a critical missing component in autism research: large, representative population-based studies that can answer multiple, high-priority questions needed to determine the causes of autism, and to develop prevention strategies for this complex disorder.
- CDC has also taken an active role in promoting early screening and intervention for children with autism. This is the cornerstone message of CDC's current campaign, "Learn the Signs. Act Early." To date the campaign has reached over three million healthcare professionals, distributed over 14,000 professional resource kits and reached every state and United States territory. Over 20,000 parent information kits have been distributed; the campaign website has received over 120,000 unique visitors and more than 30,000 materials have been downloaded. The call center has received over 8,000 calls.
- An update on the investigation of the incidence and associated risk factors of bacterial meningitis among children with cochlear implants was published by *Pediatrics* in January 2006.
- In August 2005, the U.S. Surgeon General released a "Call to Action to Improve the Health and Wellness of Persons with Disabilities," appealing to all Americans to help increase the quality of life for people with disabilities through better health care and understanding. CDC and other federal agencies worked closely in

the preparation of this Call to Action. The Call to Action included four major goals: (1) Increase understanding nationwide that people with disabilities can lead long, healthy, and productive lives; (2) Increase knowledge among health care professionals and provide them with tools to screen, diagnose, and treat the whole person with a disability with dignity; (3) Increase awareness among people with disabilities of the steps they can take to develop and maintain a healthy lifestyle; and, (4) Increase accessible health care and support services to promote independence for people with disabilities.

- In 2005, through a public/private partnership, CDC funded ten pilot centers to study why some hemophilia patients do not respond to blood products and develop inhibitors or antibodies to blood products currently used to stop or prevent a bleeding episode.
- In 2005, the UDC program was expanded to include collection of data on persons with bleeding disorders under the age of two to obtain information about early diagnosis and first bleeding episodes. The expansion also includes a quality of life component for youth and adults.
- In 2005, CDC collaborated with hemophilia treatment centers to develop a uniform electronic data collection system to collect information for surveillance as well as a future clinical research database for patients with bleeding disorders.

RATIONALE FOR THE BUDGET

The FY 2007 President’s Budget reflects a total funding level of \$110,481,000 for Birth Defects, Developmental Disabilities, Disability and Health, a decrease of \$14,281,000 below the FY 2006 Enacted level of \$124,762,000.

Pay Raise (+\$0.2 million)

The request includes funds to cover the projected FY 2007 increase.

Program Reductions (-\$13.5 million)

The FY 2007 President’s Budget proposes reductions to activities that are outside the scope of CDC’s mission to focus on primary prevention. Included in this reduction are CDC’s Attention-Deficit Hyperactivity Disorder, Paralysis, Tourette Syndrome, and Cooley’s Anemia programs. The budget also proposes reductions to fund base activities at FY 2006 President’s Budget levels.

Administrative and Information Technology (IT) Savings (-\$1.0 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC’s budget lines. The FY 2007 President’s Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Prevent Birth Defects and Developmental Disabilities				
Programs funded for birth defects surveillance and prevention research	15	15	15	0
CDC projects to develop, test, and distribute educational messages for the folic acid campaign	4	4	4	0
FAS prevention state capacity programs	8	8	8	0
Programs to develop effective interventions with children with FAS	5	5	5	0

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BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of states participating in research on Autism and Other Developmental Disabilities	7	6	6	0
Number of states conducting monitoring for autism and other developmental disabilities	18	17	17	0
Improve the Health and Quality of Life of Americans with Disabilities				
Disability Research Grants	7	7	7	0
Disability State Capacity Grants	16	16	16	0
Disability and Health Information Centers	3	3	1	(2)
National Spina Bifida Program Research projects	4	4	4	0
State tracking program for Early Hearing Detection and Intervention	32	35	35	0
Research projects for Early Hearing Detection and Intervention	12	11	11	0
States conducting surveillance for DBMD	4	6	6	0
State Research projects for DBMD	5	5	5	0
Attention Deficit Hyperactivity Disorder projects (includes resource center)	4	3	0	(3)
Hemophila/Thalassemia Treatment Centers	140	140	140	0
Hemostasis/Thrombosis Pilot Sites	8	8	8	0
Percentage of persons with hemophilia being seen at a HTC who also participate in CDC's UDC blood safety monitoring program.	87%	90%	90%	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

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BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

FUNCTIONAL TABLE

Birth Defects, Developmental Disabilities, Disability and Health Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Birth Defects & Developmental Disabilities	\$39,239	\$38,659	\$38,298	(\$361)
Human Development and Disability	\$65,111	\$66,242	\$54,395	(\$11,847)
Hereditary Blood Disorders	\$20,226	\$19,861	\$17,788	(\$2,073)
Total -	\$124,576	\$124,762	\$110,481	(\$14,281)

HEALTH INFORMATION AND SERVICE

Health Information and Service (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$94,439	\$88,668	\$127,439	\$38,771
PHS Evaluation Transfers	\$134,235	\$134,235	\$134,235	\$0
Total	\$228,674	\$222,903	\$261,674	\$38,771

INTRODUCTION

The Health Information and Service budget activity is responsible for assuring that CDC provides the highest-quality information, programs, and services in the most effective ways to help people, families, and communities protect their health and safety. For the first time in CDC's history, a unique set of functions and activities have been combined to help the agency reach out more effectively to the public and improve health impact. This is done through three major activities: assembling and reporting on the most current Health Statistics and trends in health; Public Health Informatics to efficiently collect information to identify early outbreaks and fluctuations in health and to effectively manage the wealth of informational needs by CDC, its partners and the public; and Health Marketing to persuasively communicate vital health information and interventions to various target audiences and the general public. Some of the ways these activities are already benefiting the public include:

Health Statistics – Delivering up-to-the-minute health statistics and data to guide and evaluate public health policy and public health program development.

CDC places health information at the center of public health through a comprehensive effort to compile statistics on the nation's health. CDC monitors the health status and behaviors of the American public through highly respected data systems such as the National Health Interview Survey and the National Vital Statistics System. CDC also monitors the health care system and, through the National Health and Nutrition Examination Survey, develops and monitors biomarkers for health. These health indicators are especially valuable for identifying health disparities and informing efforts to eliminate those disparities. Many of these respected data sources are utilized by other federal agencies, health care organizations, public health, and others to monitor and understand the trends in health.

Public Health Informatics – Using state of the art information science to gather, process, store, protect, and communicate public health information and making certain that these data are made useful to both the public health community and the nation as a whole.

CDC applies the power of information and state of the art computer science and technology to gather and manage the vast wealth of information which will ultimately be required by and inform CDC programs and health policies worldwide. Public health informatics helps to address the need for urgent information in "real-time" during a potential crisis; and, indeed may be the tool that identifies the potential health crisis. An ongoing, pressing challenge in these uncertain times is responding to possible bioterrorism or other emergency events. The modern discipline of informatics greatly improves our ability to respond immediately with the right information, bridging urgent health needs with timely health data. CDC is currently implementing an exciting new project to provide ongoing reporting on health issues. The "BioSenseRT" is CDC's national program designed to improve the nation's capabilities for disease detection and monitoring. It is designed to help provide an accurate picture of community health during a potential crises by using appropriate and secured data from health care information.

Health Marketing – Communications and health marketing are vital tools in bridging the gap between science and effective interventions for health and implementation by the target audience to gain ultimate impact for health. Implementing state of the art communications and marketing strategies, many of which are new and even revolutionary in the world of public health, will assure that CDC is effectively reaching its target audience in an effort to inform, persuade, and ultimately impact health.

Vital to the success of CDC's programs and imperative to maintain and improve health impact are the diverse partners with which CDC collaborates. In addition to its traditional partner organizations in public health, CDC has identified and is currently working with partners from business, faith, and other community groups, health care, education, and other sectors of society to assure maximum outreach and effectiveness of its programs. In our

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HEALTH INFORMATION AND SERVICE

outreach to partners, CDC builds relationships that incorporate shared learning, mutual trust, and diversity in points of view and sectors of society.

Through continuous consumer input, prevention-related research, and public health information technology, CDC identifies and evaluates health needs and interests, translates science into actions to meet those needs, and engages its partners in improving the health of the nation.

HEALTH STATISTICS

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 307, 308; 1 percent Evaluation: PHSA § 241 (non-add), (Superceded in the FY 2002 Labor HHS Appropriations Act – Section 206).

Health Statistics (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
PHS Evaluation Transfers	\$109,021	\$109,021	\$109,021	\$0

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects total funding of \$109,021,000 for Health Statistics, maintained at the FY 2006 Enacted level.

PROGRAM DESCRIPTION

CDC conducts a variety of programs designed to obtain and use health statistics to support decision making and research on health. CDC's Health Statistics highlighted performance goal is to monitor the nation's health through high-quality data systems.

CDC's health statistics activities provide critical data that represent the society's health in various areas. Statistics inform the public about current public health challenges and provide a foundation for understanding existing health problems. Health statistics are used to recognize emerging trends (e.g. obesity), to create a basis for comparisons between population groups or geographic areas, to identify health disparities and target action, and to understand how trends in health change and develop over time.

Health statistics guide national policy and support public programs and goals. Current health information is needed in all sectors of society as a prerequisite for linking risk behavior to health outcomes, targeting health messages, and planning and evaluating programs that can lead to improvements in health and quality of life.

Statistics make government accountable. Health statistics are used to monitor our effectiveness in addressing public health concerns. These data are used to formulate strategic plans, monitor performance and monitor progress on national goals.

CDC's health statistics surveys serve the needs of a broad range of programs, researchers, and policy makers in CDC, HHS, and across the health community. They are based on sound statistical methods and are conducted in an open, independent, and objective manner. Maintaining and building on HHS' existing data systems are important from a management standpoint, as these systems are more efficient than launching multiple independent systems to meet individual agency information needs.

Investments in CDC health statistics systems are critical to advancing our ability to measure health and guide health improvement. In a period of rapid change in health and welfare policy, medical practice, and biomedical knowledge, it is important to make the investments necessary to monitor trends so that we can assess the impact of these changes and guide future policy.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Health Statistics activity, the following performance measure has been selected as a highlight of the program's performance plan:

Performance Goal	Results	Context
1. Monitor the nation's health through high-quality data systems.	CDC conducts ongoing surveys to monitor the nation's health, works to increase participation rates to produce meaningful data, and collaborates with partners improve timeliness and quality of data.	Major health surveys include the National Health and Nutrition Examination Survey (NHANES), the National Health Interview Survey (NHIS), the National Health Care Survey (NHCS), and the National Vital Statistics System (NVSS).

Current Activities

NHANES:

- Collect information annually on health status obtained through personal interviews with standardized physical and dental examinations, diagnostic procedures, and lab tests.
- Maintain continuous field operations on a nationally representative sample of 5,000 individuals at 15 U.S. sites.
- Address priority population groups and issues through efforts to over sample African-Americans, Mexican-Americans, adolescents, persons over 60 years of age, pregnant women, and low-income whites.
- Collaborate with other federal agencies to address specific research and program-driven needs on areas such as oral health, body composition, food activity, lower extremity disease, mental health, vision, diabetes, diet, and nutrition, and balance these program-specific needs with broad health topics of continuing importance.
- Serve as the data collection mechanism to monitor diet and nutritional status of Americans by providing information needed for food policy and dietary guidelines.

NVSS:

- Release data findings on a regular basis addressing topics such as cholesterol, growth charts for pediatricians, osteoporosis, environmental smoke, obesity, changes in food/diet, and immunizations.
- Provide the nation's official vital statistics data based on the collection and registration of birth and death events at the state and local level.
- Work with federal and state partners on development of minimum standards for the issuance of birth certificates in compliance with the Intelligence Reform and Terrorism Act, Section 7211.
- Work with states on the implementation of a Web-based system for collection of statistics including implementation of content revisions of the U.S. Standard Certificates of Live Birth, Death and Fetal Death.
- Assist states in the development of systems specifications for their new registration systems based on the use case models developed by Social Security Administration (SSA), the National Association for Public Health Statistics and Information Systems (NAPHSIS), and CDC.
- Provide data to monitor key national indicators, including reductions in teen pregnancies, low birth weight and preterm birth, and maternal risk factors including smoking during pregnancy, hypertension, and anemia.
- Provide state-level data used for the welfare reform performance objective of reducing out-of-wedlock births.

NHIS:

- Provide information annually on the health status of the U.S. civilian non-institutionalized population through confidential interviews conducted in households.
- Publish data on a quarterly basis on lack of health insurance coverage to reflect different policy-relevant perspectives on persons with access to care. The data provide three fundamental measures of health insurance coverage at the time of interview: 1) persons who currently lack coverage; 2) the estimate of persons who were uninsured at any time in the past year; and 3) the measure of lack of coverage for more than one year. These measures are released six months after collection.
- Collect and publish data on a quarterly basis on health status and disability, access to care, use of health services, immunizations, health behaviors, ability to perform daily activities, and child mental health.
- Design and implement a new sample for the NHIS to ensure it accurately reflects the shifting U.S. population demographics identified in the decennial census and refocus surveys on population groups that are growing.

NHCS:

- Provide a picture of how hospitals, emergency and outpatient departments, ambulatory surgery centers, nursing homes, hospices, and office-based physicians deliver health care.
- Prepare data for analysis after CDC redesigned and conducted the 2004 National Nursing Home Survey (NNHS). This survey includes an increased sample size, expanded clinical content, new information on staffing and turnover, data on facility policies and practices, and the use of computer-assisted personal interviewing. The NNHS includes the first-ever nationwide survey of nursing assistants.
- Increase the utility of the National Ambulatory Care Medical Care Survey and the National Hospital Ambulatory Medical Care Survey by increasing the number of participating providers. In addition, the "Bioterrorism and Mass Casualty Preparedness Supplement," was added to these surveys in 2003 and 2004 to describe key characteristics of emergency preparedness plans in hospitals and physicians' offices.
- Implement new methods and technology to better reflect the changing distribution of the population and changes in the mix and range of health care providers to take advantage of existing record systems, particularly electronic systems, to incorporate a wider range of data items such as prescription drugs and clinical quality measures.
- Conduct the National Survey of Ambulatory Surgery (the survey has not been conducted since 1996) that will complement the National Hospital Discharge Survey which focuses on inpatient care. The survey will allow CDC to provide more comprehensive data on surgical procedures, many of which have moved from inpatient to outpatient settings.

Significant Accomplishments

- Released NHANES 2003-2004 data in December 2005, just over 10 months after the end of data collection, an improvement of several months over previous years.
- Data such as overweight prevalence and increased calorie consumption document the country's epidemic of overweight and obesity and are used to illustrate that the percentage of Americans at elevated risk of a variety of health problems. The data resulted in the Secretary and CDC Director bringing public attention to the obesity problem and discussing positive steps for the public to take with exercise and making better choices in the foods we eat. The data led to legislative initiatives and changes in messages and food choices from the food industry.
- Data provide answers for researchers and nutritionists, and are used as the basis for recommendations on food fortification decisions, on the recommended amount of vitamins and minerals essential for a healthy diet (i.e., iron for women of childbearing age, preschool children, and the elderly).
- Expanded exposure monitoring activities to assess the exposure of the U.S. population to 148 environmental chemicals, published in the *2005 Third National Report on Human Exposure to Environmental Chemicals*. NHANES data are used to determine reference (or normal) ranges of exposure to these chemicals and to monitor which environmental chemicals Americans are exposed to, how much of a chemical Americans are exposed to, and trends in exposure over time.

- Data from the National Survey of Family Growth showed that sexual activity declined significantly for younger teenage girls and boys between 1995 and 2002. The *Washington Post* reported that "Researchers praise the periodic survey as one of the most authoritative sources of information on adolescents, in part because it reaches teenagers in and out of school and because it measures not only attitudes but also specific behaviors."
- Data for 2003 show the teen birth rate has dropped 33 percent since 1991. Between 2002 and 2003 the teen birth rate dropped 3 percent, from 43.0 to 41.7 per 1,000 females 15-19 years of age. Tracking these vital statistics is critical to national policy on teen pregnancy prevention and initiatives to reduce out-of-wedlock births.
- Data for 2003 show life expectancy in the U.S. at birth was 77.6 years for all races, 78.0 years for whites, and 72.8 years for blacks. The infant mortality rate increased from 6.8 infant deaths per 1,000 live births in 2001 to 6.9 in 2003. A rise in neonatal infant deaths (infants less than 28 days old) prompted the overall rate to increase in 2003. These data are crucial for public health officials at the national, state and local level to monitor progress toward achieving health goals.
- Developed a consensus national documentation of best practices for how electronic birth and death certificate systems will operate in partnership with SSA and NAPHSIS. This documentation includes technical standards and specifications that will enable rapid progress in the development and implementation of software that can greatly accelerate timeliness and quality of vital statistics. Phase 1 requirements for the model vital statistics system are complete and now publicly available. The state of Georgia is in the process of developing a new electronic birth system based on these requirements, and New York City is also developing a re-engineered death registration system based on the model requirements.
- Successfully completed development and implementation of new technology for collecting and processing the NHIS, using state-of-the-art computer assisted survey interview methods and automated systems for processing data into analytic form. Data from the 2004 NHIS was made public in micro-data form on the internet five months earlier than past years. Future annual releases of the NHIS data are scheduled to be made only six months after data collection is completed.
- Collaborated with NIH and published the *Complementary and Alternative Medicine Use Among Adults*. The survey included questions on 27 types of CAM therapies commonly used in the U.S., including 10 types of provider-based therapies, and 17 other therapies that do not require a provider. Due to the success of this collaboration, the survey will be conducted again in 2007. The report showed that 36 percent of U.S. adults aged 18 years and over use some form of CAM. When prayer specifically for health reasons is included in the definition of CAM, the number of U.S. adults using some form of CAM increases to 62 percent.
- Data are used by public health officials to gain a more complete understanding of the uninsured population, those with less access to care and those less likely to be receiving preventive services, and by policy makers to show the proportion of the population that lack coverage and to understand the shifts in coverage from private to public sources (such as SCHIP and Medicaid) Data from 2004 show the percentage of uninsured persons at the time of the interview was 19.3 percent for persons aged 18-64 years and 9.4 percent for children under age 18. A total of 51.6 million persons (17.9 percent) of all ages were uninsured for at least part of the 12 months prior to the interview.
- Data are used to examine prescribing practices for medications as well as patient safety issues such as the extent to which complications, injuries or adverse effects result from medication uses. For example, during 2003, there were an estimated 1.7 million visits to emergency departments (EDs) in the U.S. for adverse effects of medications. These injuries comprised 4.2 percent of all ED visits during 2003.
- Data are used to document hospitals' readiness for treating patients from terrorism attacks and mass casualty incidents. While data from 2003 show that the vast majority of hospitals had written plans for responding to natural disasters and terrorism attacks, they reported that their drills lagged behind written response plans, formal patient transfer arrangements lagged behind cooperative planning with other hospitals, and drills that included public health departments and volunteer organizations lagged behind drills that included emergency medical services and fire departments.
- Data are used to show public health officials at the national, state, and local level that the nation's emergency departments form a major part of our nation's health care safety net and are often the provider of last resort. Data show 113.9 million visits to hospital emergency rooms in 2003, an increase of 26 percent over the 90.3 million visits made in 1993.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects total funding of \$109,021,000 for Health Statistics, maintained at the FY 2006 Enacted level.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Monitor Trends in the Nation's Health through High-quality Data Systems Addressing Issues Relevant to Policymakers				
Number of key elements of the health care system for which data are collected	3	3	3	0
Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey	15	15	15	0
Data systems for which significant efforts will be underway for redesign, reengineering, or transformation	3	3	3	0
Number of households interviewed in the National Health Interview Survey	-40,000	-40,000	-40,000	0
Disseminate Health Data in Innovative Ways				
Improvements in data dissemination via the Internet (# new products developed for Internet per year)	1	1	1	0
Release data on high priority issues in new formats (# new reports per year)	2	2	2	0
Increase number of new users to NCHS Web site	5%	5%	5%	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

FUNCTIONAL TABLE

Health Statistics Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Field Operations	\$59,833	\$59,833	\$59,833	\$0
Statistical Program Infrastructure	\$49,188	\$49,188	\$49,188	\$0
Total -	\$109,021	\$109,021	\$109,021	\$0

PUBLIC HEALTH INFORMATICS

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 307, 308, 310, 311, 317, 318, 319, 319A, 319B, 319C, 327, 352, 391, 1102, 2315, 2341, Clinical Laboratory Improvement Amendments of 1988, §4

Public Health Informatics (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$51,251	\$45,890	\$84,442	\$38,552
PHS Evaluation Transfers	\$24,751	\$24,751	\$24,751	\$0
Total	\$76,002	\$70,641	\$109,193	\$38,552

STATEMENT OF THE BUDGET

The FY 2007 President’s Budget reflects a total funding level of \$109,193,000 for Public Health Informatics, an increase of \$38,552,000 above the FY 2006 Enacted level of \$70,641,000.

PROGRAM DESCRIPTION

Information systems and information technology (IT) are critical to the practice of public health in the 21st century. Informatics provides new and creative solutions by using information and information systems to address public health problems. In doing so, informatics extends the reach of public health professionals, allowing them to achieve more. Public health involves collecting, managing, analyzing, and sharing information that drives evidence-based decisions and improves health impact. Public Health Informatics supports these functions and provides new capabilities for preventing diseases, disability and other public health threats to avoid the burden of illness. Public Health Informatics activities further enhance discovery, innovation, and application of public health information and information systems so as to support public health and public health preparedness. CDC will strengthen its leadership role in public health informatics policy and standard setting, in defining informatics needs nationally, working with other national health information technology activities, and increasing capacities for public health informatics research.

CDC provides national leadership in public health to define and document the functional needs of public health information systems; define the information and technical architectures for public health and ensure integration with other national health IT activities; identify industry standards and develop the specifications that implement interoperability; advance the best of breed processes and practices for the development and implementation of IT; develop systems and software components where necessary; and advance public health informatics capacities nationally. CDC also elevates public health informatics as a discipline nationally—making it an area of focus across all of public health, especially at the state and local level. Public Health Informatics ensures that the best information systems solutions are available, but also reinforces that public health professionals and information technologists are fully utilizing available information technology solutions.

CDC activities reflect ongoing efforts to build a national network of public health information systems that will enhance public health partner capabilities in detection and monitoring, surveillance, data analysis and interpretation, information resources and knowledge management, alerting and communications, and response. Information systems designed to support these areas will integrate and interoperate to provide state and local public health partners with near real-time access to information that can effectively assess the health of their community, identify the causes of a disease, provide the tracking and management capabilities necessary in responding to and containing an outbreak, and work to connect public health to the clinical care information environment.

PERFORMANCE ANALYSIS

Current Activities:

CDC's public health informatics activities support a variety of public health programs at federal, state and local levels.

- The Public Health Information Network (PHIN) ensures that necessary public health information systems are present and working together at the state, local, and federal levels. Through PHIN and PHIN Preparedness, CDC will help state and local public health partners develop informatics solutions using national industry-based standards and specifications for exchanging data to ensure that the nation is prepared in the event of a terrorism attack or other public health emergency.
- The BioSense Initiative focuses on early event detection by connecting electronic health records from hospitals, clinics, and other health-related sources and using them for early-detection purposes, the initiation of outbreak management, communications and alerting, connecting laboratory systems, and countermeasure and response administration. BioSense provides federal, state and local public health professionals with near real-time views of their community's health status at the zip code level.
- Public health surveillance is the systematic, ongoing assessment of the health of a community through routine collection, analysis, and dissemination of information on disease and injury. By using surveillance information and the electronic informatics applications that facilitate the transmission and reporting of this information, state and local public health agencies or communities can set priorities, take appropriate action to prevent illness, and evaluate the effectiveness of their programs. The National Electronic Disease Surveillance System (NEDSS) is an initiative that promotes the use of data and information system standards to advance the development of efficient, integrated, and interoperable surveillance systems at federal, state, and local levels. A primary goal of NEDSS is the ongoing, automatic capture and analysis of data that are already available electronically.
- Partner Communications and Alerting (PCA) capabilities include the rapid distribution of health alerts, collaborative communications among public health professionals and the broad sharing of information with the public. The management and dissemination of urgent and non-urgent information to public health partners (e.g. state and local public health workers, primary care physicians, public health laboratories, other federal agencies, etc.) can be achieved using multiple channels of distribution, including e-mail and secure Web sites. PCA capabilities will provide real-time access to information, establish alerting protocols, and ensure information remains constantly available regardless of the recipients' locations.
- Countermeasure and Response Administration (CRA) manages the administration of vaccine, prophylaxis, isolation, and quarantine to contain an outbreak or respond to a public health event, and support the allocation of limited supply pharmaceuticals to ensure coverage of high risk population groups. Specifically, CRA enables coordination and management of pharmaceutical and/or non-pharmaceutical responses; tracks the administration of treatments, prophylaxes, vaccinations and isolation; manages the allocation, based on priority risk groups, of products that have limited supply; monitors adverse events and tracks follow-ups such as "take" responses; and exchanges information across systems (federal, state and local) involved in the identification, confirmation, and management of an event.
- The management of data and test results associated with a public health event can be complex and unsupported by any form of standardized electronic reporting between participating organizations. CDC is developing technology for Connecting Laboratory Systems (CLS) which enables the timely electronic exchange of laboratory results to public health partners, coordinates laboratory services for laboratory testing, and easily links laboratory findings to related epidemiological data that ultimately provides rapid analysis and improved situational awareness. CLS establishes common specifications and processes for information exchange among the nation's laboratories (public health, clinical, and hospital-based) and their partners.
- Managing increasing amounts and types of public health information and data and ensuring its timely and intuitive access by citizens, federal, state, and local partners, and the internal CDC community is a critical necessity to achieve and advance the objectives and goals of public health. To meet these needs, CDC has developed a unified knowledge management approach implemented across the agency.
- CDC is working with Federal Health Architecture (FHA) to implement the Consolidated Health Informatics (CHI) standards for reducing the burden of private sector reporting through the automated use of electronic clinical data for public health purposes as an alternative to manual reporting. We are also supporting national electronic health record (EHR) activities to ensure that public health needs are represented in EHRs and to ensure that EHRs and electronic public health systems can interoperate and work together to improve clinical and public health outcomes.

- As a part of the CDC Research Agenda, Public Health Informatics will be elevated as a discipline nationally, making it an area of focus for expanding public health research capacity across all of public health. The informatics research topic areas include analytical methods, information and data visualization, communications and alerting technologies, decision support, electronic medical records, and knowledge management). Focusing on these areas enables CDC and its partners to define and manage the architecture for public health information systems nationally by establishing the capabilities for federal, state, and local information systems to work together and connect with clinical care and other organizations. These systems provide new and creative solutions to extend the reach of public health, allowing it to achieve more through collecting, analyzing, and sharing data that drive evidence-based decisions with the goal of improving health impact. Public Health Informatics supports these functions and provides new capabilities for preventing and managing diseases and other public health threats to support even greater health impact.

Significant Accomplishments:

- Accumulated and refined the requirements and key performance indicators for information systems for the public health preparedness areas of early event, outbreak management, connecting laboratory systems, countermeasure and response administration and partner communications and alerting. These requirements, available on CDC's PHIN website site (www.cdc.gov/phn), have been directed for use at the state and local levels and will be the basis for ensuring that interoperable preparedness systems will be in place to support a wide variety of public health activities.
- Developed message specifications and implementation guides to support reporting from states and larger local jurisdictions for over 100 notifiable conditions; developed message specifications to support laboratory reporting from clinical and public health laboratories for human and environmental testing, including bioterrorism, to public health; developed messages and standards for use at the state and local levels for vaccination reporting, smallpox vaccination program and active surveillance reporting; developed messages and standards for the exchange of alert information between public health agencies, and between public health and other emergency response/emergency management agencies, using the Common Alert Protocol (CAP) as advised by OMB and Department of Homeland Security.
- Widely used PHIN standards to transmit public health information used for event detection and routine surveillance reporting. To date, CDC has sent, received and/or processed numerous records from various sources and significantly improved disease reporting times.
- As part of its national influenza surveillance effort, the CDC receives weekly mortality reports from 122 cities and metropolitan areas within two to three weeks from the date of death. CDC updated the 122 Cities Mortality Reporting System Manual of Procedures and the Quick Guide for weekly reporting of pneumonia and influenza mortality. These materials were distributed to city reporters, State Epidemiologists, and other public health surveillance staff. Pneumonia and influenza mortality data from this system are published each week in the MMWR. Information from this system (and others) provides CDC epidemiologists with preliminary information with which to evaluate the impact of influenza on mortality in the United States.
- CDC published the *Summary of Notifiable Diseases, United States* for the years 2002 and 2003. The annual *Summary* highlights public health surveillance findings collected by 50 states, two autonomous reporting jurisdictions (New York City and Washington, D.C.), and five U.S. Territories. These data are reported to CDC's National Notifiable Diseases Surveillance System (NNDSS). Provisional NNDSS data were disseminated in tabular and graphical format each week throughout each year in CDC's *Morbidity and Mortality Weekly Report (MMWR)*.
- The NEDSS Base System is currently "live" in ten states: Nebraska, South Carolina, Tennessee, Texas, Alabama, Oregon, Vermont, Nevada, Virginia, and Idaho. CDC staff are actively involved in training and installation of the system in Arkansas, Maryland, New Mexico, Rhode Island, Maine, Wisconsin, Minnesota, Montana, Wyoming, and New Hampshire.
- Increases in the number, completeness and timeliness of disease reports, a key fundamental in effective public health response, is due in large part to the development of standards-based electronic reporting. This has reduced the burden on CDC's key reporting sources: healthcare providers and laboratories.
- Using the enterprise content management system, CDC launched ATACS (All Threats, Agents Content System) which serves as a specialized password protected repository of sensitive and non-sensitive information for emergency responders in CDC's bioterrorism preparedness program.
- CDC has successfully implemented an electronic workflow application based in the content management system designed to support the Agency's scientific clearance process.

- CDC has successfully launched a public health partner portal aimed at delivering information and services to a broad range of CDC's partners. A critical service offered to public health partners during the flu vaccine shortage was the flu vaccine finder application which allowed local public health officials to track vaccine supplies and distribution in their area.
- CDC has successfully implemented a Public Health Directory system that consolidates information on people, organizations, and public health roles from multiple other sources, serves as a central repository of this information for several new CDC systems, and implements the PHIN standards for electronic directories.
- CDC has contracted with the Federation of State Medical Boards to establish national directory data collection standards for State Medical Boards and protocols for sharing of data with public health agencies, in order to facilitate emergency alerting of private physicians in the event of a public health emergency.
- Developed a series of CDC UP Process Guides that guide project teams through processes required by regulatory mandates and PHIN and CDC standards (e.g., Information Security, Capital Planning, Privacy, Enterprise Architecture, and PHIN).
- The CDC Information Center won the Library Services A-76 competition. The new Library Services MEO achieves efficiencies by reorganizing library services across the agency into a single library system which emphasizes customer service.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$109,193,000 for Public Health Informatics, an increase of \$38,552,000 above the FY 2006 Enacted level of \$70,641,000.

Develop Vaccine Registry to Monitor Vaccine Use (Safety/Efficacy) and Distribution (+\$29.7 million)

The development of a vaccine and antiviral tracking system that includes records of vaccination and the administration of other countermeasures is critical to ensuring that vaccines reach the targeted audience and that antivirals are appropriately administered. In FY 2007, CDC will develop and deploy national capabilities to track and manage the distribution of influenza vaccine and other countermeasures through government purchase, stockpile, or commercial purchase from the point of manufacture through their delivery. CDC will also integrate such information with adverse event monitoring and surveillance tracking.

Real Time Assessment and Evaluation of Interventions (+\$9.9 million)

Models can be an effective and efficient means of anticipating problems and needs, but they are heavily dependent on the availability of complete and current data. Current models of the influence of influenza and the evaluation of interventions are almost always based on old data and thus are frequently incomplete. They also do not account for the need to rapidly redistribute scarce resources such as staff, vaccines, equipment, and information systems.

With increased funding in FY 2007, CDC will improve decision makers' ability to understand the current disease burden, develop predictions, and integrate key surveillance data by enhancing system capabilities in three key ways: 1) collect and collate all suitable existing influenza-related surveillance data from various databases and systems to develop a population-based analysis of disease impact and evaluation of interventions; 2) design and implement robust models that will use these data to provide frequently updated population-based estimates of disease burden and impact of interventions; and, 3) create decision tools based on these data and usable by decision makers at local, state, and national levels.

Pay Raise (+\$0.6 million)

The request includes funds to cover the projected FY 2007 increase.

Administrative and Information Technology (IT) Savings (-\$1.7 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
National Electronic Disease Surveillance System				
States actively engaged in ongoing NEDSS/PHIN-compatible systems integration	21	27	35	8
States developing NEDSS-compatible systems, in deployment, or live with the NEDSS Base System	36	40	50	10

FUNCTIONAL TABLE

Public Health Informatics Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
PHIN	\$9,827	\$4,863	\$4,756	(\$107)
NEDSS	\$24,751	\$24,751	\$24,751	\$0
Vaccine Registry	\$0	\$0	\$29,700	\$29,700
All Other Public Health Informatics	\$41,424	\$41,027	\$49,986	\$8,959
Total -	\$76,002	\$70,641	\$109,193	\$38,552

HEALTH MARKETING

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 308, 307, 310, 311, 317, 318, 319, 319A, 319B, 319C, 327, 352, 391, 1102, 2315, 2341
Clinical Laboratory Improvement Amendments of 1988, §4

Health Marketing (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$43,188	\$42,778	\$42,997	\$219
PHS Evaluation Transfers	\$463	\$463	\$463	\$0
Total	\$43,651	\$43,241	\$43,460	\$219

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$43,460,000 for Health Marketing, an increase of \$219,000 above the FY 2006 Enacted level of \$43,241,000.

PROGRAM DESCRIPTION

CDC's Health Marketing activities reflect CDC's commitment to its direct link with the people whose health we work to improve and protect. This activity uses commercial, non-profit, and public service marketing practices to better understand people's health-related needs and preferences; to motivate changes in individuals and organizations to protect and improve health; and to develop and enhance CDC's partnerships with public and private organizations to more effectively accomplish CDC's health protection goals. Health Marketing focuses on providing people with knowledge that empowers them to make informed personal choices about their health and on developing and improving systems to give people more opportunities to act on those choices.

As applied at CDC, health marketing is a:

- Management function, strategically connecting all activities within CDC – research, surveillance, program services, policy, and communications.
- Creative function, developing and delivering health messages and programs which get people's attention and resonate emotionally to position health as a means of achieving what people really value, such as having energy, staying independent, performing satisfying work and fulfilling emotional and spiritual needs.
- Scientific function, grounded in theory and practice from a number of academic disciplines, operating from an evidence base of effectiveness, and evaluating and improving itself by seeking customer input and feedback rigorously and continuously.

In carrying out these functions, CDC accesses, promotes, and conducts research and analysis on customers, partners, and health intervention approaches; develops and evaluates strategies and methods for providing information, programs, and services; develops and tests communication messages and information and service-delivery programs for public and professional audiences; develops and coordinates high-priority partnerships; manages policy and strategy for CDC's brand identity; delivers CDC information and services to the public; and manages marketing-related shared services (e.g., channels, graphics).

As a whole, these activities:

- Ensure that CDC obtains and analyzes the necessary data about its customers to develop information, interventions, and programs that respond to customers' needs, values, and uses.
- Ensure that CDC employs innovative and rigorous strategies for reaching its customers based on audience and communication research.
- Provide value-added cross-cutting scientific support that ensures that the best available public health science is rapidly and reliably translated into effective practice and policy.

- Ensure efficient, focused use of CDC's resources, expertise and mechanisms for delivering health information and services.
- Ensure that customers will have effective, real-time access to needed health and safety information, interventions, and programs through communication channels they prefer.
- Assure CDC content disseminated through various channels to the public and other targeted audiences is coordinated throughout the agency and is accurate, consistent, accessible, actionable, and evaluated for usability and customer satisfaction.
- Assure CDC's ability to communicate on terrorism and non-terrorism health events with timely, accurate and effective information to the public and targeted audiences.
- Ensure CDC, states, and other clinical and public health partners have a secure network to rapidly share, discuss, and analyze emerging information about potential threats and outbreaks.
- Ensure effective strategic partnerships and alliances to extend CDC's reach for effective health protection.
- Increase public awareness and partner actions to enhance the public health infrastructure.
- Help people understand what public health is as well as its relevance and value to people across all life stages.
- Promote and facilitate efforts to measure progress toward agency goals and evaluate the impact of agency programs.

Achieving CDC's health impact goals requires vigorous and active partnerships with state and local health agencies as well as with organizations representing those agencies. Through sector management, Health Marketing is providing a distinct focus on our public health partners, identifying their priorities and developing strategies for efficient and effective working relationships.

Many activities essential to disease prevention and health promotion occur outside of the traditional public health sector, such as in businesses, health care organizations, educational institutions, other federal agencies, and faith-based and community organizations. CDC has developed a systematic agency-wide approach to engage these organizations in CDC's health impact goals. With a special focus on private and public partnerships, the Health Marketing activity provides staff and resources to enable the agency to engage these sectors more rapidly and effectively in health promotion and disease prevention.

CDC's Health Marketing activity provides leadership in the development of CDC principles, strategies, and practices for effective communication to the public and other key CDC audiences for health promotion and disease prevention. It also functions as a CDC-wide forum for discussion, development, and adoption of emergency and "long-lead" (e.g., feature magazine articles and television drama storylines) health communication policies and procedures.

CDC's Health Marketing activity supports the development of high quality educational products to effectively deliver messages to professional and public audiences about crosscutting, emergency, and public health programs. This support includes designing and producing visual materials; managing the inventory, archiving and distribution of selected photo and other graphic images through the Public Health Image Library (PHIL); planning, producing, broadcasting, and archiving instructional television products; providing both scientific and general photographic services; and supporting translation of agency materials to multiple languages. Outreach via the Web is managed for special audiences, such as the CDC en Español Web site for Spanish-speaking audiences. Use of television broadcast technology is being planned to reach public and professional audiences through HHS- and eventually CDC-TV. The Public Health Training Network (PHTN) was developed over the past decade as a national distance learning network to provide access to training for public health workers in all disciplines.

CDC's main channel to communicate public health news about disease outbreaks and trends in health and health behavior is a family of publications that includes the *Morbidity and Mortality Weekly Report (MMWR) Weekly*, *MMWR Recommendations and Reports*, *MMWR Surveillance Summaries*, *MMWR Supplements*, and the *MMWR Summary of Notifiable Diseases*. These reports are the principal mechanisms for communicating public health information to state and local health agencies, health care providers and other health-related groups. All *MMWR* publications are published in hard copy but can be published online as *MMWR Dispatches* or *Early Releases* at any time during episodes of critical public health need.

CDC engages in applied research and methods development activities in various areas such as economic analysis, systematic reviews, performance measurement, burden of disease estimation, and intervention implementation and evaluation. Through close collaboration with an independent non-federal Task Force on Community Preventive Services and numerous other scientific and public health partners, CDC produced the *Guide to Community*

Preventive Services (Community Guide) to evaluate and communicate state of the art knowledge about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease.

The goal of the Health Marketing activity is systematically to change health-relevant attitudes, knowledge, and actions of organizations and individuals to protect and improve health.

PERFORMANCE ANALYSIS

Current Activities

- Developing and establishing a systematic approach that will identify, monitor and evaluate gaps in the public health system and guide public health systems research to address CDC's prevention and health promotion objectives effectively.
- Promoting excellence in domestic and international laboratory practices and service through a quality systems approach and expands relationships representing public health and private sector laboratories. These efforts provide essential support for public health programs as well as information addressing individual health care needs.
- Working with the Association of Public Health Laboratories to continue developing the National Laboratory System (NLS), an enhanced communication and collaboration network among public health and clinical laboratories. The NLS facilitates effective detection of public health threats and provides timely reports of such threats to minimize any negative impact of such health events.
- Maintaining the National Laboratory Database (NLD), a database that provides demographic and testing capability information on the more than 190,000 clinical laboratories in the United States, in collaboration with CMS and the Veterans Administration. The NLD enhances state public health laboratories' ability to identify, communicate, and share relevant data and information with other laboratories in their states.
- Developing a comprehensive database of public and private partnerships to provide access to descriptive information on federal, state, local, tribal and private organizations that currently have funded or collaborative partnerships with the agency. This repository of information enables CDC to strategically connect all activities within CDC and is an important vehicle to examine programmatic linkages and develop key strategies to meet health goals. In FY 2007, CDC will provide public access to the database to enable external partners to develop an understanding of the comprehensive nature of CDC linkages with public health systems.
- Building and engaging a network of influential organizations across the sectors of society to work with the CDC on health promotion and emergency preparedness. The network consists of key organizations representing business, educational, healthcare, faith-based and community organizations. The network also includes other federal agencies. Work with these organizations includes assessing the needs of their sectors for health information and services, and then producing and delivering those services. Developing within CDC a network of primary points of contact - called partner coordinators - for the external partners in each sector. Developing a database providing detailed information about CDC's external partners. A Partnership Tool Kit is being finalized for CDC staff to serve as a resource in creating effective partnerships. This will be available in hard copy and on the intranet.
- Work is exemplified by activities for pandemic influenza preparedness. Working with influential partner organizations in the various sectors to assess the pandemic influenza preparedness needs of those sectors. Responded to the most immediate needs by quickly developing pandemic influenza preparedness checklists to meet the needs of specific constituencies - businesses, local education agencies (K-12), colleges and universities, medical offices, home health care agencies, emergency medical services, child care organizations, and faith-based and community organizations. Currently working to developed more detailed and specific guidance for each of the sectors through the production of toolkits that will be available on-line.
- Hosting and maintaining the Web-based PHTN calendar of nationwide satellite and Web cast programs. The calendar is a well-known national clearinghouse for health-related distance learning programs including more than two dozen on terrorism-related topics such as anthrax, ricin, and smallpox as well as epidemic threats such as SARS and West Nile virus.
- Providing safety and health-related information in dozens of languages other than English to improve compliance with Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." Spanish to English and English to Spanish translations are provided internally. A variety of other language translations are made available via the use of Blanket Purchase Agreements. Multilingual services at CDC assure that all translations distributed for public access are reviewed, edited as needed,

certified as accurate and of the highest quality, and consistently follow terminology approved across the agency to help assure uniformity of product quality and writing style.

- Receive, on average, 13 to 15 million hits per month on the MMWR Web site. During times when there are urgent public health concerns, such as during the height of SARS outbreak and the outbreak of monkeypox in early 2003, the number of hits increases dramatically.
- Distributing the MMWR in paper and electronic format to more than two million persons annually.

Significant Accomplishments

- Developed an international HIV rapid testing training package for worldwide distribution in co-sponsorship with the World Health Organization. The training package provides the tools and information needed to create a country-specific rapid HIV testing training program.
- Expanded the Model Performance Evaluation Programs (MPEP), quality assessment programs for AIDS-related laboratory tests such as HIV and tuberculosis, to include a SARS survey. Approximately 1,500 U.S. public and private laboratories and more than 330 laboratories in 102 countries are enrolled in MPEP.
- Supported the Institute for Quality in Laboratory Medicine (IQLM), a partnership of over 70 organizations representing approximately 350,000 physicians and 200,000 laboratory professionals. IQLM, the only established organization to utilize a broad representation of stakeholders to promote improvements in laboratory testing and services to benefit public health, is now incorporated as a public-private partnership in the State of Virginia.
- Supported the development of a National Center for Public Health and Faith Collaborations at Emory University's Rollins School of Public Health as part of the White House's Faith-Based and Community Initiative. The overall purpose of the new center is to serve as a global hub for strengthening the partnership among CDC, Faith-Based Organizations, State and local governments, and other key national and international organizations so that they can align their unique assets to build capacity and advance knowledge to promote and protect the public's health.
- Published CDCynergy (an evidenced-based communication planning guide) in 13 customized versions (e.g., Basic Edition, Emergency Risk Communication, Social Marketing, violence prevention, diabetes prevention and special editions for tobacco prevention, micronutrients, cardiovascular health, immunizations, diabetes, STD prevention), with three editions in production (malaria, environmental health, and 5-A-Day among American Indians/Alaska Natives).
- Ensured that CDC information related to key health crisis situations in 2005 – most notably, the U.S. influenza vaccination shortage, the December 26 earthquake and tsunami, California mudslides, Washington, DC anthrax attacks, Viral Hemorrhagic Fever/Marburg Virus Outbreak, TOPOFF 3, and Hurricanes Katrina and Rita, – was accurate, internally consistent, timely, and coordinated with CDC partners responding to these emergency events through the ECS.
- Posted 1,778 reports of outbreaks, Epi-Aids, and notification tests including reports on avian and pandemic influenza, anthrax, plague, tularemia, polio in the United States, imported measles, and responses to hurricanes Katrina and Rita, to date through Epi-X. Epi-X staff successfully evaluated the terrorism and non-terrorism emergency preparedness aspects of Epi-X through participation in the TOPOFF 3 exercise and unannounced notification testing in all 50 states and three major metropolitan areas.
- Produced 30 interactive satellite-based instructional programs, 28 videos, and 42 instructional multimedia programs reaching more than 250,000 public and private health workers at state and local levels since 2003 through the PHTN. These competency-based programs carry professional accreditation for clinicians, nurses, health educators, and other professionals.
- Published 12 issues of MMWR Recommendations and Reports, 7 issues of MMWR Surveillance Summaries, and 1 supplement in FY 2005. In addition, MMWR has published 14 MMWR Recommendations and Reports and 8 MMWR Surveillance Summary as well as continued weekly reports, 1 MMWR Supplement, 11 MMWR Dispatches, and 4 Early Release.
- Published (through Oxford University Press) a book version of the *Community Guide* including approximately 120 public health interventions and policies in January 2005. This book version will become the gold standard for evidence-based public health and will serve as a primary resource for helping to improve health and prevent disease in states, communities, local organizations, health care organizations, worksites, or schools.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$43,460,000 for Health Marketing, an increase of \$219,000 above the FY 2006 Enacted level of \$43,241,000.

Pay Raise (+\$0.6 million)

The request includes funds to cover the projected FY 2007 increase.

Administrative Savings (-\$0.4 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of MMWR Publications	76	86	90	4
Number of Published <i>Community Guide</i> Findings annually	25	30	32	2
Public Health Communications				
Number of monthly visits to CDC Web site	11.5 million	13 million	15 million	2 million
Customer satisfaction with CDC Web site	74%	75%	76%	1%
Number of monthly calls to 800-CDC-INFO	48,000	50,800	93,600	42,800
Customer satisfaction with 800-CDC-INFO	N/A	68%	72%	4%
Public health workers trained in CDCynergy	N/A	175	425	250
Programs produced for broadcast on PHTN and/or CDC-TV	17	27	30	3
CDC-wide priority campaigns coordinated through Executive Communications Council	2	3	5	2
Reports of outbreaks reported by Epi-X	1,400	1,475	1,500	25
Public Health, Public, and Private Partnerships				
Partners included in partnership coordination database	60	100	250	150
CDC users of partnership coordination database	30	38	39	1

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

ENVIRONMENTAL HEALTH AND INJURY PREVENTION

Environmental Health and Injury Prevention (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$289,432	\$289,021	\$279,309	(\$9,712)

INTRODUCTION

The Environmental Health and Injury Prevention budget activity is responsible for the planning, direction, and coordination of national and global public health research and programs that maximize health and minimize illness, disability, and/or death caused by environmental exposures or injuries. In carrying out this mission, CDC promotes excellence in public health science and programs across all activities related to Environmental Health and Injury Prevention, assures the establishment of priorities related to Environmental Health and Injury Prevention goals, coordinates their alignment with CDC and HHS priorities, and assures that Environmental Health and Injury Prevention resources are aligned with these priorities and goals. CDC also identifies synergies related to environmental health and injury prevention and control across CDC while assuring that CDC meets statutory and mandated requirements.

Many of the public health successes that were achieved in the 20th century can be traced to innovations in environmental health practices. However, emerging pathogens and environmental toxins continue to pose risks and significant challenges to public health. The task of protecting people's health from hazards in their environment requires a broad set of tools. Principal among these tools is surveillance and data collection to determine which substances in the environment are affecting people and to what degree. The determination must be made as to whether these substances are harmful to humans and at what level of exposure.

CDC is the lead federal agency for injury prevention and control. Programs are designed to prevent premature death and disability and reduce human suffering and medical costs caused by fires and burns; poisoning; drowning; violence; lack of bicycle helmet use; lack of seatbelt and proper baby seat use; and other injuries. Injury prevention and control activities at CDC encompass non-occupational injury and applied research in acute care and rehabilitation of the injured. Funds are utilized for both intramural and extramural research as well as assisting state and local health agencies in implementing injury prevention programs.

ENVIRONMENTAL HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 317A, 317B, 317I, 327, 352, 1102; Housing and Community Development Act, §1021 (15 U.S.C. 2685).

Environmental Health (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$151,195	\$149,985	\$141,095	(\$8,890)

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$141,095,000 for Environmental Health, a decrease of \$8,890,000 below the FY 2006 Enacted level of \$149,985,000.

PROGRAM DESCRIPTION

CDC's Environmental Health program was established in 1980 to focus on preventing disability, disease, and death caused by environmental factors. Today, CDC uses a combination of science, service, and partnerships to protect human health from environmental hazards by investigating the effects of the environment on health through laboratory and field research; tracking and evaluating environment-related health problems through surveillance systems; developing and implementing interventions and preventative actions; and assisting domestic and international agencies and organizations to prepare for and respond to environmental emergencies. CDC recently consolidated its Offices of the Director for the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry. The two public health programs now share a management team and support staff.

CDC's Environmental Health program achieves its overall mission via multiple systems and interventions:

Through its Environmental Hazards and Health Effects Program, CDC investigates the human health effects of exposure to environmental hazards ranging from *Pfiesteria* and other harmful algae, chemical pollutants, air pollutants, mold, and radiation to natural, technological, or terrorist disasters. The results of these investigations are used to develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their consequences.

Biomonitoring is the standard for assessing the exposure of people to toxic substances. It consists of measuring the levels of environmental chemicals in people's blood, urine, or other biological sample. For more than three decades, CDC laboratory scientists have been determining which environmental chemicals people have been exposed to, how much of these chemicals enter their bodies and stay long enough to be detected, and what levels of chemicals in their bodies are related to health effects.

CDC established its National Environmental Public Health Tracking Program during FY 2002. The program's general aim is to provide federal, state, and local agencies with data that will enable them to be better prepared to develop and evaluate effective public health actions related to preventing or mitigating health effects from exposure to environmental hazards. The data will also help health care providers offer more targeted and preventive services. In addition, the data facilitate better public understanding of health trends and events in their communities and of actions they can take to protect and improve their health.

CDC's National Asthma Control Program was developed to assist people with managing their asthma. Although the cause of asthma is unknown, genetic and environmental factors are thought to be involved. Currently, no known method prevents the initial onset of asthma, and there is no cure. However, much is known about how to control asthma. CDC supports asthma data tracking, interventions and partnerships nationwide. CDC's National Asthma Control Program aims to reduce the number of deaths, hospitalizations, emergency department visits, school or workdays missed, and limitations on activity due to asthma.

Childhood lead poisoning remains a major preventable environmental health problem, especially among poor, inner-city and minority children. Childhood lead poisoning was recognized as a public health crisis in the United States between the years of 1976–1980, when analysis of blood lead levels (BLLs) in children from the *National Health and Nutrition Examination Survey II* (NHANES II) revealed that 88 percent of children from one to five years of age had BLLs of 10 micrograms per deciliter (µg/dL) or higher. Children from low-income backgrounds, especially racial and ethnic minorities living in substandard, poorly maintained housing built before 1950, are at highest risk for lead exposure.

Public Law 99-145 (1986) requires HHS/CDC to review the Department of Defense’s (DOD’s) “particulars and plans” for the transportation and disposal of lethal chemical weapons and provide recommendations to protect the public health. CDC’s goal is to continue to prevent potential exposures to, and health effects from, nerve and blister agents among workers and the surrounding communities.

Environmental Public Health Services (EPHS) activities strive to strengthen the role of state, local, and national environmental public health programs and professionals to better anticipate, identify, and respond to adverse environmental exposures and the consequences of these exposures to human health. EPHS, though necessary at all levels, are mainly carried out at the local level (i.e., food safety, vector control, water and sanitation, indoor air quality, etc.) and are provided by front-line environmental public health professionals.

Finally, the International Emergency and Refugee Health Program (IERHB) uses public health and epidemiology to reduce the impact of complex humanitarian emergencies (CHEs) on the health of civilian populations.

CDC’s environmental health efforts support the Secretary’s 500-Day Plan in the area of research, where interdisciplinary and interagency collaboration in scientific pursuits is the standard and broad scientific advances measurably reduce the burden of all chronic diseases.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Environmental Health activity, the following performance measures have been selected as highlights of the program’s performance plan.

Performance Goal	Results	Context
1. Number of environmental chemicals, including nutritional indicators that are assessed for exposure of the U.S. population.	230	Currently, CDC can measure at least 300 chemicals or their metabolites in human blood or urine. However, not all of these are yet measured in specimens obtained from participants in the National Health and Nutrition Examination Survey (NHANES.) For FY 2005, the exposure results for the U.S. population for 230 environmental chemicals will be reported to the National Center for Health Statistics, which administers NHANES. CDC publicly released data on 148 chemicals in the U.S. population in July 2005 by publishing the <i>Third National Report on Human Exposure to Environmental Chemicals</i> . The Report is published every two years, with the <i>Fourth Report</i> expected in 2007.

Performance Goal	Results	Context
2. Number of children under age 6 with elevated blood lead levels.	The percentage of children with BLLs over 10 µg/dL has decreased from an estimated 4.4 percent in NHANES III (1991–1994) to the 1.6 percent estimated in the <i>Third Report</i> (1999–2002).	Childhood lead poisoning remains a major preventable environmental health problem. Children from low-income backgrounds, especially racial and ethnic minorities living in substandard, poorly maintained housing built before 1950, are at highest risk for lead exposure.

Current Activities

- CDC assesses people's exposure to environmental chemicals as part of meeting its goal to determine human health effects associated with such exposures. Examples of work in this area include the following:
 - Evaluated exposure of the U.S. population to 230 environmental chemicals and nutritional indicators.
 - Analyzed blood levels of folate, vitamin B-12, homocysteine, and methylmalonic acid in the U.S. population before and after the folic acid fortification of cereal-grain products began in 1998. Adequate levels of folic acid in women prevent birth defects. CDC scientists determined that every segment of the U.S. population appears to benefit from folic acid fortification. Continued monitoring of B-vitamin concentrations in the U.S. population is warranted.
- CDC is developing new methods for measuring human exposures to help meet its goal of determining the human health effects of environmental exposures. For example, during FY 2005 CDC published laboratory methods for measuring perchlorate, aflatoxin, perfluorinated chemicals, and bisphenol A and other environmental phenols in people. CDC scientists also developed methods that measure free nicotine and heavy metals in tobacco smoke.
- CDC launched the Newborn Screening Translational Research Initiative, which is aimed at developing new screening methods for specific diseases affecting newborns. This initiative, along with CDC's continuing efforts to ensure quality standards in 904 laboratories throughout the country and in nations around the world, helps meet the goal of determining human health effects associated with environmental exposures. CDC certifies quality standards for tests such as newborn screening; blood lead, cadmium, and mercury; those predictive of type 1 diabetes; and nutritional factors.
- CDC meets its goal of determining the human health effects associated with environmental exposures by conducting or collaborating on a variety of scientific studies. Example activities include the following:
 - Funding and working with state, local and other federal public and environmental health agencies, universities, research organizations, national organizations and others to identify, investigate, and track environmental hazards; measure exposure of people to these hazards; and prevent health effects from these hazards. Hazards include radiation, chemicals, air pollutants (e.g., carbon monoxide and mold), and water contaminants (e.g., algal toxins and chemicals).
 - Teaming with academic institutions, state health departments, and other partners on 58 studies. For example, CDC analyzed human samples for approximately 150 chemicals for an investigation of a cluster of cases of acute lymphocytic leukemia among children living in Sierra Vista, Arizona.
- CDC is funding 21 state and local health departments, three cities, and four schools of public health to build a sustainable National Environmental Public Health Tracking Network; enhance environmental public health tracking workforce and infrastructure; disseminate information to guide policy, practice, and other actions to improve the nation's health; advance environmental public health science and research; and foster collaboration among health and environmental programs.
- CDC's Environmental Health Laboratory collaborated on 58 environmental health studies in FY 2005. This research is critical in helping to meet the goal of determining the human health effects associated with exposures to environmental chemicals. In addition, CDC provided measurements for research studying genetic susceptibility, nutritional factors, and selected chronic diseases. For example, CDC is working with researchers from the University of Rochester to examine the health effects of exposure to phthalates among pregnant women and their children. Phthalates are commonly used in consumer products as solvents and to soften plastics. Phthalates are also found in soft vinyl plastic toys; medical tubing and fluid bags; and in a variety of cosmetics such as perfume, lotions, shampoo, make-up, nail polish, and hairspray. This research identified, for the first time, an association between pregnant women's exposure to phthalates and adverse effects on development in male children.
- CDC's National Asthma Control Program funded grantees in 35 states, the District of Columbia, Puerto Rico, and a number of other partners—including other federal agencies, universities, and national organizations—to meet its goal of preventing and reducing illness and asthma-related hospitalizations. Efforts to accomplish this goal include health education, research, intervention, tracking, and other programs. Sample projects include:
 - Supporting collection of in-depth state and local asthma data through development and testing of a National Asthma Survey module. In 2005, eight states (Alabama, California, Illinois, Minnesota, Michigan, Oregon, New York, and Texas) were in various phases of implementing the module .

- Supporting state efforts to evaluate their state asthma control programs and activities by developing evaluation guidance and plans.
- Providing evaluated intervention resources on the internet and funding grantees to conduct projects related to evaluated interventions, such as replication and implementation of scientifically proven asthma interventions.
- Partnering with national organizations (e.g., the American Lung Association, the Asthma and Allergy Foundation of America, and the Allergy and Asthma Network Mothers of Asthmatics) to conduct asthma education. These activities range from identifying effective educational programs for adults to educating asthmatic children as well as their families and caregivers.
- CDC provides technical assistance, public health training, and evaluation of responses to large-scale public health emergencies. This work helps to meet the goal of preventing or reducing environment-related injuries and deaths. CDC's efforts include the following projects:
 - Coordinating CDC's response to several public health emergencies, including those resulting from the flight of refugees from Sudan; the Indonesian tsunami; the war in Iraq; and Hurricanes Katrina and Rita.
 - Providing technical assistance to other federal agencies, the United Nations, and other organizations in protecting the health of people affected by international complex humanitarian emergencies (CHEs), applying epidemiological and public health principles to the study of CHEs, working with international partners to identify the number and nature of landmine-related injuries and deaths, providing technical assistance and training in public health emergency planning, and conducting training for constituents at CDC, educational institutions, and international organizations.
 - Providing public health-related training on nutrition, water, and sanitation for the U.N. and international nongovernmental organizations (NGOs). CDC has training courses planned in Cambodia for UNICEF mine-action workers and in Thailand for Work Food Program staff;
 - Developing a distance-learning program to increase field-level capacity to respond to CHEs. These training courses will significantly increase the capacity of the U.N. and international NGOs to respond to emergencies and appropriately target donor aid.
 - Conducting and evaluating the impact of health responses to CHEs. CDC is currently a key partner in a multinational effort to provide an evaluation framework for health interventions in CHEs. CDC continues to support missions in war-affected countries to refine methods that will help aid providers to better target their interventions.
- CDC funded 14 cooperative agreements in 11 states to help meet its goal of helping states and tribal governments to improve their environmental public health services. This funding went to state and local public health departments and to academic centers as part of CDC's effort to support its National Strategy to Revitalize Environmental Public Health Services. For example, CDC:
 - Funded three state public health departments (New York, New Hampshire, New Mexico [representing a consortium of six states: Arizona, Colorado, Montana, New Mexico, Utah, and Wyoming]) to conduct biomonitoring for chemicals of interest within their borders;
 - Provided technical assistance and information to a total of more than 3800 state, local, and tribal environmental health programs throughout the U.S.; and
 - Responded to states' requests for technical assistance in conducting environmental outbreak investigations, hazard evaluations, or community environmental assessments.
- CDC funds five schools of public health to meet its goal of training environmental public health services professionals. Activities include the following:
 - Training state and local health officials in developing effective environmental public health programs aimed at improving response to current and emerging public health threats. This training also advances public health practice by expanding the science base in environmental public health.
 - Providing training through workshops, conferences, web casts, and meetings on a variety of topics, including water quality, food safety, terrorism, vector management, healthy homes, systems-based problem solving during hazard evaluations, and outbreak investigations.

Significant Accomplishments

- Published CDC's *Third National Report on Human Exposure to Environmental Chemicals (Third Report)*, which contained data on 148 chemicals. Data published in the *Third Report* document the success of public health interventions in reducing exposure to environmental chemicals on several fronts:
 - Exposure of nonsmokers to secondhand tobacco smoke has declined. Levels of a chemical called cotinine, a marker of exposure to secondhand smoke in nonsmokers, have dropped significantly since levels were first measured from 1988–1991. Compared with median levels for 1988–1991, median cotinine levels measured from 1999–2002 have decreased 68 percent in children, 69 percent in adolescents, and about 75 percent in adults.
 - Results from the Third Report show undetectable or very low serum levels of the pesticides aldrin, endrin, and dieldrin. These three pesticides are similar and were once used widely as insecticides in agriculture. Production and use of endrin was discontinued in 1986. Agricultural uses of aldrin and dieldrin were discontinued in the United States in 1970, and their use for termite control ended in 1987. While these pesticides are no longer used in the U.S., they are still in use elsewhere.
- Developed methods to measure additional substances, among them acrylamide, speciated forms of arsenic and mercury, perchlorate, copper, and polybrominated diphenyl ethers. CDC scientists also developed methods to measure perfluorinated compounds in serum and fuel oxygenates in whole blood and in tap water.
- Developed 18 new laboratory methods to measure human exposure to additional priority chemicals and nutritional indicators. Among these advances are methods that allow measurement of free nicotine and heavy metals in tobacco smoke.
- Ensured that laboratory quality standards are maintained in certified or participating laboratories. In FY 2005, 904 laboratories participated in quality assurance or clinical laboratory certification programs.
- Supported 21 environmental public health tracking assessments examining the possible association between a health effect and an environmental exposure and/or hazard. These data led to 21 interventions. One tracking effort in New York City (NYC) helped in the discovery of a patient with a high level of mercury poisoning. The patient was found to have used one of several commonly available, but illegal, skin lighteners that list mercury as the active ingredient. The city's health department launched a wider investigation into the use of this skin lightener in the city, worked with the FDA laboratory, and confirmed heavy mercury content in six commonly available skin-lightening products. NYC issued alerts and press releases to health care practitioners. NYC also ordered 163 stores to stop selling the products and provide it with names of distributors. These assessments will help lay the groundwork for a National Environmental Public Health Tracking Network.
- Funded partnership with the Illinois Department of Public Health, which tracked the presence of trichloroethylene and perchloroethylene in drinking water from wells near an industrial site in DuPage County. The findings led to the passage of a bill that ensures communities' right-to-know about potentially dangerous local environmental threats. The bill also provides new power to expedite cleanup when the public may be at risk of exposure to contaminants. In addition, the Governor signed legislation establishing a Children's Environmental Health Officer charged with protecting children from environmental hazards.
- Responded to large-scale public health emergencies following major hurricanes during 2004 and 2005. During these events, CDC personnel extensively supplemented state and local public health staff by performing vital services when normal operations were disrupted. During the Katrina response, for instance, CDC provided rapid assessments of environmental public health needs and deployed numerous personnel to perform critical tasks, including health surveillance, assessments of drinking water safety, evaluation of chemicals carried in the floodwaters, and many other services.
- Completed 44 studies to determine the harmful health effects from environmental hazards. These studies focused on the health effects of air pollutants such as carbon monoxide, water contaminants such as algal toxins, chemicals, and radiation.
- Helped develop and disseminate the "National Asthma Training Curriculum" for the public health workforce. The training covers asthma pathophysiology and diagnosis, management, epidemiology, surveillance, education for patients, providers, and the public, and administration of asthma public health programs.
- Provided technical assistance to states that did not receive grant funds for addressing childhood lead poisoning. For example, the program's work with Mississippi resulted in the first ever submission of Mississippi blood lead surveillance data to CDC. Also provided technical assistance to Mississippi in developing its strategic plan for elimination of childhood lead poisoning.

- Reduced the percentage of children with blood lead levels above the 10 µg/dL threshold. This figure has declined from an estimated 4.4 percent 1991–1994 to 1.6 percent in 1999–2002.
- Developed and validated method to measure aflatoxin in human serum. This method was used for the Kenya aflatoxin epidemic. CDC also facilitated identification of public health strategies and a research agenda for preventing aflatoxin exposures from contaminated food crops.
- Promoted a nationwide measles campaign in Liberia which has immunized 1.3 million children to date. Coverage surveys estimate that over 90 percent of children have been vaccinated. An estimated 20,000 deaths among children less than five years of age have been averted through this campaign.
- Conducted the first emergency nutrition and mortality survey of refugees from the Darfur region of Sudan. The survey found acute malnutrition at rates of up to 39 percent in refugee camps and border settlements. CDC found that, among children ages 6 months to 5 years in refugee camps and border settlements, 35–58 percent have diarrheal diseases, and measles vaccination is inadequate (ranging from 24–83 percent in the camps and settlements) to prevent outbreaks. This data has been used to guide U.S. government humanitarian activities in the region and to improve allocation of resources.
- Responded to the public health crisis caused by the December 2004 Indian Ocean earthquake and resulting tsunami. CDC continues to coordinate a measles vaccination campaign on the Indonesian island of Aceh. To date, the campaign has vaccinated over 250,000 children against the deadly disease. CDC staff also conducted the first health facilities assessment in Indonesia following the disaster and provided mental health support to hundreds of relief workers, medical staff, and mortuary staff in Thailand.
- Responded to a Congressional request to analyze the Army's proposal for off-site treatment and disposal of caustic VX hydrolysate from the Newport, Indiana, Chemical Agent Stockpile Disposal Facility. The final analysis is expected by summer 2006.
- Provided public health oversight of the Army's successful start-up of the disposal facilities in Anniston, Alabama and in Pine Bluff, Arkansas.
- Worked on issues at all of the four incineration and two neutralization sites dedicated to disposing of chemical weapons. While several serious incidents occurred during the year, there were no deaths or serious injuries associated with chemical agents.
- Developed and distributed to all state, local, and tribal public health agencies information related to the 10 Essential Environmental Public Health Services and a guide for local environmental public health practitioners to use when inspecting swimming pools.
- Funded eight states related to CDC's Environmental Health Specialists Network (EHSNet) which collaborates with epidemiologists and laboratorians to identify and prevent environmental factors contributing to food-borne and water-borne illness and disease outbreaks.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$141,095,000 for Environmental Health, a decrease of \$8,890,000 below the FY 2006 Enacted level of \$149,985,000.

Pay Raise (+\$0.4 million)

The request includes funds to cover the projected FY 2007 increase.

Program Reductions (-\$8.4 million)

The FY 2007 President's Budget proposes reductions to activities that are outside the scope of CDC's mission to focus on primary prevention. Included in this reduction is CDC's Pfiesteria program. The budget also proposes reductions to fund base activities at FY 2006 President's Budget levels.

Administrative Savings (-\$0.9 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
New or improved methods developed for measuring environmental chemicals in people	18	16	16	0
Clinical laboratories certified for measuring Lipids, Newborn Screening, Blood Lead, and Urinary Iodine	982	990	1001	11
EHHE Health Tracking Data (number of states)	14	10	10	0
Laboratory studies conducted to measure levels of environmental chemicals in exposed populations	58	50	50	0
Funded state and local lead programs that develop and implement elimination plans ¹	42	43	43	0
State, local, and territorial programs funded to develop or implement comprehensive asthma control plans	35	35	35	0
States with Web-based systems to track children's blood	10	10	10	0
States assisted with screening newborns for preventable diseases	50	50	50	0
Number of nations with surveillance systems to detect injuries and death related to landmines and unexploded ordinance	6	8	8	0
Professionals trained to provide public health services in complex humanitarian emergencies	466	500	500	0
Percentage of nations with unified and coordinated strategy for responding to international health emergencies	10	12	12	0
Percentage of chemical stockpiles that are disposed of without serious injuries or deaths from chemical agents	100	100	100	0
Percentage of agencies trained to improve their environmental health services programs	25	86	86	0
Percentage of agencies who have demonstrated improvement in the environmental health services program	25	86	86	0

¹This is an estimate based on past grant information. State and local programs are currently submitting proposals to a new RFA.
*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

NARRATIVE BY ACTIVITY
 ENVIRONMENTAL HEALTH AND INJURY
 ENVIRONMENTAL HEALTH

FUNCTIONAL TABLE

Environmental Health Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Environmental Health Laboratory	\$27,564	\$27,064	\$26,878	(\$186)
Environmental Health Activities	\$54,735	\$54,916	\$46,694	(\$8,222)
Asthma	\$32,422	\$31,994	\$31,776	(\$218)
Childhood Lead Poisoning	\$36,474	\$36,011	\$35,747	(\$264)
Total -	\$151,195	\$149,985	\$141,095	(\$8,890)

INJURY PREVENTION AND CONTROL

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 319, 327, 391-394A; Sec. 413 of the Keeping Children and Families Safe Act of 2003.

Injury Prevention and Control (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$138,237	\$139,036	\$138,214	(\$822)

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$138,214,000 for Injury Prevention and Control, a decrease of \$822,000 below the FY 2006 Enacted level of \$139,036,000.

PROGRAM DESCRIPTION

Injuries are the leading cause of death among children and adults under 44 years of age in the U.S. In 2002, more than 161,000 people died from injuries and violence, and nearly 30 million people sustained injuries serious enough to require treatment in an emergency department. Many injured people are left with long-term disabilities. The total lifetime costs associated with both fatal and nonfatal injuries is estimated to exceed \$260 billion.

CDC works to prevent premature death and disability and to reduce the human suffering and medical costs caused by injuries and violence. To prevent injuries and minimize their consequences when they occur, CDC uses the public health approach to define the injury problem, identify risk and protective factors, develop and test prevention strategies, and ensure the widespread adoption of effective strategies.

CDC funds public health research on injury prevention and control as outlined in the Injury Research Agenda. Focus areas include: injuries in the home and community; injuries in sports, recreation, and exercise; transportation injuries; intimate partner violence, sexual violence, and child maltreatment; suicidal behavior; youth violence; and acute care, disabilities, and rehabilitation. Research identifies effective strategies to prevent injuries, strategies that must then be widely disseminated. In line with the Secretary's 500 Day Plan, Injury research is an interdisciplinary and interagency collaboration.

CDC supports injury prevention programs at the state and local level and works to build injury prevention and control capacity. This is particularly important to protect vulnerable populations and improve outcomes for those who have been injured. A robust injury prevention infrastructure at the state and local level will help the dissemination and implementation of programs proven to prevent disability and death. CDC's youth violence and injury prevention programs are in support of the First Lady's Initiative on Making a Difference for America's Youth.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Injury Prevention and Control activity, the following performance measure has been selected as a highlight of the program's performance plan:

Performance Goal	Results	Context
1. Among the states receiving funding from CDC, reduce deaths from residential fire.	In FY 2002, residential fire deaths, among states receiving funding for residential fire prevention activities, were reduced to 1.15/100,000 people	CDC funds 16 states to continue smoke alarm installation and fire safety education programs in high-risk communities, where fire death rates are higher than state and national averages and median household incomes are below the poverty level. A survey of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that approximately 1,053 lives have been saved to date.

Current Activities:

- State Injury Prevention and Control Programs: CDC funds 30 states to build basic injury prevention programs, including the planning, implementation and integration of comprehensive injury prevention and control activities with basic injury surveillance activities, including traumatic brain injury (TBI) surveillance. CDC also supports efforts in six states to gather more in-depth information about the incidence of TBI using state-wide hospital discharge and emergency department data, and/or to provide individuals who have sustained a TBI with information about available services in their state.
- Rape Prevention and Education: CDC addresses rape prevention by supporting every state, Washington, D.C., Puerto Rico, and seven territories through the Rape Prevention and Education grant program. CDC provides resources and assistance to states and territories for rape prevention and education programs conducted by rape crisis centers, state sexual assault coalitions, and other public and private nonprofit entities. CDC assists state and coalition staff through training opportunities, support for the National Sexual Violence Resource Center, and research to learn what works in preventing rape.
- Intimate Partner Violence Prevention Programs: The Domestic Violence Prevention Enhancement and Leadership through Alliances (DELTA) program is funded by CDC in 14 states. DELTA supports state domestic violence coalitions to provide prevention-focused technical assistance, training, and funding to local communities. CDC is also funding two projects for the prevention of sexual violence and intimate partner violence among racial and ethnic minority populations. The focus is on working with men and boys in culturally appropriate ways to prevent sexual violence and intimate partner violence before it occurs. In addition, intervention and evaluation trials are funded by CDC in four sites to test intervention strategies to prevent intimate partner violence and its negative consequences.
- Preventing Child Abuse and Neglect:
 - Focusing on adult and community responsibility to prevent the perpetration of child sexual abuse by Funding three states (Georgia, Massachusetts, and Minnesota) to create collaboratives. The collaboratives complement existing programs that focus on victim identification and services in order to build a comprehensive approach to child sexual abuse.
 - Supporting three national organizations for the BECAUSE (Building and Enhancing Community Awareness United for Safety and Empowerment) Kids Count! Program to build or expand their capacity and the capacity of their state, local, and/or regional affiliates to address the prevention of child maltreatment, which includes physical abuse, emotional abuse, neglect, and sexual abuse.
 - Applies public health approaches to the prevention of violence perpetrated toward or among children and adolescents so that it is raised as a public health priority within the state, through CDC funding and support for eight state health departments. This project focuses on identifying strategies at the individual, relationship, community, and societal levels that would reduce shared risk and enhance shared protective factors for violence affecting children and adolescents.
- Eliminating Residential Fire Deaths: CDC funds 16 states to continue smoke alarm installation and fire safety education programs in high-risk communities, where fire death rates are higher than state and national averages and median household incomes are below the poverty level.
- National Violent Death Reporting System (NVDRS): CDC funds 17 states to implement the NVDRS and gather and share state-level data about violent deaths. This state-based system collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. This information can be used to develop, inform, and evaluate violence prevention programs.
- National Electronic Injury Surveillance System- All Injury Program (NEISS-AIP): NEISS-AIP is a national probability sample of hospitals with emergency departments in the U.S. and its territories. NEISS-AIP data are utilized to calculate national estimates of all types and causes of nonfatal injuries treated in hospital EDs and are important for monitoring trends over time and for designing and evaluating national, state and community-based injury prevention programs. NEISS-AIP is collaboration between the U.S. Consumer Product Safety Commission and CDC. Data collected this system are available through WISQARS™ (Web-based Injury Statistics Query and Reporting System), an interactive database system that can be accessed at <http://www.cdc.gov/ncipc/wisqars>.

- Injury Control Research Centers: CDC's Injury research demonstrates what works to keep people safe through injury research. CDC funds 12 university-based Injury Control Research Centers throughout the U.S. to conduct research and provide state and community training and technical assistance. These research centers work to identify critical gaps in knowledge of injury risks and protection, particularly among vulnerable populations; conduct important research to address these gaps and disparities; and communicate their findings to community public health workers to shape effective programs that benefit all of us.
- Centers of Excellence on Youth Violence: CDC funds 8 National Academic Centers of Excellence on Youth Violence to foster joint efforts between university researchers and communities to address the problem of youth violence. The centers focus on developing and implementing community response plans, training health care professionals and conducting research projects to evaluate effective strategies for preventing youth violence.
- Extramural Research Grants Program: CDC supports a highly successful investigator-initiated, peer-reviewed grant program for academic research institutions across the country. In FY 2004, CDC received almost 300 applications for injury prevention and control research, and made 41 awards (13.8 percent success rate). Some of the crosscutting areas of research include biomechanics, trauma care research, violence prevention, home and recreational injuries, motor vehicle injuries, and disability prevention for injured persons. CDC also provides funds to new investigators in the field of injury and provides dissertation awards to graduate students to further develop the capacity of the injury research community. Small Business Innovation Research (SBIR) projects in injury prevention and control explore new technologies, such as ways to evacuate people in mass casualty events and an alert for motor vehicle occupants exposed to dangerous carbon monoxide levels.

Significant Accomplishments:

- Prevented Residential Fire Deaths: A survey of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that approximately 1,053 lives have been saved to date. Program staff have canvassed over 380,000 homes and installed almost 270,000 long-lasting or lithium-battery powered smoke alarms in high-risk homes, targeting households with children ages five years and younger and adults ages 65 years and older. Fire safety messages have reached millions of people as a result of these programs.
- Linking Data to Better Understand Violent Deaths: In 2005, the first data from the NVDRS was released reporting suicide and homicide rates for six states in *Morbidity and Mortality Weekly Reports* (MMWR). This report broke homicide and suicide rates down by sex and age. Among the important findings was an increasing rate of death by homicide in males under 25 years of age and in increasing rate of death by suicide in males age 25-64 years; these groups explained the overall increase in homicide and suicide rates.
- Examined the Consequences of Nonfatal Fall-Related TBI Among Older Adults: A CDC-funded study found that nonfatal, hospitalized fall-related TBIs have significant consequences on the health care delivery system in California. For example, an estimated annual average of 3,000 elderly nonfatal falls result in hospitalizations for TBI costing approximately \$50 million. Researchers also found that for those over 85 years old, three out of every five hospitalizations resulted in a discharge to a residential facility with skilled nursing or to a home health service with outpatient rehabilitation services.
- Published Acute Injury Care Research Agenda: CDC identified gaps that existed in the area of acute injury care and updated the *CDC Injury Research Agenda (2002)* to clearly state CDC's highest priorities for acute injury care research. CDC is responding to the public's needs and focusing upon acute injury care research that will ultimately make a difference in improving acute injury care systems and the care individuals receive when they are injured.
- Preventing and Managing Sports-Related Concussions: CDC is helping to prevent high school sports-related concussion through the *Heads Up: Concussion in High School Sports* toolkit. CDC developed and evaluated this toolkit to improve coach's knowledge about and management of concussions in high school athletic programs. Of nearly 500 respondents, more than two-thirds of coaches interviewed reported they were aware of incidents of sports-related concussions at their schools; and a third of the coaches did not have access to materials about preventing and managing concussion prior to receiving the *Heads Up* tool kit. Additionally, 20 percent of coaches reported that their athletic department does not have a plan for dealing with concussions; however, most of these coaches (96 percent) thought the tool kit materials could be used to develop one.

NARRATIVE BY ACTIVITY
ENVIRONMENTAL HEALTH AND INJURY
INJURY PREVENTION AND CONTROL

- Evaluating Strategies to Prevent Dating Violence Among Latino Youth: Over 2600 Latino youth from 11 schools participated in a program to prevent dating violence. Students received a 3-session intervention focusing on legal aspects of violence toward dating partners, and completed surveys to assess changes in knowledge, attitudes, and beliefs. Results indicate that the intervention changed teens' knowledge about dating violence, attitudes toward dating violence, and willingness to seek help if they experienced dating violence. This project represents one of the first research studies addressing dating violence in a Latino population.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$138,214,000 for Injury Prevention and Control, a decrease of \$822,000 below the FY 2006 Enacted level of \$139,036,000.

Pay Raise (+\$0.4 million)

The request includes funds to cover the projected FY 2007 increase.

Administrative Savings (-\$1.2 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Injury Prevention and Control Surveillance and Programs				
Core State Injury Prevention and Control Programs	30	30	30	0
Rape Prevention and Education Grants	59	59	59	0
Intimate Partner Violence Prevention Programs	20	20	20	0
Child Maltreatment Prevention Activities	14	14	14	0
Residential Fire-Related Injury Prevention Programs	16	16	16	0
National Violent Death Reporting System	17	17	17	0
National Electronic Injury Surveillance System – All Injury Program (NEISS-AIP)	1	1	1	0
Injury-Related Research				
Injury Control Research Centers	12	12	12	0
National Academic Centers of Excellence in Youth Violence	8	8	8	0
Research Grants to Individual Investigators for Injury Prevention	53	53	53	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

NARRATIVE BY ACTIVITY
 ENVIRONMENTAL HEALTH AND INJURY
 INJURY PREVENTION AND CONTROL

FUNCTIONAL TABLE

Injury Prevention and Control Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Intentional Injury	\$103,138	\$104,033	\$103,440	(\$593)
Unintentional Injury	\$35,099	\$35,003	\$34,774	(\$229)
Total -	\$138,237	\$139,036	\$138,214	(\$822)

OCCUPATIONAL SAFETY AND HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 307, 310, 311, 317, 317A, 317B, 327; Occupational Safety and Health Act of 1970 (P.L. 91-596), §§ 20-22; Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164, §§ 101, 102, 103, 202, 203, 204, 205, 206, 301, 501, 502, 508, and P.L. 95-239, §19; Federal Fire Prevention and Control Act, § 209, (29 U.S.C. 671(a)); Radiation Exposure and Compensation Act, §§ 6 and 12 (42 U.S.C. 2210); Housing and Community Development Act of 1922 § 1021 (15 U.S.C. 2685); Floyd D. Spence National Defense Authorization Act §§ 3611, 3612, 3623, 3624, 3625, 3626 of P.L. 106-393; Energy Employers Occupational Illness Compensation Program Act (2000) 42 U.S.C. 7384 et. Seq. (as amended); National Defense Authorization Act for FY 2006, P.L. 109-163; Toxic Substances Control Act (15 U.S.C. 2682); Prohibition of Age Discrimination Act (29 U.S.C. 623).

Occupational Safety and Health (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA¹	\$164,170	\$168,201	\$163,123	(\$5,078)
PHS Evaluation Transfers	\$87,071	\$87,071	\$87,071	\$0
Total	\$251,241	\$255,272	\$250,194	(\$5,078)

¹The FY 2007 Estimate carries forward the proposal in the FY 2006 Conference language to move management and administrative costs (\$34.8 million) from Occupational Safety and Health to Business Services Support. Funding for FY 2005 is shown on a comparable basis.

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$250,194,000 for Occupational Safety and Health, a decrease of \$5,078,000 below the FY 2006 Enacted level of \$255,272,000.

PROGRAM DESCRIPTION

Around the world, millions of men and women work in poor and hazardous conditions. Each year, more than two million people die of work-related accidents and diseases, and more than 160 million workers fall ill due to workplace hazards. The mission of CDC is to provide national and world leadership to prevent work-related injuries and illnesses among workers. CDC conducts research to reduce work-related injuries and illnesses and promotes safe and healthy workplaces through interventions, recommendations and capacity building.

To address this enormous challenge, CDC introduced its most significant collaborative effort, the National Occupational Research Agenda (NORA) in 1996. For the past ten years, NORA has served as a framework to guide occupational safety and health research - not only for CDC but for the entire occupational safety and health (OSH) community. NORA has resulted in a number of benefits, including:

- Concentrated efforts between government, academia, labor unions and industry that lead to faster, more effective implementation of OSH-related workplace solutions.
- Full integration of the CDC extramural research program into the National Institutes of Health (NIH) grants management system (known for its exemplary peer review standards and staffed by leading extramural scientists from the field of public health).

CDC is now entering the second decade of NORA (NORA II), building on past successes while preparing for new challenges in designing research to address the 21st century workplace. NORA II provides a framework for OSH research using a sector-based approach. CDC and its partners are forming eight Sector Research Councils and each will draft sector-based research goals, objectives, and action plans. In addition, a Cross-sector Research Council is being formed to identify opportunities for common research across sectors.

CDC has placed increased attention on the transfer and translation of research to practice. The NORA Research Councils will provide guidance to the entire OSH community on moving research findings, technologies, and information into highly effective prevention practices and products that are adopted in the workplace. CDC's goal is to reduce injury and illness by increasing workplace use of effective research findings. To achieve this, CDC continues to work with its partners to focus research on ways to develop effective products, to translate research

findings into practice, to target dissemination efforts, and to evaluate and demonstrate the effectiveness of these efforts in improving worker safety and health.

CDC conducts research on the full scope of occupational illnesses and injuries: from basic research on mechanisms and etiology of occupational diseases to applied research on specific ways to prevent illness and injury in the workplace. Research is conducted both intramurally and extramurally, through cooperative efforts with a wide range of federal and non-federal partners. These efforts have been largely facilitated through the establishment of NORA, and CDC has aggressively aligned its intramural and extramural programs within the NORA framework. CDC intervention and recommendation activities bring tools, techniques, information, and procedures into the workplace that are intended to improve the health and safety of workers. CDC's capacity building efforts are meant to develop the capabilities of individuals and agencies in the field of occupational safety and health. This is accomplished through training and disseminating current and applicable occupational safety and health information to industry, workers, governments, and scientific and professional communities, both nationally and internationally. CDC's research efforts support the Secretary's 500-Day Plan's ideals of:

- Building interdisciplinary research teams that combine skills and knowledge from the biological, physical, and social sciences to yield biomedical insights that could not have been achieved by a single-discipline approach, and
- Interdisciplinary and interagency collaboration in scientific pursuits is the standard.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Occupational Safety and Health activity, the following performance measure has been selected as a highlight of the program's performance plan.

Performance Goal	Results	Context
<p>1. Increase workplace use of control and personal protective technologies in targeted sectors.</p> <p>A) Increase the availability of CBRN-certified respirators for use during a CBRN event to a specified percentage of the professional firefighters.</p> <p>B) Increase the percentage of U.S. pavers with installed engineering controls to a specified percentage.</p>	<p>Based on a CDC survey of professional firefighters, CDC has increased availability of CBRN-approved respirators to professional firefighters to 46 percent.</p> <p>70 percent of U.S. pavers are equipped with installed engineering controls.</p>	<p>CDC has issued Chemical, Biological, Radiological and Nuclear (CBRN) Air Purifying Respirators (APR) approvals and implemented standards for upgrading traditional firefighter Self Contained Breathing Apparatus (SCBA) to CBRN protection levels. CDC is committed to ensuring that CBRN-protective respirators are available to professional firefighters.</p> <p>More than 350,000 U.S. workers are exposed to fumes generated during the manufacture or use of asphalt. CDC's goal is to facilitate the installation of engineering controls on virtually all U.S. highway-class pavers by 2010.</p>

Current Activities

- Agriculture ranks among the most hazardous industries. CDC conducts a national program in agricultural safety and health that includes both intramural and extramural components ranging from studies to assess pesticide exposure among farm families to the development of technology designed to reduce injuries due to tractor rollovers. To further enhance these efforts in FY 2005, CDC funded ten Agricultural Safety and Health Centers that are located throughout the nation to be responsive to issues unique to the different regions.
- In 2005, CDC continues to work with key construction safety and health partners to coordinate research, evaluate the effectiveness of interventions, and disseminate those that emerge as best practices. As part of its focus on the building and construction industry, CDC pursues both intramural and extramural research on construction fatalities.
- CDC is participating in an international effort to understand the health impact of nanotechnology and how to control potential occupational health effects. In 2005, CDC designated an additional \$0.5 million for the expansion of the Nanotechnology Health and Safety Program, under NORA. This initiative will study the toxicity and health impact of a range of nanomaterials. The program will primarily focus on the role of surface area as an exposure metric, the toxicity and health effects associated with carbon nanotubes and other nanomaterials, and the nature and control of occupational diesel emissions. This effort is part of a government-wide program to ensure that the U.S. will remain a world leader in nanotechnology research and development.
- Motor vehicle-related incidents are consistently the leading cause of work-related fatalities in the U.S. In response, CDC initiated the multidisciplinary Occupational Motor Vehicle Safety and Health Research

Program under NORA to address topics such as ambulance crash survivability, the influence of fatigue in truck drivers, and the risk factors for vehicle crashes among public employees. CDC also actively engages employers to promote motor vehicle safety by providing technical assistance and disseminating Hazard Alerts and Fact Sheets that present practical prevention strategies in both English and Spanish.

- CDC translates and disseminates research findings for the occupational safety and health community. In 2004, CDC established the Office of Science Policy and Technology Transfer to ensure that all occupational safety and health research funded by the agency (both intramural and extramural) is focused on the application of the research findings to prevent work related illness or injury. This is accomplished by facilitating partnerships throughout the entire research process so that findings are most amenable to implementation; bringing inventions to market; transferring knowledge and products to employers, workers, and policy makers; and evaluating programs for their impact. In FY 2005 and FY 2006, all research projects to be funded under NORA must be consistent with the research-to-practice principles.
- CDC responds to employer, employee, and state and local requests for worksite health hazard evaluations (about 400 each year). CDC assesses the workplace and health of employees by reviewing records and/or conducting on-site testing. These evaluations present the opportunity to obtain information on occupational exposures where standards are lacking, or do not protect all workers. After completion of the evaluations, CDC conducts follow-up surveys of participants to assess their satisfaction with the process and to learn whether the recommendations provided led to workplace improvements.
- CDC provides workplace-related safety and health information to employers, workers, industry, academia, the occupational safety and health community, and the general public through its English and newly implemented Spanish web sites.
- CDC increases workplace use of control and personal protective technology, particularly for emergency responders to chemical, biological, radiological, and nuclear (CBRN) terrorist events.

Significant Accomplishments:

- The CDC *Worker Health Chartbook, 2004*, published in September 2004, forms the cornerstone of occupational injury and illness surveillance in the U.S. The *Chartbook* includes statistics on workplace injuries and illnesses in addition to data on the race, ethnicity, gender, age, geographic location and occupations of American workers. In FY 2005, the *Chartbook* won several CDC awards including an Alice Hamilton Award and two Communicators Roundtable Awards. It has been very useful in raising attention to the distribution and determinants of occupational injuries and illnesses in the U.S and identifying occupational health priorities.
- CDC, in collaboration with manufacturers, labor, and industry, developed a new personal dust monitor (PDM) for assessing coal miners' exposure to coal dust in underground coal mines. The first advancement in more than 30 years for monitoring exposures, the PDM was awarded a Research & Development 100 Award as one of the top 100 innovations of the year. The PDM provides real-time exposure data during a work shift so that mine operators can reduce over-exposures that might lead, over time, to the development of coal workers' pneumoconiosis or "black lung," a debilitating lung disease that caused 14,000 deaths between 1991 and 2000. In FY 2005, CDC conducted in-mine performance testing and found the PDM to be effective in more than 90% of the shifts when employed. CDC and the Mine Safety and Health Administration have now established a joint committee to look at how the PDM can be utilized on a daily basis in underground U.S. coal mines.
- Respirator Certification – CDC continues to conduct a respirator certification program to ensure respiratory protective equipment conforms to established regulatory standards, issuing 376 approvals in 2005. These include 36 self-contained breathing apparatus (SCBA), five air-purifying respirators, and 32 air purifying escape respirators for occupational use by emergency responders against CBRN agents. To enable responders to obtain CBRN protection without purchasing new equipment, CDC has initiated a CBRN SCBA retrofit certification program. Subsequently, over 30 retrofit kits have been approved for use in upgrading existing SCBA to current performance standards. In addition, CDC has implemented a CBRN temperature and vibration facility to improve the timing and decrease the expense of CBRN testing.
- Evaluation of Young Workers Occupational Safety and Health Curriculum – CDC, in collaboration with partners in industry, academia, and other government agencies, developed an OSH curriculum for high school students to raise awareness about OSH hazards and regulations pertaining to youth workers; teach basic skills in hazard recognition and control; and lead to a reduction in workplace injuries and fatalities among school age youth. In 2005, CDC partnered with the Career Clusters Initiative of the National

Association of State Directors of Career Technical Education Consortium (NASDCTEc) to pilot test the curriculum. The pilot tests were successful and final versions of the curriculum are being completed for each of the fifty states and Puerto Rico. CDC plans to release the curriculum as a web-accessible product nationwide by spring 2006.

- **Noise-Induced Hearing Loss** – Noise-induced hearing loss is one of the most common occupational diseases and the second most self-reported occupational illness or injury. Approximately 30 million workers are exposed to hazardous noise on the job, and an additional 9 million are at risk for hearing loss from other agents such as solvents and metals. CDC engineers have designed and developed a new noise dosimetry system to assess and evaluate exposure to impulsive noise. Currently, commercial noise dosimeters are not capable of measuring exposure to impulsive noise accurately. The new dosimeter designed by CDC will enable OSH professionals to assess this potential hazard. CDC has partnered with a leading instrument manufacturer to implement the technology into their next generation of dosimeters.

RATIONALE FOR THE BUDGET

The FY 2007 President’s Budget reflects a total funding level of \$250,194,000 for Occupational Safety and Health, a decrease of \$5,078,000 below the FY 2006 Enacted level of \$255,272,000.

Pay Raise (+\$2.1 million)

The request includes funds to cover the projected FY 2007 increase.

Program Reductions (-\$5.8 million)

The FY 2007 President’s Budget proposes reductions to fund base activities at the FY 2006 President’s Budget level.

Administrative Savings (-\$1.4 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC’s budget lines. The FY 2007 President’s Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
NORA Intramural Research Projects	255	255	255	0
Safety and Health Patent Filings	5	5	5	0
Certification Decisions Issued for Personal Protective Devices and Industrial Hygiene Instruments Evaluated for Certification	450	450	500	50
Estimated Academic Graduates	565	550	550	0
Hazard Evaluations/ Fatality Assessment and Control Evaluations	585	585	575	(10)
Number of Research Articles Published in Peer-Review Publications	262	200	200	0
Agricultural Centers	10	10	10	0
Number of States Receiving Public Assistance	35	35	35	0
Research Grants	182	180	180	0
Training Grants	55	55	55	0
CDC NIOSH Web site Visitors Sessions	7.6M	7.6M	7.6M	0

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

GLOBAL HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 361-369, 2315, 2341; International authorities: P.L. 109-149 sec. 215. Foreign Assistance Act of 1961, §§ 104, 627, 628; Federal Employee International Organization Service Act §3; International Health Research Act of 1960 §5; Agricultural Trade Development and Assistance Act of 1954 §104; Economy Act (22 U.S.C. 3968); Foreign Employees Compensation Program (41 U.S.C. 253); International Competition Requirement Exception, P.L. 107-116, §215; H.R. 5656 §220; FY 2001 Appropriations Bill.

Global Health (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA ¹	\$317,153	\$313,251	\$381,103	\$67,852
Department of Defense Appropriation	\$0	\$68,000	\$0	(\$68,000)
Total	\$317,153	\$381,251	\$381,103	(\$148)

¹Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$439.0 million in FY 2005), as part of the President's Emergency Plan for AIDS Relief.

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$381,103,000 for Global Health, a decrease of \$148,000 below the FY 2006 Enacted level of \$381,251,000.

PROGRAM DESCRIPTION

CDC has recently established three global health goals:

CDC's Global Health Promotion Goal recognizes the critical role CDC plays in sharing knowledge, tools and other resources with people and partners to promote health and prevent disease around the world. CDC addresses critical global public health challenges through working with a diverse set of partners to support the development and implementation of culturally-appropriate public health interventions. Through our health promotion activities, CDC will contribute to reductions in global morbidity and mortality.

CDC's Global Health Protection Goal seeks to ensure that Americans at home and abroad will be protected from health threats through a transnational prevention, detection and response network. To this end, CDC works with international partners to achieve rapid and accurate detection, diagnosis and verification of emerging global public health threats, and works to contain threats at their source to prevent international spread. In addition to making the world a safer and healthier place for all, CDC's health protection activities play a critical role in ensuring the health of Americans living and traveling abroad, and protecting U.S. economic interests.

CDC's Global Health Diplomacy Goal recognizes the important benefits that accrue to both the United States and the world through investments in public health capacity development and the creation of partnerships with the developing world. Through our health diplomacy activities, CDC and the United States Government will be a trusted and effective resource for health development and health protection around the globe. In cooperation with Ministries of Health (MOH) and other appropriate institutions, CDC assesses evolving global health issues and identifies and develops activities to apply CDC's technical expertise to be of maximum public health benefit.

Included in the summary below are descriptions of the Global AIDS Program (GAP), the Global Immunization Program, CDC's Global Disease Detection Initiative, the Global Malaria Program, and a brief outline of other major Global Health activities at CDC. Funding for these international programs is contained within the Global Health budget activity. In addition to these programs, there are numerous other global public health efforts across CDC that compliment and strengthen CDC's domestic public health efforts.

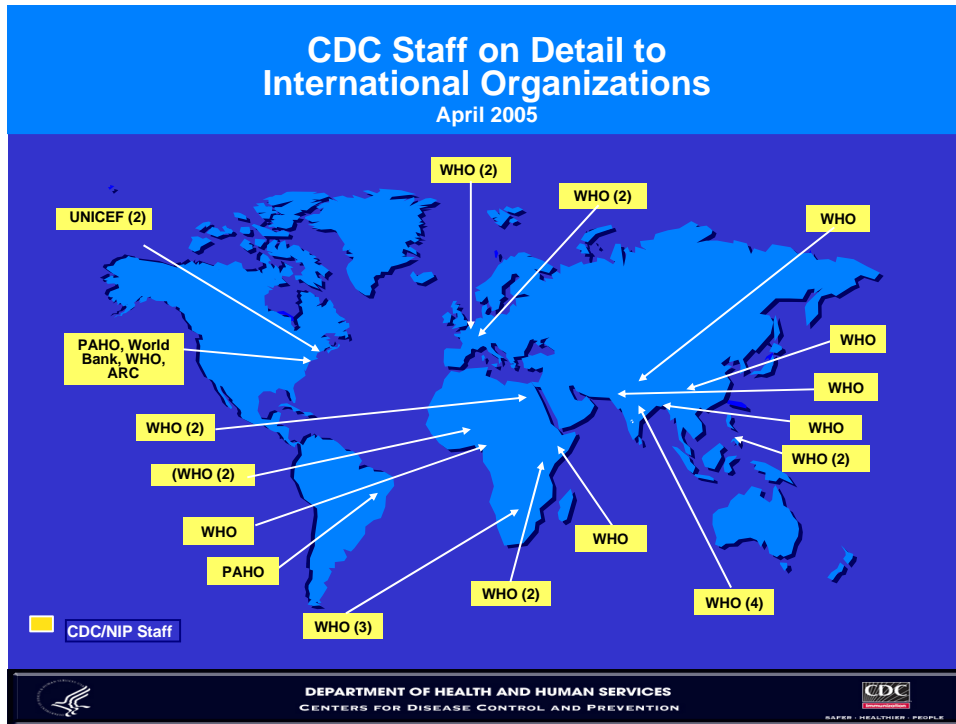
GLOBAL AIDS PROGRAM

Since 2000, CDC, through the Global AIDS Program (GAP), has helped resource-constrained countries throughout Africa, Asia, Latin America and the Caribbean to implement comprehensive HIV prevention programs in conjunction with integrated treatment, care and support programs for people living with HIV; and built human capacity through training and infrastructure to address the global HIV/AIDS pandemic in a high quality and sustainable manner. Specifically, the CDC Global AIDS Program's (GAP) highly trained epidemiologists, medical officers, public health advisors, behavioral scientists, and laboratory scientists provide essential technical assistance to implement the President's Emergency Plan for AIDS Relief (the Emergency Plan). GAP has offices in 24 countries, including all 15 Emergency Plan focus countries. There are also four regional offices in Asia, the Caribbean, Central America, and Southern Africa. GAP headquarters supports an additional 31 countries including Swaziland, Mali, Sudan, Senegal, Russia and Lesotho. GAP also has technical staff detailed to the Office of the Global AIDS Coordinator, USAID, and the HHS Office of Global Health Affairs in Washington, D.C., as well as to the World Health Organization and UNAIDS. GAP provides surveillance, laboratory capacity building, training, monitoring and evaluation, and implementation of HIV/AIDS prevention, treatment and care programs through partnerships with host governments, nongovernmental organizations, international organizations, U.S.-based universities, and the private sector to help implement The Emergency Plan, including supporting the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In FY 2005, \$439 million from the Foreign Operations appropriation were transferred to CDC's Global AIDS Program from the Department of State, Office of Global AIDS Coordinator, through the Office of Global Health Affairs, HHS to support global HIV/AIDS activities.

GLOBAL IMMUNIZATION PROGRAM

CDC supports global immunization initiatives to protect American children from vaccine-preventable diseases imported into the United States or acquired abroad, to protect against the medical costs of morbidity and mortality associated with vaccine-preventable diseases, and for humanitarian reasons. CDC priorities in FY 2007 are global polio eradication, measles mortality reduction and regional measles elimination, and strengthening childhood immunization programs in developing countries. CDC supports these initiatives by providing epidemiologic, laboratory, and programmatic support to the World Health Organization (WHO) and United Nations Children's Fund (UNICEF), by assigning expert staff overseas (see map below) to help implement global immunization programs, and providing short-term technical assistance abroad through temporary assignments of CDC experts from Atlanta. CDC provides extensive financial support through WHO and UNICEF, most notably for procurement of measles and polio vaccine through UNICEF. CDC operates in partnership with public and private sector partners to achieve global immunization objectives including Rotary International, American Red Cross, United Nations Foundation, International Federation of Red Cross and Red Crescent Societies, Bill and Melinda Gates Foundation, WHO, UNICEF, and World Bank. As of April, the overall number of polio cases has been reduced from more than 350,000 polio cases annually in 1988 to 1,628 cases reported by December 2005. Today, more than 200 countries and territories are polio free and the disease is now endemic in six countries in the world: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt. The sixth (Egypt) reported its last poliovirus in an environmental sample in January 2005. Additionally, 11 previously polio-free countries have reported polio cases in 2005 (Somalia, Yemen, Indonesia, Sudan, Ethiopia, Angola, Mali, Cameroon, Chad, Eritrea and Nepal) as a result of spread of poliovirus from Nigeria.



GLOBAL DISEASE DETECTION

As demonstrated with the SARS outbreak, a highly pathogenic infectious disease in a remote region of the world can spread around the world in a matter of days, or weeks. The goal of the Global Disease Detection Initiative is to develop national and regional capacity to better detect and respond to infectious disease outbreaks of potential international importance, whether the cause is an intentional act of terrorism or the natural emergence of a deadly infectious pathogen, before they spread in the particular country, to other nations, or to the United States. In support of the Secretary's 500 Day Plan, CDC is expanding the international network of early warning infectious disease surveillance and is working to provide early warning of naturally occurring manmade threats through improved domestic and international surveillance. In addition, helping protect U.S. citizens living and working abroad and helping safeguard the economic interests of various partners are also important considerations. Key to this effort is enhanced capabilities in disease detection and response in "strategic partner" countries, a connected and secure information technology infrastructure, and improved pandemic influenza preparedness and response. To organize this initiative, CDC is employing proven and effective interventions. CDC is also increasing global connectivity to help ensure rapid detection and response to emerging health threats. Having CDC staff on the ground was invaluable in providing initial response support for the December 2004 tsunami, particularly in Thailand.

GLOBAL MALARIA PROGRAM

Globally, malaria transmission occurs in more than 100 countries. Malaria was declared eradicated in the U.S. in the late 1950s, but up to 1,400 people in the U.S. get malaria each year from travel to places where malaria transmission is occurring. Each year approximately 20 million U.S. travelers must use malaria prevention medicines, and an estimated 50,000 U.S. blood donors are rejected because of concern about malaria transmission via the blood supply. In endemic countries, malaria kills a child approximately every 30 seconds, causes more than one million deaths and 500 million infections each year, is increasingly resistant to available medicines for treatment and to prevent infection in travelers, and gross domestic product is up to 20 percent lower than it would have been if there had been no malaria during the last 15 years. Malaria, along with HIV/AIDS and TB, is a destabilizing factor and continues to pose a critical threat to the national security of all sub-Saharan African countries. The U.S. is committed to helping these governments address this crisis. On June 30, 2005, President Bush announced a five-year, \$1.2 billion U.S. Government initiative to reduce malaria mortality by 50 percent in up to 15 African countries with a population of 175 million. The President has challenged other countries to join this initiative and contribute another \$4.2 billion over five years to include 20 more countries with a population of 420 million. The program will support national malaria control programs to achieve 85 percent coverage with known effective strategies including prompt and effective treatment, insecticide-treated bednets and insecticide indoor residual spraying, and preventive treatment for pregnant women.

CDC supports prevention and control of malaria throughout the world in partnership with local, state, and federal agencies in the United States; medical and public health professionals; national and international organizations; and foreign governments by:

- Conducting malaria surveillance, prevention, and control activities in the United States;
- Providing consultation, technical assistance, and training to malaria endemic countries to change and implement proven policies to decrease malaria burden;
- Conducting multidisciplinary research in the United States and internationally, in the laboratory and in the field, to develop new tools and improve existing interventions against malaria worldwide;
- Translating research findings into appropriate global policies and effective practices through the Roll Back Malaria Consortium and other international partners.

OTHER GLOBAL HEALTH ACTIVITIES

FIELD EPIDEMIOLOGY & LABORATORY TRAINING PROGRAM (FELTP)

For decision-makers in foreign ministries of health to impact public health issues in their countries, they need credible scientific information. Such public health information is collected by central and front line staff who need to be trained in both applied epidemiology and laboratory surveillance. CDC works with its partners to design, implement, and evaluate health information systems and to integrate and strengthen existing information systems. These systems measure the status and determinants of the population's health. The information is used to improve the strategies and processes for health delivery and the capacity of the health system to respond to the needs of the community. Modeled after CDC's Epidemic Intelligence Service (EIS), the FELTP collaborates with international partners and the Ministries of Health (MOH) to build the capacity for long-term applied public health training programs. FELTPs utilize instructional design methods to produce their training curriculum. Strategies and content for training activities emphasize three principal areas of competency: applied epidemiology and evidence-based decision making for public health actions; effective communication with the public, public health professionals, and the community; and health program design, management, and evaluation. Training programs are customized in collaboration with local counterparts according to specific situations and assessed needs. Emphasis on specific skills in each competency area varies depending on the goals and objectives of the specific training program and target audience. CDC is also involved in assisting countries in the development and implementation of dynamic, cost-effective public health systems by:

- Developing and strengthening institutional and organizational capacity to provide core public health functions,
- Strengthening and integrating health information systems and,
- Communicating public health messages and providing managers and decision-makers with timely information through national health bulletins.

SUSTAINABLE MANAGEMENT DEVELOPMENT PROGRAM (SMDP)

The SMDP strategy includes working with international donor partners to provide technical assistance to public health professionals as they establish in-country management training programs. Technical assistance focuses on 1) needs assessment; 2) curriculum development; 3) marketing, organizing, and teaching workshops; and 4) supervising applied learning projects.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Global Health activity, the following performance measures have been selected as highlights of the program’s performance plan.

Performance Goal	Results	Context
1. Number of countries in the world with endemic wild polio virus.	Global polio incidence has declined by more than 99 percent from about 350,000 cases in 1988 to 1,628 cases as of December 2005. About 250,000 lives have been saved, four million cases of childhood paralysis have been avoided, and the number of polio-endemic countries has dropped from 125 in 1988 to six in 2005.	Polio, a disease of the nervous system, has been and continues to be responsible for paralyzing and killing children. Spread through contact with other infected people, it requires a strong vaccination effort. Polio was eliminated from the Americas in 1994 but continues to circulate in Asia and Africa. Factors affecting immunization coverage have led to continued risks in parts of Africa (particularly Nigeria) and India, but continuous efforts are being made to control these outbreaks and eliminate cases of polio worldwide.

Performance Goal	Results	Context
2. Number of non-import related measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission.	Measles transmission has been interrupted in all countries of the Western Hemisphere since November 2002. However, imported measles cases, with limited secondary spread, continue to occur in several countries, including the U.S. deaths from measles complications in the Americas have virtually disappeared.	Measles is a highly contagious disease spread through the air. It is the leading cause of preventable blindness and a leading cause of death in children. Global efforts are needed to stop transmission of measles both in endemic countries and through importation. Due to an aggressive measles vaccination program, measles elimination from the Americas appears to have been achieved. As the global health community works to end the spread of measles region-by-region, CDC can work toward the eventual goal of measles elimination.

Current Activities:

- Works with the Office of Global Health Affairs/HHS, OGAC/Department of State and other agencies to implement the President’s Emergency Plan for AIDS Relief (the Emergency Plan) aimed at preventing 7 million new HIV infections, treating 2 million HIV-infected people, and caring for 10 million persons living with HIV/AIDS and AIDS orphans.
- In 2006, under the Emergency Plan, CDC/GAP supports HIV prevention, care, treatment programs, and surveillance, and capacity building in 15 focus countries, and in 4 additional phase II countries. (Countries receiving over \$10 million total USG funds—India, Cambodia, Malawi, and Zimbabwe).
- In 2006, supports HIV/AIDS prevention, care, treatment, surveillance, and capacity building directly in 5 additional countries (Brazil, Angola, Democratic Republic of the Congo (DRC), Thailand, and China).
- Supports four regional GAP offices to address the needs of 31 additional countries which do not receive direct bilateral support.
- Providing funds through the United Nations Children’s Fund (UNICEF) and the UN Foundation (UNF) for the purchase of polio and measles vaccines, and for conducting supplemental immunization activities (SIAs).
- Providing immunization technical assistance to WHO and UNICEF in polio and measles endemic countries through the deployment of CDC epidemiologists and public health experts, and recruiting and training health professionals for Stop Transmission of Polio (STOP) teams.

- Conducting surveillance to monitor and direct polio eradication and measles mortality reduction efforts, certifying the eradication of polio, and helping to build the laboratory platform for detection and surveillance of polio, measles, and other diseases.
- Continuing the Measles Initiative in African countries and expanding to Asia to support WHO's 47 priority countries and the Global Immunization Vision and Strategy goal to reduce measles deaths by 90% by 2010 after meeting the goal of 50% reduction in measles mortality in Africa in 2005.
- Providing immunization technical assistance to WHO and UNICEF in rubella endemic countries through the deployment of CDC epidemiologists and public health experts.
- Assisting the WHO in building global polio and measles laboratory networks and helping build the platform for detection of other diseases.
- Establishing GDD response centers in Kenya and Thailand, which are strategically placed to integrate disease surveillance, applied research, prevention and control activities. Further expansion is planned to be completed in FY 2006.
- Providing support for global disease detection in China, Guatemala, Kenya and Brazil to provide additional support for epidemiology, lab training, and outbreak investigations.
- Enhancing the capability of WHO's Global Outbreak Alert and Response Network (GOARN) to monitor infectious disease events globally and respond as necessary to limit their spread.
- Targeting global disease detection efforts to improve surveillance and pandemic preparedness for H5N1 avian influenza in Asia through: (1) furnishing bilateral support to foreign Ministries of Health (MOH) to build influenza surveillance networks, (2) providing scientific assistance and training, and (3) developing infrastructure upon which research leading to vaccine policy, vaccine production and better pandemic preparedness can be built.
- Establishing additional global disease detection and response interventions, such as laboratory response networks, communications, and management activities, with selected "strategic partners", including China, Guatemala, Kenya, and Thailand.
- Conducting national malaria surveillance, providing technical assistance to clinicians caring for patients with malaria, and establishing prevention and treatment guidelines for U.S. travelers and clinicians.
- Providing technical assistance, including monitoring and evaluation, to WHO, the World Bank, UNICEF, UN Foundation, and USAID in malaria endemic countries in Africa, Asia, and the Americas in support of the global Roll Back Malaria program and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
- Supporting universities and other investigators for malaria research including: the development of novel antimalarial drugs to address the growing problem of drug resistant malaria, evaluating improved insecticide treated bednets (ITN), preventive intermittent treatment for pregnant women and infants, the impact of artemisinin-containing combination drug regimens, the interaction of HIV and malaria and mosquito larval ecology for the reduction of vector breeding.
- Collaborating with Liverpool School of Tropical Medicine, the Kenya Medical Research Institute, the Ifakara Health Research and Development Center in Tanzania, the Malaria Research and Training Center in Mali, the Malaria Research Center in India, and other institutions to strengthen international collaborative efforts to identify, evaluate, and implement malaria control strategies in sub-Saharan Africa and Asia.
- Working in partnership with USAID to implement the President's Malaria Initiative.
- Provided technical and resource support to establish Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET) programs which link epidemiology, laboratory training, and institutional support. The newest program, in Kenya, is currently training its second class.
- Rapidly deployed FELTP graduates and trainees from Thailand and India after the Southeast Asia Tsunami.
- Conducts a six-week course through the SMDP for trainers from developing countries in the basic management skills of planning, priority setting, problem solving, budgeting, and supervision.
- Supporting active management training programs in Botswana, Guam, India, Macedonia, Malawi, Mexico, Nicaragua, the Philippines, Serbia, Taiwan, Thailand, Uganda, Vietnam, and Zambia. Programs beginning in the fall of 2005 include Lesotho, Mozambique and Swaziland.

Significant Accomplishments:

- In 2005, provided technical assistance and support for programmatic activities (e.g., prevention, laboratory capacity, surveillance, Prevention of Mother-to-Child Transmission (PMTCT)) and care and treatment for 25 GAP countries and 31 other countries served by regional offices; assigned over 100 CDC staff to the field; and employed over 1,000 local staff to implement country programs.
- Contributed to the overall U.S. Government Emergency Plan efforts of supporting antiretroviral treatment (ART) for over 400,000 patients in the 15 focus countries in FY 2005, and providing PMTCT services for almost 2 million pregnant women in the fifteen focus countries in FY 2005. Approximately 125,000 HIV-positive women received short-course antiretroviral (ARV) prophylaxis in PMTCT settings, which resulted in an estimated 23,000 infant infections being averted.
- Provided counseling and testing to 322,510 individuals who received their HIV test results through the GAP program and PMTCT services to over 272,788 pregnant women, of which 145,133 received their HIV test results, who reside in the ten countries receiving other bilateral support in FY 2005.
- Prevented five million cases of childhood paralysis and saved an estimated 250,000 lives since the global polio initiative began in 1988.
- Reduced the number of polio cases from more than 350,000 in 1988 to 1,628 cases reported as of December 2005. Today, more than 200 countries and territories are polio free and the disease is now endemic in six countries in the world: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt. In 2005 nine countries have had importations of polio (Yemen, Indonesia, Somalia, Ethiopia, Angola, Mali, Nepal, Eritrea and Cameroon) and two countries have re-established transmission (Sudan and Chad).
- Making significant progress in Polio-endemic countries in Asia (Afghanistan, India and Pakistan) that appear to be on target to interrupt polio transmission in early 2006.
- Reduced by more than 99 percent the number of measles cases in the Western Hemisphere from approximately 250,000 in 1990 to 101 (all associated with imported viruses) provisionally reported in 2004.
- Met the World Health Assembly endorsed goal to reduce measles related mortality in Africa by 50% between 2001 and 2005. The goal was achieved ahead of schedule and under budget by immunizing over 200 million children in 33 countries and saving over a million lives since mid-2001.
- Established active International Emerging Infectious Program (IEIP) surveillance for all cases of pneumonia in a total population of 1.2 million persons in two provinces in Thailand.
- Strengthened the global influenza surveillance network through bilateral support to 12 countries (China, India, Indonesia, Kazakhstan, Malaysia, Mongolia, New Caledonia consortium, Pakistan, Philippines, South Korea, Thailand, and Vietnam).
- Investigated 38 global disease outbreaks including a range of infectious diseases: such as cholera, hemorrhagic fever, epizootic of monkey deaths, influenza H3N2, paratyphoid fever, pharyngeal conjunctival fever, and leptospirosis.
- Conducted 37 in-country surveillance system evaluations, which help establish and improve surveillance for key infectious diseases, helping CDC's global disease detection capacity.
- Increased the number of international sites with the capacity to conduct disease identification and intervention activities by building and sustaining strong FELTPs in collaboration with MOH in China, Kenya, Central America, and Brazil.
- Provided a Resident Advisor for consultation and support to 26 countries from 1980 to 2005 for FELTP. Of these, 20 no longer require CDC external technical assistance and 18 countries are still producing graduates. During this 24 year period, more than 1,262 epidemiologists have graduated from these programs.
- Collaborated with Roll Back Malaria partners on the development of the African Strategic Framework for Malaria Prevention in Pregnancy and provided financial support and/or technical assistance for malaria program implementation in 14 countries and seven regional networks in Africa.
- Completed data collection in Tanzania for a comprehensive evaluation of the impact of artemisinin containing combination anti-malarial therapy which will inform treatment policies in Africa.
- Conducted a field study that demonstrated infant mortality can be reduced by 25 percent when there is high coverage with insecticide-treated bednets in an area with high malaria transmission.

- Assisted Togo to carry out an integrated child health campaign that delivered insecticide-treated bednets with immunizations and other preventive measures. This campaign increased insecticide-treated bednet ownership from less than 10 percent to greater than 60 percent in one week with no disparity across income classes.
- Provided 107 on-site technical consultations to 30 countries and numerous partner organizations on malaria-control activities and implementation of research projects.
- Provided, in partnership with USAID, assessments and strategic planning with the national malaria control programs in Angola, Uganda and Tanzania to begin the scale-up of interventions in the President's Malaria Initiative.
- Concluded staffing plans based on CDC and HHS priorities for CDC's regional/country platforms in Thailand, Kenya, and China focusing on meeting the human resource and technical requirements necessary for combating newly emerging infectious diseases and on going programs. CDC also made projections for additional sites in Brazil, Central America, Central Asia, and India. CDC's action to track HHS personnel and contractors abroad will save HHS and CDC significant funds in future years.
- Awarded assessment contracts to improve connectivity among all the CDC offices worldwide and worked directly with the Department of State and proactively advised HHS on matters related to costs associated with the State Department's new Capital Security Cost Sharing initiative.
- Trained 264 trainers from 58 countries around the world through the Sustainable Management Development Program. The graduates have returned home to teach these skills in a variety of public health settings including academic institutions, government training programs, and non-governmental organizations.
- Scheduled the third SMDP biennial conference on "Strengthening Global Public Health Management Training Capacity" for Capetown, South Africa in May 2006 and anticipates about 150 participants.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$381,103,000 for Global Health, a decrease of \$148,000 below the FY 2006 Enacted level of \$381,251,000.

Rapid Outbreak Response for High Priority Countries (+\$2.8 million)

When a potential pandemic flu strain is identified, swift and decisive action can make the difference in whether the strain is contained or spreads globally. Based on the available epidemiologic information, CDC will continue to identify countries as high risk for the emergence of a potential pandemic and in need of current and potentially future monitoring efforts and help develop in-country response teams. The goal will be to have four to five member teams trained to undertake emergency field epidemiology studies, collect samples for shipment to laboratories, dispense antiviral medications, and institute emergency control measures such as quarantine stations in a standardized manner. Funds will allow CDC to enhance activities undertaken with funding in FY 2006 to ensure the target countries are monitored and safeguarded from disease spread that could elevate to pandemic levels.

Human-Animal Interface Studies (+\$1.0 million)

To complement NIH epidemiological studies, CDC will enhance FY 2006 activities by continuing to support studies that examine the risk and frequency of human infections with animal influenza A viruses with pandemic potential. CDC will analyze epidemiologic case control studies of risk factors for severe disease and cross sectional seroprevalence studies of antibodies of H5N1 virus in different risk populations. Risk populations may include people with occupational exposure to poultry; persons living in rural areas with ,or in close contact with, poultry and pigs; persons involved in poultry culling activities; and health care workers who have cared for H5N1 patients.

Pay Raise (+\$0.8 million)

The request includes funds to cover the projected FY 2007 increase.

International Surveillance, Diagnosis, and Epidemic Investigations (-\$2.5 million)

With increased resources in FY 2006 and continued funding in FY 2007, CDC will enhance its efforts to address these preparedness gaps through increasing laboratory capacity and technical support at local levels; assisting in the development of surveillance, diagnosis, and epidemic investigations; and assisting the WHO in creating and maintaining proper coordinating and monitoring infrastructure in high risk countries.

Administrative Savings (-\$2.1 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines.

OUTPUT TABLE¹

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Global HIV/AIDS				
Focus Countries – The numbers below reflect total USG efforts contributed to by CDC ²				
Number of individuals receiving HIV/AIDS treatment in the 15 focus countries	401,233	860,000	1,300,000	440,000
Number of countries conducting surveillance	15	15	15	0
Other Bilateral Country Programs – The numbers below reflect total USG efforts contributed to by CDC ³				
Number of countries conducting surveillance	10	9	9	0
Number of persons trained in the provision of laboratory-related activities	1636	1130	1370	240
Global Immunization Activities				
Number of measles vaccine doses purchased for use internationally	66M	66M	66M	0
Global Disease Detection				
Number of "Strategic Partner" countries with disease detection and response interventions	4	5	6 ⁴	1
Other Global Health ⁴				
Number of countries participating in the Field Epidemiology Training Program	32	34	36 ⁴	2
Sustainable Management Development Program graduates	293	323	353	30

¹Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

²Outputs for Focus Countries are a result of the USG effort to stem the tide against the global HIV/AIDS epidemic. As part of the President's Emergency Plan for AIDS Relief, CDC contributes to this effort, but the data provided is indicative of the USG effort as a whole.

³Outputs for Other Bilateral Countries are a result of the USG effort to stem the tide against the global HIV/AIDS epidemic. As part of the President's Emergency Plan for AIDS Relief, CDC contributes to this effort, but the data provided is indicative of the USG effort as a whole.

⁴As the strategic operational plan and budget are in development, there are no specific outputs for the influenza funding in "other global health." It is anticipated that the output for these specific areas will likely increase due to influenza funding.

FUNCTIONAL TABLE

Global Health Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Global AIDS Program ¹	\$123,830	\$122,644	\$121,952	(\$692)
Global Immunization Program	\$144,386	\$145,036	\$144,254	(\$782)
Global Disease Detection	\$21,426	\$33,168	\$33,259	\$91
Global Malaria Program	\$9,108	\$9,022	\$8,970	(\$52)
FY 2005 Avian Flu Supplemental	\$15,000	\$0	\$0	\$0
Other Global Health	\$3,403	\$71,381	\$72,668	\$1,287
<i>Other Global Health - Department of Defense Appropriation (non-add)</i>	\$0	\$68,000	\$0	(\$68,000)
Total -	\$317,153	\$381,251	\$381,103	(\$148)

¹Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$439.0 million in FY 2005), as part of the President's Emergency Plan for AIDS Relief.

PUBLIC HEALTH RESEARCH

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 317, 327.

Public Health Research (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
PHS Evaluation Transfers	\$31,000	\$31,000	\$31,000	\$0

STATEMENT OF THE BUDGET

The FY 2007 President’s Budget of \$31,000,000 for Public Health Research maintains funding at the FY 2006 Enacted level.

PROGRAM DESCRIPTION

Public health research is conducted across CDC and works to understand the best methods to assist individuals and communities to establish and maintain healthful lifestyles and environments. The Public Health Research budget activity includes the cross-cutting Health Protection Research Initiative (HPRI). The HPRI was implemented in FY2004 as a multi year program that promotes much needed research in critical public health areas addressing two overarching health protection goals for CDC:

- Promoting health/or preventing disease, injury or disability;
- Protecting people from health threats including infectious, environmental and terrorist threats

The focus in FY 2004 was to support research on developing effective health promotion and prevention programs at the workplace and to support new training efforts and new centers of excellence. The workplace affords opportunities to reach employees to promote their health in order to reduce absenteeism and health care costs associated with preventable chronic diseases.

In FY 2005, this program addressed the need for an interdisciplinary approach to research in health marketing and health communication and in public health informatics by funding two centers of excellence in each of these areas. These new centers will conduct research in applied settings, including community, regional, and national settings and to build interdisciplinary research teams that include economists, educators, informaticians, mathematicians, marketing and communications specialists, public health practitioners, and others, to address critical research needs. The two Centers of Excellence in Public Health Informatics conduct interdisciplinary research that will lead to major scientific advances in knowledge, implementation and new applications in public health informatics to promote effective public health practice. The two Centers of Excellence in Health Marketing and Health Communication will develop interdisciplinary approaches that promote the spread and adoption of effective public health interventions.

In FY 2006, no new grants will be awarded although the program will fund continuation awards for year two (centers funded in FY2005) and year three (projects, training, institutional training, and centers funded in FY2004) of the HPRI projects. In FY 2007, the funding period will end for the grants awarded in FY 2004. Funds will be recycled into new grant awards that develop translation and dissemination research to address the CDC Health Protection Goals within four major themes:

- Healthy people in every stage of life
- Healthy people in healthy places
- People prepared for emerging health threats
- Healthy people in a healthy world

CDC is committed to funding high-quality public health research that makes the transition from research to practice. All research is proposed by researchers working with communities, health practitioners, and policymakers to address local priority health concerns. All research projects also undergo peer review by expert researchers external to CDC to identify the highest quality proposals. Research awards are evaluated at least annually by program officials to determine if adequate progress is made. CDC promotes interagency collaboration in scientific pursuits by publishing the Health Protection Research Initiatives in the NIH Guide for Grants and Contracts so that CDC and NIH can

participate jointly in initiatives and where scientists can find competitive funding opportunities for both agencies. CDC also participates in the NIH Early Notification System that circulates program announcements to all NIH Institutes and Centers to encourage co-sponsoring of research initiatives prior to publication.

PERFORMANCE ANALYSIS

The challenges to public health require a coordinated approach to build capacity throughout the country for practical, applied research by leveraging the scientific capabilities and creativity of experienced investigators, by developing a cadre of new public health researchers, and by supporting the collaboration of multidisciplinary scientists.

Current Activities

- In FY 2006, CDC will fund continuation awards for years two and three of the HPRI and continue program evaluation efforts. CDC will develop a Program Announcement for translation and dissemination research to address the CDC Health Protection Goals
- In FY 2007, CDC will fund continuation awards for year three of the four centers of excellence and new awards for FY 2007 that are aligned with the CDC health protection goals.

Significant Accomplishments

- In FY 2004, CDC awarded 58 extramural research grants to support research on developing effective health promotion and prevention programs at the workplace and to support new training efforts and new centers of excellence in health promotion economics. These awards were made using four mechanisms of support (R01, K01, T01, & P30) totaling \$22 million.
- CDC has developed the first CDC-wide research guide with extensive external involvement of researchers, public interest groups, professional associations, and others. The Health Protection Research Guide will be aligned with new health protection goals providing direction for future research.
- In FY 2005, Principal Investigators of the 58 grants met in Atlanta to discuss how to best identify the impact of their research on public health practice and on policy.
- In FY 2005, CDC awarded four centers of excellence grants: two in Public Health Informatics and two in Health Marketing and Health Communication.
- CDC is standardizing best practices for extramural research across CDC, similar to those used by NIH and also meets all HHS standards and guidelines.
- CDC solicits public health research and research training and selects the most highly meritorious applications through external peer review. In FY 2005, CDC met its 90% goal of all research applications having external peer review.
- CDC is building a cadre of public health researchers, public health research training programs, and centers of excellence that encourage multidisciplinary approaches. This research will provide much needed evidence to support specific programs, practices and policies that affect health decisions made by the American public and those responsible for health policies and programs.

RATIONALE FOR THE BUDGET

The FY 2007 President’s Budget of \$31,000,000 for Public Health Research maintains funding at the FY 2006 Enacted level.

OUTPUT TABLE

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Extramural health promotion research grants:				
New awards	4	0	54	54
Continuation awards	58	58	4	(54)

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 311, 319, 319A, 319C, 327, 352, 361, 362, 368, 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.

Public Health Improvement and Leadership (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$247,389	\$189,823	\$190,165	\$342
Department of Defense Appropriation	\$0	\$75,000	\$0	(\$75,000)
Total	\$247,389	\$264,823	\$190,165	(\$74,658)

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$190,165,000 for Public Health Improvement and Leadership, a decrease of \$74,658,000 below the FY 2006 Enacted level of \$264,823,000.

PROGRAM DESCRIPTION

The Public Health Improvement and Leadership (PHIL) budget activity supports several cross-cutting areas within CDC whose purposes are to ensure more efficient and effective science and program development. This activity includes the Leadership and Management function, which funds the CDC Office of the Director (OD), coordinating centers, and each constituent center. The PHIL budget activity also supports CDC's newly coordinated workforce and career development efforts. Additionally included are the Director's Discretionary Fund and CDC's Congressional projects.

LEADERSHIP AND MANAGEMENT

To enhance public health program, science, and practice effectiveness and achieve greater impact on America's health, CDC's Leadership and Management activity supports critical areas such as strategy and innovation, goals management, and health disparities. Components of this activity are described below.

CDC OFFICE OF THE DIRECTOR

The CDC OD is comprised of the offices that manage and direct CDC's domestic and international health protection programs. The OD provides leadership, advises on strategy, and develops and evaluates the progress of goals and objectives related to disease prevention and control, including the correlation of these activities to health impact.

CDC is enhancing its efforts to accomplish greater health impact by developing and monitoring agency-wide goals, ensuring that CDC's goals focus on reducing and eliminating health disparities, and balancing health protection needs, science, and available resources to accomplish CDC's mission. To this end, CDC's executive leadership is provided with decision-making support through analytical assessments and strategy recommendations for achieving the greatest health impact for the public.

CDC's OD provides leadership, coordination, assessment, and evaluation for minority health initiatives; supports internal and external partnerships; and synthesizes, disseminates, and encourages use of scientific evidence identifying effective interventions to reduce health disparities. The OD also supports cooperative agreements with academic institutions and national nongovernmental organizations to conduct prevention research, program development, analysis, and evaluation to improve the health status of minorities and reduce health disparities. CDC funds key sectors to carry out student and professional research internship and fellowship opportunities that contribute to the improvement of diversity and cultural competency in public health.

CDC has expanded and enhanced activities related to scientific vision and leadership in science innovation, research, ethics, and science administration to ensure stability and commitment to long-term scientific investments to achieve its overarching health protection goals. To improve public health, the OD upholds scientific ideals and establishes an environment thriving with scientific excellence, innovation and integrity, learning and discovery, and the timely dissemination and translation of scientific information, innovations, and technology into practice. It facilitates

developing approaches for long-term planning and evaluation of CDC's scientific enterprise and ensuring sustainability of scientific output; establishing and sustaining high-level national and global alliances and synergy; and ensuring development of public health policies using a scientific foundation. The OD facilitates research prioritization, planning, and evaluation across both intramural and extramural programs. The CDC research portfolio is designed for maximum impact on public health to achieve its desired ends.

CDC's science activities maintain the integrity and productivity of scientists by resolving controversial scientific issues, supporting training and information exchange, and providing direction on matters of scientific integrity. CDC ensures the protection of human subjects in public health research and participates in national and international initiatives in human subject protection. The CDC OD also manages CDC's intellectual property (e.g., patents, trademarks, copyrights) and promotes the transfer of new technology from CDC research to the private sector to facilitate and enhance the development of diagnostic products, vaccines, and products to improve occupational safety.

CDC's communications and issues management activities are coordinated and interconnected across the agency through the CDC OD. The OD collaborates with program, policy, and communications professionals to develop multi-faceted strategic responses to issues relevant to the whole agency or enterprise. The OD responds to urgent issues as they emerge and analyzes a range of information to proactively identify and propose responses to issues before they become urgent concerns. These activities ensure that CDC leadership has critical information with which to respond to urgent issues and ensure that enterprise staff and partners are aware of this information and the rationale that supports it.

The OD also incorporates the principal advisor to the CDC Director and manager of daily activities of the OD. These activities ensure that the multi-faceted and cross-cutting issues relating to efficiency and effectiveness of key decisions made by the CDC Director are reviewed and analyzed. The flow of information to the Director and CDC senior staff is also managed, as well as ensuring the CDC director is advised on key programmatic and policy issues.

CDC's activities in Washington D.C. allow for a presence to represent CDC leadership and programs to Congress, officials from HHS, and Washington, D.C.-based organizations that are existing or potential partners with CDC. This function provides service and products to these entities so that CDC can achieve its ultimate goal of improving health. In addition, CDC's Washington, D.C. office provides strategic representation for the agency with other federal agencies during management of crises and develops strategic partnerships with other federal agencies to accomplish administration and agency health goals in non-acute but high priority situations. Finally, the office advises agency leaders and scientists about developments in Washington, D.C. that bear on the accomplishment of administration and agency health goals.

Public health practice is a significant area of CDC's activities, ensuring coordination and synergy between scientific and practice activities throughout CDC. The principal means for achieving this level of coordination is to ensure practice-relevant standards, policies and legal tools.

COORDINATING CENTERS, COORDINATING OFFICES, AND CENTER OFFICES OF THE DIRECTOR

CDC's new structure includes several coordinating centers and offices, responsible for the coordination of thematic areas within and across operational centers; identification of areas for collaboration; reduction of redundancies in business practices in concert with CDC's OD; incorporation of quality science and program to meet the agency's goals; leadership, decision-making, and management of operational units; and advising the Director on scientific, strategic, and programmatic issues. The coordinating centers work closely with the center ODs, which are responsible for developing scientific knowledge and quality program development; ensuring scientific credibility and integrity in all areas of expertise needed to address public health; accountability for addressing programmatic key performance indicators; serving as the foundation and core of CDC's science and services; and maintaining expertise needed to address public health emergencies.

PUBLIC HEALTH WORKFORCE DEVELOPMENT

CDC's workforce and career development activities are focused to achieve the following:

- Workforce needs are anticipated and filled through strategic recruitment;
- Skills and competencies of the health workforce are improved and sustained;
- Competent and diverse health and leadership cadres are in place when and where needed;
- Practices of health organizations and systems are improved;
- Workforce development activities are grounded in sound science; and
- Best practices, standards, and guidelines are used in workforce and career development efforts sponsored by CDC.

To protect the public's health across the life stages and to be prepared for outbreaks and public health emergencies, the public health workforce, at all levels and in sufficient numbers, must have the skills and competencies necessary to work effectively in a rapidly changing and complex environment. The knowledge and breadth of skills needed by the public health workforce, whether at CDC or in another setting, is growing and changing more rapidly than ever. To meet these needs, training programs must be transformed into an ongoing process of re-skilling and re-tooling so the workforce can acquire and maintain the competencies needed to perform essential public health services and to satisfy changes in mission, technology, and the content of work.

Toward this end, CDC will provide assistance to both internal and external partners, on a broad range of training-related issues, including development of training courses and materials, selection of most effective delivery methods, implementation of training-related activities, and evaluation of training efforts. This assistance will be based on the scientific understanding of best practices related to training and further enhanced by CDC's collective practical experience and expertise in the development and delivery of training. In addition to serving as consultants regarding these general training-related issues, CDC will also convene and work with experts in developing topic-specific training. Finally, CDC, in consultation with the agency's Excellence in Learning Council, will be responsible for developing, revising, administering, and evaluating the policies governing the newly established Individual Learning Accounts at CDC. CDC is committed to providing all employees with flexible learning opportunities that will be accessible through agency-funded Individual Learning Accounts.

In preparing for the future, CDC will implement targeted strategies for building a diverse, competent, and sustainable workforce. To this end, CDC will create a learning environment that will enhance CDC's ability to attract and retain leaders that are prepared to meet current and emerging health protection priorities. In addition, CDC will assess and evaluate current training.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the PHIL activity, the activities have been selected as highlights of the program's performance plan:

Performance Goal	Results	Context
1. Increase the number of local, state, and federal health care professionals who participate in training in epidemiology, lab or public health leadership management.	Epidemiologic training has been developed to address state and local needs. Additionally, competencies in epidemiology are being assessed in front-line public health workers.	The nation has a growing need for trained epidemiologists to address current public health problems as well as problems with emerging and re-emerging infectious diseases. As demonstrated by the events of 2001, the nation needs "rapid response" capabilities to meet the real and ongoing threats of terrorism and bioterrorism. CDC needs an available cadre of trained epidemiologists to ensure frontline protection of the public's health.
2. Evaluate the impact of training programs conducted by the National Lab Training Network (NLTN) on laboratory practices.	The NLTN conducts training courses through cost-effective, cutting edge training in the laboratory sciences.	The nation has a growing need for trained health care workers in the laboratory sciences to address current public health problems in areas such as biological and chemical terrorism preparedness, molecular diagnostics, detection of antimicrobial resistance, and other areas of public health concern.

Current Activities

- CDC continues to develop trained professional staff able to investigate health problems affecting the nation's population.
 - Epidemic Intelligence Service (EIS) officers participate in domestic and international infectious disease investigations ranging from epidemics of meningococcal disease and Ebola hemorrhagic fever to West Nile Virus, monkeypox, Marburg virus, and Severe Acute Respiratory Syndrome (SARS). As their predecessors eradicated smallpox from the globe, today's officers are working to eliminate poliomyelitis and measles, as well as battling to prevent chronic diseases, violence, and injury. Approximately 70 percent of EIS graduates pursue public health careers.
 - The Preventive Medicine Residency combines clinical medical skills with public health practice expertise (e.g., epidemiology, health services management, environmental health). CDC sponsors one of the nation's largest accredited Public Health and General Preventive Medicine Residencies by training ten residents a year.
 - The Public Health Prevention Service Program trains approximately 25 Prevention Specialists annually. This three-year training and service program for master's level public health professionals focuses on public health program management and provides Prevention Specialists with experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and state and local health agencies.
- The two-year post-doctoral Prevention Effectiveness Fellowship Program, tailored for economists and health services researchers, trains them to apply the tools of economics and decision analysis to public health policies, programs, and practices; and to systematically assess the costs and benefits of public health programs while emphasizing fiscal accountability and responsible stewardship of public funds.
- The Public Health Informatics Fellowship program trains professionals to translate and apply new and emerging information technologies to support the needs of public health programs. This two-year fellowship provides a unique training experience that equips professionals with the ability to develop, evaluate, implement, and manage new public health information systems and adapt and support existing systems.
- Supports 17 state and regional leadership institutes; 2 national leadership development programs (Public Health Leadership Institute, Management Academy for Public Health), the National Leadership Network, and the Public Health Leadership Society. Public health officials in all 50 states and the U.S. Territories are eligible to participate in either the national, state or regional institutes. Approximately, 725 health officials are participating in these programs in 2005.
- The National Laboratory Training Network (NLTN) provides cost-effective cutting edge and basic training in the laboratory sciences. During FY 2005, the NLTN provided more than 200 courses and trained over 29,000 public health and other health care workers in areas such as biological and chemical terrorism preparedness, molecular diagnostics, detection of antimicrobial resistance, and other areas of public health concern.
- The Excellence in Learning Council provides a cross-agency forum for enhancing agency-wide workforce and career development policies, programs, science and practices which assure a competent and sustainable workforce to address current and emerging public health needs.

Significant Accomplishments

- Examined evidence linking workforce training/certification and health outcomes. Examined evidence linking cultural competency- based training to improved health outcomes.
- As of September 30, 2005, headquarters EIS officers have responded to 66 outbreaks in a variety of locations, of which 54 were in the United States and eight were in other countries. In addition, field EIS officers assigned to state or local health departments conducted another 273 field investigations. Requests for assistance were primarily for infectious disease problems, but they also addressed environmental health, injuries, maternal and child health, and other problems.
- In the fourth quarter of FY 2005, more than 125 trained professional staff were engaged in the response to Hurricanes Katrina and Rita: 95 EIS officers were deployed to the field and 13 to the Director's Emergency Operating Center (DEOC); 12 Prevention Specialists worked on relief efforts at the local level through their health agencies in eight states and the District of Columbia; five informatics fellows were deployed to help state/local agencies; and two PMR staff members were deployed (one to the DEOC and one to the National Center for Environmental Health to address mold and air pollution hazards).

- As of September 30, 2005, Prevention Effectiveness Fellows determined the economic burden of diabetes in children and adolescents, HIV infection in children, Meningococcal disease in adolescents, influenza, lyme disease, cancer, cardiovascular diseases, child maltreatment, smoking during pregnancy, tractor overturn injuries, obesity and physical inactivity in the United States, and the impact of Head Start on children's health outcomes, latent TB Screening for HIV-infected persons in Uganda, and HIV re-screening during late pregnancy in South Africa.
- The NLTN presented six public health teleconferences for public health laboratory workers nationwide on topics including the Validation of Molecular Methods, Select Agent Rule and Antimicrobial Susceptibility Testing – the Clinical and Laboratory Standards Institute. These courses have been archived for access on the NLTN Web site.
- In the second quarter of FY 2005, four courses were presented on Time-Resolved Fluorescence (TRF) to a total of 64 public health laboratorians from around the country. TRF is a Laboratory Response Network (LRN) Rapid Method for the identification of agents of terrorism. Three courses on the LRN Confirmatory Tests for Bioterrorism Agents have been presented during FY 2005, providing training to an additional 48 public health laboratorians.
- First-ever set of scientifically-derived competencies for applied epidemiologists developed in collaboration with the Council of State and Territorial Epidemiologists. Other participants in the expert panel included the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, the Association of Schools of Public Health, with representatives from each of those organizations.
- Implemented agency-wide program to train managers, supervisors and employees in how to develop competency-based individual development plans which are aligned with CDC mission and goals.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$190,165,000 for Public Health Improvement and Leadership, a decrease of \$74,658,000 below the FY 2006 Enacted level of \$264,823,000.

Pay Raise (+\$2.2 million)

The request includes funds to cover the projected FY 2007 increase.

World Trade Center (-\$75.0 million)

The FY 2006 appropriation provided \$75.0 million for the continuation of World Trade Center Health Registry, which began as a result of the September 11, 2001 terrorist attacks. This registry, a collaboration between CDC/ATSDR and the New York City Department of Health and Mental Hygiene, has identified and tracked the long-term health effects of the tens of thousands of workers and community members who were the most directly exposed to smoke, dust, and debris from the World Trade Center collapse. The additional funds provided in FY 2006 will allow for continued analysis and interpretation of the data collected since the program's inception in 2003 to ensure the health needs of all those exposed are understood and can be addressed. These funds will be used over several years to complete all necessary follow-up.

Administrative and Information Technology (IT) Savings (-\$1.8 million)

An administrative savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing of interagency agreements. This savings has been applied across CDC's budget lines. The FY 2007 President's Budget also includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of new Public Health Informatics Fellows annually	5	5	5	0
Number of Prevention Effectiveness Fellows annually	10	10	10	0

NARRATIVE BY ACTIVITY
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Outside Preventive Medicine Resident assignments sponsored at CDC	4	2*	4	2
Number of new Public Health Prevention Service Specialists annually	25	25	25	0
National, state and regional leadership development program graduates annually**	725	30**	30	0
States participating in public health leadership and management training annually**	40	25**	25	0

*These residents are usually funded by OWCD through Association of Teachers of Preventive Medicine (ATPM) (\$14k/resident). For FY 2006, we have one resident from Tulane, but at no cost to OWCD. We could potentially have an additional resident in FY 2006, depending on appropriation.
**Reductions in outputs for these activities reflect decisions related to priorities that result in a decrease in total available funding through all sources within the Public Health Improvement and Leadership budget activity.

FUNCTIONAL TABLE

Public Health Improvement and Leadership Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Congressional Projects	\$60,450	\$0	\$0	\$0
Leadership and Management	\$163,746	\$162,251	\$162,550	\$299
World Trade Center - Department of Defense Appropriation	\$0	\$75,000	\$0	(\$75,000)
Director's Discretionary Fund	\$3,273	\$7,851	\$7,867	\$16
Public Health Workforce Development	\$19,920	\$19,721	\$19,748	\$27
Total -	\$247,389	\$264,823	\$190,165	(\$74,658)

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

AUTHORIZING LEGISLATION

Grants: PHSA Title XIX; Prevention Activities: PHSA §§ 214, 301, 304, 306, 307, 308, 310, 311, 317j, 327.

Preventive Health and Health Services Block Grant (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$118,526	\$99,000	\$0	(\$99,000)

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects the elimination of the Preventive Health and Health Services Block Grant, a decrease of \$99,000,000 below the FY 2006 Enacted level. While this funding will no longer be available, new appropriations language provides authorization for states to utilize funds within categorical grant programs for purposes related to those conducted with PHHSBG funds to allow for a source of flexible funding in the absence of PHHSBG funds.

PROGRAM DESCRIPTION

The PHHSBG has been a tractable source of funding, providing 61 grantees (50 states, the District of Columbia, two American Indian Tribes, and eight U.S. territories) the autonomy and flexibility to tailor prevention and health promotion programs to their particular needs. A portion of PHHSBG funding for prevention activities supports public health agencies in six states to improve health information and data systems.

PERFORMANCE ANALYSIS

Current Activities

The PHHSBG provides funding support for primary prevention activities and health services that address more than 30 different health problems in local communities. Programs have targeted major issues such as cardiovascular disease, cancer, diabetes, tuberculosis, emergency medical services, injury and violence, infectious disease, environmental health, and sex offenses. In addition, the PHHSBG has supported activities such as clinical services, preventive screening, laboratory support, outbreak control, training, public education, and program evaluation.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 President's Budget reflects the elimination of the Preventive Health and Health Services Block Grant, a decrease of \$99,000,000 below the FY 2006 Enacted level. While this funding will no longer be available, new appropriations language provides authorization for states to utilize funds within categorical grant programs for purposes related to those conducted with PHHSBG funds to allow for a source of flexible funding in the absence of PHHSBG funds.

OUTPUT TABLE

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Number of states, territories, American Indian Tribal organizations funded	61	61	0	(61)

BUILDINGS AND FACILITIES

AUTHORIZING LEGISLATION

PHSA § 319D, 321(a).

Buildings and Facilities (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$269,708	\$158,400	\$29,700	(\$128,700)

STATEMENT OF THE BUDGET

The FY 2007 President's Budget requests a total funding level of \$29,700,000, a decrease of \$128,700,000 for Buildings and Facilities below the FY 2006 Enacted level of \$158,400,000. The FY 2007 request level will allow CDC to fund nationwide repairs and improvements.

PROGRAM DESCRIPTION

With the charge of protecting the public health security of the nation, CDC is responsible for ensuring adequate facilities and equipment to carry out the agency's mission.

CDC is making dramatic progress in implementing its Buildings and Facilities Master Plan so that all facilities, particularly laboratories, are safer for both workers and the community; that the taxpayers' investments in these facilities are protected through effective maintenance and operations; that all CDC facilities are designed and operated responsibly to reduce consumption of resources (energy, water, and capital); and, that strategic planning and asset management processes are identified and implemented to continually align CDC with HHS strategic goals and objectives as well as the President's Management Agenda. To meet these goals, CDC continuously monitors the adequacy of space assignments and the need for repairs and improvements to our facilities. CDC schedules major and minor renovation, construction, and other facilities projects that it determines to be needed.

CDC is making substantial progress in replacing inadequate and energy inefficient buildings and facilities in Atlanta. In 2005, several new construction projects became operational on the Roybal and Chamblee Campuses: the Emerging Infectious Disease and the Environmental Toxicology laboratories; the Global Communications Center; and, the Headquarters and Emergency Operations Center.

In 2006 and 2007, CDC anticipates the opening of three additional facilities: the Vector-Borne Infectious Disease Laboratory in Ft. Collins, Colorado; the Environmental Health Facility, housing the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry at CDC's Chamblee Campus in Atlanta; and, the Research Support Facility component of the Roybal Infrastructure and Transshipment Project, also in Atlanta.

CDC will continue to address the remaining inefficient operational environments and other deficiencies in Atlanta with added emphasis on the non-Atlanta inventory to ensure that CDC's owned facilities meet applicable standards.

There remains a concern that the next public health emergency could overwhelm CDC's capacities to respond. Daily, CDC faces the potential need to respond to a terrorism event, an environmental disaster, or a public health threat such as a global flu pandemic. With the opening of new facilities in 2005, CDC's capabilities to respond to an emergency have dramatically increased. In addition, the East Campus Consolidated Laboratory Project on the Roybal Campus will further enhance CDC's response capacity through the consolidation of Atlanta laboratories with better insect, animal, and environmental facilities to support research and response efforts.

In addition to CDC's government-owned Atlanta campuses, scientists and public health professionals occupy leased space in 23 different buildings at five separate locations. This is a situation that continues to evolve as CDC grows to respond to new public health threats. For reasons of efficiency, physical security, and cost effectiveness, CDC undertook a facility planning effort to assess the work that would be needed to consolidate its Atlanta operations into two secure campuses.

PERFORMANCE ANALYSIS

Performance Goal	Results	Context
<p>1. Placement of NCID & NCEH laboratorians in CDC standard space (Projects occupied or underway).</p>	<p>By moving select components of the National Center for Infectious Diseases (NCID) into Building 18, the Emerging Infectious Disease Laboratory, CDC met its goal of 70 percent occupancy by NCID for 2005.</p> <p>With the occupancy of Building 110, the Environmental Toxicology Laboratory, CDC met 100 percent of its 2005 goal to move the National Center for Environmental Health (NCEH) into CDC standard space.</p>	<p>The movement of CDC laboratorians into CDC standard space will facilitate CDC's ability to meet its scientific mission. CDC standard space includes standards for bio-safety, CDC design, space planning, and accreditation of laboratory animal care and HHS utilization rate policy. This metric has underlying assumptions concerning the stability of CDC's growth rates, workforce composition, laboratory standards, and applicable codes</p>

Current Activities

- CDC has completed and occupied four Atlanta Master Plan Projects in FY 2005.
- CDC has begun or completed pre-project planning for three Atlanta Master Plan projects.
- Additionally, CDC has begun pre-project planning for three, non-Atlanta projects.
- Construction on a major laboratory facility in Fort Collins, Colorado is underway and due to be completed in FY 2006.

Significant Accomplishments

- Efficiency:
 - Construction Manager as Contractor (CMc) - CDC uses a highly competitive process to “pre-qualify” architecture and construction firms to form a pool of resources readily available for use on a task order basis for design and construction. To date, CDC has successfully procured services for six major new construction projects in approximately one-third to one-quarter the time previously needed for traditional procurements.
 - Design/Build (D/B) - In support of the HHS D/B initiative, CDC is aggressively implementing the use of this process to deliver major new building projects. CDC awarded a D/B contract for a 305,000 square foot Environmental Health Facility, Building 106. Use of this process allows CDC to deliver projects with reduced risk, accelerated delivery, and net savings. As a result, CDC invested net savings in additional program and sustainable design and development features as encouraged by the Federal Facility Council.
- Accelerated Delivery – CDC has determined that projects under CMc and D/B methods reduce delivery time by one-third over other methods.
 - Atlanta Roybal Campus, Building 20: By re-siting the building, CDC is able to accelerate major elements of the project schedule by 14 months.
 - Atlanta Chamblee Campus, Building 106: By utilizing the D/B process, CDC is able to accelerate the total project schedule by 10 months.
- Quality Control – Under both new contracting structures, the architect and builder are brought together from the inception of a project rather than from the completion of a design. This feature ensures a better final

- product, reduces change orders, and allows better adherence to budget and schedule. These features also provide much greater control of risk for CDC.
- Environmental Design - The CDC Buildings and Facilities Program is committed to excellence and leadership in protecting the environment through compliance with environmental laws and regulations, specifying environmentally beneficial products and services and by promoting environments that are healthier, safer and more productive places to live and work. CDC measures its performance using the standards set forth by the Leadership in Energy and Environmental Design (LEED) Green Building Rating System of the US Green Building Council (USGBC). CDC projects, encompassing buildings, infrastructure and landscaping, are encouraged to obtain basic LEED certification. Currently, CDC Facilities has 4 projects registered with the USGBC for LEED certification. Projects not registered with the LEED program incorporate as many of the LEED guidelines as economically viable. Through these actions CDC continues its commitment to the environment.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 President's Budget requests a total funding level of \$29,700,000, a decrease of \$128,700,000 for Buildings and Facilities below the FY 2006 Enacted level of \$158,400,000. The FY 2007 request level will allow CDC to fund nationwide repairs and improvements.

CDC is dedicated to the efficient maintenance and operations of new and existing facilities to protect the interest and investment of the government so that deterioration of CDC facilities does not occur again. The nationwide repairs and improvements program covers CDC-owned facilities in metropolitan Atlanta, Cincinnati, Fort Collins, Morgantown, Pittsburg, San Juan, and Spokane.

FIVE-YEAR PLAN

CENTERS FOR DISEASE CONTROL AND PREVENTION BUILDINGS AND FACILITIES FIVE YEAR PLAN (DOLLARS IN MILLIONS)						
Facilities Project	Bldg No.	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate
Roybal Campus:						
East Campus Consol. Lab Project	23/3	---	\$123.6	\$71.3	\$120.0	---
Epi Office Tower	24	---	---	---	---	---
Emerging Infectious Disease Lab	18	\$22.2	\$15.0	---	---	---
Scientific Communications Center	19	\$25.5	---	---	---	---
Transshipment Center / Campus-wide Utility Infra (includes Labs) / Security	20	\$43.0	\$45.8	---	---	---
HQ & Emergency Ops Center	21	\$89.4	\$19.7	---	---	---
West Campus Infra/Security	---	---	---	---	---	---
Chamblee Campus:						
Research Support Facility	107	---	---	---	---	---
Research Support Facility	108	---	---	---	---	---
Environmental Health Facility	106	---	\$12.0	\$101.3	---	---
Chamblee Campus Entrance and Site Work	---	\$6.0	---	\$2.1	---	---
Environmental Toxic. Lab	110	\$29.9	---	---	---	---
Other:						
Nationwide R&I	---	\$18.8	\$20.6	\$57.9	\$7.5	\$29.7
Data Center/Recovery Site	---	---	---	\$15.0	\$7.1	---
Ft. Collins, CO	---	\$18.0	\$9.6	\$22.0	\$23.8	---
Advanced Planning for Atlanta Projects in the 5-year Plan / Master Plan	---	---	---	\$0.2	---	---
IT Security	---	\$6.0	\$6.0	---	---	---
Cincinnati (NIOSH)	---	---	\$2.4	---	---	---
Roybal Campus Main Entrance Security	---	---	\$5.7	---	---	---
Coop Facility Lawrenceville Campus	---	\$3.0	---	---	---	---
Blast Resistant Glazing	---	\$2.5	---	---	---	---
Emergency Fire and Lifesafety Initiative	---	\$2.0	---	---	---	---
TOTAL, CDC B & F Funding		\$266.3	\$260.5	\$269.7	\$158.4	\$29.7

BUSINESS SERVICES SUPPORT

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 3173, 317F1, 319, 327, 361, 362, 368, 399F1; Federal Technology Transfer Act of 1986, (15 U.S.C. 3710); Bayh-Dole Act of 1980, P.L. 96-517.

Business Services Support (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA¹	\$319,152	\$298,616	\$303,854	\$5,238

¹The FY 2007 Estimate carries forward the proposal in the FY 2006 Conference language to move management and administrative costs (\$34.8 million) from Occupational Safety and Health to Business Services Support. Funding for FY 2005 is shown on a comparable basis.

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$303,854,000 for Business Services Support, an increase of \$5,238,000 above the FY 2006 Enacted level of \$298,616,000.

PROGRAM DESCRIPTION

Over the past two years, CDC's business support structures and systems have been significantly revised to achieve greater effectiveness and efficiencies. CDC has revised its budget structure to ensure greater transparency and accountability for programmatic dollars by identifying and separating costs related to business operations and processes into the Business Services Support budget activity. The work conducted within this activity supports the premiere public health programs and science that make CDC America's lead public health agency and a respected resource for improving public health worldwide.

Guided by the new CDC and the President's Management Agenda (PMA), CDC has combined best practices of the business community with those of the public sector to become a more efficient, effective, and accountable steward of taxpayer dollars. To meet the goal of providing cutting-edge business services, CDC has engaged in numerous business process improvements and continues to adapt to realize additional benefits from advancements in this area.

Current Activities

CDC's business functions are carried out within the Office of the Chief Operating Officer (OCOO) with the function of:

- Overseeing business services support for CDC and ensuring that CDC's business practices are efficient by applying proven public- and private-sector systems and practices.
- Overseeing and carrying out PMA functions. (Please refer to the PMA section of this document for information about related accomplishments and activities.)
- Assuring that funds are appropriately allocated throughout the agency and that CDC's programs have the tools and facilities needed to ensure top-quality science and programs.
- Protecting CDC employees' health and safety.
- Utilizing Key Performance Indicators (KPIs) to evaluate performance and effectiveness related to CDC's business functions, a snapshot of critical information about the most important aspects of business operations. Business-related KPIs measured at CDC include hiring, personnel, workforce development, grants and contracts, financial management, information technology, travel, diversity, and

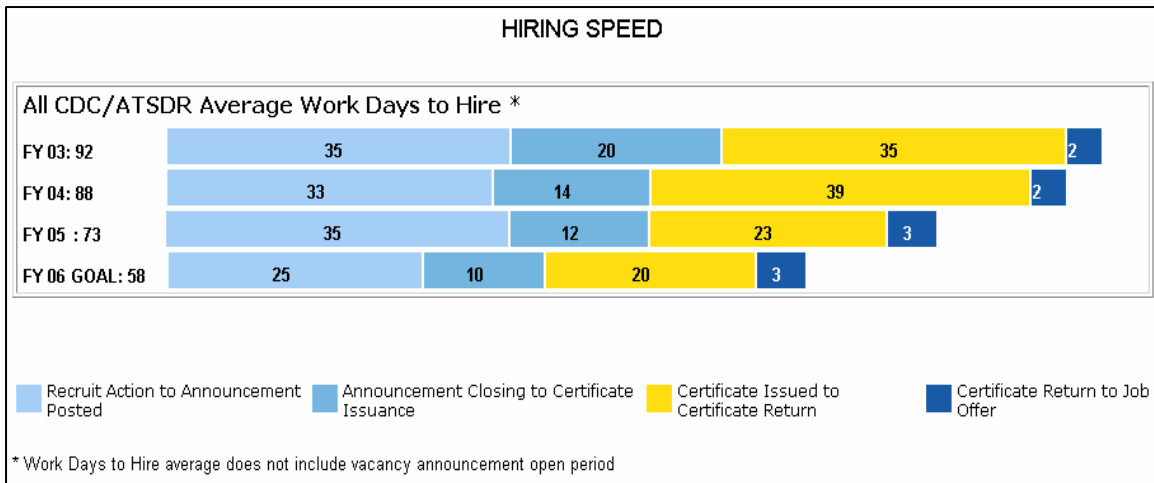
The offices within the OCOO include the following:

- **Administrative Services and Program**
- **Alternative Dispute Resolution**
- **Atlanta Human Resources Center**
- **Capital Planning and Investment Control**
- **Ethics**
- **Financial Management**
- **Facilities Planning and Management**
- **Security and Emergency Preparedness**
- **Information Technology Services**
- **Management Analysis and Services**
- **Chief Information Security Officer**
- **Procurement and Grants**

facilities. KPIs are an essential performance management tool through which CDC proactively manages administrative performance and ensures efficient use of appropriated funds.

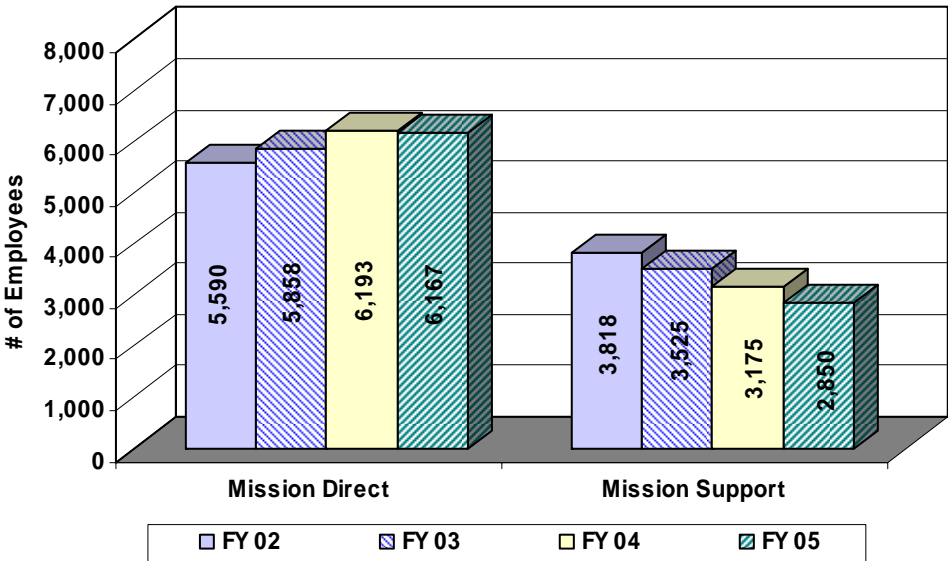
Significant Accomplishments

- Reduced hiring time significantly through concurrent operation efficiencies within the Atlanta Human Resources Center (AHRC). In FY 2003, days-to-hire ("date recruitment action is received in AHRC" to "job offer date") averaged 92 workdays. At present, the days-to-hire average is 73 workdays and the FY 2006 goal is 58 workdays (all averages exclude announcement open periods). These gains have occurred despite an almost 50 percent increase in staffing workload within AHRC. In addition, the AHRC key performance indicators show that we are exceeding OPM's hiring goal of 45 workdays from announcement closed to job offer (i.e., in 42 workdays).

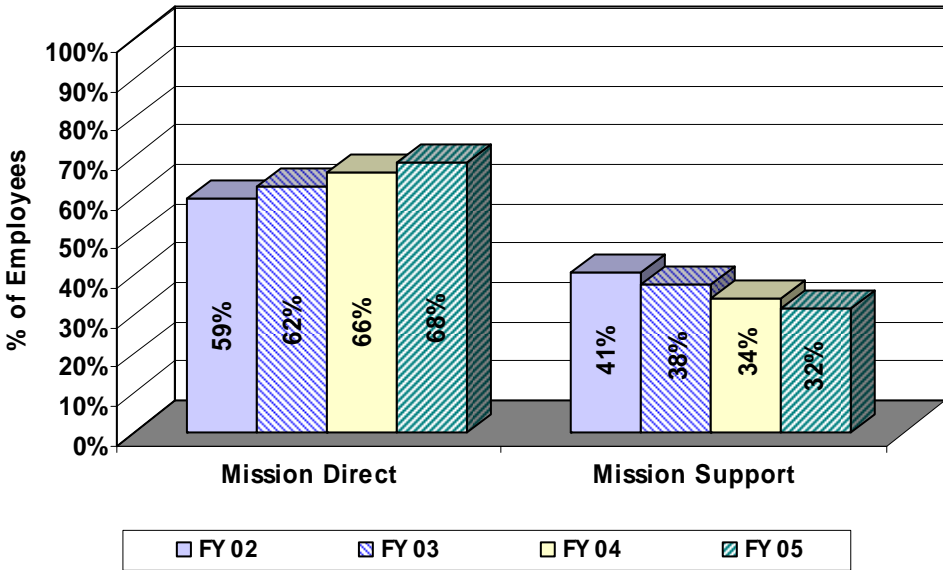


- Continued to lead a multi-year initiative to shift more staff to frontline public health programs, thereby increasing CDC's positive impact on America's health and well-being. For example, AHRC worked with the OCOO to develop a FY 2005 Voluntary Separation Incentive Payment (VSIP) plan (approved by OPM) to help CDC reduce the number of mission-support staff. This plan was extremely successful. For example, by the third quarter of FY 2005, a total of 301 individuals in mission-support positions had elected regular or early-retirement with a VSIP. Furthermore, at least half of these FTEs were redirected to mission-direct positions.

Mission Direct vs. Mission Support Number of Employees

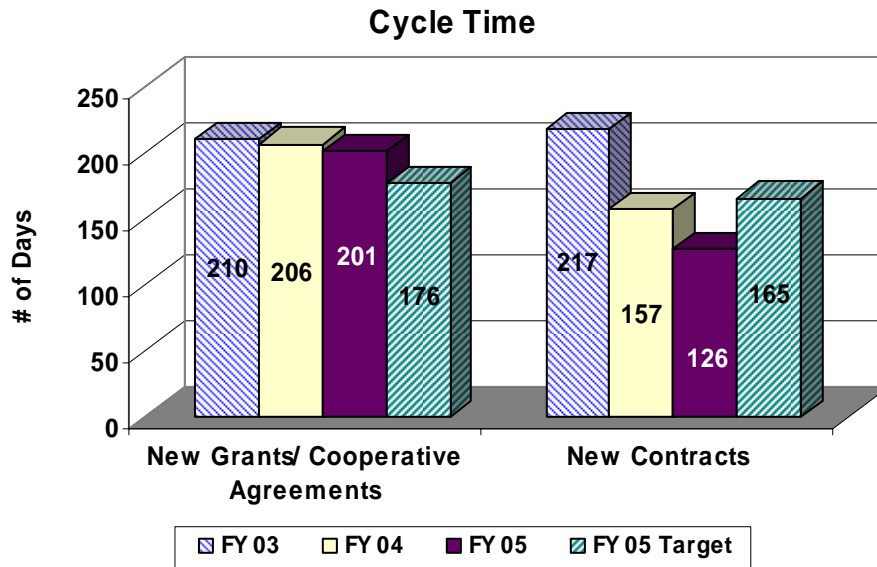


Percent of Employees

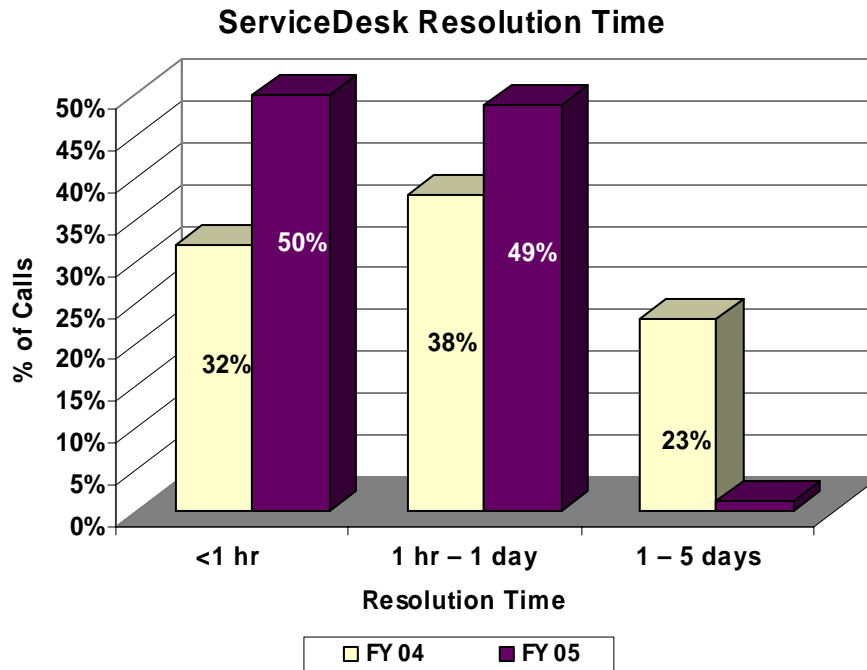


- Enabled CDC's programs to implement health-related programs and initiatives through the acquisition and assistance activities of the Procurement and Grants Office (PGO). PGO also protects the public trust by ensuring the integrity, efficiency and effectiveness of financial assistance and acquisition processes. PGO provides management of all CDC acquisition and assistance awards. PGO is also implementing process improvement measures and KPIs to decrease the amount of time taken to award contracts and grants, thereby increasing the speed with which public health interventions can be put into place.
- Set an aggressive target of 165 days for new contracts in FY 2005, which is much lower than the FY 2003 baseline. Although it is slightly greater than FY 2004 actual performance, CDC seeks to ensure process improvements established in FY 2004 are sustainable before adjusting the target. Also, new procedures are

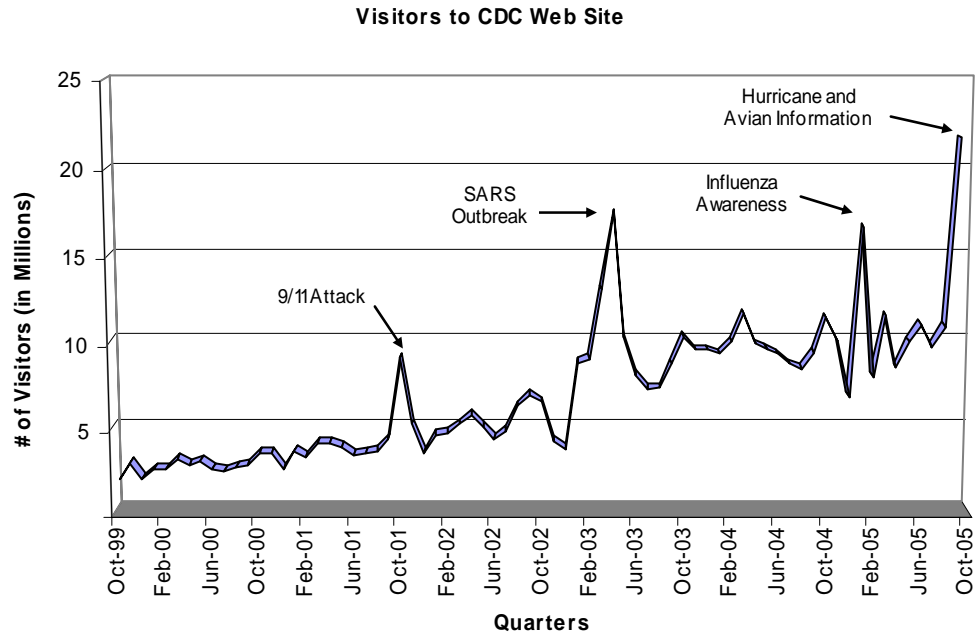
being developed in FY 2005 to improve efficiency, which may slightly increase cycle time over FY 2004 levels due to the initial implementation complexities.



- Consolidated all common CDC IT infrastructure services to achieve higher performance at lower cost through the Information Technology Services Office (ITSO). During its first year, ITSO reduced costs over 20 percent while increasing service offerings, expanding service hours and locations, improving service levels, and reaching a "best-in-class" customer satisfaction result.



- Experienced over 30 percent growth per year in visits to CDC's Web site, compounded over the last five years, now exceeding 11 million visitors per month on average. Visits to the CDC Web site reflect the quality, timeliness, trust, and value of CDC's information to the public. During public health emergencies, visits to the site spike dramatically as the public seeks emergency-related information.



In addition to the KPIs included in this document, OCOO is responsible for tracking and reporting many business services functions. The Business Services Support budget activity is an extension of this system of accountability for business. By separating these costs, CDC assures greater transparency and accountability, ensuring funds are used for their intended purpose and by providing CDC with one funding stream through which its major business processes are managed. These include the OCOO as well as resources for areas such as rent, utilities, telecommunications, and security for CDC employees.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$303,854,000 for Business Services Support, an increase of \$5,238,000 above the FY 2006 Enacted level of \$298,616,000.

Unified Financial Management System, Service and Supply Fund, and Rent (+\$3.4 million)

Additional funding for UFMS and the Service and Supply Fund will support increasing needs for existing activities through FY 2007. The FY 2007 estimate also includes funds to cover projected FY 2007 rent increases.

Pay Raise (+\$1.8 million)

The request includes funds to cover the projected FY 2007 increase.

TERRORISM

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 311, 317, 319,319A, 319D, 319F, 319G and 361-368, (42 U.S.C, 262 note), 2801-2811. Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

Terrorism (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$1,622,757	\$1,577,257	\$1,657,161	\$79,904
Department of Defense Appropriation	\$0	\$55,000	\$0	(\$55,000)
Total	\$1,622,757	\$1,632,257	\$1,657,161	\$24,904

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$1,657,161,000 for Terrorism Preparedness and Emergency Response, an increase of \$24,904,000 above the FY 2006 Enacted level of \$1,632,257,000.

PROGRAM DESCRIPTION

The health and security of the United States depends on our preparedness against terrorism, bioterrorism and natural public health emergencies. Helping lead this effort is the Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER). The national focus on bioterrorism preparedness is having a positive effect on state and local public health systems. Preparedness funds enable communities to develop the building blocks needed to respond to varied disaster scenarios, including chemical, biological, radiological and nuclear (CBRN) events. Community leaders have stated that this infrastructure has multiple uses that benefit broader public health responsibilities, especially those related to infectious disease control. CDC has received more than \$8 billion since 2001, and will continue its commitment to building preparedness and response capacities across the nation and to build the capacity of the federal, state and local public health systems to address all potential hazards.

The Coordinating Office of Terrorism Preparedness and Emergency Response has established a framework to execute and implement the agency's overarching preparedness goals and the HHS Strategic Plan to Combat Bioterrorism and Other Public Health Emergencies. Combined, these goals lay a foundation for overcoming the challenges that public health faces against terrorism and will continue to be reshaped as necessary to meet evolving needs and priorities. Directed by the mission statement – "People in all communities will be protected from infectious, occupational, environmental, and terrorist threats", - CDC has identified the following six components necessary to an effective preparedness framework: Prevention, Detection and Reporting, Investigation, Control, Recovery and Improvement. This framework is designed to be outcome and performance driven while providing a structure for the execution of the agency's strategic goals and to create a pathway for smooth implementation of a comprehensive preparedness and emergency response program.

To support and help track these efforts the following nine goals have been established to help measure and gauge performance.

1. **Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally occurring health threats.** This goal is centered on increasing CDC's and its partner's ability to prevent public health emergencies. It is designed to encourage investments and application of known interventions, such as the use of vaccines and personal protective equipment, but also provides room for the innovation of new and effective interventions based on scientific discovery.
2. **Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.** Here CDC encourages the use of modern tools to enhance surveillance, epidemiology and laboratory capacity, as well as the integration of national security data and resources with health information from around the globe. The public health community is in a unique position to use scientific measures to detect and report unusual health events quickly by using systems like PulseNet and integrating state and local health departments into the Public Health Information Network (PHIN). The

- BioSense project is prototype for such an effort through its innovative surveillance of different clinical and health data streams and its ability to analyze them to help spot potential outbreaks or bioterrorist attacks.
3. **Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.** This goal demonstrates CDC's commitment to continue providing resources to state and local public health departments and laboratories to determine the cause and extent of public health emergencies.
 4. **Improve the timeliness and accuracy of communications regarding threats to the public's health.** In order to accomplish this goal CDC is combining advances in information technology with the long standing relationship CDC has with health care providers, to create a continuum of efforts from the individual provider to the community and the nation.
 5. **Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.** This provides the framework for the public health system's ability to conduct investigations to determine the cause and breadth of public health emergencies. It includes the famous "disease detection" work public health epidemiologists are known for, as well as the speed with which messages can reach the public regarding the issue and ways to protect oneself from the threat. CDC and its public health partners are putting into place plans and systems designed to control the damage of a catastrophic event. By increasing the number of quarantine stations and increasing the surveillance and monitoring capabilities CDC and its partners will be able to provide increasing timely and proper care.
 6. **Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.** This goal allows for opportunities to create structures to provide immediate information and medication, if needed, to the masses. It also provides for planning and training to quickly receive and distribute the Strategic National Stockpile (SNS), a national repository of life saving pharmaceuticals, medical material and equipment. CDC supports programs, such as the Cities Readiness Initiative (CRI), to enhance and test capabilities related to receipt and distribution of the SNS in large metropolitan areas. The final components, stated in three goals, relate to assuring that state and local health departments in conjunction with federal teams can quickly restore services, and learn and improve from each event.
 7. **Decrease the time needed to restore health services and environmental safety to pre-event levels.** This goal sets the stage for rapid re-establishment of vital public health services for non-emergency conditions. CDC's close partnerships with state and local health departments will allow for materials and personnel to be quickly dispatched and integrated, thereby decreasing the time that vital services are adversely affected.
 8. **Increase the long-term follow-up provided to those affected by threats to the public's health.** Here CDC allows for additional scientific knowledge, health care, and data collection to support continuous improvements in the delivery of public health interventions and the prevention of morbidity and mortality during subsequent events. The knowledge gained from these studies will provide useful information for future responses.
 9. **Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.** The final goal includes requirements for robust tracking of lessons learned and implementation of corrective actions to support enhanced response in the future. This constant re-evaluation is designed to ensure maximum efficiency and the best possible response to those affected by a CBRN or other public health emergency.

Investments in strengthening early detection and containment of biological public health threats are being implemented through several key initiatives. Begun in FY 2004, Project BioShield provides for the purchase and storage of needed vaccines and antibiotics under the administration of the SNS. Second is the Biosurveillance Initiative which is a multi-agency program to better the early detection and containment of potential health threats to the US population. CDC's portion of this initiative includes the BioSense project. Through it, CDC is assuring that information technology tools are being leveraged to provide data from multiple disparate data sources into a fully functioning, real-time surveillance system. Utilizing these tools, federal, state and local health officials will have access to real-time data that could potentially be the first sign of a public health emergency or even a bioterrorist attack.

CDC is also focusing on increasing border security through the creation of additional quarantine stations. With only 8 in FY 2004 these critical security areas were able to expand to 18 by the end of FY 2005 and will reach 35 by the end of FY 2007. Currently they are now operational at airports and other major sites of entry into the US. Finally, CDC is investing Biosurveillance resources to increase real-time lab reporting. This program is helping to increase information systems supporting laboratories across the nation. These systems are providing real-time test requests and results to CDC that are included among data points used to monitor the public's health.

Over the past six years, CDC has invested resources, time, and concerted efforts to assure that preparations and measures are in place to provide a comprehensive and effective public health response to a bioterrorist incident or an infectious disease emergency, like SARS, Avian Influenza or a new influenza pandemic. The newly established framework is a result of lessons learned from our state and local partners, from exercises conducted at the federal state and local levels and from the dedicated efforts of scientists and leaders across the country responding to the heightened attention on bioterrorism preparedness and in increasing awareness.

Investments are yielding dividends with many public health officials crediting CDC's work with everything from increased visibility of public health issues allowing for better community engagement to encouraging more people to look for jobs in public health fields. Close communication and coordination across all sectors of the public health system now exists. In the past, differences in organizational cultures, terminology and approaches to emergency response have been barriers to effective interagency collaboration, but the imperatives of public health preparedness has required that these agencies understand each other's roles and capabilities in the case of a disaster. As a result, stronger relationships have developed between public health officials and their counterparts in medical care and public safety. Relationships among federal, state and local agencies have improved. In addition to the CDC, state and local interactions have increased with other federal agencies, such as the Federal Bureau of Investigation, and the Department of Homeland Security. A number of states have established regions through which local organizations work together. Though much has been accomplished, there is still much to be done. The federal, state and local partners have committed to creating a flexible system of exploration, vision and improvement through coordinated exercises and thorough evaluation in order to create a more robust public health system.

After a natural disaster or weapons of mass destruction event, patients seeking treatment will likely exceed 100,000, overwhelming local and regional medical resources with a surge in both those who are injured and the worried well. HHS serves as the lead federal agency in coordinating mass casualty medical response and recovery efforts in support of the National Response Plan and Homeland Security Presidential Directive 10. In this capacity, HHS is expanding federal resources to augment existing regional, state, and local hospital resources. For example, the SNS is developing the Federal Medical Shelters (FMS) medical shelters to increase bed capacity and aid recovery efforts at the state and local levels. The SNS will store and deliver FMS assets to an event site. FMS' modular design facilitates rapid transit by land or air and can be set up in close proximity to hospitals and inside large structures (e.g., convention centers, sports arenas). These transportable shelters are capable of providing a continuum of health care services from basic nursing to specialized care for pediatric, adult, and elderly patients; FMS also allows for quarantine of patients. Capacity for FMS is between 50 to 250 beds depending on the magnitude of the incident and existing health care resources. The FMS includes administrative, treatment, infirmary, and pharmacy modules and is staffed around the clock with federal, state, and local personnel including nurse, physician, pharmacy, and support services skill-sets. The FY 2007 HHS budget includes funds to procure, configure, and maintain the existing inventory and field the next 5,000 beds toward a goal of 30,000 beds.

The FY 2007 budget for terrorism will strengthen CDC's ability to continue the investment in preparedness and response efforts, expanding terrorism preparedness for chemical, biological, radiological and mass trauma events and assessing the effects of these investments on public health preparedness capacities.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by the Terrorism activity, the following performance measures have been selected as highlights of the program's performance plan.

Performance Goal	Results	Context
<p>1. 100 percent of state public health agencies are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC.</p>	<p>41 out of the 54 states and directly-funded cities have met the minimum standards* for demonstrating preparedness to use SNS assets and thus received a rating of amber or better.</p> <p>*Demonstrated preparedness by developing a plan that addresses the 12 core functions critical to the ability to receive, distribute, and dispense SNS assets in the event of a national emergency.</p>	<p>CDC acquires, manages and deploys the nation's stockpile of life saving pharmaceuticals and other medical assets for a response to a terrorist event or other type public health emergency. CDC has outlined 12 functions of SNS Preparedness required for states to effectively manage and use deployed SNS materiel.</p>

Performance Goal	Results	Context
2. Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents.	CDC is making considerable progress regarding increasing proficiency testing. At the end of FY 2004, 96 percent of LRN laboratories could test for <i>Bacillus anthracis</i> ; 93 percent could test for <i>Yersinia pestis</i> ; and 94 percent for <i>Francisella tularensis</i> . At the end of December 2005, the 82 percent (54/66) of the labs could test for Ricin and 75 percent (49/65) could test for Food-B anthracis.	All possible measures should be taken to detect an event so that intervention can begin as early as possible to minimize morbidity and mortality. Rapid diagnostics and rapid testing of potential bioterrorism agents is important to the mission of the LRN. Speed and accuracy in analyzing a potential bioterrorist agent is key to mitigating the effects on morbidity and mortality following an attack.

PREVENT

CDC provides resources to address the science and application of interventions to decrease the morbidity and mortality resulting from threats to the public's health. CDC encourages investments in and the application of known interventions, such as the use of vaccines and personal protective equipment to provide defense against diseases, but also encourages innovation of new and effective interventions based on scientific discovery.

GOAL 1: INCREASE THE USE AND DEVELOPMENT OF INTERVENTIONS KNOWN TO PREVENT HUMAN ILLNESS FROM CHEMICAL, BIOLOGICAL, RADIOLOGICAL AGENTS AND NATURALLY OCCURRING HEALTH THREATS.

Current Activities

- Anthrax vaccination program: provides anthrax vaccinations to laboratorians across the nation who work with *Bacillus anthracis* in public health laboratories.
- American Red Cross: project to develop and disseminate educational messages that provide self-instruction to citizens preparing for public health emergencies.
- Standards development: further refinement of standards for respirators used to protect first responders and other workers from chemical, biological, radiological or nuclear threats.
- The Centers for Public Health Preparedness (CPHP) program is a network of academic-based preparedness programs in 23 accredited schools of public health and 18 other schools of medicine, veterinary medicine, nursing, biological sciences, and medical centers at colleges and universities. The CPHP provides preparedness education and other requested services to health agencies in 46 states.

Significant Accomplishments

- CDC has completed the anthrax vaccine clinical trial interim safety analysis, has presented the results to key stakeholders, and has submitted the final report detailing all findings from the safety analysis to the Food and Drug Administration.
- CDC developed and issued performance standards for four classes of respirators for use in CBRN environments, including one for self-contained breathing apparatus (SCBA) respirators and one for full-face piece air-purifying (FFAP) respirators for occupational use by emergency responders.
- CDC developed comprehensive response planning guidance for Autonomous Detection Systems, detection systems installed in over 250 U.S. postal facilities across the nation to monitor for hazardous biological agents.
- The CPHP has delivered over 380 preparedness education activities, reaching over 250,000 learners nationwide. Approximately 250 programs specifically target state and local public health workers. Eighty activities were related to education of university and college students to help build the pipeline for the public health workforce needed to meet preparedness and emergency response needs.
- CDC and HRSA have held joint meetings with the Centers for Public Health Preparedness and HRSA's academic medical centers

GOAL 2 – DECREASE THE TIME NEEDED TO CLASSIFY HEALTH EVENTS AS TERRORISM OR NATURALLY OCCURRING IN PARTNERSHIP WITH OTHER AGENCIES.

Current Activities

- The Select Agent and Toxins Program is designed to help further the nation's capacity to monitor and regulate entities that possess, use, and transfer select agents and toxins to ensure their safety and security.
- The PulseNet surveillance system for *y. pestis* and *f. tularensis* is designed for molecular subtyping of infectious organisms to allow public health officials to establish links between cases. Additionally, for Category A agents, PulseNet can provide critical insight into whether or not outbreaks are naturally occurring or result of intentional release.
- Since implementation of BioSense, the program has received daily data feeds from an initial set of data providers, and to date has received and processed over 416 million records from the Department of Defense and Veteran's Administration. The BioSense application has been made available to 34 city jurisdictions and all 50 States through the enrollment of BioSense administrators and standard users and currently supports over 330 users in all States and major metropolitan areas.
- CDC established the BioIntelligence Center to monitor incoming data from data providers, such as laboratory test orders and results from a national clinical laboratory performing over 300,000 tests daily and other BioSense data feeds.
- To further expand and improve national laboratory response to an event, the Integrated Consortium of Laboratory Networks (ICLN) was established during FY 2005 to promote collaboration, communication, and technical acuity throughout the government's overall response strategy. This group is led by the Department of Homeland Security and includes representatives from various federal agencies. Together, all of these lab networks cover the diverse biological, chemical, radiological and nuclear materials that may be detected in clinical, environmental or food samples.

Significant Accomplishments

- Through CDC's Select Agent and Toxins Program, CDC initiated the investigation of all thefts, losses, and releases of select agents or toxins within 5-days of receipt of report. Additionally, the program has developed and tested a national Select Agent database and system that will provide a single source for registration, transfer, amendments, inspection data, and other required information.
- In addition to VA and DoD health data, in 2005 BioSense began receiving real-time clinical data from 45 private hospitals in 10 large metropolitan areas in order to better provide early event detection and community health situational awareness capabilities for federal, state, and local public health. By the end of 2006, it is anticipated BioSense will be receiving data from at least 32 cities and over 150 hospitals.

DETECT

Detection activities center on CDC's commitment to continue providing resources to state and local public health departments and laboratories to determine the cause and extent of public health emergencies. CDC believes that all possible measures should be taken to detect an event so that intervention can begin as early as possible to minimize morbidity and mortality.

GOAL 3: DECREASE THE TIME NEEDED TO DETECT CHEMICAL, BIOLOGICAL, RADIOLOGICAL AGENTS IN TISSUE, FOOD OR ENVIRONMENTAL SAMPLES THAT CAUSE THREATS TO THE PUBLIC'S HEALTH.

Current Activities

- CDC's Environmental Health Laboratory is developing new methods and substantially improving current methods for 20 chemical agents. Additionally, CDC will maintain and expand its proficiency testing and technology transfer activities to the 62 state and territorial laboratories in order to enhance their capacity to assess exposure to chemical agents using measurement in blood and urine.
- The Specimen Tracking and Results Reporting System (STARRS) aims to create an environment for sample tracking and results aggregation to enable the sharing of laboratory information across CDC laboratories.

Significant Accomplishments

- The inaugural Laboratory Response Network (LRN) meeting occurred in May 2005. The purpose of the meeting was to provide LRN laboratories with an update on LRN growth and expansion, select agent and other regulatory issues, environmental testing and triage guidelines, current and emerging technologies, proficiency testing for biological and chemical laboratories, and the upcoming CDC Preparedness Cooperative Agreement announcement.
- CDC has increased the number of LRN labs to 152 from 91 in 2001. This number includes food and veterinary labs, allowing for greater ability to detect threat agents in the nation. These labs are located in all 50 states and the LRN even boasts several installations abroad. Ninety-six percent of these labs can confirm the presence of anthrax, 94 percent can confirm tularemia, and 63 percent can perform presumptive screening for smallpox. CDC has trained more than 8,800 clinical laboratorians to play a role in the detection, diagnostics, and reporting of public health emergencies.
- CDC's LRN was one of 18 finalists for the 2005 Innovations in American Government (IAG) award, sponsored by Harvard University's Ash Institute and the John F. Kennedy School of Government. The LRN was selected from more than 1,000 applicants based on the program's novelty, effectiveness, significance in national terrorism preparedness and the transferability of its concept.

GOAL 4: IMPROVE THE TIMELINESS OF COMMUNICATIONS REGARDING THREATS TO THE PUBLIC'S HEALTH

Current Activities

- The Smallpox – Rash Illness Surveillance projects increase national capacity for evaluation and response to a suspected smallpox case, decrease the time in detecting a smallpox case and improve the timeliness of gathering information on a potential smallpox case.
- The LRN Real time Laboratory Information Exchange will enable integration of laboratory test results from LRN reference labs, sentinel labs, and CDC.
- Through adoption of PHIN standards applied at state and local health departments, information may be exchanged through alerting, laboratory, directory, and other systems through support of CDC Enterprise Communication Technology Platform.

Significant Accomplishments

- CDC has been working to improve public health's surveillance of chemical exposures and other potential health hazards by developing the infrastructure necessary to systematically collect, analyze, interpret, and disseminate data related to health events. CDC has improved the ability of poison control centers to respond to public health emergencies related to chemicals or toxins in the environment by detecting a problem or an incident immediately and effectively.

INVESTIGATE

This goal provides the framework for the public health system's ability to conduct investigations to determine the cause and breadth of public health emergencies. It includes the famous "disease detection" work public health epidemiologists are known for, as well as the speed with which messages can reach the public regarding the issue and ways to protect oneself from the threat. CDC and its public health partners are putting into place plans and systems designed to control the damage of a catastrophic event.

GOAL 5: DECREASE THE TIME TO IDENTIFY CAUSES, RISK FACTORS, AND APPROPRIATE INTERVENTIONS FOR THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH

Current Activities

- Biosurveillance: With funding in the FY 2007 budget, CDC will complete its current expansion to 35 nationwide quarantine stations. These quarantine stations are staffed with multidisciplinary teams of quarantine officers, public health advisors, epidemiologists, and information technicians who respond to public health emergencies at U.S. ports of entry, allowing communication of disease intelligence information to domestic and international partners as well as expeditious movement of clinical and research materials for through ports of entry.
- The creation of the Epidemic Information Exchange (Epi-X) enables CDC to provide secure, moderated communications and notification services.

- The Career Epidemiology Field Officer (CEFO) program provides skilled epidemiologists to state and local health departments, continuing support of its mission to enhance public health preparedness in state and local health departments.
- The Epidemiologic Intelligence Service (EIS) provides a competent epidemiological science workforce to the Public Health Service, CDC and State and local partners.
- CDC provides skilled staff, guidance and technical assistance to state and local health departments when planning for and responding to public health emergencies.

Significant Accomplishments

- The CEFO program prepared a cadre of subject matter experts in applied epidemiology who are adequately trained and ready to provide tailored services for building frontline epidemiologic and emergency capacity in state and local jurisdictions. Through FY 2005, the program enrolled and trained 80 EIS officers CEFOs, with recruitment efforts that will lead to maintaining this level.
- The Epidemic Information Exchange (Epi-X) program made Epi- X available in all 50 states and in 87 major metropolitan areas and increased the number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events to over 3,300 professionals nationwide. An increased number of authorized and active Epi-X users allows for the rapid dissemination of information about emerging threats and possible terrorist activities to the affected or potentially affect public health professionals.

CONTROL

This goal allows for opportunities to create structures to provide immediate information and medication, if needed to those affected by a threat to the public's health. It also provides for planning and training to quickly receive and distribute the Strategic National Stockpile (SNS), a national repository of life saving pharmaceuticals, medical material and equipment. The final components, stated in three goals, relate to assuring that State and local health departments in conjunction with federal teams can quickly restore services, and learn and improve from each event.

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH

Current Activities

- All 50 states, five territories, three freely associated states of the Pacific, the District of Columbia, and three major U.S. cities participate in the Health Alert Network (HAN), allowing for the high-speed exchange of critical public health information to improve the practice of public health; providing linkages between all local public health jurisdictions via continuous, high speed, secure connections.
- CDC, through the SNS, acquires, manages and deploys the nation's stockpile of life saving pharmaceuticals and other medical assets for a response to a terrorist event or other type public health emergency. Portions of the stockpile are configured in 50-ton, 12-Hour Push Packages that contain supplemental medicine and medical supplies designed to be deployed rapidly and used in the event of mass casualty incidents. These packages can be delivered to any point in the country within 12 hours of a Federal decision to deploy. Additionally, SNS assists state and local planners with the receipt, staging, storage, distribution and dispensing of SNS assets.
- CDC is continuing with the Cities Readiness Initiative (CRI) that began in FY 2004 by providing special funding targeted to 21 selected cities / Metropolitan Statistical Areas (MSAs). Designed with a goal of helping these areas deliver medicines and medical supplies during a large-scale public health emergency such as a terrorist attack or natural disaster, funding is being expanded to incorporate additional geographic areas within these metropolitan regions, which were not included in the CRI Pilot. Additional funding is also being provided to conduct planning activities for the next phase of selected CRI cities. The intent of the targeted and expanded funding is to develop plans and infrastructure so that these selected cities (defined as the metropolitan area) are prepared to provide oral medications during an event to their entire population within 48 hours. Ongoing levels of collaboration between CDC and the United States Postal Service (USPS) to develop successful strategies for support of the CRI will also continue in FY 2007.

Significant Accomplishments

- All state public health partners have developed or are in the process of developing a statewide communication system capable of sending and receiving critical health information during an emergency response event, 24/7.

- Prior to August 2005, the FMS program consisted of four prototype units (approximately 1000 beds) designed for a low to mid-acuity patient hospital bed surge mission. Hurricanes Katrina and Rita triggered the rapid development of FMS from prototype to deployable capacity resulting in the deployment of 5500 beds to provide care for the victims of these disasters. Given the extensive medical needs created by the hurricanes, the operation of the shelters expanded to include the care of non-hospitalized patients with medical needs exacerbated by the disaster.
- Two successful FMS prototype demonstrations were conducted in Atlanta and Denver. During these exercises, HHS tested admission procedures, triage, patient care processing, infection control, transportation, and logistics functions. In Denver, approximately 112 medical surgical and pediatric patients were triaged. These tests demonstrated that FMS resources can quickly be integrated into existing hospitals resources to increase the supply of hospital beds and medical services in time of a national emergency.
- During FY 2004 and 2005, CDC purchased a large number of anthrax antibiotics, chemical antidotes, and influenza countermeasures.

RECOVER

CDC supports continuous improvements and analysis of knowledge gained to provide useful information for future responses. These goals also set the stage for rapid re-establishment of vital public health services for non-emergency conditions.

GOAL 7: DECREASE THE TIME NEEDED TO RESTORE HEALTH SERVICES AND ENVIRONMENTAL SAFETY TO PRE-EVENT LEVELS

Current Activities

- CDC is developing standardized tests that clearly indicate if viable bioterrorism agents are still present on environmental surfaces in a previously contaminated building or office.

Significant Accomplishments

- Following the tsunami emergency, CDC provided immediate multinational relief and rapid needs assessment to determine the suitability of health care infrastructure in the affected countries.

GOAL 8: INCREASE THE LONG-TERM FOLLOW-UP PROVIDED TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH

Current Activities

- CDC initiated a strategic partnership with key public health nursing professional groups to enhance public health capacity at the state/local level and assist CDC in meeting its goal to improve health impact.
- CDC is examining the link between physical and mental illness, trauma and violence, and preparedness, a better understanding of the psychological and behavioral responses to terrorism to gain and thereby enable CDC to build resiliency in the nation's communities.

IMPROVE

The final goal includes requirements for robust tracking of lessons learned and implementation of corrective actions to support enhanced response in the future. This constant re-evaluation is designed to ensure maximum efficiency and the best possible response to those affected by a CBRN or other public health emergency.

GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATIONS FROM AFTER-ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH

Current Activities

- CDC is developing and disseminating web-based education and information materials to clinician audiences, which will enhance the nation's ability to respond to injuries from terrorism and injuries from natural disasters. These materials are expected to fill gaps in existing knowledge regarding injuries from terrorism.

Significant Accomplishments

- In May 2005, CDC released guidance for the Public Health Emergency Preparedness Cooperative Agreement. As part of this comprehensive guidance, CDC developed a performance framework to help

guide the applicants in developing their application for funds and, more importantly, to establish a national system to measure public health system response performance. The performance framework consists of the following components:

- Section 1.01: Draft preparedness goals, which form a framework for public health activities related to preparedness -- Outcomes, created in relation with Homeland Security Presidential Directive-8 as a comprehensive description of the major roles and capabilities needed to respond to an event of significance.
- Section 1.02: Required critical tasks, obtained from the Target Capabilities List, which are public health specific tasks associated with an outcome -- Performance measures, defined as leading indicators that will allow a national “snapshot” to show how the preparedness and response activities, and the associated resources, aid in making a public health system that responds more quickly and comprehensively in a public health emergency.

RATIONALE FOR THE BUDGET

The FY 2007 President’s Budget reflects a total funding level of \$1,657,161,000 for Terrorism Preparedness and Emergency Response, an increase of \$24,904,000 above the FY 2006 Enacted level of \$1,632,257,000.

Strategic National Stockpile (+\$69.2 million)

The mission of the SNS has expanded dramatically since the creation of the program in 1999. From an initial small cache of pharmaceuticals, the SNS is now poised to help respond to a potential pandemic of influenza, catastrophic natural disasters such as Hurricane Katrina, and biological, chemical, radiological, or nuclear terrorist attacks. The increase will allow CDC, through the SNS, to continue to purchase and store needed countermeasures, vaccines, and treatments. It will also allow CDC to meet the expanded need for pediatric dosing requirements and unit of use bottling for quicker pharmaceutical distribution.

To address the nation’s shortfall in providing an all-hazard mass casualty care event, a federal-level contingency care program has been developed pursuant to HSPD-10, the Presidential directive setting policy for protection against a bioterrorist attack. CDC has designated \$49 million from the FY 2007 budget for the FMS program. This will be used to procure additional units, manage program and logistics, warehouse shelters, purchase supplies, and conduct training. This program compliments the Cities Readiness Initiative by targeting resources in response to mass casualty events.

The increase to the SNS will assist the federal government in purchasing more antivirals. Stockpiled drugs can be used to help treat the nation’s first responders and populations most at risk in the first stages of a pandemic. Additionally, in the event of a pandemic, medical equipment could become in short supply. The SNS also contains critical medical supplies to support state and local response.

With FY 2007 funding, CDC will make critical expansions in SNS storage capacity so that the SNS is capable of managing its increasing inventory. Steps will also be taken to ensure that critical drugs are used to their utmost, and only replaced when necessary. Not only is this designed to save money in the long run, but it also strives to increase the number of individuals CDC is capable of assisting through the SNS. The increase for SNS does not reflect the IT reduction. This increase does not include an IT reduction for the SNS.

Botulinum Toxin Research (+\$3.0 million)

Botulinum toxin is one of the most toxic substances known and is of significant concern because of its potential use by terrorists. Major public health decisions about detecting, treating, and preventing illness or death from botulinum toxin and other toxins rely on sensitive, specific, high-quality, and timely laboratory information about the presence of toxin-forming organisms and the toxins they produce. CDC is developing a mass spectrometry method for detecting botulinum toxin and its seven subtypes in people and the nation’s milk supply. This new method allows for the measurement of botulinum A, B, and F (each done in about 15 seconds) and produces results very quickly – 80 samples per day with first result in 3-4 hours. This new method can detect all seven subtypes, is able to see small amounts of the toxin, and is confirmatory rather than a screening test.

With additional funding in FY 2007, CDC will use this method to detect anthrax lethal factor, ricin, and other toxins used as bioweapons; improve the speed of analysis to up to 1,000 samples per day; simplify the method for use by external laboratories; develop this method as a cost-effective method for preventive screening of milk samples; and, use this method in “toxin fingerprinting,” which will allow scientists to detect minor variations that will help identify the source of the toxin, provide identifying forensic information, and assist epidemiologists investigating the cause and pathways of disease. Overall, these breakthrough advances based on mass spectrometry techniques to detect and measure botulinum and other toxins will improve early detection and help ensure prompt, appropriate treatment and prevention of additional exposure.

BioSense (-\$15.2 million)

The BioSense initiative improves the nation's capabilities for near real-time disease detection by using data from existing health-related databases without identifying information to enable early detection in all major metropolitan areas. Increased funding in FY 2006 will expand the total number of metropolitan areas in the system from 10 to 41 and will extend the number of clinical care sites and sentinel hospitals in major metropolitan areas that are streaming real-time information to BioSense. In FY 2007, these activities can be maintained with fewer funds, thus requiring decreased resources to continue utilizing BioSense for the highest quality real time data. Through BioSense, CDC provides community, state, and federal decision makers up-to-date information to confirm or refute the presence of pandemic influenza.

Fund Enhancements and Completion of 35 U.S. Quarantine Stations (-\$15.1 million)

In FY 2007, CDC will complete its latest expansion to 35 quarantine stations in major U.S. ports of entry (POE) and continue to enhance the number and quality of personnel stationed there. Expansive infrastructure work will have been completed in FY 2006 and continued enhancements will require fewer funds to be completed. CDC will also develop comprehensive quarantine and isolation approaches that include: POE interventions to prevent introduction and spread such as rapid detection isolation and quarantine; in-transit interventions and protocols to interrupt transmission from ill passengers; and, point-of-exit interventions to prevent exportation from affected countries. This approach to enhancing the nation's capability to prevent, detect, and control disease will ensure a potential outbreak is identified early.

Anthrax (-\$13.9 million)

In FY 2007, CDC proposes to eliminate funding for the anthrax research study. With the completion of the anthrax vaccine clinical trial interim safety analysis, CDC has presented the results to key stakeholders and has submitted the final report detailing all findings from the safety analysis to the Food and Drug Administration. This brings the long running anthrax study near its conclusion. The information gleaned over the course of this study will not be compromised due to the cessation in funding, and the expected benefits will have been gained by the time of the project's completion.

Information Technology Savings (-\$3.1 million)

The FY 2007 President's Budget includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Percent of state health departments that acknowledge receipt of Health Alert messages within 30 minutes of delivery 24/7.	65%	70%	75%	5%
No. of network and other partnerships who distribute or deliver CDC and PHTN training and education to target audiences.	10	10	10	0
No. of state and local public health agencies in key jurisdictions that access BioSense data regularly to monitor for possible events	44	70	96	26
Academic Centers for Public Health Preparedness	27	27	27	0
No. of local health departments developing advanced information technology in support of terrorism preparedness and response	5	5	5	0

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
No. of U.S. quarantine and border health stations at U.S. international airports and other selected ports of entry	18	35	35	0
No. of veterinary and food laboratories in the LRN	22	28	28	0
No. of states, territories, and major metropolitan areas formally assessing public health capacity and preparedness	62	62	62	0
Percent of state health departments that have interoperable redundant communication systems.	25%	30%	35%	5%

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

FUNCTIONAL TABLE

Terrorism Budget by Functional Activity (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
Upgrading State & Local Capacity	\$919,148	\$823,674	\$823,674	\$0
Upgrading CDC Capacity	\$140,972	\$136,592	\$135,628	(\$964)
Anthrax	\$16,666	\$13,860	\$0	(\$13,860)
Botulinum Antitoxin Research	\$0	\$0	\$2,970	\$2,970
Biosurveillance Initiative	\$79,271	\$133,431	\$102,241	(\$31,190)
<i>Biosurveillance - Department of Defense Appropriation (non-add)</i>	\$0	\$55,000	\$0	(\$55,000)
Strategic National Stockpile	\$466,700	\$524,700	\$592,648	\$67,948
Total -	\$1,622,757	\$1,632,257	\$1,657,161	\$24,904

REIMBURSEMENTS AND TRUST FUNDS

AUTHORIZING LEGISLATION

PHSA §§ 301, 306(b)(4), 353; Clinical Laboratory Improvement Act; User Fee: Labor-HHS FY Appropriations.

Reimbursements and Trust Funds (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA	\$574,983	\$597,983	\$610,540	\$12,557

STATEMENT OF THE BUDGET

The FY 2007 estimate for Reimbursements and Trust Funds of \$610,540,000 reflects an increase of \$12,557,000 over the FY 2006 estimate of \$597,983,000.

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 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.

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.

The Clinical Laboratory Improvement Amendments of 1967 (CLIA) transferred responsibility for the laboratory licensure programs from CDC to the Centers for Medicaid and Medicare Services (CMS), formerly the Healthcare Financing Administration (HCFA), which resulted in the disbanding of CDC's regulatory staff. Under CLIA of 1988, the Secretary directed that the CLIA program be jointly implemented by CMS and CDC. CDC will provide scientific/technical support related to patient test management, Quality Assurance/Quality Control, personnel requirements, and test categorization; develop information materials including brochures, a slide presentation, and a user guide; develop and facilitate information education for newly regulated public health laboratories and clinics; and work with CMS to initiate a process for accrediting programs developed by nonprofit organizations and states to apply the CLIA standards.

The CDC program to implement the Federal Technology Transfer Act (FTTA) has three components: sharing research and materials, patenting inventions, and licensing inventions. CDC scientists have a long history of successful collaboration with scientists in private industry and other government agencies.

The FTTA allows government scientists to enter into formal agreements with scientists outside the government and in other government agencies. Two types of formal agreements are used for this purpose: Cooperative Research and Development Agreements (CRADA) and Biologic Materials Licensing Agreements. The FTTA gives preference to small businesses and to businesses producing products in the United States for the CRADA. Federal participants – individuals as well as organizations – can share patent rights and license fees for inventions made jointly under CRADAs.

RATIONALE FOR THE BUDGET

The FY 2007 estimate for Reimbursements and Trust Funds of \$574,983,000 reflects an increase of \$12,557,000 over the FY 2006 estimate of \$597,983,000.

OUTPUT TABLE

OUTPUT TABLE (DOLLARS IN THOUSANDS)	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Agency for International Development 8 Agreements for various projects: infectious disease project, and family planning logistics.	\$57,709	\$57,709	\$58,920	\$1,212
Department of Agriculture 8 Agreements for various projects: National Nutrition Monitoring, National Health and Nutrition Examination Survey, to support active Surveillance Systems for bacterial diseases in the U.S.	\$1,685	\$1,685	\$1,720	\$35
Department of Commerce 7 Agreements for various projects: Develop Standards for Respiratory Protection Equipment and National Death Index Services.	\$3,506	\$3,506	\$3,580	\$74
Department of Defense 33 Agreements to perform various tasks such as BioWatch.	\$3,618	\$3,618	\$3,694	\$76
Department of Energy 7 Agreements for various projects including energy related analytical epidemiological research.	\$18,616	\$18,616	\$19,007	\$391
Department of Health and Human Services 199 Agreements to perform various projects, provide ongoing participation in clinical laboratory improvement, develop questions for the National Health Interview Survey, and an estimated \$265,100,000 derived from evaluation funding under section 241 of the Public Health Service Act.	\$320,502	\$340,502	\$347,653	\$7,151
Department of Homeland Security 3 Agreements to evaluate and assess fire prevention grants to firefighters, and for National Pharmaceutical Stockpile and Smallpox activities.	\$14,535	\$14,535	\$14,840	\$305
Department of Housing and Urban Development 1 Agreement for the Healthy Homes Initiative.	\$2,978	\$2,978	\$3,041	\$63
Department of Interior 3 Agreements for various projects: Understanding of the Geography and Pathway of West Nile virus, and for the Pacific Emergency Health Initiative.	\$247	\$247	\$252	\$5
Department of Justice 5 Agreements for the evaluation of hand-held assays for threat agents.	\$1,133	\$1,133	\$1,157	\$24

NARRATIVE BY ACTIVITY
REIMBURSEMENTS AND TRUST FUNDS

OUTPUT TABLE (DOLLARS IN THOUSANDS)	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Department of Labor 7 Agreements to perform various tasks: NIOSH response to Energy Employees Occupational Illness, and space commodities and support services.	\$58,514	\$58,514	\$59,743	\$1,229
Department of State 6 Agreements for Consultation and Assistance in Addressing Refugee Health Needs, for International Cooperative Administrative Support Services (ICASS)- IAG Working Group Chairperson, and Decontamination of State Annex 32.	\$274	\$274	\$280	\$6
Department of Transportation 1 Agreement for various projects including: carbon monoxide houseboats study and for a public health assessment	\$307	\$307	\$313	\$6
Environmental Protection Agency 22 Agreements for various projects including, health issues along the U.S./Mexican border, cost effectiveness measures, studies on occupational and environmental risks, and research of microbes on the Contaminant Candidate List.	\$567	\$567	\$579	\$12
Federal Emergency Management Agency 5 Agreements for health monitoring of response and recovery personnel in New York City.	\$86,571	\$86,571	\$88,389	\$1,818
Various Agencies/Organizations 41 Agreements for various projects with various agencies and organizations	\$4,220	\$7,220	\$7,372	\$152

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

AUTHORIZING LEGISLATION

The Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980 (as amended) §104(l); Resource Conservation and Recovery Act (RCRA) §3001; the Great Lakes Critical Programs Act of 1990; the 1990 amendments to the Clean Air Act; the Housing and Community Development (Lead Abatement) Act of 1992; the Defense Environmental Restoration Program (Section 211 of CERCLA).

Agency for Toxic Substances and Disease Registry (ATSDR) (Dollars in Thousands)	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 +/- FY 2006
BA¹	\$76,041	\$74,905	\$75,004	\$99

¹ FY 2006 funding for ATSDR includes a rescission of 0.476% for Interior, Environment, and Related Agencies.

STATEMENT OF THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$75,004,000 for ATSDR, an increase of \$99,000 above the FY 2006 Enacted level of \$74,905,000. The FY 2007 President's Budget includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

PROGRAM DESCRIPTION

ATSDR is the principal federal public health agency charged with evaluating the human health effects of exposure to hazardous substances. The agency's mission is to serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease related exposures to toxic substances. In FY 2005, ATSDR served over one million people in 551 communities.

ATSDR was created in 1980 by CERCLA, commonly known as the Superfund law. The Superfund program is responsible for finding and cleaning up the most dangerous hazardous waste sites in the country. Currently, the U.S. Environmental Protection Agency (EPA) lists for cleanup 1,238 "final" National Priorities List (NPL) sites. ATSDR leads federal public health efforts at these and other sites with actual or potential toxic exposures. In accomplishing this purpose, ATSDR's priorities include 1) mitigating the risks of health effects at sites with documented exposures, 2) preventing exposures and resulting health effects, and 3) determining health effects associated with exposures.

To achieve these priorities, ATSDR conducts a variety of activities, including the following:

- Exposure Investigations to collect and analyze site information and perform biological tests, and when appropriate, to determine whether people have been exposed to hazardous substances.
- Public Health Assessments (PHAs) to review information about hazardous substances found at a waste site. PHAs evaluate whether people living or working at the site or nearby may be exposed to harmful levels of these substances. These assessments may also recommend that EPA or other agencies take certain actions to protect public health such as conducting blood tests for children or remediating a waste site. ATSDR conducts a PHA for each site proposed for the NPL and for other sites in response to petitions from communities.
- Health Consultations provide guidance on specific, health-related questions about hazardous wastes in communities. More limited in scope than PHAs, health consultations may be written or oral, and may contain recommendations.
- Health Education programs offer information and training to affected communities and their medical professionals about ways to assess, control, or prevent exposure to hazardous substances in the environment.
- Health Studies help determine whether exposures to hazardous substances can lead to increased risk for various health problems, such as cancer, leukemia, multiple sclerosis, asthma, and other illnesses. ATSDR conducts its own health studies and supports others through agreements with state health departments and universities.

ATSDR's efforts align with the Secretary's 500-Day plan in the area of advancing medical research, where interdisciplinary and interagency collaboration in scientific pursuits is the standard and broad scientific advances measurably reduce the burden of all chronic diseases. Additionally, ATSDR supports the priority of securing the homeland by working with partners to seamlessly and rapidly provide resources and public health personnel when needed anywhere in the United States.

PERFORMANCE ANALYSIS

To reflect the public health impact achieved by ATSDR, the following performance measures have been selected as highlights of the agency's performance plan.

Performance Goal	Results	Context
1. Increase EPA's, state regulatory agencies', or private industries' acceptance of ATSDR's recommendations at sites with documented exposure.	Currently, there is an 80% acceptance level of ATSDR's recommendations to EPA, state regulatory agencies, and private industries.	The agency is able to prevent ongoing and future exposures when EPA, state regulatory agencies, or private organizations accept the agency's recommendations and take appropriate actions. This measure reports the percentage of ATSDR's total urgent and public health hazard recommendations that have been accepted.

Performance Goal	Results	Context
2. Document the reduced occurrence or risk of health effects by selecting for each urgent or public health hazard site the best or most appropriate measure for that site.	For each site, an ATSDR committee selects the most appropriate measure, such as comparing morbidity/mortality rates, reduction of environmental exposures, biomarker tests, and behavior change of community members and/or health professionals.	This measure captures the agency's impact on human health in communities exposed or potentially exposed to toxic substances. This measure ensures that ATSDR and its partners follow-up on the implementation of its recommendations and provides evidence of reduced occurrence or risk of health effects as a result of ATSDR's interventions at its most urgent and hazardous sites.

Current Activities

- The asbestos exposures that took place in Libby, Montana, have become well known. In Libby, ATSDR studies and screening defined the extent of the health problem. Medical screening for exposed individuals continues and a registry to track their ongoing health status has been established. The contamination was not limited to Libby. Vermiculite was shipped for processing to over 200 plants around the country. ATSDR is now studying a group of 28 sites that processed nearly 80 percent of the Libby vermiculite mined from 1964 through 1980. With particular attention to former workers and their families, ATSDR is working to determine whether past (or current) exposures took place at or near these sites. ATSDR will then develop interventions to help those exposed avoid or minimize any existing or potential health effects.
- Naturally occurring asbestos (NOA) poses another asbestos-related challenge. In El Dorado Hills, California, workers found a vein of NOA during construction of a soccer field at Oak Ridge High School. The agency has evaluated the public health threat associated with exposures to airborne asbestos fibers at the school, and the document is currently under review by HHS. In the future, ATSDR plans to consult with state and local agencies and to work with EPA on addressing this issue in El Dorado County and elsewhere.
- ATSDR plays a significant role in planning for and responding to terrorism events and other large-scale public health emergencies. Located in EPA regional offices, regional ATSDR staff work with EPA and state partners on a daily basis to ensure immediate access to local expertise in planning for and responding to chemical emergencies. An example from FY 2005 is ATSDR's extensive response to the public health emergency that followed Hurricane Katrina.
- Registrants in the World Trade Center Health Registry, launched in September 2003, will be interviewed periodically over the next 20 years to track the long-term health effects of exposures during the event. The first follow-up interviews are scheduled to begin in FY 2006.

- Studies are currently underway for Multiple Sclerosis (MS)/amyotrophic lateral sclerosis (ALS) in Illinois, Massachusetts, Missouri, Texas, and Oregon.
- ATSDR continues its efforts in mitigating and preventing health risks at sites by providing PHAs, Health Consultations, technical assistance, and other services that aid officials in making appropriate public health decisions. The agency is also reviewing ways to improve its ability to provide more timely assistance by greatly accelerating the agency's reporting of exposure and risk evaluations.
- ATSDR also remains focused on determining the relationship between toxic exposures and disease. Through the development of its toxicological profiles, health studies, disease tracking projects, and surveillance studies, the agency improves the science base for environmental public health decision-making by filling the gaps in knowledge about human health effects from exposure to hazardous substances.
- CDC/ATSDR continues to form new partnerships to help meet its goals. For example, through a cooperative agreement with CDC, the National Center for Healthy Housing (NCHH) launched the National Healthy Homes Training Center and Network (HHTC) to create healthier indoor environments. Specifically, the network seeks to increase the knowledge and skills of housing, health, and environmental professionals by delivering "healthy homes" training to front-line practitioners and contractors/trades people, providing technical assistance, evaluating programs.

Significant Accomplishments

- *Responding to Real and Potential Chemical Hazards* — Immediately following Hurricane Katrina, ATSDR staff deployed to the area to work with EPA in resolving public health issues. Specifically, ATSDR personnel:
 - Helped assess and reopen approximately 200 schools in Jefferson Parish;
 - Delivered technical support to local and state officials on environmental health issues (e.g., infection control, potable water, waste water, food services, sleeping areas, etc.) to protect the health of survivors, evacuees, and response personnel.
 - Helped rebuild the New Orleans Environmental Health Department's functionality;
 - Aided EPA during abatement of chemical spills in Mississippi;
 - Worked with EPA, the Coast Guard, and other responders to avert widespread hazardous exposures for thousands of people. For example, ATSDR staff helped:
 - Search for, collect, and/or remediate potential industrial and residential hazards, such as dislodged or leaking fuel tanks, chlorine and propane cylinders, hospital biohazards, and 55-gallon chemical drums the storms floated from barges to front lawns;
 - Survey rail lines for damaged or leaking chemical and freight cars;
 - Investigate industrial facilities, including a chemical plant, to determine whether these facilities posed hazards as a result of hurricane damage;
 - Deliver critical health guidance to returning residents on carbon monoxide, water sanitation, electrical hazards, and other topics; and
 - Evaluate NPL sites in the area for hazards following the storms.
- *ATSDR-Provided Expertise and Equipment Help Protect Family from Mercury Exposure* — When a resident of Benton Harbor, Michigan, reported a mercury spill, state and local health investigators discovered a dangerous situation requiring immediate action. Using equipment and guidance provided by ATSDR, they found that improper cleanup by the resident had dispersed mercury vapor inside the home to levels 50 times greater than the concentration ATSDR considers safe. The investigators immediately evacuated the residents and ventilated the home. At the same time, Michigan's Department of Community Health advised the resident, a mother of three, to get blood tests for her family as soon as possible. They also recommended she tell the parents of several visiting children to do the same. The house was ultimately remediated and the residents cleared to return. Aided by ATSDR funding and expertise, the investigators and other health department officials were able to take decisive action. Their efforts minimized exposures and helped the affected family avoid serious injury.
- *West Virginia Residents Avoid Exposures to Carcinogen* — ATSDR expertise and guidance helped health officials in West Virginia protect people from exposure to benzene, a known carcinogen. When a rail car valve failed at the TechSol facility in Huntington, West Virginia, some 22,000 gallons of coal tar light oil spilled into a creek and storm sewers. The contamination forced people in some 500 homes and an elementary school to evacuate. To ensure that residents returning to their homes would be safe, officials

from the West Virginia Cooperative Partners Program (WVCPP), a CDC partner, and the county determined safe reoccupancy levels and conducted indoor air tests. As a result of this guidance and action, most of those evacuated were able to return home within three days. Cleanup of the creek continues, and WVCPP is following up with the community to address concerns about exposure.

- *Children's Blood-lead Levels Reduced* — ATSDR and state efforts have helped decrease average blood-lead levels (BLLs) in children living in Eureka City, Utah. Because of the city's history as a mining center, children in Eureka City are 10 times more likely to have elevated BLLs (over 10 micrograms per deciliter, or $\mu\text{g}/\text{dL}$) than children elsewhere in Utah. ATSDR and the state health department developed a successful education program that led to BLLs in area children dropping below $10\mu\text{g}/\text{dL}$.
- *Remediating Contaminated Indoor Air* — Wisconsin's Department of Health and Family Services (DHFS) and ATSDR helped protect occupants of a building in Beloit from breathing hazardous levels of volatile organic compounds (VOCs). Investigating complaints about chemical odors, state health officials detected high levels of VOCs in the building's air. The VOCs, apparently from fuel oil-contaminated water seeping into the basement, posed an intermittent, short-term health hazard when vapors from the basement entered the main building. DHFS consulted with the building's owners and recommended interim measures to prevent exposures. The suspected source, an underground fuel oil tank on an adjoining property, has now been removed and the landlord has taken steps to improve air handling in the building. No new odor complaints have been received.
- *Preventing Future Exposures* — Work accomplished by ATSDR and the Massachusetts Department of Public Health (MDPH) is helping protect against future pesticide exposures. MDPH, in collaboration with ATSDR, helped to ensure that homes were ventilated properly after residents of North Hatfield had to evacuate their homes due to an influx of heavy pesticide fumes from a nearby tobacco field. The field had been sprayed with a fumigant called Telone ® C-35. Following MDPH's recommendations, Massachusetts and Helena Chemical Corporation have discontinued use of this fumigant. In addition, the state now requires more extensive certification and education for those who work with soil fumigants. Previously, applicators needed only to be licensed to work with such pesticides under supervision of a certified pesticide applicator. The state now requires that applicators must themselves be certified to work with soil fumigants.
- *Children Protected from Methamphetamine Lab Exposures* — The Michigan Department of Community Health (MDCH), funded in part by ATSDR, helped state lawmakers take a crucial first step in reducing the public health risk posed by methamphetamine ("meth") labs. The number of meth labs in Michigan has increased dramatically within the last five years. MDCH provided key testimony before the Michigan Senate in April 2005 on a bill that would restrict access to "over-the-counter" medications critical for meth production, including products that contain ephedrine or pseudoephedrine. The testimony was a key component to demonstrate that meth labs threaten people in surrounding homes and businesses with high-levels of contamination and chemical exposure. The testimony also emphasized the danger children face when their homes are used as labs. Both chambers of the Michigan Congress overwhelmingly passed the bill, and the Governor signed it in July. The new law took effect in December 2005.
- *Helped Community Avoid Lead Exposures* — Following recommendations by ATSDR and the Illinois Department of Public Health, EPA has begun removing lead-contaminated soil from certain residential yards in Collinsville, Illinois. The homes involved are in a subdivision built, in part, on the site of the former St. Louis Smelting and Refining facility. Slag is visible on the soil surface, which means that children may come into contact with lead-contaminated soil as they play in their yards. Although just one of the 32 children tested had a BLL over CDC's level of concern ($10\mu\text{g}/\text{dL}$), the soil removal will prevent future exposures.
- *Quick Response Helps Limit Hazardous Exposures Following Fatal Train Wreck* — Nine people died after a freight train collision in Graniteville, South Carolina, released an estimated 11,500 gallons of chlorine gas in January 2005. ATSDR's Hazardous Substances Emergency Events Surveillance system quickly revealed that over 500 people in the area had arrived at area emergency rooms suffering symptoms of chlorine gas exposure. This information helped state officials to grasp the severity of the accident much more quickly than would otherwise have been possible. As a result, they evacuated some 5,400 residents in the area, and consequently, likely prevented many more exposures.
- *Helped Protect California Residents from Contaminated Groundwater* — Acting on recommendations from CDC and the California Department of Health Services (CDHS), state officials took action to protect people living near a closed municipal landfill in Laytonville, California, from exposures to contaminated groundwater. CDHS found that long-term exposure to liquid leaking from the edges of the landfill cap could pose a health hazard to nearby residents, members of the Cahto tribe. In addition, CDC recommended additional groundwater monitoring. On the basis of CDHS's and CDC's recommendations, state officials have ordered a complete overhaul of the failed cap, and additional monitoring wells have been installed. The new cap and wells will help prevent further exposures.

- *New Jersey Neighborhood Gets Safe Water Supply* — ATSDR and the New Jersey Department of Health and Senior Services (DHSS), helped people in the Cedar Brook area of Winslow Township, New Jersey, attain safe drinking water. When residents asked for an investigation of well water contamination, DHSS began working with other state and local agencies to test 241 area wells. More than half contained VOCs and some wells contained nitrate and metals, including lead and mercury. Treatment systems installed in the area eliminated exposures to VOCs and mercury. Lead and nitrate remained a concern for infants and children, however, so ATSDR and DHSS recommended that safe water be provided to all residents of the area. As a result, a main water line to the area has been installed, and service began in April 2005. DHSS has also determined that past exposures to VOCs posed a public health hazard. This determination is important because it gives community members useful information they can share with health care providers in addressing health effects that might be related to the exposures.
- *Protecting Workers from Asbestos Exposures* — EPA excavated and removed 35,000 tons of asbestos-contaminated soil from the former W.R. Grace facility site in Wilder, Kentucky, and conducted cleanup of residual asbestos inside the building. ATSDR helped EPA design follow-up sampling to ensure that the indoor cleanup had been effective. Sampling confirmed that asbestos fibers were below detection limits.
- *Key Asthma Studies Released* — Asthma studies released during 2005 may help parents protect their asthmatic children from increased risk. A study conducted by ATSDR and the New York State Department of Health, examining children in Buffalo, New York, revealed data that supported an association between elevated risk for children with asthma and exposure to urban air pollutants, indoor air pollutants, and other risk factors. Another study, which ATSDR conducted with the Utah Department of Health, found links between asthma and proximity to hazardous waste sites. Findings suggested that asthmatic children living near a hazardous waste site have higher rates of hospitalization for asthma. In addition, the study concluded that the number of hazardous emission sources within a census tract was predictive of tracts reporting elevated incidences of children admitted to hospitals for asthma.
- *ATSDR Program Honored for Research in Children's Health* — ATSDR's Great Lakes Human Health Effects Research Program received one of the 2005 Children's Environmental Health Excellence Awards. The ongoing program works to characterize exposure to contaminants via consumption of Great Lakes fish and investigates the potential for short- and long-term adverse health effects. ATSDR research has helped to specify which local subpopulations, namely women of reproductive age and young children, are particularly vulnerable to pollution affecting Great Lakes fish. This research has led to consumption advisories being targeted specifically to children and women of childbearing age in eight Great Lakes states.

RATIONALE FOR THE BUDGET

The FY 2007 President's Budget reflects a total funding level of \$75,004,000 for ATSDR, an increase of \$99,000 above the FY 2006 Enacted level of \$74,905,000. The FY 2007 President's Budget includes an IT savings, realized based on select systems moving from the development phase into implementation and operations as well as greater internal efficiencies realized in areas related to IT.

OUTPUT TABLE*

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
State Cooperative Agreements	29	29	29	0
Sites Evaluated/Chemical Release Responses ¹	399	400	400	0
Public Health Assessments/Health Consults (includes chemical specific health consults) ¹	338	300	300	0
Technical Assists ¹	1,842	2,000	2,000	0
Exposure Investigations	9	10	12	2
Emergency Responses and Exercises ¹	126	126	126	0
Health Studies ²	53	48	43	(5)

NARRATIVE BY ACTIVITY
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

OUTPUT TABLE	FY 2005 ACTUAL	FY 2006 APPROPRIATION	FY 2007 ESTIMATE	FY 2007 +/- FY 2006 APPROPRIATION
Surveillance (# of states) and Registries (# of registries by exposure type) ¹	15	12	11	(1)
Hazardous Substances Emergency Event Surveillance (states and events) ³	15 states/ 8,858 events	15 states/ 8,000 events	8 states/ 4,000 events	(7)/(4,000)
Great Lakes Research Projects (grants)	5	5	5	0
Minority Health Professions Foundation (studies)	7	7	7	0
Toxicological Profiles	16	13	13	0
Information Dissemination**	2,589,843	2,580,000	2,640,000	60,000
Pediatric Environmental Health Specialty Units	11	11	11	0
Health Professionals Trained ¹	42,145	40,000	40,000	0
Community Members Educated ^{1,4}	183,649	29,000	29,000	0

1. This is a new or revised output category. For the Outputs that were revised, ATSDR has changed the definition from previous years.

2. Reduction in number of Health Studies is due to a completion of a portion of the studies. No new studies are funded in FY06 and FY07.

3. This output reduction is a result of reduced funding for this project

4. 155,508 is a result of the WebMD Health Education Project. Since this was a pilot project, funding is uncertain for FY06/FY07.

*Any GPRA-related outputs have been removed and are further detailed in the Detail of Performance Analysis section of the Performance Budget.

** More specific information dissemination data was gathered, including unique ATSDR Web site hits, which, in turn, now reflect larger numbers in all years.

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PERFORMANCE DETAIL

SUMMARY OF MEASURES

CDC SUMMARY OF MEASURES							
	Measures	Total Reported		Met		Not Met	
FY	Total in Plan	Results Reported	% Reported	Total Met	% Met	Total Not Met	Improved
2002	178	176	99%	136	77%	42	23
2003 ^{1,2}	134	130	97%	96.20	74%	33.8	13
2004 ²	116	100	86%	73.36	73%	26.64	6.81
2005 ^{2,3}	149	77.75	52%	62.67	81%	15.08	7.5
2006 ³	141	N/A	N/A	N/A	N/A	N/A	N/A
2007 ³	136	N/A	N/A	N/A	N/A	N/A	N/A

¹ FY 2003 data have been revised based on updated information.

² FY 2003 – FY 2005 reflect the results of multiple targets for some measures within the performance plan.

³ FY 2005 – FY 2007 performance plans include one measure which is double-counted, serving as both an efficiency measure and an outcome measure as a result of the FY 2007 PART process.

DETAIL OF PERFORMANCE ANALYSIS

The legend below provides detail for the icons referenced within the Detail of Performance Tables. Note the addition of the Secretary's 500-Day Plan.

DETAIL OF PERFORMANCE LEGEND	
E	Efficiency Measure
HHS#	HHS Strategic Plan Goal
HP#	Healthy People 2010 Objective
O	Outcome Measure
PAR	Performance and Accountability Report
PART	Program Assessment Rating Tool
 #	President's Management Agenda Initiative
500#	Secretary's 500-Day Plan: 1 – Transform the Healthcare System 2 – Modernize Medicare and Medicaid 3 – Advance Medical Research 4 – Secure the Homeland 5 – Protect Life, Family, and Human Dignity 6 – Improve the Human Condition around the World

INFECTIOUS DISEASES

INFECTIOUS DISEASES CONTROL

The Infectious Diseases Control program participated in the Program Assessment Rating Tool (PART) for the FY 2006 budget cycle. This document reflects the additional measures adopted as a result of the PART process. While some measures may seem redundant, there are slight variations in what or how an outcome is being measured. The PART measures are ambitious and will become a permanent element of this performance plan. In addition, as previous GPRA measures and goals are retired, the program will use one overarching goal – To Protect Americans from Infectious Diseases – and lessen the categorical nature of this plan.

Efficiency Measure	FY	Target	Result
1. Increase access to health information for international travel with the same funding. [E]	2005	5%	27% (Exceeded)
	2004	Establish Baseline	3,704,938 website visits
2. 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. [E]	2007	28,633 isolates	12/2007
	2006	24,866 isolates	12/2006
	2005	21,471 isolates	22,684 (Exceeded)
	2004	17,876 isolates	18,729 (Exceeded)
	2003	Baseline	14,864
Data Source: Data is obtained from Omniture using the Most Popular Sites Sections Report. Before August 2004, WebTrends was the software used for monitoring use of the Travelers Health website.			
Data Validation: The report is obtained monthly and has been recorded since 2004.			
Cross Reference: Measure 1 - HHS-8, Measure 2 – HHS-8, PART			

Efficiency Measure 1:

With the introduction of new technology, most notably the Internet, CDC has dramatically reduced the number of staff hours required to respond to inquiries surrounding travelers' health. In 1995, there were over 60,000 live phone calls (in addition to sending 177,000 responses to the automated fax system and 181,000 uses of the AT&T voice system) but only 137,000 hits to the travelers' health website. By 2000, the number of phone calls, automated faxes, and uses of the AT&T voice system had dropped dramatically (less than 4,000 phone calls, 41,000 automated faxes and 72,000 uses of the AT&T voice system), while there were over 2.5 million visits to the travelers' health website. Because CDC is no longer using WebTrends for monitoring web usage, a new baseline had to be estimated. The methodology in measuring website usage is significantly different. In order to re-estimate the 2004 baseline, data from the period July 2003-December 2003 had to be extrapolated from WebTrends data and the comparison of WebTrends and Omniture data during 2004. The new baseline is 3,704,938 visits to the Travelers' Health Website. In 2005, there were 4,717,661 visits to the Travelers' Health Website, an increase of 27 percent. This measure will be retired after data are reported for FY 2005.

Efficiency Measure 2:

PulseNet, an early warning system for outbreaks of foodborne disease, is a national network of public health laboratories that performs DNA fingerprinting on bacteria that may be foodborne. CaliciNet is a similar DNA fingerprinting network for Norovirus. These networks identify and label each disease-causing organism by its fingerprint pattern and rapidly compare new patterns to those existing in the electronic database at CDC to identify related strains. The DNA fingerprinting can distinguish strains of disease-causing organisms such as Escherichia coli (E. coli), Salmonella, Shigella, Listeria and Norovirus, allowing early detection of disease clusters.

Currently, databases are available for E. coli, Salmonella, Listeria monocytogenes, Shigella, Campylobacter, and Norovirus. CDC will increase the number of online submissions during 2004 – 2007 by increasing the number of individuals at the participating laboratories who are certified to electronically submit pulsed field gel electrophoresis (PFGE) patterns directly to the database.

PROTECT AMERICANS FROM INFECTIOUS DISEASES

GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES – HEPATITIS C, CHRONIC LIVER DISEASE, AND VIRAL HEPATITIS.			
Measure	FY	Target	Result
1. Provide support to up to 65 health departments for coordinators to initiate hepatitis prevention and control activities.	2005	50 health departments	51 (Exceeded)
	2004	50 health departments	52 (Exceeded)
	2003	48 health departments	50 (Exceeded)
2. By 2010, reduce the number of new cases of hepatitis A to 2.25 new cases per 100,000 population. [0]	2007	2.5 new cases	12/2007
	2006	2.6 new cases	12/2006
	2005	2.6 new cases	1.9 (Exceeded)
	1997	Baseline	11.3
Data Source: <u>Measure 1</u> – Grants management information system; <u>Measure 2</u> - The National Notifiable Diseases Surveillance System (NNDSS).			
Data Validation: <u>Measure 1</u> – Updated annually as grants are awarded; <u>Measure 2</u> - NNDSS data are received from state health departments weekly and reviewed. Reports are checked and any pre-specified data are verified by contacting the appropriate state health department. All data are once again checked and verified with state health departments at the end of each calendar year.			
Cross Reference: <u>Measure 1</u> - HHS-1, 4, HP-14.9; <u>Measure 2</u> - HHS-1, PART			

Goal 1, Performance Measure 1:

To date, CDC has exceeded the targeted number of health departments to receive funding. In FY 2005, CDC continued to implement the National Hepatitis C Prevention Strategy by funding: hepatitis C coordinators in 52 jurisdictions, including states, large metropolitan health departments and the Indian Health Service; five Viral Hepatitis Integration and Intervention Projects (VHIPS) to establish best practices for prevention of hepatitis C and other causes of viral hepatitis, and 12 Viral Hepatitis Education and Training Projects (VHETS) to develop and disseminate hepatitis C education and training materials; and the development of state-based hepatitis C/viral hepatitis prevention plans in 24 states. Hepatitis C coordinators in state and local health departments help initiate and integrate hepatitis prevention activities in existing public health programs (e.g., HIV and STD prevention, immunization, epidemiology, and surveillance) in various settings. They also develop and provide educational programs and materials. This measure will be retired after data are reported for FY 2005.

Goal 1, Performance Measure 2:

CDC is on track to achieve the long-term target for hepatitis A. Overall, hepatitis A rates have declined dramatically; more than 78 percent since the last nationwide outbreak in 1995. The Healthy People 2010 target for reducing hepatitis A rates, 4.5 new cases per 100,000 population, was achieved in 2001. The rate in 2005, 1.9 new cases per 100,000 population, is the lowest rate recorded since surveillance for hepatitis A began in 1966. This precipitous decline in hepatitis A rates has coincided with the implementation of the Advisory Committee on Immunization Practices' (ACIP) recommendations for use of hepatitis A vaccine for the prevention and control of hepatitis A. In particular, in 1999, the ACIP recommended routine vaccination of children living in 11 states which had consistently elevated hepatitis A rates during the previous decade (1987-1997) and suggested that vaccination be considered in another six states. Compared to the average rates during 1987-1997, the rate in these 17 states declined 89 percent in 2003, but only by 52 percent elsewhere. Cases occurring in these 17 states accounted for more than 65 percent of national cases during 1987-1997, but represented only 33 percent of cases in 2003. Declines in the rates where routine hepatitis A vaccination for children has been recommended, strongly suggests that the reductions are attributable to the vaccine strategy. Although increases in rates may still occur, it is expected that the downward trend in rates will continue with ongoing implementation of the ACIP vaccination strategy, which has recently been updated to recommend hepatitis A vaccination of all children at one year of age (i.e., 12-23 months) as part of the routine childhood and adolescent vaccination schedule.

GOAL 2: PROTECT AMERICANS FROM INFECTIOUS DISEASES – INFLUENZA.

Measure	FY	Target	Result
1. Monitor influenza viruses in states (1 site/250,000 population domestically) and support influenza surveillance sites and networks internationally to enhance early detection of viruses with pandemic potential and improve vaccine decision-making.	2005	1000 sites/9 networks	1,300/12 (Exceeded)
	2004	800 sites/2 networks	1,004/9 (Exceeded)
	2003	750 sites/1 network	891/1 (Exceeded)
2. By 2010, enhance preparedness for pandemic influenza by establishing in-country influenza networks that are actively producing usable samples for testing as measured by geographic and population coverage.	2007	14 networks	12/2007
	2006	9 networks;	12/2006
	2005	9 networks;	12 (Exceeded)
	2004		9 networks; 1 with 100% geographic coverage and 70% population coverage; 8 with 10-40% geographic coverage and 10-40% population coverage per country network.
	2003	Baseline	1 network; 60% geographic coverage; and, 60% population coverage per country network

Data Source: The U.S. Sentinel Provider Influenza Surveillance Network.

Data Validation: CDC epidemiologists analyze the data for outlying information and perform routine checks for coherence. Given that sentinel surveillance provides an index of current influenza activity, consistent reporting by a stable group of providers is imperative for data reliability. Increasing sentinel providers sites and sentinel providers participation in each state greatly increases the validity of the data.

Cross Reference: Measure 1 – HHS-1, 4, HP-14.1, 500-4; Measure 2 - HHS-4, 5, PART, 500-4

Goal 2, Performance Measure 1:

CDC has improved preparedness for both epidemics and a possible pandemic of influenza by expanding influenza surveillance. To date, CDC has exceeded the number of targeted domestic sites through recruitment of U.S. sentinel physicians and follow-up by CDC staff to ensure constant reporting. These domestic and international sites provide surveillance data that are critical to influenza vaccine decisions. In FY 2005, CDC continued a major initiative to enhance international surveillance particularly in countries affected by avian influenza viruses. Bilateral cooperative agreements were awarded to 12 countries affected by avian influenza to enhance or develop influenza surveillance networks. These grants will allow better geographic representation of circulating influenza viruses, enhance the “early warning system” for detection of novel strains, and contribute to vaccine strain selection. CDC will continue to build capacity for influenza surveillance sites and networks internationally. These international networks strengthen global surveillance capabilities to increase the likelihood of early detection of an influenza pandemic and effective tracking of its spread. They also provide critical information needed to improve vaccine decision-making.

Improving U.S. sentinel physician surveillance is a priority because it is the primary system for measuring annual influenza morbidity and is a source for measuring the potential impact of an influenza pandemic in the U.S. Data collected about circulating influenza viruses are used to form the basis for annual vaccine decisions. This measure will be retired after data are reported for FY 2005.

Goal 2, Performance Measure 2:

This measure will track CDC's efforts to increase the number of influenza networks in Asia to enhance early detection of viruses with pandemic potential and improve vaccine decision-making. Early detection of pandemic viruses will benefit the international community by allowing the maximum lead time possible to develop pandemic vaccines, thus reducing morbidity and mortality globally. The accomplishment of this measure will also establish the influenza surveillance foundation necessary to conduct influenza burden studies, formulate vaccine policy, and reduce illness due to influenza through vaccination. Ideally, a network will be a nationwide system developed to collect virologic and epidemiologic data for influenza by establishing five or more sites with good distribution throughout the country. Each site will consist of a local laboratory and one or more clinics or hospitals for data collection. However, some flexibility of this definition may be needed based on geographic and resource considerations.

Currently, CDC supports 12 influenza surveillance networks globally through cooperative agreements. Support is provided through on-site training, the provision of technical assistance and funding for equipment and supplies. As part of the overall plan to develop networks in Asia, key staff have been located in Asia with CDC assignments to Vietnam, Laos, Cambodia and the Western Pacific Office of WHO. CDC provides technical assistance and support for enhancing or developing influenza surveillance networks. In addition, CDC provides support and assistance to foreign governments for the establishment of surveillance networks in Korea, Indonesia, Pakistan, India, Philippines, Thailand, Mongolia, Malaysia, China Vietnam, Kazakhstan and Pacific Public Health Surveillance Network (a consortium of seven countries and territories including Cook Islands, Fiji, Guam, Wallis and Futuna, Palau and Tonga). Finally, CDC has provided critical support to our partners in Department of Defense (DOD) at both Naval Medical Research Unit (NAMRU)-2 in Jakarta and NAMRU3 in Cairo. These collaborations enhance technical assistance regionally and improve sharing of international specimens.

GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.				
Measure	FY	Target	Result	
1. Expand the number of public health laboratories using PulseNet for early identification of and response to foodborne disease outbreaks (number of agents may increase as new pathogens are identified).		<i>E. coli</i> 0157:H7	<i>E. coli</i> 0157:H7	
	2005	45 labs	48 (Exceeded)	
	2004	45 labs	45 (Met)	
	2003	45 labs	45 (Met)	
			<i>Salmonella</i> Typhimurium	<i>Salmonella</i> Typhimurium
	2005	45 labs	50 (Exceeded)	
	2004	45 labs	45 (Met)	
	2003	45 labs	45 (Met)	
			<i>Listeria monocytogenes</i>	<i>Listeria monocytogenes</i>
	2005	30 labs	30 (Met)	
	2004	30 labs	30 (Met)	
	2003	30 labs	30 (Met)	
			<i>Shigella sonnei</i>	<i>Shigella sonnei</i>
	2005	15 labs	41 (Exceeded)	
	2004	15 labs	15 (Met)	
	2003	15 labs	15 (Met)	
			<i>Clostridium perfringens</i>	<i>Clostridium perfringens</i>
	2005	5 labs	5 (Met)	
	2004	3 labs	3 (Met)	
	2003	0 lab	0 (Baseline)	
		<i>Campylobacter jejuni/C. coli</i>	<i>Campylobacter jejuni/C. coli</i>	
2005	5 labs	9 (Exceeded)		
2004	5 labs	5 (Met)		
2003	0 lab	0 (Baseline)		

GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.				
Measure	FY	Target	Result	
		<i>Vibrio parahaemolyticus</i>	<i>Vibrio parahaemolyticus</i>	
	2005	5 labs	5 (Met)	
	2004	5 labs	5 (Met)	
	2003	0 lab	0 (Baseline)	
			<i>Vibrio cholerae</i>	<i>Vibrio cholerae</i>
	2005	5 labs	5 (Met)	
	2004	5 labs	5 (Met)	
	2003	0 labs	0 (Baseline)	
2. Enhance FoodNet by increasing the number of pathogens and syndromes under active surveillance.	2005	11 pathogens/syndromes	11 (Met)	
	2004	11 pathogens/syndromes	11 (Met)	
	2003	11 pathogens/syndromes	11 (Met)	
3. By 2010, reduce the incidence of infection with four key foodborne pathogens by 50%. [O]		<i>Campylobacter</i>	<i>Campylobacter</i>	
	2007	15.14	5/2008	
	2006	16.10	5/2007	
	2005	17.03	5/2006	
			<i>Escherichia Coli 0157:H7</i>	<i>Escherichia Coli 0157:H7</i>
	2007	1.25	5/2008	
	2006	1.30	5/2007	
	2005	1.42	5/2006	
			<i>Listeria monocytogenes</i>	<i>Listeria monocytogenes</i>
	2007	0.31	5/2008	
	2006	0.33	5/2007	
	2005	0.35	5/2006	
			<i>Salmonella species</i>	<i>Salmonella species</i>
	2007	8.39	5/2008	
	2006	8.90	5/2007	
	2005	9.45	5/2006	
Data Source: Measure 1 – National PulseNet Databases; Measure 2, 3 - FoodNet Active Sentinel Surveillance Network Data.				
Data Validation: Measure 1 - PulseNet databases are updated and reviewed daily by CDC staff. State participants are trained in CDC training workshops, and certified by performance assessment. QA/QC is conducted by the Association of Public Health Laboratories. Measure 2, 3 - FoodNet data are transmitted and updated and reviewed monthly. Incomplete data are reviewed with sites on monthly basis, as are cross checks comparing local data with national data for data validity. Data are closed out and summarized on an annual cycle to produce preliminary report, published in MMWR in spring of following year, and final report, later that year, once the updated population denominator data are available from the US Bureau of Census.				
Cross Reference: Measure 1 - HHS-2, HP-10.2; Measure 2 - HHS-2, HP-10.2; Measure 3 - HHS-1, PART				

Goal 3, Performance Measure 1:

CDC, in cooperation with state partners, designed and implemented the PulseNet DNA fingerprinting network in public health laboratories to provide early detection and investigation of foodborne disease outbreaks within and between states. CDC has prioritized the expansion of PulseNet because of the increased demand from participating sites. This measure will be retired after data are reported for FY 2005.

The United States and Canada executed a Memorandum of Understanding (MOU) on August 12, 2005 in which the two countries agreed to share DNA “fingerprint” patterns of foodborne illness-causing bacteria between PulseNet USA and PulseNet Canada in real time. This will provide early warning to both countries on clusters of foodborne

disease that may turn out to be outbreaks. This MOU will serve as the template for future agreements on data sharing between PulseNet USA and other international PulseNet networks (PulseNet Europe, PulseNet Asia Pacific, and PulseNet Latin America) that are being set up with technical support from CDC.

Goal 3, Performance Measure 2:

CDC led the development and implementation of FoodNet, a network of sentinel sites, which provides accurate trend information for important foodborne infections and improved methods for early detection of foodborne disease problems within and between states. These programs and other CDC efforts have accomplished the following results:

- strengthened and expanded the tracking system for foodborne illness.
- improved and expanded pathogen-detection methods.
- improved techniques to avoid, reduce, and eliminate foodborne illness.
- improved outbreak containment.

In FY 2005, CDC continued active surveillance for eight common bacterial pathogens, two parasites, and one syndrome (Hemolytic Uremic Syndrome) in FoodNet. This measure will be retired after data are reported for FY 2005.

Goal 3, Performance Measure 3:

A summary of FoodNet data from 1996–2004 published on April 15, 2005 showed significant declines in rates of infection with E. coli O157, Listeria, Campylobacter, and to a lesser degree Salmonella, suggesting the current efforts to reduce these diseases are largely on track towards the Healthy People 2010 objectives. Rates of infection with Salmonella have only modestly decreased, and rates for Vibrio infections have actually increased from the 1996 through 1998 baseline. New interagency efforts in research and surveillance to improve and document the effectiveness of food safety measures are underway. Listeria infections have declined since 2003 after broader implementation of the national Listeria Action Plan. This plan is a joint effort between FDA and CDC to reduce Listeria cases through efficient risk management, by empowering consumers, and improving consumer safety. The reporting dates have been adjusted due to data being available in April each year.

GOAL 4: PROTECT AMERICANS FROM INFECTIOUS DISEASES – GROUP B STREPTOCOCCAL INFECTIONS.			
Measure	FY	Target	Result
1. Reduce the incidence of perinatal group B streptococcal infections to 0.3 per 1,000 live births. [O]	<i>2004</i>	0.3	0.33 (Met)
	<i>2003</i>	0.3	0.32 (Met)
	<i>2002</i>	0.3	0.42 (Unmet)
Data Source: The Active Bacterial Core Surveillance (ABCs) system tracks several pathogens that cause invasive disease.			
Data Validation: Routine laboratory audits to ensure the completeness of data collection are performed. Each month, CDC staff review data and transmit potential errors to state personnel for evaluation. Detailed instructions for completion of case report forms ensure consistency across sites. Process and quality improvements occur through monthly conference calls, annual meetings, and site visits.			
Cross Reference: HHS-1			

Goal 4, Performance Measure 1:

CDC met the FY 2004 target to reduce the incidence of perinatal group B streptococcal (GBS) infections to 0.3 per 1,000 live births. However, rates continue to vary by ethnic groups with the rate for blacks above the target of 0.5 per 1000 live births. After a plateau in early-onset GBS disease incidence from 1999-2002, rates dropped by 34 percent in 2003, following the release of universal prenatal screening guidelines. In 2004, the overall rate was sustained. A multi-state labor and delivery record review of births in 2003 and 2004 will shed more light on GBS prevention implementation and highlight opportunities for missed prevention. This measure will be retired after data are reported for FY 2004.

ANTIMICROBIAL RESISTANCE

GOAL 5: REDUCE THE SPREAD OF ANTIMICROBIAL RESISTANCE.			
Measure	FY	Target	Result
1. Reduce the number of courses of antibiotics for ear infections for children < 5 years to 57 courses per 100 children. [O]	2007	60 courses	9/2008
	2006	60 courses	9/2007
	2005	61 courses	9/2006
	2004	62 courses	42 (Exceeded)
	2003	63 courses	53 (Exceeded)
2. Reduce the number of courses of antibiotics prescribed for a sole diagnosis of the common cold to 1,268 courses per 100,000 population. [O]	2005	1,917 courses	9/2006
	2004	1,917 courses	1,007 (Exceeded)
	2003	2,017 courses	1,871 (Exceeded)
	2002	2,144 courses	1,913 (Exceeded)
3. Decrease the number of antibiotics prescribed for ear infections in children under 5 years of age per 100 children. [O]	2007	60 courses	9/2008
	2006	60 courses	9/2007
	2005	61 courses	9/2006
Data Source: Measures 1 - 3: National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.			
Data Validation: A 10% quality control sample of survey records was independently keyed and coded.			
Cross Reference: Measure 1 - HHS-1, HP-14.18; Measure 2 - HHS-1, HP-14.19; Measure 3 - HHS-4, 5, HP-14.18, PART			

Goal 5, Performance Measure 1 and 3:

The number of courses of antibiotics given for ear infections to children under five years of age declined from 63 courses per 100 population in 2002 to 53 courses per 100 population in 2003 to 42 per 100 population in 2004. Data show that antibiotic ear infection prescriptions for children under five have declined considerably, compared to the 1997 baseline of 69 courses.

CDC's public health campaign "Get Smart: Know When Antibiotics Work" is the focus of this measure. The campaign involves an alliance of partners working to reduce inappropriate antibiotic use and reduce the spread of resistance to antibiotics. This national campaign includes a series of television, radio, and print public service announcements and comprehensive national, state, and local outreach. For example, in September 2003, CDC launched a national ad campaign created to promote appropriate antibiotics use knowledge among parents, which generated over 90 million audience impressions through television, print, and online media. Other current campaign activities include funding states to develop, implement, and evaluate local campaigns and evaluating and promoting a medical school curriculum on appropriate use of antibiotics. In addition, this year the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) will include two measures on appropriate antibiotic use that were promoted through the campaign.

In May 2004, the American Academy of Pediatrics and the American Academy of Family Physicians issued new guidelines for the management of ear infections. These guidelines present an option of observing selected children with ear infections without prescribing an antibiotic. CDC expects that as these guidelines are implemented prescribing antibiotics for ear infections will decline, accelerating their movement towards achieving this goal.

Goal 5, Performance Measure 2:

Because the common cold is caused by a virus, antibiotic therapy is ineffective in treating these infections. Reducing the use of antibiotics in the treatment of the common cold remains one of the prime targets of CDC's antimicrobial resistance campaign. Success in exceeding this measure may reflect efforts by CDC and partners to promote appropriate antibiotic use in the community. This measure will be retired after data are reported for FY 2005.

MEDICAL ERRORS AND HEALTHCARE-ASSOCIATED INFECTIONS

GOAL 6: PROTECT AMERICANS FROM DEATH AND SERIOUS HARM CAUSED BY MEDICAL ERRORS AND PREVENTABLE COMPLICATIONS OF HEALTHCARE.			
Measure	FY	Target	Result
1. Reduce the rate of central line-associated bloodstream infections in adult ICU patients to 3.8. [O]	2005	3.8	5/2006
	2004	3.8	3.5 (Exceeded)
	2003	3.8	4.0 (Unmet)
	2002	3.8	4.3 (Unmet)
2. Reduce the rate of central line associated bloodstream infections in medical/surgical ICU patients. [O]	2007	3.54	5/2008
	2006	3.58	5/2007
	2005	3.62	5/2006
	2004	3.66	3.6 (Met)
	2003	Baseline	3.7
Data Source: Before December 2004 - National Nosocomial Infections Surveillance (NNIS) system. After January 2005 - National Healthcare Safety Network (NHSN), which has replaced NNIS.			
Data Validation: Extensive cross-field edit checks ensure the accuracy of the data and incomplete data cannot be transmitted. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.			
Cross Reference: <u>Measure 1</u> - HHS-1, 5, 500-1; <u>Measure 2</u> - HHS-1, 5, PART, 500-1			

Goal 6, Performance Measure 1:

The FY 2004 target for reducing central line-associated bloodstream infections was exceeded. This measure will be retired after data are reported for FY 2005.

Goal 6, Performance Measure 2:

This measure uses data from combined medical/surgical intensive care units (ICUs) from hospitals not designated as major teaching facilities because this is the most prevalent unit reported in NNIS System and thus, most representative. From 2003 to 2004, the rate of central-line associated bloodstream infections in medical/surgical ICUs in non-major teaching hospitals decreased from 3.7 in 2003 to 3.6 in 2004.

Due to delays in deployment of NHSN, which replaced NNIS in January 2005, most of the data will be reported later than previously anticipated. The reporting dates have been adjusted to May of each year.

GOAL 7: PROTECT AMERICANS FROM INFECTIOUS DISEASES - PNEUMOCOCCAL DISEASE.				
Measure	FY	Target	Result	
1. By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults aged 65 years and older to 42 per 100,000. [O]		<i>Children under 5 years of age</i>	<i>Children under 5 years of age</i>	
	2007	47	6/2008	
	2006	48	6/2007	
	2005	50	6/2006	
			<i>Adults 65 years and older</i>	<i>Adults 65 years and older</i>
	2007	45	6/2008	
	2006	47	6/2007	
	2005	55	6/2006	
Data Source. The Active Bacterial Core surveillance (ABCs)/ Emerging Infections Program Network.				

GOAL 7: PROTECT AMERICANS FROM INFECTIOUS DISEASES - PNEUMOCOCCAL DISEASE.

Data Validation: These data are collected by 10 states through active contact with all clinical laboratories in population catchment areas; the data are sent to CDC monthly for review, editing and cleaning. States conduct audits for missed cases either monthly or in some cases 6-monthly. Pneumococcal isolates are collected and validated at three quality-controlled reference laboratories.

Cross Reference: HHS-1, HP-14.5, PART

Goal 7, Performance Measure 1:

Incidence of pneumococcal disease fell between 2001 and 2003. These data indicate that CDC is on track to reach disease reduction targets. Progress is aided by the introduction of the pneumococcal conjugate vaccine that was licensed for use in children in the U.S. in 2000. Vaccinating children has reduced disease in adults through reduced transmission. However, some challenges remain. Supplies of the conjugate vaccine have been inadequate for much of the time since licensure. CDC has worked with the vaccine manufacturer, ACIP, and professional organizations to promote optimal and equitable use of vaccine during times of shortage. Vaccine supply is now adequate. The reporting dates have been adjusted due to the timing of receiving data from state health departments.

GOAL 8: PROTECT AMERICANS FROM INFECTIOUS DISEASES - LABORATORY RESPONSE.

Measure	FY	Target	Result
1. Increase the percentage of Laboratory Response Network (LRN) labs with cumulative proficiency testing scores of 90% or better.	2007	88% of labs	12/2007
	2006	84% of labs	12/2006
	2005	80% of labs	83% (Exceeded)
	2004	Baseline	79%

Data Source: LRN labs report Proficiency Testing (PT) data to LRN secure website. Grading and summary of results are maintained on LRN website.

Data Validation: All of PT results are reviewed to meet grading criteria: 1. Proper identification of agent in the samples that contain the agent; 2. Ability of LRN labs to follow appropriate algorithm for obtaining results; 3. Ability to report with prescribed timelines. Automated grading tool is used to calculate PT passing rates. Designated individual review PT grading for errors.

Cross Reference: HHS-4, 5, PART, 500-4

Goal 8, Performance Measure 1:

The purpose of proficiency testing (PT) is to determine if LRN laboratories are continuously able to accurately identify the biological agents that may appear in naturally-occurring outbreaks or that may be used as agents of bioterrorism by using the instruments and protocols employed by the LRN. CDC provides a special PT program to each LRN laboratory that is, in turn, required to successfully participate. With each event, the PT program sends one or more select agents to each laboratory as pure cultures, genetic fragments, or substances embedded in a sample matrix mimicking an environmental powder or other sample. Laboratories are challenged to provide the correct genus and species answer using the established protocols within a limited and specified timeframe. The cumulative PT score for a year is calculated by averaging the scores from each quarterly PT and then at the end of the year, calculating a national average from the total number of sites that participate in the program.

The PT program has been in place since the LRN was initiated in 1999. At the onset of the program, very few state laboratories had the ability to rapidly and accurately identify biological and select agents. Because of the difficulty in identifying certain select agents and logistical issues, the success rate in 2003 was about 75 percent. In order to achieve a goal of a cumulative average of 90 percent or greater for all labs in the LRN, it is necessary to maintain constant communication regarding the standard operating plan regarding specimen analysis, to provide updates on protocols, to provide remediation and training to those laboratories that do not achieve the 95 percent goal, and to engage the Association of Public Health Laboratories (APHL) to assist in achieving this national goal. APHL has agreed to assume responsibility for monitoring its members. Because the current average is only 83 percent accuracy, and because some organisms are very difficult to identify, the goal of reaching and maintaining 90 percent on a national scale is ambitious. While the goal of the LRN is to achieve a 100 percent accuracy rate, it is reasonable to assume that successful participation on a national scale would entail a success rate of 90 percent or greater accuracy.

HIV/AIDS, STD, AND TB PREVENTION

Efficiency Measure	FY	Target	Result
1. Decrease the amount of time in the review and oversight process for directly-funded Community-Based Organizations (CBOs), as reflected in the number of CDC programs for CBOs. [E]	2006	3 program announcements	12/2006
	2005	3 current announcements	3 current announcements (Met)
	2004		3 program announcements
	2003	Baseline	9 current program announcements
2. Increase the number of states using confidential name-based HIV reporting systems. [E]	2007	44	12/2007
	2006	42	12/2006
	2005	Baseline	38
3. Reduce division-level printing costs by offering updated tuberculosis (TB) educational and training materials on CD ROM rather than printed materials. [E]	2007	2% decrease	10/2007
	2005	Baseline	\$500,000
Data Source: HIV/AIDS Reporting System (HARS) is used to collect state HIV and AIDS data.			
Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.			
Cross Reference: HHS-8			

Efficiency Measure 1:

In FY 2004, CDC consolidated six program announcements for CBOs into one program announcement. The consolidation decreased the administrative work at CDC required to develop, publish, compete, review and award six different program announcements. This consolidation also provided CDC with the opportunity to improve oversight of grantees by reducing the number of different grant requirements which project officers are expected to know. Finally, the new program announcement included a set of core performance indicators to monitor and evaluate grantee performance.

The review process used to evaluate applications involves convening special emphasis panels, obtaining subject matter experts, conducting pre-decisional site visits and budget negotiations, and developing technical reports for each program announcement. With a consolidation of six program announcements to one announcement, CDC was able to streamline the review and oversight process thereby decreasing staff time and cost for all of these functions.

This efficiency measure was a temporary measure that was used to demonstrate efficiency of CDC staff in developing, publishing, and completing the review and award of funds for one comprehensive program announcement for directly funded CBOs compared with six different announcements. The measure will be retired after data are reported for FY 2006.

Efficiency Measure 2:

As available treatments prolong the lives of those infected with HIV and slow the progression to AIDS, AIDS data are increasingly insufficient to describe the national epidemic. Accurate, reliable, and comparable HIV data are needed from all states to describe the epidemic nationally. Although all states have implemented HIV reporting, reporting occurs via a number of methods. As of November 2005, 38 states and five territories have adopted confidential, name-based reporting; five states have adopted name-to-code systems; and seven states and the District of Columbia have adopted systems based on coded identifiers. In the 13 areas using codes, 12 different codes are used. Except for HIV, all other reported infectious diseases, including AIDS, are routinely reported to states using name-based reporting systems. Personal identifiers are removed from this data prior to submission to CDC. Because of the lack of standard methods for reporting diagnoses and the potential for duplication of cases arising from these multiple methods, HIV data are not sufficiently accurate and reliable to provide data on HIV prevalence nationwide. CDC's policy is to accept HIV infection and AIDS case surveillance data only from areas conducting confidential name-based reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. Further, only confidential name-based HIV reporting integrated with AIDS surveillance data can be used by states to remove duplicate cases reported to CDC's national surveillance database. For these reasons, in July 2005, CDC recommended that states conduct HIV reporting using the same name-based approach currently used for AIDS surveillance nationwide. Two states and the city of Philadelphia have switched to using a confidential name-based approach since CDC made its recommendation. This measure will monitor changes from

coded systems to confidential, name-based reporting. Such changes will increase the proportion of HIV cases that are included in the national database, thereby providing a more accurate picture of the epidemic nationwide and enabling better targeting of federal HIV resources.

Efficiency Measure 3:

Updated TB education and training resources are now available on CD-ROM, rather than printed materials. The costs associated with publishing and distributing copies of the CD-ROM are significantly less than those for print-based materials. Cost savings from this effort will support programmatic activities.

OVERARCHING HIV/AIDS PREVENTION

Historically, new AIDS cases (AIDS incidence) were the basis for assessing needs for prevention and treatment programs. However, potent new antiretroviral therapies are delaying or preventing the development of AIDS in many HIV-infected persons, and AIDS data are no longer sufficient to describe the epidemic. Data on HIV are now needed to monitor the effect of the epidemic. Measures reported below are based on data from states with long-standing confidential, name-based HIV reporting systems integrated with AIDS case surveillance. CDC is working with states to implement and improve HIV reporting and is studying methods to estimate HIV incidence nationally.

GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.			
Measure	FY	Target	Result
1. Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age. ¹ [O]	2007	<4000 cases in 30 areas	11/2008
	2006	Overall: 2,420 reported cases in 30 areas	11/2007
	2005	Overall: 1,800 reported cases in 25 states	11/2006
	2004	Overall: 1,900 reported cases in 25 states	2,606 in 25 states; 3,465 in 30 areas (Unmet)
	2003		2,286 in 25 states; 3,134 in 30 areas
	2002		2,154 in 25 states; 3,028 in 30 areas
2. Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 235 cases. [O]	2007	<100 cases	11/2008
	2006	<100 cases	11/2007
	2005	<100 cases	11/2006
	2004	<100 cases	48 (Exceeded)
	2003	<139 cases	69 (Exceeded)
	2002	141 cases	109 (Exceeded)
Data Source: HIV/AIDS Reporting System (HARS).			

GOAL 2: DECREASE THE NUMBER OF PERSONS AT HIGH RISK FOR ACQUIRING OR TRANSMITTING HIV INFECTION.

Data Source: CDC Supplement to the HIV/AIDS Surveillance (SHAS), CDC Morbidity Monitoring Project (MMP) (Beginning in 2006).

Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. The SHAS project was discontinued in June 2004. Data for 2004 reflect six months of data.

Cross Reference: HHS-1, 500-6

Goal 2, Performance Measure 1:

Because every new HIV infection is the result of transmission from an infected person, encouraging infected persons to adopt safe behaviors is one of the highest priorities of HIV prevention. Helping those who are infected to adopt safer behaviors is a key strategy of CDC's HIV initiative, Advancing HIV Prevention (AHP). In 2004, CDC asked state grantees to prioritize interventions with those who are HIV-infected, and included prevention with infected persons as a key component of its new directly-funded CBO program. Targets and actual performance estimates represent the median figure from 16 participating areas. Beginning in 2006, data for this measure will be collected through the new Morbidity and Mortality Monitoring Project (MMP). The reporting date for this measure has been changed to allow for complete analysis of data.

**GOAL 3: BY 2010, INCREASE BY 13% THE PROPORTION OF HIV-INFECTED PEOPLE WHO KNOW THEY ARE INFECTED, AS MEASURED BY THE PROPORTION DIAGNOSED BEFORE PROGRESSION TO AIDS
 (BASELINE: 76% IN 2000; TARGET FOR 2010: 85%)**

Measure	FY	Target	Result
1. Among persons with HIV infection, increase the proportion diagnosed before progression to AIDS. [O]	2007	79%	11/2008
	2006	79%	11/2007
	2005	80%	11/2006
	2004	80%	78% (Unmet)
	2003		78%
	2002		77% Data are from 30 areas with stable HIV reporting systems
2. Increase the percentage of HIV-positive tests with post-test counseling sessions reported from CDC funded test sites. [O]	2007	75%	10/2009
	2006	75%	10/2008
	2005	80%	10/2007
	2004	80%	10/2006
	2003	75%	71% (Unmet)
	2002	75%	71% (Unmet)

Data Source: CDC HIV/AIDS Reporting System, CDC HIV Counseling and Testing System (CTS).

Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. As of November 2005, 38 states have confidential, name-based reporting for persons diagnosed with HIV who have not developed AIDS. An area must have HIV reporting for at least four years to allow for stabilization of data collection and for adjustment of the data in order to monitor trends. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate estimates of trends for that year. All data have been modified to update annual "actual performance" numbers based on the most recent HIV/AIDS surveillance data. Therefore, estimates vary slightly from year to year.

Cross Reference: Measure 1 – HHS-1, HP-13.15, PART, 500-6; Measure 2 – HHS-1, 500-6

Goal 3:

As deaths due to AIDS have decreased and the rate of new infections has remained stable, the number of persons living with HIV/AIDS has increased. If incidence does not decrease, the number of persons living with HIV and AIDS is expected to continue to increase slightly each year. Further, of the estimated 1,039,000 to 1,185,000 persons infected with HIV in the U.S., one-fourth are unaware of their infection. Reducing the incidence of both new infections and HIV associated morbidity and mortality will require earlier testing and improved access to prevention and care services for persons with HIV. Research shows that persons who are aware of their infection are more likely to adopt behaviors to protect themselves and their partners. Thus, promoting knowledge of serostatus among those who are infected is essential in preventing new infections.

Goal 3, Performance Measure 1:

This measure is an indicator of the percentage of persons who learn of their infection before the development of an AIDS-defining condition. Compared with early testers, late testers are more likely to be young, black or Hispanic and to receive HIV testing because of illness. Early testers are more likely to seek testing because of self-perceived risk. The percentage of persons diagnosed with HIV and AIDS simultaneously should decrease over time if a greater proportion of HIV-infected persons find out their HIV status earlier. Activities related to these measures include efforts to increase knowledge of HIV status through voluntary counseling and testing, and to encourage routine testing for HIV in health care settings. To this end, CDC is developing new recommendations for HIV screening in health care settings.

Goal 3, Performance Measure 2:

Each year, approximately two million publicly funded HIV tests are reported from over 11,000 sites, each with varying rates of clients returning for their test results. In 2002, there was a reported increase from 69.3 percent in 2000 to 71 percent in the percentage of HIV-positive test results from CDC-funded sites with post test counseling reported. CDC is working with all grantees to continue improving the return rates for HIV-positive test results. HIV rapid tests now allow return of preliminary HIV test results "while you wait" increasing the number of people who receive their preliminary results. HIV positive test results still require confirmatory testing, with results shared at post-test counseling sessions. In FY 2002, two jurisdictions reported incomplete data and were not included in the overall calculation.

GOAL 4: BY 2010, INCREASE TO AT LEAST 80% THE PROPORTION OF HIV-INFECTED PEOPLE WHO ARE LINKED TO APPROPRIATE PREVENTION, CARE, AND TREATMENT SERVICES, AS MEASURED BY THOSE WHO REPORT HAVING RECEIVED SOME FORM OF MEDICAL CARE WITHIN 3 MONTHS OF THEIR HIV DIAGNOSIS (2001 BASELINE: 79%).			
Measure	FY	Target	Result
1. Increase the proportion of HIV-infected people who received some form of medical care within 3 months of HIV diagnosis. [O] (Data are from interviews taken from a sample of persons in 16 areas.)	2007	80%	11/2008
	2006	80%	11/2007
	2005	80%	11/2006
	2004	80%	86.1% (Exceeded)
	2003		83.3%
	2002		83.0%
Data Source: CDC SHAS, MMP (Beginning in 2006).			
Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. The SHAS project was discontinued in June 2004. Data for 2004 reflect six months of data.			
Cross Reference: HHS-1, PART, 500-6			

Goal 4, Performance Measure 1:

This measure reflects linkage to care after initial diagnosis. A physician should evaluate an HIV-infected person soon after receiving the initial positive results. However, many persons are not evaluated because of fear or lack of access to medical care. The data for this measure are collected through interviews with HIV-infected persons in 16 areas. The reporting date for this measure has been changed to allow for complete analysis of data. Beginning in 2006, data will be collected using the new MMP.

GOAL 5: STRENGTHEN THE CAPACITY NATIONWIDE TO MONITOR THE EPIDEMIC; DEVELOP AND IMPLEMENT EFFECTIVE HIV PREVENTION INTERVENTIONS; AND EVALUATE PREVENTION PROGRAMS.

Measure	FY	Target	Result
1. Increase the number of states and the District of Columbia that conduct HIV case reporting in adults and adolescents.	2007	50 states and D.C.	10/2007
	2006	50 states and D.C.	10/2006
	2005	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2004	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2003	50 states	49 states and D.C.; 34 use confidential, name-based reporting (Unmet)

Data Source: CDC HIV/AIDS Reporting System (HARS).

Data Validation: CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.

Cross Reference: HHS-1, 500-6

Goal 5, Performance Measure 1:

Currently, all states have implemented some form of HIV reporting. HIV reporting in the U.S. is currently conducted using one of three methods: 1) name-based; 2) code; and 3) name-to-code. As of November 2005, a total of 38 states and five territories use confidential name-based reporting systems for HIV case surveillance. CDC recommends that all states use confidential name-based methods for HIV case surveillance.

SEXUALLY TRANSMITTED DISEASES

CDC supports STD prevention and control by: 1) monitoring disease trends using national and local data to focus and assess current prevention activities; 2) conducting behavioral, clinical, and health services research and program evaluation to provide a scientific base for improving program efforts; 3) providing education and training through guideline development, 10 regional STD/HIV Prevention Training Centers, and programs to ensure that health care professionals are prepared to provide optimal STD treatment, care, and prevention services; 4) building national partnerships for STD prevention to educate health professionals, the public, and policymakers about the importance of STD prevention and the impact of STDs on the health of Americans, particularly women and infants, adolescents, and minority populations; and 5) providing financial, direct personnel, and technical assistance to state and local health departments to deliver clinical and prevention services.

Two foci are syphilis elimination and infertility prevention. CDC also supports special surveillance studies for Human Papillomavirus (HPV) and HSV-2; supports epidemiologic, behavioral, laboratory and health services research on a variety of STDs; provides program support, training and health communications for national STD prevention programs; and works to develop recommendations for HPV vaccines and implementation issues pertinent to such vaccines.

GOAL 6: REDUCE STD RATES BY PROVIDING CHLAMYDIA AND GONORRHEA SCREENING, TREATMENT, AND PARTNER TREATMENT TO 50% OF WOMEN IN PUBLICLY FUNDED FAMILY PLANNING AND STD CLINICS NATIONALLY.

Measure	FY	Target	Result
1. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics. [O]	2005	<5% median	10/2006
	2004	<5% median	6.3% (Unmet)
	2003	<5% median	5.9% (Unmet)
	2002	<5% median	5.6% (Unmet)
2. Reduce the incidence of gonorrhea in women aged 15 to 44. [O]	2005	<250/100,000 women	10/2006
	2004	<250/100,000 women	278/100,000 women (Unmet)

GOAL 6: REDUCE STD RATES BY PROVIDING CHLAMYDIA AND GONORRHEA SCREENING, TREATMENT, AND PARTNER TREATMENT TO 50% OF WOMEN IN PUBLICLY FUNDED FAMILY PLANNING AND STD CLINICS NATIONALLY.

Measure	FY	Target	Result
	2003	<250/100,000 women	268/100,000 (Unmet)
	2002	<250/100,000 women	279/100,000 (Unmet)
3. Reduce the incidence of Pelvic Inflammatory Disease (PID), as measured by a reduction in hospitalizations for PID, in women aged 15 to 44. [O]	2003	<125/100,000 women	136/100,000 (Unmet)
	2002	<125/100,000 women	142/100,000 (Unmet)
4. Reduce the number of initial visits to physicians for PID in women aged 15 to 44. [O]	2004	<225,000 visits	132,000 (Exceeded)
	2003	<225,000 visits	123,000 (Exceeded)
	2002	<225,000 visits	197,000 (Exceeded)

Data Source: CDC STD Morbidity Surveillance System, CDC Infertility Prevention Program (IPP), the U.S. Department of Labor National Job Training Program, CDC National Center for Health Statistics, and National Diagnostic and Therapeutic Index by IMS America, Ltd.

Data Validation: Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff. PID hospitalization data are collected by the National Center for Health Statistics. Data for PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.

Cross Reference: Measure 1 - HHS-1, HP-25.1a, 500-1; Measure 2 - HHS-1, HP-25.2, 500-1; Measure 3 - HHS-1, 500-1; Measure 4 - HHS-1, HP-25.6, 500-1

Goal 6, Performance Measure 1:

In 2004, the median chlamydia test positivity among 15-24 year-old women who were screened during visits to selected family planning clinics in all states and outlying areas was 6.3 percent (range: 3.2 percent to 16.3 percent). However, in nearly all states, chlamydia positivity was greater than the Healthy People 2010 objective of three percent. The source for these data is the CDC IPP. The continued expansion of screening programs to populations with higher prevalence of disease, use of more sensitive diagnostic tests and high rates of reinfection due to untreated sex partners have likely contributed to the increase in overall median positivity. This measure has been revised for FY 2006 (see below).

Goal 6, Performance Measure 2:

The U.S. experienced a 74.3 percent decline in the reported rate of gonorrhea from 1975 to 1997. After a small increase in 1998, the gonorrhea rate has decreased slightly since 1998.

Among women aged 15 to 44, the 2004 gonorrhea rate was 278 per 100,000 population, which is above the target rate of 250. Although increased screening (usually associated with simultaneous testing for chlamydial infection), use of more sensitive diagnostic tests, and improved reporting may account for a portion of the recent increase, true increases in disease in some populations and geographic areas also appear to have occurred. The source for these data is the STD Morbidity Surveillance System, CDC. This measure has been revised for FY 2006 (see below).

Goal 6, Performance Measure 3:

Hospitalizations for PID decreased throughout the 1980s and early 1990s, but remained relatively constant between 1995 and 2001. These trends may reflect changes in the etiology of PID (with increasing proportions of more asymptomatic chlamydial infection) as well as changes in the clinical diagnosis and management of PID rather than true trends in disease. Since the early 1990s, a greater proportion of women diagnosed with PID were treated in outpatient rather than inpatient settings when compared to women diagnosed with PID in the 1980s. In general, incidence is declining, but because of variations in the sampling frame from year to year, annual fluctuations are likely. Because of this variability in sampling frame, CDC focuses on trends in disease incidence rather than a single year data point. This measure will be retired after this year.

Goal 6, Performance Measure 4:

The reported number of initial visits to physicians' offices for PID through the National Disease and Therapeutic Index declined from 1993 through 2003. CDC conducts screening for chlamydia and gonorrhea to prevent PID resulting from untreated infection. This measure has been restated as a goal for FY 2006 to reflect the importance of reducing this adverse health outcome.

GOAL 7: REDUCE THE INCIDENCE OF P&S SYPHILIS.			
Measure	FY	Target	Result
1. Increase the percentage of U.S. counties with an incidence of P&S syphilis in the general population of 4/100,000. [O]	2005	>95% of counties	10/2006
	2004	>95% of counties	94.5% (Unmet)
	2003	>95% of counties	95% (Met)
	2002	>92% of counties	94% (Exceeded)
2. Reduce the racial disparity (reported ratio is black: white). [O]	2005	11:1	10/2006
	2004	13:1	5.6:1 (Exceeded)
	2003	15% to 14:1	38% reduction to 5:1 (Exceeded)
	2002	15% to 17:1	50% reduction to 8:1 (Exceeded)
Data Source: STD Morbidity Surveillance System, CDC.			
Data Validation: Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
Cross Reference: <u>Measure 1</u> - HHS-1, HP-25.3; <u>Measure 2</u> - HHS-3, HP-25.3, 500-1			

Goal 7, Performance Measure 1:

The rate of primary and secondary (P&S) syphilis in the U.S. declined by 89.7 percent from 1990 through 2000. In 2004, 94.5 percent of U.S. counties had an incidence of P&S syphilis in the population equal or below four per 100,000. Recent outbreaks of syphilis among men who have sex with men (MSM) have been reported, possibly reflecting an increase in risky sexual behavior in this population and negatively affecting the significant reductions in P&S syphilis in the past decade. The rate of P&S syphilis increased slightly in 2004 from 2.5 to 2.7 per 100,000 population. This increase was observed only in men (4.2 to 4.7 per 100,000 population); syphilis rates in women remained steady between 2003 and 2004 (0.8 per 100,000 population). The number of P&S syphilis cases reported to CDC increased to 7,980 in 2004 from 7,177 in 2003. In FY 2006, this measure will be replaced with measures to reduce the incidence of primary and secondary syphilis among men and women.

Goal 7, Performance Measure 2:

P&S syphilis remains an example of racial disparity in health, with 2004 rates among African Americans 5.6 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. While substantially reduced from previous years, this disparity (5.6:1) is still much higher than that for other health outcomes: including infant mortality (2.5:1), and deaths attributable to heart disease (1.3:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. CDC aims to continue reducing this racial disparity in 2004 and 2005. This measure has been revised for FY 2006.

GOAL 8: REDUCE THE INCIDENCE OF CONGENITAL SYPHILIS.			
Measure	FY	Target	Result
1. Reduce the incidence of congenital syphilis per 100,000 births. [O]	2005	<12	10/2006
	2004	<12	8.8 (Exceeded)
	2003	<12	10.3 (Exceeded)
	2002	<12	11.4 (Exceeded)
Data Source: STD Morbidity Surveillance System, CDC			
Data Validation: Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
Cross Reference: HHS-1, HP-25.9, 500-1			

Goal 8, Performance Measure 1:

The continuing decrease in the rate of congenital syphilis likely reflects the substantial reduction in the rate of P&S syphilis among women that has occurred in the last decade. During 1994 through 2004, the average yearly percentage decrease in the congenital syphilis rate was 17.1 percent. The average yearly percentage decrease in the rate of P&S syphilis reported among women for the years 1994 through 2004 was 19.6 percent. This measure has been revised for FY 2006 (see below).

Insufficient syphilis serologic testing and treatment of women for syphilis during pregnancy remains the major reason that congenital syphilis persists in the U.S. When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in utero. This may result in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. Each positive test in a child is considered a medical emergency with immediate health services follow-up. The absence of testing is often related to complete lack of, or late initiation of prenatal care. Between 2003 and 2004, the overall rate of congenital syphilis decreased 17.8 percent in the U.S., from 10.7 to 8.8 cases per 100,000 live births.

Goals 9 and 10:

During the FY 2006 budget process, CDC's STD Prevention program underwent a PART review by the Office of Management and Budget. This process helped CDC redirect and refine its performance measures for STD prevention and control. Based on its PART review, CDC has revised its goals for STD prevention. CDC will track the following goals and measures (Goals nine and 10) and will no longer report on goals six through eight, after reporting for their FY 2005 targets has been completed.

GOAL 9: BY 2010, REDUCE THE INCIDENCE OF PELVIC INFLAMMATORY DISEASE (PID) BY 15% (AS MEASURED BY INITIAL VISITS TO PHYSICIANS BY WOMEN AGES 15-44).			
Measure	FY	Target	Result
1. Reduce the prevalence of chlamydia among high-risk women under age 25 by 15%. [O]	<i>2007</i>	9.3%	10/2008
	<i>2006</i>	9.3%	10/2007
	<i>2002</i>	Baseline	10.1%
2. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics by 15%. [O]	<i>2007</i>	6.3%	10/2008
	<i>2006</i>	6.3%	10/2007
	<i>2002</i>	Baseline	5.6%
3. Reduce the incidence of gonorrhea in women aged 15 to 44 by 15%. [O]	<i>2007</i>	278/100,000	10/2008
	<i>2006</i>	278/100,000	10/2007
	<i>2002</i>	Baseline	279/100,000
Data Source: The source for these data is the U.S. Department of Labor; U.S. Job Corps, IPP, CDC, and the STD Morbidity Surveillance System, CDC. 2002 data from the U.S. Job Corps are from 28 states and Puerto Rico. 2004 data are from 38 states and Puerto Rico.			
Data Validation: Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff. Data for PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.			
Cross Reference: Measure 1 - HHS-1, PART, 500-1; Measure 2 - HHS-1, HP-25.1a, 500-1; Measure 3 - HHS-1, HP-25.2, 500-1			

Goal 9, Performance Measure 1:

Data on the prevalence of chlamydial infection in defined populations have been useful to monitor disease burden and guide screening programs. For example, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program for economically disadvantaged women aged 16 to 24 who entered this program. Increased efforts to promote screening by medical practitioners are needed to achieve reductions in chlamydia in this and other populations. The FY 2007 target reflects what is achievable given current trends.

Goal 9, Performance Measure 2:

Chlamydia remains widespread and is a significant threat to women's health. Because chlamydia is usually asymptomatic and is most common among young women, CDC recommends annual chlamydia screening for sexually active women under age 25. This measure reflects chlamydia prevalence in programs receiving support from CDC. The FY 2007 target reflects what is achievable given current trends.

Goal 9, Performance Measure 3:

Chlamydia and gonorrhea are the most important preventable causes of infertility and potentially fatal tubal pregnancy. CDC conducts screening for chlamydia and gonorrhea to prevent PID from untreated infection. If not adequately treated, up to 40 percent of women infected with chlamydia or gonorrhea will develop infection (i.e., PID) in the uterus or fallopian tubes. PID can lead to infertility or ectopic pregnancy. These measures reflect the importance of reducing this adverse health outcome. The FY 2007 target reflects what is achievable given current trends.

GOAL 10: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY (P&S) SYPHILIS BY 12% AND CONGENITAL SYPHILIS BY 62%.			
Measure	FY	Target	Result
1a) Reduce the incidence of P&S syphilis in men per 100,000 population by 7%. [O]	2007	4.5/100,000	10/2008
	2006	Establish Baseline **	10/2007
1b) Reduce the incidence of P&S syphilis in women per 100,000 population by 65%. [O]	2007	0.8/100,000	10/2008
	2006	0.58/100,000	10/2007
	2002	Baseline	1.1/100,000
2. Reduce the incidence of congenital syphilis per 100,000 live births. [O]	2007	8.8/100,000	10/2008
	2006	8.8/100,000	10/2007
	2002	Baseline	11.4/100,000
3. Reduce the racial disparity of P&S syphilis by 63% (reported ratio is black:white). [O]	2007	5.6 to 1	10/2008
	2006	5.6 to 1	10/2007
	2002	Baseline	8.1 to 1
Data Source: STD Morbidity Surveillance System, CDC.			
Data Validation: Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
Cross Reference: <u>Measure 1a</u> – HHS-1, PART, 500-1; <u>Measure 1b</u> – HHS-1, PART, HP-25.3, 500-1; <u>Measure 2</u> – HHS-1, HP-25.9, 500-1; <u>Measure 3</u> - HHS-3, HP-25.3, 500-1			

** In FY 2002, the incidence of P&S syphilis in men was 3.8 per 100,000 (initial FY 2002 baseline). However, because of an outbreak of syphilis among men who have sex with men that occurred after 2002, CDC will report a new baseline for FY 2006. The overall goal for 2010 is a decrease in incidence of 12 percent as compared to the FY 2006 baseline.

Goal 10:

Syphilis, a genital ulcerative disease, is highly infectious, but easily curable in its early (primary and secondary – P&S) stages. If untreated, it can lead to long-term complications including nerve, cardiovascular and organ damage and even death. Congenital syphilis (transmission from mother to child) can cause stillbirth, death soon after birth, physical deformity and neurological complications in children who survive. Syphilis also facilitates the spread of HIV, increasing transmission of the virus at least two-to-five fold.

Goal 10, Performance Measure 1a:

Although the rate of P&S syphilis in the U.S. declined by 89.7 percent during 1990-2000, the rate of P&S syphilis remained unchanged between 2000 and 2001, and increased annually in 2002, 2003 and 2004. Overall increases in rates during 2001-2004 were observed only among men. Recent outbreaks of syphilis occurring among MSM have been reported and have been characterized by high rates of HIV co-infection and high-risk sexual behavior. FY 2007 targets reflect what is achievable given current trends.

Goal 10, Performance Measure 1b:

Syphilis rates in women have declined with the implementation of the Syphilis Elimination Plan (from 2.0/100,000 in 1999 to 0.8/100,000 in 2004). CDC will continue to strive to decrease syphilis cases among women, both to protect the health of women and to prevent congenital syphilis. Untreated early syphilis during pregnancy results in perinatal death in up to 40 percent of cases, and, if acquired during the four years preceding pregnancy, may lead to infection of the fetus in over 70 percent of cases. The FY 2007 target reflects what is achievable given current trends.

Goal 10, Performance Measure 2:

When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in *utero*. This often results in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. The FY 2007 target reflects what is achievable given current trends.

Goal 10, Performance Measure 3:

Syphilis remains an example of racial disparity in health, with 2004 rates among African Americans 5.6 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. The racial disparity (5.6:1) is higher compared to many other health outcomes including infant mortality (2.5:1), and deaths attributable to heart disease (1.3:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. The FY 2007 target reflects what is achievable given current trends.

TUBERCULOSIS

GOAL 11: PROGRESS TOWARDS TB ELIMINATION IN THE U. S. (DEFINED AS LESS THAN 1 CASE/1,000,000 POPULATION) BY ACHIEVING AN INTERIM TB RATE OF 1 CASE/100,000 POPULATION IN U.S.-BORN PERSONS AND 20 CASES/100,000 POPULATION IN FOREIGN-BORN PERSONS RESIDING IN THE U. S., AND 3 CASES/100,000 POPULATION OVERALL, BY 2010.			
Measure	FY	Target	Result
1. Decrease the number of persons with TB among US-born persons, foreign-born persons, and overall (per 100,000 population). [O]	<i>2007</i>	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2008
	<i>2006</i>	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2007
	<i>2004</i>	Baseline	US born: 2.6; Foreign-born: 22.8; Overall: 4.9
2. Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months).* [O]	<i>2007</i>	88%	9/2010
	<i>2006</i>	88%	9/2009
	<i>2005</i>	88%	9/2008
	<i>2004</i>	88%	9/2007
	<i>2003</i>	88%	9/2006
	<i>2002</i>	88%	80.9% (Unmet)
	<i>2001</i>		80.5%
	<i>2000</i>		80.2%
	<i>1999</i>	Baseline	67.6%
3. Increase the percentage of TB patients with initial positive cultures who also have drug susceptibility results. [O]	<i>2007</i>	95%	9/2008
	<i>2006</i>	95%	9/2007
	<i>2005</i>	95%	9/2006
	<i>2004</i>	95%	93.9% (Unmet)
	<i>2003</i>	95%	90.1% (Unmet)
	<i>2002</i>	95%	93% (Unmet)
	<i>1994</i>	Baseline	74.7%

GOAL 11: PROGRESS TOWARDS TB ELIMINATION IN THE U. S. (DEFINED AS LESS THAN 1 CASE/1,000,000 POPULATION) BY ACHIEVING AN INTERIM TB RATE OF 1 CASE/100,000 POPULATION IN U.S.-BORN PERSONS AND 20 CASES/100,000 POPULATION IN FOREIGN-BORN PERSONS RESIDING IN THE U. S., AND 3 CASES/100,000 POPULATION OVERALL, BY 2010.

Measure	FY	Target	Result
4. Increase the percentage of contacts of infectious (Acid-Fast Bacillus (AFB) smear-positive) cases that are placed on treatment for latent TB infection and complete a treatment regimen. [O]	2007	43%	12/2010
	2006	59%	12/2009
	2005	61%	12/2008
	2004	61%	12/2007
	2003	63%	12/2006
	2002	63%	2/2006
	2001	63%	43.4% (Unmet)
	2000	70%	38.7% (Unmet)
	1999	Baseline	45.5%

Data Source: Data are obtained from the national TB Surveillance System and the national Aggregate Reports for TB Program Evaluation.

Data Validation: TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies.

Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.

Cross Reference: [Measure 1](#) - HHS-1, HP-14.11, PART, 500-1; [Measure 2](#) - HHS-1, HP-14.12, 500-1; [Measure 3](#) - HHS-1; [Measure 4](#) - HHS-1, HP-14.13, 500-1

*Data reports come to CDC after therapy is completed, which can be as long as two years.

Goal 11, Performance Measure 1:

TB is a leading infectious killer of young adults worldwide, claiming the lives of more than two million people each year. Approximately one third of the world's population is latently infected with the bacterium that causes TB. An estimated 10 to 15 million U.S. citizens have latent TB infection, and about 10 percent of these individuals will develop TB at some point in their lives. In 2004, TB cases declined for the 12th straight year and, from 2003 to 2004, reported cases of TB in the U.S. declined 1.3 percent (from 14,852 to 14,517). Persons born outside the U.S. now account for more than half of all U.S. TB cases.

Goal 11, Performance Measure 2:

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. Its achievement is vital to reduce TB cases and to eventually eliminate TB. Patients who do not complete therapy within 12 months are often difficult to treat and require numerous interventions. Significant new efforts must be made to achieve this objective. CDC supports outreach workers, hired from language, cultural, and ethnic groups with high TB incidence to help meet this objective.

Outreach workers help patients complete treatment through directly observed therapy incentives and other adherence strategies. CDC and the CDC-funded Model TB Centers also design and implement training and educational aids for health department and healthcare providers to improve the skills they need to help achieve this objective.

Goal 11, Performance Measure 3:

Healthcare providers must know if a newly diagnosed infectious patient is infected with drug-sensitive or drug-resistant organisms so that appropriate drug therapy can be initiated. If this information is unknown, patients may receive inadequate treatment leading to the spread of drug-resistant organisms, additional morbidity, and mortality. Progress towards this measure is attributable to increased efforts of state and local health departments and hospital infection-control practitioners to address the resurgence of TB and increased funding for health department

laboratories to purchase state-of-the-art equipment needed to perform more accurate and rapid laboratory testing and confirmation for TB and multi-drug resistant TB.

Goal 11, Performance Measure 4:

Completion of treatment for latent TB infection among contacts of infectious TB cases is a cornerstone of U.S. efforts to reduce TB and eliminate the disease, second only to ensuring that those with active TB complete treatment with appropriate drugs. Contacts of smear-positive TB patients are at high risk of developing TB and therefore must be screened for infection. If infected, these contacts should be offered complete treatment for latent infection. Performance reporting dates for FY 2002 – 2006 have been revised to accurately reflect the time lag in reporting data to CDC. In 2000, CDC adopted a new system for reporting on this measure. As a result, baseline data is substantially lower than that gathered under the previous system. Previous targets were set with a different data system which reflected a much higher baseline. The FY 2007 target has been revised in consideration of the new baseline data.

Through cooperative agreements with state and local health departments, CDC supports identifying and examining contacts of persons with active TB, as well as completing treatment for contacts who have latent TB infection. CDC is designing training for health department TB staff to improve their skills in this area. CDC is also working with the Health Resources and Services Administration (HRSA) and other federally funded programs serving groups at high risk for TB to facilitate testing and completion of treatment of latent TB infection.

IMMUNIZATION

Efficiency Measure	FY	Target	Result
1. Establish a target range for VFC and Section 317 funds requested by grantees for assessing vaccination coverage levels and providing feedback (AFIX) in healthcare provider office and clinic settings, and continue to monitor progress toward achieving the AFIX cost range. [E]	2007	Continue to reassess grantee progress toward achieving target range of AFIX visit costs and quality.	12/2008
	2006	Continue to provide feedback to grantees on methods to improve quality factors and decrease AFIX visit costs.	12/2007
	2005	Identify quality factors that are associated with grantee funding requests within the estimated baseline cost ranges for the different methods of implementing AFIX visits.	12/2006
	2004	Establish estimated baseline cost ranges for the different methods of implementing AFIX visits.	2/2006
Data Source: Grantee annual reports, budget submissions and supplemental surveys will be used to gather this information.			
Data Validation: Data submitted from grantees will be tracked and analyzed by the CDC program consultants working with the grantees.			
Cross Reference: HHS-8			

Efficiency Measure 1:

AFIX (Assessing immunization coverage levels in public and private provider settings, providing Feedback, encouraging Incentives to motivate providers to improve performance or for improved performance and eXchange of information on best practices) is a proven quality improvement strategy for increasing vaccination rates. CDC will establish estimated target ranges for the cost per visit for the various methods of implementing AFIX by reviewing grantee expenditure data in conjunction with data submitted annually on the number of AFIX visits completed. CDC will encourage grantees to align their AFIX visit costs with the target range for the implementation method, so that additional AFIX visits can be conducted with the subsequent cost savings. The efficiency measure was revised because the original efficiency measure was only designed for the Section 317 Immunization Grant Program. The revised efficiency measure will address both funding streams for AFIX, Section 317 and the Vaccines for Children (VFC) Program. CDC is close to establishing estimated baseline cost ranges per visit for the different methods of implementing AFIX. The reporting date was changed from December 2005 to February 2006 due to process delays.

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.				
Measure	FY	Target	Result	
1. The number of indigenous cases of paralytic polio ¹ , rubella ¹ , measles ¹ , <i>Haemophilus influenzae</i> invasive disease (type b and unknown types) ² , diphtheria ³ , congenital rubella syndrome ⁴ , and tetanus ³ will remain at or be reduced to 0 by 2010. [O]		<i>Paralytic Polio</i>	<i>Paralytic Polio</i>	
	2007	0	9/2008	
	2006	0	9/2007	
	2005	0	9/2006	
	2004	0	0 (Met)	
	2003	0	0 (Met)	
	2002	0	0 (Met)	
			<i>Rubella</i>	<i>Rubella</i>
	2007	15	9/2008	
	2006	15	9/2007	
	2005	15	9/2006	
	2004	15	10 (Exceeded)	
	2003	15	7 (Exceeded)	
	2002	20	10 (Exceeded)	
			<i>Measles</i>	<i>Measles</i>
	2007	50	9/2008	
	2006	50	9/2007	
	2005	50	9/2006	
	2004	50	11 (Exceeded)	
	2003	50	32 (Exceeded)	
	2002	60	26 (Exceeded)	
			<i>Haemophilus influenzae</i>	<i>Haemophilus influenzae</i>
	2007	150	9/2008	
	2006	150	9/2007	
	2005	150	9/2006	
	2004	150	196 b + unknown (Unmet)	
	2003	175	259 b+unknown (Unmet)	
	2002	175	187 b+unknown (Unmet)	
			<i>Diphtheria</i>	<i>Diphtheria</i>
	2007	5	9/2008	
	2006	5	9/2007	
	2005	5	9/2006	
	2004	5	0 (Exceeded)	
	2003	5	0 (Exceeded)	
	2002	5	0 (Exceeded)	
			<i>Congenital rubella Syndrome</i>	<i>Congenital rubella Syndrome</i>
	2007	5	9/2008	
	2006	5	9/2007	
	2005	5	9/2006	

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Measure	FY	Target	Result
	2004	5	0 (Exceeded)
	2003	5	1 (Exceeded)
	2002	5	1 (Exceeded)
		<i>Tetanus</i>	<i>Tetanus</i>
	2007	25	9/2008
	2006	25	9/2007
	2005	25	9/2006
	2004	25	6 (Exceeded)
	2003	25	6 (Exceeded)
	2002	25	6 (Exceeded)
2. Reduce the number of indigenous cases of mumps in persons of all ages from 666 (1998 baseline) to 0 by 2010. [O]		<i>Mumps</i>	<i>Mumps</i>
	2007	200	9/2008
	2006	200	9/2007
	2005	200	9/2006
	2004	200	245 (Unmet)
	2003	250	222 (Exceeded)
	2002	250	253 (Unmet)
3. Reduce the number of indigenous cases of pertussis among children under 7 years of age. [O]		<i>Pertussis</i>	<i>Pertussis</i>
	2007	2,300	9/2008
	2006	2,300	9/2007
	2005	2,300	9/2006
	2004	2,300	6,850 (Unmet)
	2003	2,500	3,719 (Unmet)
	2002	2,500	4,109 (Unmet)
Data Source: National Notifiable Disease Surveillance System (NNDSS), National Congenital Rubella Syndrome Registry (NCRSR), Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs.			
Data Validation: <u>NNDSS</u> - CDC receives reports of notifiable diseases from the 50 state health departments, New York City, the District of Columbia, and five U.S. Territories. These reports are initiated when health-care providers suspect or diagnose a case of a notifiable disease. Clinical laboratories also report results consistent with reportable diseases. Reporting of nationally notifiable diseases to CDC by the states is voluntary and only mandated (i.e., by state legislation or regulation) at the state level. All case reports, especially for low incidence and internationally quarantinable diseases, must be verified by the appropriate state officials. NNDSS case counts are likely incomplete, and therefore, these data are considered to represent a minimum number of cases. State reporting practices and some administrative procedures used in processing the NNDSS data may impact surveillance data reports and analyses. CDC staff provides technical assistance relevant for data verification to ensure data accuracy, completeness, and timeliness, specifically, assistance includes: computer specifications and software for reporting from state and territorial health departments, development and implementation of procedures to validate surveillance data, and identification of incomplete records, transmission errors, and deviations from expected numbers. <u>NCRSR</u> - CDC maintains the NCRSR with supplemental information to NNDSS. The registry includes data only on cases classified as confirmed or compatible. Cases are also classified as indigenous (exposure within the United States) and imported (exposure outside the United States) and are tabulated by year of birth. In contrast, cases reported to the NNDSS are tabulated by year of report. <u>ABCs</u> is an active laboratory and population-based surveillance system for invasive bacterial pathogens of public health importance, and currently operates in 10 sites in the U.S. For each case of invasive disease in the surveillance population, a case report with basic demographic information is completed and bacterial isolates are sent to CDC and other reference laboratories for additional laboratory evaluation. The ABCs program provides routine laboratory audits to ensure the completeness of data collection. Each month, CDC staff review data and communicate potential errors to state personnel for evaluation. Performance standards for active surveillance have been established in each site to permit aggregation of data collected via somewhat different approaches. Detailed instructions for completion of case report forms ensure consistency across sites. Timeliness and completeness of reporting in ABCs is evaluated using threshold percentages of isolate collection and enrollment into special studies. Surveillance "fatigue" or operational problems are assessed using			

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Measure	FY	Target	Result
isolate shipping schedules, audit sensitivities, and the timeliness of the audit data being completed by set deadlines.			
Cross Reference: <u>Measure 1</u> - HHS-1, HP-14.1a, 14.1b, 14.1c, 14.1e, 14.1h, 14.1i, 14.1j, PART, 500-1; <u>Measure 2</u> - HHS-1, HP-14.1f, 500-1; <u>Measure 3</u> - HHS-1, HP-14.1g, 500-1			

¹ All ages.
² Children under five years of age.
³ Persons under 35 years of age.
⁴ Children under one year of age.

Goal 1, Performance Measure 1:

Haemophilus influenzae type B (Hib) – Conjugate vaccines for the prevention of Hib are highly effective. Hib is no longer the leading cause of meningitis among children younger than five years old in the U.S. The number of possible cases reported decreased from 259 cases in 2003 to 196 cases in 2004. However, the FY 2004 target of 175 cases remains unmet. In accordance with the Healthy People 2010 goal, this measure includes both type b cases and those with unknown serotypes. The number of cases with unknown serotypes that are actually type b cannot be confirmed. Neither Healthy People 2010 targets nor GPRA targets have been adjusted to adjust for cases with unknown serotype. Therefore, while this goal remains unmet, the actual number of type b cases (both serotyped and not) for which the vaccine would have been effective may have remained the same or even decreased; the increase in cases from 2002 – 2003 may be explained by these disease reporting challenges. To address this issue of incomplete serotyping, CDC is working with state partners to provide technical assistance for enhanced Hib surveillance and laboratory support.

Goal 1, Performance Measure 2:

CDC exceeded its mumps disease reduction target in 2003, yet the goal was not met in 2004. However, there have been great strides in reducing mumps; the 1998 baseline of 666 cases has been reduced by almost two-thirds to 245 confirmed and probably indigenous cases in 2004. At this time, it is not clear whether the increased number of mumps reports in 2004 is due to increased awareness and enhanced surveillance, or due to an actual increase in disease. Continued monitoring over time will clarify this trend.

Goal 1, Performance Measure 3:

Pertussis (whooping cough) is a highly contagious, vaccine-preventable bacterial illness characterized by prolonged and severe cough and sometimes pneumonia. Although pertussis affects all age groups, complications and death are most frequently recognized among unvaccinated infants. The 2004 target was to reduce the number of pertussis cases among children under seven years of age to 2,300. The actual number of cases in this age group was 6,850. Most of these cases occurred among children who are not fully protected from disease. Children are not fully protected until they receive four doses of the vaccine by 15-18 months. Many cases occur among infants who are exposed to disease before they receive their first vaccination at two months of age. Introduction in 2005 of adolescent and adult versions of improved acellular pertussis vaccines with tetanus and diphtheria booster (Tdap vaccine) provides new opportunities for reducing severe pertussis and its complications in all age groups in the U.S. In addition, to propel efforts to regain control of pertussis in the U.S., CDC convened a meeting and an international panel of pertussis experts to develop a plan to improve control of pertussis in the U.S. Four publications are forthcoming which will guide the deliberations of four expert working groups. The interactions of the participants and especially the feedback provided by CDC's constituents suggest the panel generated new energy and new collaborations needed to reduce the pertussis disease burden in the U.S.

GOAL 2: ENSURE THAT 2-YEAR-OLDS ARE APPROPRIATELY VACCINATED.			
Measure	FY	Target	Result
1. Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: -4 doses DTaP vaccine ¹ -3 doses Hib vaccine -1 dose MMR vaccine ² -3 doses hepatitis B vaccine -3 doses polio vaccine -1 dose varicella vaccine -4 doses pneumococcal conjugate vaccine	2007	90% coverage	8/2008
	2006	90% coverage	8/2007
	2005	90% coverage	8/2006
	2004	90% coverage	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)

GOAL 2: ENSURE THAT 2-YEAR-OLDS ARE APPROPRIATELY VACCINATED.			
(PCV7) ³	2003	90% coverage	DTaP 96%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 85% (Exceeded, with the exception of Varicella)
	2002	90% coverage	DTaP 95%; Hib 93%; MMR 91%; Hepatitis B 90%; Polio 90%; Varicella 81% (Exceeded, with the exception of Varicella)
Data Source: Data are collected through the National Immunization Survey (NIS) and reflect calendar years.			
Data Validation: The NIS uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines—with dates—that appear on the child's "shot card" kept in the home, and demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are then contacted by mail to provide a record of all immunizations given to the child. Examples of quality control procedures include 100% verification of all entered data with a sub-sample of records independently entered. The quarterly data files are reviewed for consistency and completeness by CDC's National Immunization Program, Immunization Services Division - Assessment Branch and CDC's National Center for Health Statistics' (NCHS) Office of Research and Methodology. NCHS also conducts a separate qualitative assessment of 10% of the records. Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports are available to the public for review.			
Cross Reference: HHS-1, HP-14.24a, PART, PAR, 500-1			

¹ Due to a shortage in vaccine and temporary change in recommendations, 3 doses were reported from 2002 – 2003.

² Includes any measles-containing vaccine.

³ Performance targets for any newly recommended vaccines, such as pneumococcal conjugate vaccine and influenza vaccine, are reported in GPRA five years after ACIP recommendation. Measures for pneumococcal conjugate vaccine (PCV7) will begin in 2006 and influenza in 2009.

Goal 2, Performance Measure 1:

The ACIP Recommended Childhood and Adolescent Immunization Schedule recommends routine vaccination of children for these diseases. The target of 90 percent coverage was met in 2004 for most of the vaccines, except varicella and Diphtheria-Tetanus-acellular Pertussis (DTaP).

In 2004, the coverage rate for four doses of DTaP containing vaccine did not yet achieve the 90 percent goal. However, the coverage rate for the fourth dose has steadily increased since the change to a four dose schedule, as recommended by the ACIP in 1991. This goal continues to be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. Coverage rates are 96 percent for the first three DTaP doses. Although the first three doses are considered to be most critical, CDC and the ACIP feel strongly that the fourth and fifth doses are important for full vaccination. Varying state requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage. In 2002 and 2003, CDC modified reporting on DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose. This change was made because the ACIP recommends that if this vaccine is in short supply, or not available, the fourth dose of DTaP may be dropped. The performance reporting change was temporary and reporting for the fourth dose has now been implemented.

Varicella is the most recently introduced vaccine that has a measurable target. Varicella vaccination rates are rising with coverage at only 43 percent in 1998 and reaching 88 percent in 2004. CDC is close to meeting the 90 percent varicella vaccines coverage goal, which is especially impressive this soon after the introduction of this particular vaccine, since a child that has already been exposed to chickenpox does not receive the varicella vaccine. The prevention of pneumococcal infections with PCV is becoming more important because of problems with treatment due to antibiotic resistance. ACIP added PCV to the 2001 Recommended Childhood Immunization Schedule. As this vaccine was recently recommended, accountability for performance targets will begin in 2006. The vaccination coverage level for PCV in 2004 is 73.2 percent.

GOAL 3: INCREASE THE PROPORTION OF ADULTS WHO ARE VACCINATED ANNUALLY AGAINST INFLUENZA (FLU) AND EVER VACCINATED AGAINST PNEUMOCOCCAL DISEASE.			
Measure	FY	Target	Result
1. Increase the rate of flu and pneumococcal pneumonia vaccination in persons 65 years of age and older.	2007	Flu 74%; pneumococcal 69%	1/2009
	2006	Flu 74%; pneumococcal 69%	1/2008
	2005	Flu 74%; pneumococcal 69%	1/2007
	2004	Flu 74%; pneumococcal 69%	Flu 65% (Unmet); Pneumococcal 57% (Unmet)
	2003	Flu 74%; pneumococcal 69%	Flu 66% (Unmet); pneumococcal 56% (Unmet)
	2002	Flu 74%; pneumococcal 66%	Flu 66% (Unmet); pneumococcal 55% (Unmet)
2. Achieve a vaccination rate of 60% among non-institutionalized high-risk adults aged 18 to 64 years for flu and pneumococcal pneumonia by 2010.	2007	Flu 32%; pneumococcal 22%	1/2009
	2006	Flu 32%; pneumococcal 22%	1/2008
	2005	Flu 32%; pneumococcal 22%	1/2007
	2004	Flu 32%; pneumococcal 22%	Flu 35% (Met); pneumococcal 21% (Unmet)
	2003	Flu 32%; pneumococcal 22%	Flu 34% (Met); pneumococcal 21% (Unmet)
	2002	Flu 32%; pneumococcal 22%	Flu 32% (Met); pneumococcal 19% (Unmet)
Data Source: NHIS.			
Data Validation: NHIS is a cross-sectional household interview survey. Households chosen for interviews are a probability sample representative of the target population. The annual response rate is >90% of eligible households in the sample. The NHIS has three modules: 1) The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child. 2) Periodic modules collect more detailed information on some of the topics included in the basic module. 3) Topical modules respond to new data needs as they arise. Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Bureau of the Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations. Before the actual survey, cognitive testing is performed by CDC's Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.			
Cross Reference: Measure 1 - HHS-1, HP-14.29a, 14.29b, 500-1; Measure 2 - HHS-1, HP-14.29c, 14.29d, 500-1			

Goal 3, Performance Measure 1:

During the past decade, vaccination coverage levels among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization among healthcare providers and state and local governments. Influenza vaccination coverage levels among the elderly have increased from 30 percent in 1989 to 65 percent in 2004. However, data suggest that influenza vaccination levels may have reached a plateau. The vaccine shortage in 2004-2005, delays in distribution of influenza vaccine supplies during the 2000-2001 and 2003-2004 seasons, and to a lesser degree in the 2001-2002 season, posed additional challenges to increasing coverage levels. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain an influenza vaccination target of 74 percent for 2005, 2006 and 2007.

An increasing proportion of older adults also reported receipt of pneumococcal vaccination, from 15 percent in 1989 to 57 percent in 2004. However, the goal of 69 percent for 2004 was not met. Adult vaccination rates are slowly increasing and CDC has worked with the Centers for Medicaid and Medicare Services to raise the reimbursement rate for influenza and pneumococcal vaccines. The same challenges apply to pneumococcal vaccination in adults as influenza vaccination. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain the same targets for 2005, 2006 and 2007 for pneumococcal vaccination in this age group.

Goal 3, Performance Measure 2:

The ACIP Recommended Adult Immunization Schedule recommends vaccination for influenza for adults at high risk of complications each year and pneumococcal vaccination for those persons at high risk. Current levels of coverage among adults vary widely among different age, risk, and racial and ethnic groups. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza and pneumococcal vaccines. These vaccines are covered by Medicare, thus vaccinating greater numbers of adults 65 years of age and older is feasible. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk from these diseases. For this population the influenza vaccination goal has been met, and CDC and its partners are close to meeting the pneumococcal vaccination goal for high risk adults aged 18 to 46 years.

GOAL 4: IMPROVE VACCINE SAFETY SURVEILLANCE.			
Measure	FY	Target	Result
1. By 2010, improve capacity to conduct vaccine safety studies by increasing the number of persons in the Vaccine Safety Datalink (VSD) databases to 13 million.	<i>2007</i>	10 million	6/2008
	<i>2006</i>	10 million	6/2007
	<i>2005</i>	10 million	6/2006
	<i>2004</i>	10 million	7.5 million (Unmet)
	<i>2003</i>	10 million	7.5 million (Unmet)
	<i>2002</i>	Baseline	7.5 million
Data Source: Vaccine Safety Datalink (VSD).			
Data Validation: SAS computer programs developed by CDC analysts are submitted to the HMO sites at least once a quarter. The SAS programs are used to determine estimates of the performance measure. The programs also make several comparisons to check the quality of the estimates.			
Cross Reference: HHS-1, 2, 4, HP-14.31, 500-3			

Goal 4, Performance Measure 1:

The Vaccine Safety Datalink (VSD) project is a collaborative effort involving CDC and several large health maintenance organizations (HMOs). The VSD was established primarily to assess vaccine safety issues in the U.S. through analyses of Large-Linked Databases (LLDB) collected at the HMOs as part of their routine administration of health services. The databases contain the vaccination and medical records of millions of children and adults. VSD is an example of a LLDB that includes information on more than seven million people. The performance target for this goal was not met in FY 2004 because increasing populations in LLDBs is contingent on cooperating entities, resources, and technologies.

CDC's Vaccine Safety Activity relocated to the Office of the Chief Science Officer (OCSO) on April 21, 2005. This performance measure reflects one aspect of CDC's vaccine safety surveillance. CDC's vaccine safety activities are not limited to this one project.

HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

EFFICIENCY GOAL: DECREASE THE NUMBER OF HOURS SPENT EACH YEAR BY A PROGRAM TO COLLECT, AGGREGATE, ASSESS, AND ANALYZE PROGRAMMATIC DATA.			
Efficiency Measure	FY	Target	Result
1. Increase the number of Web-based management information systems (MIS) resulting in savings of program staff time. [E]	2007	6	12/2007
	2006	6	12/2006
	2005	6	7 (Met)
	2004		5
	2003	Baseline	4
2. Breast and Cervical Cancer: Reduce the funds required for CDC contractor to process and distribute grantee progress reports. [E]	2007	\$3,000	12/2007
	2006	\$3,000	12/2006
	2005	Baseline	\$12,000
3. Diabetes: Proportion of Program Development Branch (PDB) staff time dedicated to program development. [E]	2007	20% increase over baseline (30%)	12/2007
	2006	20% increase over baseline (30%)	12/2006
	2005	Establish baseline	25% (Met)
<p>Data Source: <u>Measure 1</u> - All IT operations are centralized and MIS's are deployed only when activated by Center IT staff. They keep track of all active and developmental MIS's. <u>Measure 2</u> - Data contractor deliverables indicate amount of funds required for these processes. <u>Measure 3</u> - Contractor conducted a Contribution Analysis study (specifically a work load / function / time analysis conducted by meeting with PDB team) to establish a baseline for level and time dedicated to priority staff functions. The results established the baseline.</p>			
<p>Data Validation: <u>Measure 1</u> - Center Information Systems Lead monitors active and developmental MIS's as part of normal duties. <u>Measure 2</u> - CDC Project Officer monitors the cost and performance data through the contract invoice, performance reports, and feedback reports deliverables. These are monitored on a monthly, quarterly, and semiannual basis, respectively. <u>Measure 3</u> - Division of Diabetes Translation will measure the level of effort to assess improvements (tentative timeframe is every 6 months). Primary methods of internal controls to monitor the quality of data collected in the function/time study will be supervisor feedback, grantee feedback, and EPMIS data.</p>			
<p>Cross Reference: HHS-5, 8</p>			

Efficiency Measure 1:

As project officers focus less on program administration, they spend more time providing program consulting, which increases the level of efficiency of a project officer. As such, this measure defines the number of management information systems within divisions that project officers use to provide more efficient program consulting to recipients. Currently, staff and recipients use the following five information systems to collect programmatic information: (1) Racial and Ethnic Approaches to Community Health Management Information System (REACH MIS), (2) Office of Smoking and Health's (OSH) National Tobacco Control Program Chronicle, (3) Breast and Cervical Cancer Minimum Data Elements (MDE), (4) National Breast and Cervical Cancer Early Detection Program System for Technical Assistance Reporting (STAR), (5) Division of Diabetes Translation Management Information System, (6) Prevention Research Center Information System and (7) Heart Disease and Stroke Management Information System. The STAR is undergoing reevaluation to improve the efficiency and usefulness of the data collection.

Efficiency Measure 2:

To improve program efficiencies and reduce administrative cost, CDC's contractor will process and distribute semiannual electronic data submissions to CDC through a CDC-sponsored contractor website. The CDC contractor receives, compiles and analyzes the data, and produces a series of management and progress reports. These feedback reports are provided to CDC program staff and grantees. By FY 2006, these reports will be made available to CDC staff and grantees on the website but continue to be reproduced in hard copy and mailed to CDC program staff. By FY 2007, CDC anticipates discontinuing the distribution of these reports by mail. Additional projects are planned to increase cost savings.

Efficiency Measure 3:

A management analysis review of the Program Development Branch, Division of Diabetes Translation was completed on January 18, 2005. The review identified an opportunity for increased efficiency by centralizing administrative management activities for procurement and grants, which consumed a large amount of individual project officer's time. In January 2005, the Program Development Branch reorganized into teams and the administrative management functions were redirected and consolidated to a central unit to eliminate redundancy in this area and to allow staff members who were once performing the same task to focus on program development.

The results of the Contribution Analysis (specifically a work load / function / time analysis) indicate that program staff spend approximately 25 percent of their time on program development activities. This will be used as the baseline against which the desired 20 percent increase will be tracked. Applying the targeted 20 percent increase to the baseline means that the program will spend 30 percent of its staff time on program development activities by December 2006.

HEART DISEASE AND STROKE

GOAL 1: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE AND ELIMINATE DISPARITIES.			
Measure	FY	Target	Result
1. Reduce the proportion of heart disease and stroke deaths that occur before transport to emergency services in states funded for basic implementation programs. [O]	2007	Heart disease deaths 45%; Stroke deaths 43%	2/2010
	2006	Heart disease deaths 45%; Stroke deaths 43%	2/2009
	2005	Heart disease deaths 45%; Stroke deaths 43%	2/2008
	2004	Heart disease deaths 45%; Stroke deaths 43%	2/2007
	2003 ¹		2/2006
	2002		Heart disease deaths 48%; Stroke deaths 45%
	2001	Baseline	Heart disease deaths 47%; Stroke deaths 44%
2. Reduce the prevalence of uncontrolled high blood pressure (>140/90) among patients with hypertension, especially among populations at high risk, in states that collaborate with community health centers. [O]	2007	50%	12/2007
	2006	50%	12/2006
	2005	50%	57% (Unmet)
	2004	50%	54% (Unmet)
	2003		60%
	2002	Baseline	60%
Data Source: CDC evaluates stroke registry capacity via annual state reports, deaths from heart disease and stroke via death certificate data from states, and uncontrolled high blood pressure data from HRSA and NCHS.			
Data Validation: Data is validated within HRSA and NCHS.			
Cross Reference: <u>Measure 1</u> - HHS-1, 5, HP-12; <u>Measure 2</u> - HHS-1, 5, 6, HP-12.1, 500-1,			

¹The heart disease measures for 2003 were inadvertently not included in the 2003 plan. Whereas 2003 dollars support the measures identified, 2003 targets were not provided.

Goal 1, Performance Measure 1:

Program activities are in place to achieve the performance measure of decreasing the proportion of heart disease and stroke pre-transport deaths. They include national and state-level health communication programs which cover symptom awareness and the need to call 911 for emergency transport. Intra and inter-state stroke networks, coalitions, and signs and symptoms campaigns have been developed.

The FY 2005 reporting date (and the reporting dates for subsequent targets) has changed due to a delay in 2003 mortality data; the tentative date of release of this data is January 2006.

Goal 1, Performance Measure 2:

Program activities to achieve the performance measure of reducing the prevalence of uncontrolled high blood pressure among high-risk populations and patients with hypertension include collaborations between states and their Federally Qualified Community Health Centers, which provide healthcare to underserved, uninsured, and minority populations. To date, states have assisted health centers in conducting needs assessments, and providing hypertension training and educational assistance for providers related to national guidelines for hypertension care and prevention.

Community health centers continue to enhance and align their systems and practices with evidence-based recommendations to reduce heart disease and stroke risk factors. As systems and practices are strengthened, it is CDC's expectation that the established targets will be met. The reporting date for each target was changed from August to December based on the anticipated release of data from HRSA.

EARLY DETECTION OF BREAST AND CERVICAL CANCER

GOAL 2: INCREASE EARLY DETECTION OF BREAST AND CERVICAL CANCER BY BUILDING NATIONWIDE PROGRAMS IN BREAST AND CERVICAL CANCER PREVENTION, ESPECIALLY AMONG HIGH-RISK, UNDERSERVED WOMEN.			
Measure	FY	Target	Result
1. Excluding invasive cervical cancers diagnosed on an initial screen in NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older. [0]	2007	<14/100,000	2/2009
	2006	<14/100,000 [†]	2/2008 [†]
	2005	<14/100,000 [†]	2/2007 [†]
	2004	<15/100,000 [†]	2/2006 [†]
	2003	<16/100,000 [†]	15/100,000 (Exceeded)
	2002	<22/100,000	15/100,000 (Exceeded)
Data Source: Minimum Data Elements (MDEs).			
Data Validation: States, territories, and tribal organizations (NBCCEDP grantees) submit MDEs electronically twice a year (October 15 and April 15) to a data management contractor, who analyzes the data and submits analysis data to CDC in July and February. All data collected and submitted by NBCCEDP grantees have indicators to assess completeness. Data are also assessed against established clinical standards.			
Cross Reference: HHS-1,HP-3.4, 500-1,3			

[†] FY rate based on 3 years of data (see narrative text below).

Goal 2, Performance Measure 1:

Beginning in 2003, CDC moved to calculating this rate based on a rolling three-year timeframe rather than cumulative data (for instance, the FY 2003 rate reflects data for the time period 2001–2003). Using a three-year period ensures statistical stability in the rate.

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Measure	FY	Target	Result
1. Increase the number of women screened. [0] Breast: mammogram or Clinical Breast Examination (CBE) Cervical: Pap Smear	2007	Breast 540,000; Cervical 305,000	2/2009
	2006	Breast 401,000; Cervical 280,000	2/2008
	2005	Breast 401,000; Cervical 280,000	2/2007
	2004	Breast 381,682; Cervical 275,000	2/2006
	2003		Breast 537,619; Cervical 304,407

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Measure	FY	Target	Result
	2002		Breast 394,146; Cervical 280,330
	2000	Baseline	Breast: 229,000; Cervical: 247,192
2. Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years. [O]	2007	Cervical 25%	2/2009
	2006	Cervical 25%	2/2008
	2005	Cervical 25%	2/2007
	2004	Cervical 22.5%	2/2006
	2003	Cervical 22.5%	21.3% (Unmet)
	2002		22.2%
	2000	Baseline	Cervical 21.7%
3. Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening. [O] Breast: abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE Cervical: abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells	2007	Breast 87.5%; Cervical 64.5%	2/2009
	2006	Breast 87.5%; Cervical 64.5%	2/2008
	2005	Breast 87.5%; Cervical 64.5%	2/2007
	2004	Breast 86.5%; Cervical 64%	2/2006
	2003		Breast 81.4%; Cervical 62.0%
	2002		Breast 82.8%; Cervical 63.0%
	2000	Baseline	Breast: 82.2%; Cervical: 61.2%
4. Increase the percentage of women with cancer who start treatment within 60 days of diagnosis. [O]	2007	Breast 95.5%; Cervical 92.5%	2/2009
	2006	Breast 95.5%; Cervical 92.5%	2/2008
	2005	Breast 95.5%; Cervical 92.5%	2/2007
	2004	Breast 95%; Cervical 92%	2/2006
	2003		Breast 93.0% Cervical 91.9%
	2002		Breast 92.9%; Cervical 88.6%
	2000	Baseline	Breast: 94%; Cervical: 88%
5. Cervical: Increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis (includes CIN (cervical intraepithelial neoplasia) II, CIN III, and CIS). [O]	2007	94.5%	2/2009
	2006	94.5%	2/2008
	2005	94.5%	2/2007

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.

Measure	FY	Target	Result
	2004	94%	2/2006
	2003		89.0%
	2002		90.3%
	2000	Baseline	92.4%

Data Source: MDE is used.

Data Validation: Please refer to the previous performance table for a detailed explanation.

Cross Reference: [Measure 1](#) - HHS-1, 3, 5, 6,HP-3.3, 3.4, 3.10, 500-1.3; [Measure 2](#) - HHS-1, 3, 5, 6,HP-3.4, PART, 500-1.3; [Measure 3](#) - HHS-1, 3, 5, 6,HP-3.3, 3.4, 500-1.3; [Measure 4](#) - HHS-1, 3, 5, 6,HP-3.3, 3.4, PART, 500-1.3; [Measure 5](#) - HHS-1, 3, 5, 6,HP-3.4, 500-1.3

Goal 3, Performance Measure 1:

CDC continues to increase the number of women screened through NBCCEDP by providing support for community outreach, education and recruitment. CDC also encourages programs to partner and/or collaborate with traditional and non-traditional partners to increase visibility, recruit eligible women, and increase provider networks.

Goal 3, Performance Measure 2:

CDC encourages programs to reach underserved women for screening, including women who are rarely or never screened for cervical cancer. CDC defines “never or rarely screened” women as those who have not had a Pap test within the past five years. In FY 2003, 21.3 percent of newly enrolled women were rarely or never screened, just below our target of 22.5 percent and a slight decrease from FY 2002. Because the measure relates only to newly enrolled women, projects must enroll new, rarely, and never screened women each year to meet this target. Therefore, it is a challenging target to achieve over time because programs must continually tap into communities to identify those who are rarely or never screened.

Goal 3, Performance Measure 3:

In FY 2003, 81.4 percent of women with abnormal breast cancer screening results and 62.0 percent of women with abnormal cervical cancer screening results received a final diagnosis within 60 days. The FY 2003 figures represent a slight decrease in breast and increase in cervical timeliness of diagnostic follow-up over the FY 2002 figures. The comparatively lower percentage for cervical cancer screening reflects challenges facing CDC’s programs, including delays in Pap results reporting from laboratories, long waiting periods for appointments for diagnostic services, and difficulties in tracking “hard to reach” women. Successful recall of women for diagnostic evaluation following unsuccessful earlier attempts will improve rates for completeness of follow-up, though negatively impacting timeliness.

Goal 3, Performance Measure 4:

In FY 2003, 93.0 percent of women diagnosed with breast cancer and 91.9 percent of women diagnosed with invasive cervical cancer initiated treatment within 60 days. This is an improvement over FY 2002 and significant progress toward 2004 goals, suggesting an impact of the implementation of the Breast and Cervical Cancer Treatment Act.

Goal 3, Performance Measure 5:

For women diagnosed with precancerous cervical lesions, CDC has set a target of ensuring the start of treatment within 90 days to 94 percent in 2004 and 94.5 percent in FY 2005. In 2000, the baseline for women diagnosed with precancerous cervical lesions that start treatment within 90 days was established at 92.5 percent. In 2003, the percentage of women with precancerous lesions who started treatment within 90 days of diagnosis was 89.0 percent, a slight decrease from FY 2002.

DIABETES PREVENTION AND CONTROL

GOAL 4: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL.			
Measure	FY	Target	Result
1. For states receiving CDC funding for Diabetes Prevention and Control Programs (DPCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams. [O]	2007	Eye 75%; Foot 70%	10/2008
	2006	Eye 75%; Foot 70%	10/2007
	2005	Eye 75%; Foot 70%	10/2006
	2004	Eye 72%; Foot 62%	Eye 61.9% (Unmet); Foot 66.6% (Exceeded)
	2003	Eye 72%; Foot 62%	Eye 61.3% (Unmet); Foot 67.4% (Exceeded)
	2002	Eye 72%; Foot 62%	Eye 64.2% (Unmet); Foot 66.6% (Exceeded)
2. For states receiving CDC funding for DPCPs, increase the percentage of persons with diabetes who receive at least two A1c measures per year. [O]	2007	72.5%	10/2008
	2006	72.5%	10/2007
	2005	72.5%	10/2006
	2004	72.5%	68.8% (Unmet)
	2003		63.3%
	2002	Baseline	62.0%
3. Increase the number of DPCPs that promote health system approaches among those who are at high risk for developing diabetes (New initiative).	2007	5	10/2008
	2006	5	10/2007
	2005	5	10/2006
	2004	5	5 (Met)
	2002	Baseline	0
Data Source: Data on receipt of annual eye and foot exams in persons with diabetes is collected through BRFSS.			
Data Validation: More than 30 validity and reliability studies attest to the quality and validity of data derived from the BRFSS. CDC verifies performance through quarterly state reports and periodic site visits. For efforts in American Indian/Alaska Native populations, data are verified via program reports and documentation of support. Also, CDC staff work closely with the Indian Health Service in validating data pertaining to American Indian/Alaskan Natives.			
Cross Reference: <u>Measure 1</u> - HHS-1, 3, HP-5.13, 5.14, PART, 500-1, 3; <u>Measure 2</u> - HHS-1, 3, HP-5.12, PART; <u>Measure 3</u> - HHS-1, 6, HP-5.2, 500-1, 3			

Goal 4, Performance Measure 1:

In FY 2003, CDC began analyzing the Behavioral Risk Factor Surveillance System (BRFSS) data for this measure. Rather than focusing solely on basic implementation DPCPs, CDC now analyzes data from all the basic implementation and capacity building DPCPs participating in the BRFSS. CDC is now also using adjusted data rather than crude data. These revisions have been made to clarify some of the performance measurement challenges revealed by the OMB PART review. CDC's Diabetes program was reviewed by PART during the FY 2004 budget cycle.

FY 2004 data indicate that eye exam rates increased slightly from 61.3 percent in FY 2003 to 61.9 percent in FY 2004. Eye exam rates dropped in FY 2003. While concerning, there is not yet enough data to provide a multi-year average, and for that reason, CDC cannot determine if the change signals a declining trend or an anomaly.

CDC continues to work with the state DPCPs to influence the preventive care practices of health systems and to inform providers and persons with diabetes about the importance of receiving annual eye exams to discover and treat diabetes-related eye disease in the earliest stages.

Goal 4, Performance Measure 2:

This measure captures funded states progress in increasing A1c testing rates to the recommended level. The A1c test (short for hemoglobin A1c) measures blood glucose (sugar) control over the last three months. The suggested target for people with diabetes is seven percent; however, many people with diabetes have levels of nine percent or higher. Reducing blood glucose levels by just one percent among people with diabetes reduces their risk for microvascular complications (eye, kidney, and nerve disease) by 40 percent. This measure reflects the evolution of CDC's focus from process outputs to intermediate impact outcomes.

FY 2004 data indicate that A1c testing rates increased. These data are encouraging but represent a single point in time. They are not representative of a multi-year average, and for that reason, CDC cannot determine if the change represents an increasing trend or an anomaly.

Goal 4, Performance Measure 3:

CDC and its state-based DPCPs work with HRSA's Bureau of Primary Health Care and the Institute for Healthcare Improvement (IHI) to improve diabetes and pre-diabetes performance measures through improved care delivery systems, increased access, and decreased health disparities among medically underserved populations. The Diabetes Prevention Collaborative prototype involves five federally funded health centers and five DPCPs from across the country. The objectives of the Diabetes Prevention Collaborative are to identify the pre-diabetes population and those at highest risk for developing diabetes, and provide evidence-based lifestyle interventions to prevent and/or delay the progression to diabetes. Preliminary findings indicate that methods to identify the pre-diabetes population are effective. Lifestyle interventions are being tested for their effect on reaching population level goals of more than seven percent weight loss and more than 150 minutes of exercise per week.

To date, 2,387 individuals who have met the risk criteria for pre-diabetes have received an oral glucose tolerance test; more than half of these individuals (1,392) were found to have either pre-diabetes or previously undiagnosed diabetes. The collaborative shows that better outcomes in diabetes care and prevention are possible when the focus is on empowering individuals, improving the health care delivery system, and linking to communities where people live.

TOBACCO USE PREVENTION

GOAL 5: REDUCE CIGARETTE SMOKING AMONG YOUTH.			
Measure	FY	Target	Result
1. Reduce the percentage of youth (grades 9-12) who smoke. [O]	2007	20.2	6/2008
	2005	20.2	6/2007
	2003	26.5	21.9% (Exceeded)
	2001	34.2 [†]	28.5% (Exceeded)
<p>Data Source: CDC monitors cigarette use among youth and reports performance on a biennial basis using the national Youth Risk Behavior Survey (YRBS). Three additional surveys, the National Survey on Drug Use and Health (NSDUH), the Monitoring the Future (MTF) Survey, and the National Youth Tobacco Survey (NYTS), provide complementary data for examining trends and understanding youth-related tobacco issues. The NSDUH is conducted annually by SAMHSA; the MTF is conducted annually by the University of Michigan's Institute for Social Research, and funded by NIDA. The NYTS is conducted by CDC.</p>			
<p>Data Validation: Following procedures developed by CDC staff, the NYTS data collection and survey support contractor, Macro International Inc. (Macro) checked each student's responses to certain questionnaire items for consistency with other items. Upon receipt of the final cleaned 2004 NYTS data set from Macro, CDC staff conducted quality checks of data quality, survey design, and weighting.</p>			
<p>Cross Reference: HHS-1, 7,HP-27.2, 500-1, 3</p>			

[†] YRBSS (Youth Risk Behavior Surveillance System) data released in June 2004 indicated achievement of the FY 2003 target, and CDC revised the teen smoking projections.

Goal 5, Performance Measure 1:

Between 1991 and 1997, the prevalence of current cigarette use among youth (grades 9 – 12) increased from 27.5 percent to 36.4 percent. Since 1997, cigarette use among adolescents has declined substantially, and in 2003, this rate was at the lowest level since national surveys have been monitoring youth smoking. Factors that contributed to the decline included: 1) a 90 percent increase in the retail price of cigarettes from December 1997-May 2003, 2) increases in school-based efforts to prevent tobacco use, and 3) an increase in the proportion of young persons exposed through the mass media to smoking-prevention campaigns. All of these factors are components and/or

recommendations of CDC's National Tobacco Control Program. However, other youth tobacco use surveys indicate that since 2003 this observed rate of decline may be slowing. From 2002 to 2004, factors preventing tobacco use (e.g., increasing the retail price of tobacco products, implementing smoking-prevention media campaigns, and funding for comprehensive state tobacco prevention and control programs) have declined. Meanwhile tobacco industry expenditures on tobacco advertising and promotion have been increasing, from \$5.7 billion in 1997 to \$15.2 billion in 2003. The emerging data underscore the need to fully implement evidence-based strategies that are effective in preventing youth tobacco use in order to continue progress toward meeting the Healthy People 2010 objective of reducing smoking among high school youth to 16 percent.

NUTRITION AND PHYSICAL ACTIVITY PROGRAMS TO PREVENT OBESITY AND OTHER CHRONIC DISEASES

GOAL 6: DECREASE LEVELS OF OBESITY, OR REDUCE THE RATE OF GROWTH OF OBESITY, IN COMMUNITIES THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.			
Measure	FY	Target	Result
1. Increase the number of nutrition and physical activity interventions that are implemented and evaluated in funded states.	2007	28 interventions	12/2008
	2006	25 interventions	12/2007
	2005	20 interventions	12/2006
	2004	12 interventions	12 (Met)
	2002	Baseline	0 interventions
Data Source: CDC plans to collect and evaluate state data on nutrition and physical activity programs via annual state program reports, semi-annual progress monitoring reports, site visit reports, and a program evaluation database.			
Data Validation: Data is verified through submission of additional documentation, follow-up telephone calls, site visits, and other meetings.			
Cross Reference: HHS-1, 5, HP-19, 22, 500-1, 3			

Goal 6, Performance Measure 1:

Since the inception of the program in FY 1999, funded states have been forming statewide coalitions, developing statewide action plans and initiating and evaluating interventions. State partners include public health organizations, food producers and marketers, medical and education providers, parks and recreation, transportation, and urban planning agencies, local media, and communities. All states are developing, implementing and evaluating nutrition and physical activity health promotion interventions to address overweight and chronic disease in specific populations. Results will include a number of refined programs, ready for adoption by other states and communities. Funded states are also improving their capacity to address the physical activity, nutrition and obesity prevention goals in part by working across programs such as diabetes, cardiovascular disease, asthma, school health, the Supplemental Food Program for Women, Infants and Children, as well as other programs that can benefit from overweight prevention and control.

SCHOOL HEALTH PROGRAMS

GOAL 7: REDUCE THE PERCENTAGE OF HIV/AIDS-RELATED RISK BEHAVIORS AMONG SCHOOL-AGED YOUTH THROUGH DISSEMINATION OF HIV PREVENTION EDUCATION PROGRAMS.			
Measure	FY	Target	Result*
1. Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O]	2007	90% or more	6/2008
	2005	90% or more	6/2006
	2003	90% or more	87.9% (Unmet)
	2001	90% or more	89% (Unmet)
2. Increase the proportion of adolescents (grades 9–12) who abstain from sexual intercourse or use condoms if currently sexually active. [O]		All adolescents	All adolescents
	2007	89%	6/2008
	2005	89%	6/2006
	2003	89%	87.5% (Unmet)
	2001	89%	86% (Unmet)

GOAL 7: REDUCE THE PERCENTAGE OF HIV/AIDS-RELATED RISK BEHAVIORS AMONG SCHOOL-AGED YOUTH THROUGH DISSEMINATION OF HIV PREVENTION EDUCATION PROGRAMS.

	African-American adolescents	African-American adolescents
2007	87%	6/2008
2005	87%	6/2006
2003	87%	87% (Met)
2001	87%	85% (Unmet)
	Hispanic adolescents	Hispanic adolescents
2007	88%	6/2008
2005	88%	6/2006
2003	88%	84.4% (Unmet)
2001	88%	84% (Unmet)

Data Source*: Data for both measures is collected through YBRSS. Data are released biennially.

Data Validation: Validity and reliability studies of the YBRSS attest to the quality of the data. CDC conducts quality control checks and logical edit checks on each record.

Cross Reference: Measure 1 - HHS-1, 2, 5, 7, HP-25, 500-1, 5; Measure 2 - HHS-1, 7, HP-25.11, 500-1, 5

Goal 7, Performance Measure 1:

Data from the 2003 national YBRSS indicate that this measure has decreased since 1997 (92 percent) and that the small fluctuations in 1999 (91 percent) and in 2001 (89 percent) are not significantly different from time to time when considering the confidence intervals associated with sample data. CDC will continue to analyze these data and evaluate the policies, programs, and strategies in place to continuously improve the effectiveness of school-based HIV/AIDS prevention education. This measure is highly relevant and important to prevention efforts.

Goal 7, Performance Measure 2:

CDC continues to review, analyze, and discuss the possible reasons for not reaching the FY 2003 targets for all adolescents and Hispanic adolescents, in consultation with CDC's funded states, cities, and national nongovernmental organizations, and will make programmatic adjustments as needed to improve program effectiveness required to reach the stated targets. Data are released biennially. CDC now requires funded education agencies to complete program performance indicators. The performance indicators will enable CDC to better target technical assistance and assist states in determining priorities.

REACH 2010

GOAL 8: BY 2010, IMPROVE THE LIVES OF RACIAL AND ETHNIC POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THE BURDEN OF DISEASE AND DISABILITY, AND DEVELOP TOOLS AND STRATEGIES THAT WILL ENABLE THE NATION TO ELIMINATE THESE HEALTH DISPARITIES.

Measure	FY	Target	Result
1. Develop national strategies (recommendations) to eliminate gaps in the six health priority areas based on the interventions and disseminate findings from the REACH 2010 Projects.	2007	Convene annual meeting of grantees to review and describe strategies developed to date. Disseminate promising strategies (recommendations) for the elimination of health disparities.	10/2007
	2006	Same as above	10/2006
	2003	Baseline	Grantee meetings held in December 2003, June and October 2004; Dissemination of strategies began in July 2004

GOAL 8: BY 2010, IMPROVE THE LIVES OF RACIAL AND ETHNIC POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THE BURDEN OF DISEASE AND DISABILITY, AND DEVELOP TOOLS AND STRATEGIES THAT WILL ENABLE THE NATION TO ELIMINATE THESE HEALTH DISPARITIES.

2. Collect qualitative and quantitative data in REACH 2010 communities to evaluate community capacity-building, intervention strategies, systems change, change among change agents, and change in risk/protective behaviors.	2007	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in <u>100%</u> of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); <u>85%</u> of REACH 2010 communities will collect and disseminate data (qualitative).	10/2008
	2006	Same as above	10/2007
	2005	Same as above	10/2006
	2004	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in <u>100%</u> of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); <u>60%</u> of REACH 2010 communities will collect and disseminate data (qualitative).	100%/60% (Met)

Data Source: REACH 2010 Risk Factor Survey.

Data Validation: Data is delivered to CDC every six months. Data is checked for missing values, outliers, unreasonable values, and illogical values by the contractor during the data collection process and at CDC after data have been delivered.

Cross Reference: Measure 1 - HHS-1, 3, HP-3.3, 3.4, 5, 12, 13, 14, 16.1, 500-1; Measure 2 - HHS-3, 4, 500-1, 3

Goal 8, Performance Measure 1:

CDC continues to work towards the development of national strategies (recommendations) for eliminating gaps in each of the six health priority areas based on the interventions and findings from the REACH 2010 Projects.

The dissemination of the most promising strategies and of lessons learned is critical to the overall effectiveness of this project. Preliminary measures have been taken to assess the dissemination strategies used by other programs at CDC. Partners that are critical in developing the dissemination plan include the funded communities, evaluation experts, external consultants, private partners, and other federal agencies. FY 2003 effective processes and strategies utilized by REACH 2010 Communities will be documented for replication at the federal level and with private partners. Partnerships established with the private sector and evaluation experts are critical components of this program.

Goal 8, Performance Measure 2:

The evaluation of REACH 2010 is of critical importance in determining the program's effectiveness in reducing health disparities. Working with its grantees and partners, CDC has developed an evaluation model that guides the collection of qualitative and quantitative data.

In FY 2004 and FY 2005, CDC collected and reviewed quantitative data to examine changes in risk/protective behaviors in communities with health priority areas in Breast and Cervical Cancer, Cardiovascular Disease, and Diabetes (excluding the Elderly and American Indian/Alaska Native projects). Data was collected through a behavioral surveillance instrument called the REACH 2010 Risk Factor Survey. The Survey contains a series of questions related to physical activity, nutrition, heart disease and stroke, diabetes, and breast and cervical cancer. The purpose of this data collection is to inform the REACH 2010 program of widespread risk and protective behavior

changes in the REACH 2010 communities and to assist the communities and CDC in tailoring prevention/intervention activities to the specific characteristics of the community.

In addition, CDC has collected and disseminated qualitative data related to three stages of the REACH 2010 Evaluation Logic Model: (1) community capacity-building activities, (2) intervention strategies, and (3) systems change, and change among change agents. Information was collected through an internet-based data warehousing application called the REACH Information Network (REACH IN). REACH grantees use the system to document current resources, identify specific needs, and document efforts and outcomes. The system allows funded communities and CDC to monitor indicator outcomes related to specific health priority areas.

The REACH 2010 Risk Factor Survey was conducted in 27 communities (100 percent of target communities) in FY 2004 and FY 2005. The results of this data collection were disseminated to these 27 communities at the REACH 2010 Technical Assistant Workshop (October 3-5, 2005). The CD-ROMs which contain the combined four-year data and support documents were also distributed to grantees.

Sixty percent of REACH 2010 communities have collected qualitative data in the REACH IN system for dissemination.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

Efficiency Measure	FY	Target	Result
1. Establish an ongoing data management center for developmental disabilities monitoring and research sites, resulting in savings of program staff time. [E]	2005	Establish data center	12/2006
2. Increase the number of autism cases included in the data coordinating center, resulting in savings of program and staff time and expediting efforts to understand the prevalence and find the causes of autism. [E]	2007	500	12/2008
	2006	250	12/2007
Data Source: Data Coordinating Center for Autism and Developmental Disabilities Surveillance and Epidemiologic Research			
Data Validation: Once software is operational and collaborative autism research study is underway, staff will be able to retrieve and report the number of autism cases entered into database.			
Cross Reference: <u>Measure 1</u> - HHS-8, HP-16.14, 500-1; <u>Measure 2</u> - HHS-8, HP-16.14, 500-1			

Efficiency Measure 1:

CDC supports 17 states to track autism and other developmental disabilities (including CDC's own model tracking program in Atlanta). These efforts are essential for CDC to fulfill its Congressional mandate to collect, analyze, and disseminate autism data. The establishment of an ongoing data management center for these sites will result in significant time savings. This type of data coordination requires a core of expertise, which is most efficiently used by housing it in one location rather than using CDC staff time and having each site hire staff for this function. The Data Coordinating Center for Autism and Developmental Disabilities Surveillance and Epidemiologic Research has been funded and tracking and data management software is currently being developed with input from CDC and grantee autism scientists. This measure will be retired after data are reported for FY 2005.

Efficiency Measure 2:

Following the establishment of a data management center for developmental disabilities, CDC will be able to track progress in this area by focusing on increasing the number of autism cases included in the coordinating center, thus saving program and staff time and expediting efforts to understand the prevalence and causes of autism.

GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.			
Measure	FY	Target	Result
1. Decrease the percentage of women who report any alcohol consumption during pregnancy. [O]	2007	7.5%	12/2009
	2006	8.0%	12/2008
	2005	8.5%	12/2007
	2004	10.0%	12/2006

GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.			
	2003	11.5%	10.6% (Exceeded)
	1999	Baseline	12.8%
2. Reduce by 1% per year the number of children born with spina bifida and anencephaly through promotion of folic acid consumption by women of reproductive age. [O]	2007	5%	12/2010
	2006	4% reduction	12/2009
	2005	3% reduction	12/2008
	2004	2% reduction	12/2007
	2003	1% reduction	12/2006
	2002		1,709
3. Increase the number of U.S. births covered by birth defects monitoring programs, which use these data to plan services for children and evaluate prevention strategies.	2007	3,000,000	10/2007
	2006	2,900,000	10/2006
	2005	2,800,000	2,803,301 (Exceeded)
	2004	2,700,000	2,644,925 (Unmet)
	2003	2,600,000	2,609,477 (Exceeded)
	2002	2,500,000	2,540,730 (Exceeded)
Data Source: Data are from CDC's Behavioral Risk Factor Surveillance System (BRFSS), and the National Birth Defects Prevention Network (NBDPN), and soon to be established developmental disabilities data coordinating center.			
Data Validation: <u>Measure 1</u> - BRFSS data are collected each month and from every state, D.C., and 3 U.S. territories through a random-digit-dialed telephone survey. In addition to providing training and technical assistance, CDC staff produce monthly and annual quality assurance reports. <u>Measure 2</u> - Prevalence data obtained from eight population-based surveillance systems in the NBDPN. Due to ongoing data collection with more recent years less likely to be complete, reporting lags are utilized to ensure more complete data. Denominator data are based on the number of live births reported by CDC's National Center for Health Statistics. <u>Measure 3</u> - As part of the NBDPN all data are updated annually. In addition, states conduct three validation checks in conjunction with CDC prior to publication of the identified data.			
Cross Reference: <u>Measure 1</u> - HHS-1, HP-16.17, 500-1; <u>Measure 2</u> - HHS-5, HP-16.15-16, 500-1; <u>Measure 3</u> - HHS-4, HP-16.15, 500-1			

Goal 1, Performance Measure 1:

CDC funds programs designed to build statewide capacity in Fetal Alcohol Syndrome (FAS) prevention and monitoring; a collaborative research consortium for identifying, developing, and evaluating effective strategies for intervening with children and/or adolescents with FAS and related conditions; research programs to identify and test new FAS prevention and management methods; regional training centers to increase health care providers' knowledge about how to present FAS; and education materials for parents, educators and social service providers about accessing appropriate diagnostic and treatment services for affected children and their families. In addition, CDC provides support to all 50 states to monitor alcohol consumption levels, and support targeted outreach to Cherokee nation. In February 2005, the U.S. Surgeon General released an updated Surgeon General's Advisory on Alcohol Use in Pregnancy. CDC and other federal agencies and members of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect (which is housed at CDC) worked together to craft the advisory, which is updated to reflect scientific knowledge amassed since the first advisory in 1981. The updated advisory helps stress to prospective parents, health care practitioners, and with childbearing-aged women, especially those who are pregnant, the importance of not drinking alcohol if a woman is pregnant or considering becoming pregnant. This is supported as part of the Surgeon General's "Year of the Healthy Child" along with other critical child health initiatives. CDC met and exceeded the FY 2003 target, with 10.6 percent of women reporting alcohol consumption during pregnancy. CDC plans to continue efforts to further reduce alcohol consumption among this population with the goal of reducing FAS.

Goal 1, Performance Measure 2:

Fortification of the food supply with folic acid (a B vitamin) has allowed major reductions in the rates of serious birth defects of the spine (spina bifida) and brain (anencephaly). However, more reductions are possible if all women of reproductive age consume adequate amounts of folic acid before and during pregnancy. Because Hispanic women have the highest rates of neural tube defects, CDC has made reaching these women a top priority. Preliminary results show that a targeted Spanish-language campaign raised Hispanic women's knowledge of the benefits of folic acid and when they should take it. Even more importantly, it has increased actual consumption of folic acid in campaign markets. If results bear true, CDC will work to expand the campaign to reach more Hispanic women and others at high risk. In addition, CDC recently published data documenting the effectiveness of folic acid fortification in

preventing spina bifida and anencephaly. Data from birth defects monitoring programs showed that, as a result of fortification, approximately 1,000 more babies are born without these defects each year. Data show that the number of children born with these defects was 1,709 in 2002, an 11.5 percent decrease from the 2000 baseline of 1,932.

Goal 1, Performance Measure 3:

Increasing the number of births covered by monitoring programs increases the quality of the data, which can then be used more effectively to draw programmatic and scientific conclusions. Mature birth defects tracking programs can achieve results because data that is more representative can be more effective. Establishing prevalence rates will help CDC to more effectively allocate resources, develop prevention strategies, and evaluate the effectiveness of prevention efforts. Similarly, the ability to detect regional differences in prevalence rates will give CDC important clues about risk factors and causes of birth defects. CDC publishes data from the monitoring programs in its annual congenital malformations report. In FY 2005, CDC worked to increase the number of births covered by birth defects monitoring programs by guiding and funding states to build and strengthen birth defects surveillance systems. CDC continued to fund state birth defects surveillance programs which support the NBDPN, a collaboration of individuals working at the local, state and national levels in birth defects surveillance, research and prevention. CDC met and exceeded the FY 2005 target level with 2,803,301 U.S. births covered by birth defects monitoring programs.

GOAL 2: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.			
Measure	FY	Target	Result
1. By 2010, decrease to 10% the percentage of newborns that screen positive for hearing loss but are lost to follow-up. [O]	2007	19%	12/2009
	2006	22%	12/2008
	2005	25%	12/2007
	2004	30%	12/2006
	2003	35%	31% (Exceeded)
	2002	Baseline	36.6%
2. Decrease the overall health disparity experienced by people with disability by increasing the number of states that implement a health promotion program to improve the health and quality of life for persons with disabilities.	2007	25	10/2007
	2006	20	10/2006
	2005	8	27 (Exceeded)
	2004	7	25 (Exceeded)
	2003	6	17 (Exceeded)
	2002	5	10 (Exceeded)
Data Source: Data are from the University of Montana, Directors of Speech and Hearing Programs for State Health and Welfare Agencies (DSHPHWA)			
Data Validation: <u>Measure 1</u> -- CDC checks the data on an ongoing basis but no less than quarterly by contacting grantees at the University of Montana via phone or e-mail to confirm states where "training" has taken place for implementing the Living Well With a Disability Program. <u>Measure 2</u> - The data obtained from the DSHPHWA is collected on an annual basis. A survey section is included for states to provide updated data from the previous year. This data is internally compared at CDC to monitor the quality of data being reported. Additionally, data from the National Center for Health Statistics is used to verify the reported number of live births reported by each EHDI program.			
Cross Reference: <u>Measure 1</u> - HHS-5, HP-28.11, 500-1; <u>Measure 2</u> - HHS-3, 6, HP-6.1-13, 500-1			

Goal 2, Performance Measure 1:

CDC is collaborating with the Health Resources and Services Administration (HRSA) to help states implement the new Early Hearing Detection and Intervention (EHDI) program. CDC helps states establish programs to track children who screen positive for hearing loss and ensure that these children get follow-up diagnostic testing and, if needed, enter early intervention programs. At this early stage in the program, CDC is targeting their efforts to measure the impact of the first and second phases in this process to track the number of children initially screened for hearing loss in the hospital and the number evaluated by a trained audiologist to confirm or deny screening results. Even this seemingly small step involves multiple places where children with hearing loss can be "lost to follow-up," and is essential for the achievement of targets. To help reduce the burden on states and create a central source of data, CDC has begun working with key partners to design and distribute a standardized form to gather aggregate level EHDI-related data, including "lost to follow-up." In FY 2003, CDC exceeded the target with only 31 percent of newborns that screen positive for hearing loss but are lost to follow-up.

Goal 2, Performance Measure 2:

CDC supports research and other programs to improve health and quality of life among people of all ages with disabilities. The primary goals of the research component are to identify risk and protective factors, develop effective prevention strategies, and assess the cost-effectiveness of health promotion interventions. One such intervention, "Living Well with a Disability," has demonstrated its ability to improve health and reduce medical costs. This intervention demonstrates the relationship between CDC-funded research and the translation of this research into public health programs. Because significant progress has been made on this measure, CDC will be revising the FY 2007 target to be more ambitious in the next year.

HEALTH INFORMATION AND SERVICE

HEALTH STATISTICS

Health Statistics participated in the PART review for the FY 2007 cycle. This document reflects measures adopted as a result of the PART process. While they may seem redundant, there are variations in how an outcome is being measured. The PART measures are ambitious and will eventually become a permanent element of this performance plan.

Efficiency Measure	FY	Target	Result
1. Deliver timely data to the nation's health decision-makers. [E]		<i>a) Reduce data release time lags.</i>	
	2006	Reduce time lags for release of core data systems by 5%; National Health Interview Survey (NHIS): Release quarterly 2007 data in 6 months from end of data collection year	11/2006
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
		<i>b) Make statistics Internet-accessible.</i>	
	2006	Make health statistics Internet-available, including the development of one new product	11/2006
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
		<i>c) Produce publications.</i>	
	2006	Produce reports and publications that document trends, issues, and problems in health.	11/2006
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
2. The number of months for release of data as measured by the time from end of data collection to data release on internet. [E,O]	2007	12.4	12/2009
	2006	12.9	12/2008
	2005	13.5	12/2007
	2004		13.8
	2003	Baseline	14.5

Data Source: Measure 1 - National Health Interview Survey (NHIS); Measure 2 - NHANES, NVSS, NHIS and NHCS.

Data Validation: Measure 1 - The NHIS provides information annually on the health status of the U.S. civilian non-institutionalized population through confidential interviews conducted in households. NCHS has extensive quality control processes to ensure the accuracy of its data. There are many steps during the process of collecting, "cleaning up", and analyzing data that are conducted to ensure that data disseminated are of the highest quality possible. Measure 2 - Review internal information on end of data collection and release of data for NHANES, NVSS, NHIS and NHCS.

Cross Reference: Measure 1- HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28; Measure 2 – PART, HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 27, 28

Efficiency Measure 1:

a) Reduce data release time lags.

Because the National Health Interview Survey (NHIS) is conducted throughout the year, yielding a nationally representative sample each week, data can be analyzed weekly or quarterly to monitor health insurance coverage trends and other selected estimates. In FY 2005, CDC's NHIS continued to provide the most recent health insurance coverage data, as well as quarterly trend data on selected topics, such as data on usual place to go for medical care, and the prevalence of smoking for adults. Trend data through December 2004 were released in June 2005. Trend data for the first quarter of 2006 will be released in September 2006.

CDC substituted the Early Release of Selected Estimates from the NHIS as CDC's example for this efficiency measure because it is a more accurate measure of CDC's efforts to improve timeliness, as it represents work done by CDC (rather than work done, in part, by partners outside of CDC's control).

b) Make statistics Internet accessible.

In FY 2005, CDC continued to achieve improvements in technological advances, such as the use of the Internet to make data more timely and accessible. Virtually all CDC publications are available on the Internet concurrent with their release in published form.

All CDC data are now available, from 1968 to the present, on CD-ROM. CDC also recently made its Web site accessible to visually impaired data users. Other efforts are being made to increase the accessibility and usability of the data systems and website for disabled people.

Internet-only releases, such as Health E-Stats and the Early Release of NHIS, with data through September 2004 released in March 2005, help make CDC's data more accessible to the public. *Health, United States, 2004*, released in December 2004, is available online and has been mailed to data users. *Health, United States, 2005* was released in December 2005.

c) Produce publications.

In FY 2005, CDC continued to lead the efforts to produce *America's Children, Key National Indicators of Well-Being 2005*, which was released in July 2005. *America's Children in Brief*, released in July 2004, contains data on key indicators of children's health in the U.S. monitored through federal statistics covering areas related to health, economic security, behavior, education, and social and physical environment. This report reveals that birth rates for adolescents continue to decline, and that victimization rates for youths and violent crime offending rates by youths are down.

Efficiency Measure 2:

Efficiency measure two has been developed through the PART process for the FY 2007 cycle and is also serving as a long-term outcome measure.

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH-QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION-MAKERS.				
Measure	FY	Target	Result	
1. Monitor the nation's health through high-quality data systems.		<i>a) Conduct on-going surveys</i>		
	2006	Conduct four ongoing surveys and data systems that produce detailed trend data for monitoring health	11/2006	
	2005	Same as above	4 (Met)	
	2004	Same as above	4 (Met)	
	2003	Same as above	4 (Met)	
			<i>b) Increase participant response rates</i>	
	2006	Increase and maintain 78% participation for NHANES through improved outreach with communities, constituents, states and policy makers	11/2006	

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH-QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION-MAKERS.

Measure	FY	Target	Result	
	2005	Same as above	78% (Met)	
	2004	Same as above	75% (Unmet)	
	2003	Same as above	75% (Unmet)	
	2002	Baseline	78%	
		<i>c) Work with partners</i>		
	2006	Work with NAPHSIS and other partners on efforts to implement electronic death registration systems to improve the timeliness and accuracy of vital health data	11/2006	
	2005	Same as above	Met	
	2004	Same as above	Met	
	2003	Same as above	Completed work on models, standards, and specifications needed to develop re-engineered vital statistics systems (Met)	
	2. Percentage of key data users and policy makers, including reimbursable collaborators, that are satisfied with data quality and relevance. [O]	2007	Establish baseline upon completion of survey(s)	3/2007
3. The number of new or revised charts and tables and methodological changes in <i>Health, United States</i> , as a proxy for continuous improvement and innovation in the scope and detail of information.	2007	15	12/2007	
	2006	15	12/2006	
	2005		36	
	2004		21	
	2003	Baseline	10	
4. Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data.	2007	5/7.417M	12/2007	
	2006	5/6.450M	12/2006	
	2005		5/5.608M	
	2004		7/3.775M	
	2003		6/3.745M	
	2002		7/3.448M	

Data Source: Measure 1 - National Health and Nutrition Examination Survey (NHANES), National Health Interview Survey (NHIS), National Hospital Discharge Survey (NHDS), and National Vital Statistics System (NVSS). Measure 2 - NCHS Board of Scientific Counselors and other independent groups. Measure 3 - *Health, United States*. Measure 4 - CDC/NCHS Website.

Data Validation: Measure 1 - NHANES: Passive quality control uses automated computer procedures for detecting data anomalies. Active quality control relies on examiner feedback to identify and evaluate problems and select remedies. NHIS: Data are reviewed and analyzed extensively to ensure their validity and reliability. NHDS: Ongoing quality control activities ensure the accuracy of the survey data. NVSS: New birth and death certificates have been designed through a collaborative effort with states, researchers, and other interested parties to enhance the accuracy of birth and death information (implemented in 2003). Measure 2 - Targets are under development. NCHS plans to implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers. Measure 3 - Improvement and innovation in *Health, United States* can be assessed through four components: a) new charts in the Chartbook; b) new trend tables; c) tables substantially revised; and d) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation. Measure 4 - Internal checks of data.

Cross Reference: Measure 1 - HHS-5, 500-3; Measure 2 - HHS-5, PART, 500-3; Measure 3 - HHS-5, PART, 500-3; Measure 4 - HHS-5, PART, 500-3

Goal 1, Performance Measure 1:

a) Conduct ongoing surveys.

In FY 2005, all four targeted data systems were operating and producing detailed trend data for monitoring health. For example, one system, NHANES, continued to interview and examine approximately 6,300 individuals in 15 scientifically-selected communities across the nation to generate national estimates. The National Nursing Home Survey, a component of the National Health Care Survey conducted in 2004, surveyed long term care providers for the first time since 1999.

b) Increase participant response rates.

In FY 2005, NHANES achieved a 78 percent response rate through outreach with communities, constituents, states, and policy makers. CDC expects their response rates will fluctuate from year to year as a result of the sample design and current conditions, and that the cumulative response rate over six years of the survey will be maintained between 77 to 78 percent.

c) Work with partners.

In FY 2005, CDC continued to work with the National Association for Public Health Statistics and Information Systems (NAPHSIS), individual states, and other agencies including the Social Security Administration (SSA) to advance the re-engineering of the nation's vital statistics system. This ongoing project reached several key milestones with the development of technical specifications for electronic systems that can be followed by states and their vendors in the development of systems. This measure will be retired when data are reported for FY 2006.

Goal 1, Performance Measures 2-4:

These new measures have been developed through the PART process for the FY 2007 cycle and will replace the previous GPRA measure when it is retired.

Goal 1, Performance Measure 2:

This measure addresses the performance element of quality and scope. NCHS will implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers (e.g., reimbursable collaborators, ASPE, OMB, CRS and others) relative to data quality and scope. An independent group such as the NCHS Board of Scientific Counselors will be used to help identify the list of key data users and policy makers to be surveyed, along with those organizations that directly work with NCHS through interagency agreements. Performance results will be used by NCHS managers to drive program improvements.

Goal 1, Performance Measure 3:

This measure addresses the performance element of scope. Health, United States, the most comprehensive publication produced by NCHS, draws information from each data system, as well as data from other federal partners and collaborators. Improvements in the scope and detail of Health, United States are a proxy for the scope of data produced and made available by NCHS. Improvement and innovation in Health, United States can be assessed through four components: 1) new charts in the Chartbook; 2) new trend tables; 3) tables substantially revised; and 4) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation.

Goal 1, Performance Measure 4:

A primary objective of NCHS is to maximize the use of data collected through investment of public funds. The greater the use of data, the more "bang for the buck" from the investment, and therefore, more efficient. One way to increase use is to make data available in more easily accessible forms. NCHS makes its data available in a variety of forms through the Internet and works to improve the speed and efficiency with which people access the data by: a) development of data input statements/programs that allow people quick access to our data files; b) development of masked variance files that allow researchers to more quickly access data; c) development of Fast Stats and Quick Stats to quickly access data files; and d) use of Beyond 20/20 software making it more likely that systems like the NCHS Data Warehouse on Trends in Health and Aging, Asthma, Healthy People 2010, and Healthy Women: State Trends in Health and Mortality, will be found and used, thereby increasing the use of data already collected.

HEALTH MARKETING

Efficiency Measure	FY	Target	Result
1. Provide "just-in-time" scientific information and education via distance learning to thousands of health professionals, thereby reducing the cost and time delay of traditional educational strategies. [E]	2007	5% increase from previous year in number of participants registered in distance learning activities.	12/2007
	2006	5% increase from previous year in number of participants registered in distance learning activities.	12/2006
	2005	5% increase in number of participants registered in distance learning activities.	92,790 (9% - Exceeded)
	2003	Baseline	84,112 participants registered in distance learning activities

Data Source: Data summary report for continuing education and satellite broadcasts.

Data Validation: Data figures are validated though Public Health Foundation and the CDC Office of Workforce and Career Development.

Cross Reference: HHS-2, 5, HP-23

Efficiency Measure 1:

The most important tool for frontline practitioners is current, "just-in-time" information and knowledge. Public health and healthcare information must be continuously updated, translated, and communicated to meet changing conditions and threats. Further, information must be available in the form most useful and accessible to health professionals. To meet these needs, CDC is maintaining systems for information and knowledge transfer, and ensuring that scientific and medical information is translated and communicated effectively and that the best practices of public health professionals are shared nationwide.

GOAL 1: CDC WILL DEVELOP AND IMPLEMENT TRAINING TO PROVIDE FOR AN EFFECTIVE, PREPARED, AND SUSTAINABLE HEALTH WORKFORCE ABLE TO MEET EMERGING HEALTH CHALLENGES.

Measure	FY	Target	Result
1. Increase the number of interventions adopted by state health officers that were recommended by the <i>Community Guide</i> .	2007	Baseline + 5	6/2008
	2006	Establish baseline	2/2006

Data Source: *Community Guide* surveillance survey.

Data Validation: Responses were generated via an internet based questionnaire developed in collaboration between Research Triangle Institute (RTI) and CDC, pretested by public health officials, and approved by OMB.

Cross Reference: HHS-5, HP-23, PART

Goal 1, Performance Measure 1:


The *Community Guide* Surveillance Survey is a web-based survey of *Guide* awareness and use within key audiences at the state and local levels of the public health community. Developed by RTI in consultation with *Community Guide* staff, the 18-item questionnaire will generate information on awareness, use, and satisfaction with the *Community Guide* and its distribution and will identify areas for improvement. Pending the successful completion of this pilot project, CDC hopes to re-administer the survey annually or biennially. The *Community Guide* Surveillance survey will establish this baseline. Currently, results of the survey are being analyzed and data will be available by the end of February 2006.

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.

Measure	FY	Target	Result
1. Expand frontline public health practitioners' access to Internet-based, CDC-approved public health practice guidelines, scientific/disease reference images, health and medical data, and information on the effectiveness of public health interventions.	2007	a) Expand the Public Health Image Library's (PHIL) links to "just in time" programs by 15. b) Expand PHIL by 1,000 images	a) 12/2007 b) 8/2007
	2006	a) Expand PHIL links to "just in time" programs by 15. b) Expand PHIL by 1,000 images	a) 12/2006 b) 8/2006
	2005	a) Expand PHIL links to "just in time" programs to 50 (Baseline: 35, 05/2004) b) Expand PHIL by 3,000 images c) Design customizable functionality for the Local Health website.	a) 10/2006 b) 7,300 images (Exceeded) c) Unmet
	2004	Expand PHIL by 3,000 images.	6,150 (Unmet)
	2003	Baseline	4,000 images

Data Source: Catalog of imagery on PHIL is maintained internally within the Division of Creative Services (DCS). Real time updates on numbers and downloads of imagery are captured on web interface and reported through web servers maintained by DCS personnel.

Data Validation: PHIL staff, including team of medical illustrators, review imagery for quality before posting and review data being reported on a weekly or as needed basis.

Cross Reference: HHS-4, HP-23, -5


Goal 2, Performance Measure 1:

The PHIL is a unique online gallery of scientific photographs, electronic images, videos, and other digital images representing significant public health visual information. Each image includes text meta-tags describing the image that allow for searches by users who are seeking specific images for educational purposes. Clinicians, scientists, researchers, publicists, teachers, students, and the public can access PHIL and obtain images depicting everything from microorganisms to mosquitoes, rashes to risk factors. High resolution formats of the images online allow users to download and use images directly in print or electronic materials. In FY 2004, 6,150 images were digitized, referenced and archived in PHIL. The target of expanding PHIL by 3,000 images for FY 2004 was unmet. The target was not met due to an error in recording the original measure in 2004. In FY 2004, the program developed and measured a GPRA target for PHIL, estimating that the number of PHIL images would total 5,500 by the end of 2004 and 6,500 by the end of FY 2005. These measures were met and exceeded. At the end of FY 2005, the PHIL currently stands at 7,300 images. A revised target has been established for FY 2007, "expand PHIL by 1,000 images or products." The target of designing customizable functionality for the Local Health website for FY 2005 was unmet. The PHIL has been modified to include specific audience oriented portals and interface for local public health professionals.

ENVIRONMENTAL HEALTH AND INJURY PREVENTION

ENVIRONMENTAL HEALTH

CDC's National Center for Environmental Health (NCEH) modified some of its measures as a result of feedback provided by OMB during the FY 2007 PART review process. These changes are noted in the tables and narratives below.

EFFICIENCY GOAL: PROMOTE EFFECTIVE AND EFFICIENT NCEH MANAGEMENT.			
Efficiency Measure	FY	Target	Result
1. By 2006, achieve a 20% cost savings and reduce the number of committee members from 28 to 16 as a result of the consolidation of the Advisory Committee to the Director, NCEH and the Board of Scientific Counselors (BSC), ATSDR. [E]	2006	20%/16 members	10/2006
	2005	10%/21 members	35%/19 (Exceeded)
	2003	Baseline	\$225,765 and 28 members
2. Number of FTE providing program support through the Office of the Director per \$1 million in total program budget. [E]	2007	.65	10/2007
	2006	.66	10/2006
	2005		.67
	2003	Baseline	.86
Data Source: <u>Measure 1</u> - ATSDR's Office of Science maintains the financial records associated with the Board of Scientific Counselors (BSC) member costs. <u>Measure 2</u> - NCEH/ATSDR Project Profile Database.			
Data Validation: <u>Measure 1</u> - The BSC member cost report is reviewed by Committee Management and is provided to GSA annually. <u>Measure 2</u> - Project Profile maps NCEH/ATSDR goals/measures and FTE's to budget.			
Cross Reference: <u>Measure 1</u> - HHS-8, HP-8.12,  -1, 3; <u>Measure 2</u> - HHS-8, PART			

Efficiency Measure 1:

NCEH's Advisory Committee merged with ATSDR's BSC in December 2004. This consolidation decreased the total number of board members and has resulted in a cost savings for FY 2005 and will for FY 2006. This measure will be retired after data are reported for FY 2006 and will be replaced with the new efficiency measure developed through PART listed above.

Efficiency Measure 2:

CDC/NCEH has taken a number of steps to become more efficient and productive, including reducing the size of the Office of the Director (OD) by decreasing the number of the office's program-support FTEs per million dollars. Further steps are being taken throughout the organization, including the following:

- CDC has achieved efficiencies in measuring environmental chemicals or their metabolites in human samples by developing new analytical biomonitoring methods and improving existing ones, making them faster, more accurate, easier to perform, and less costly.
- CDC has reduced costs and improved efficiency by making the vast majority of its materials available on the web. In addition to reducing printing and postal costs, electronic distribution greatly reduces the time it takes to provide the public and partners with important information.

GOAL 1: DETERMINE HUMAN HEALTH EFFECTS ASSOCIATED WITH ENVIRONMENTAL EXPOSURES.			
Measure	FY	Target	Result
1. Number of environmental chemicals, including nutritional indicators, that are assessed for exposure of the U.S. population.	2007	200	12/2007
	2006	180	12/2006
	2005	165	230 (Exceeded)
	2004	150	150 (Met)
2. Complete assessments examining the possible association between a health effect and an environmental exposure and/or hazard.	2006	17	12/2006
	2005	13	21 (Exceeded)
	2004	0	3 (Exceeded)
3. Complete studies to determine the harmful health effects from environmental hazards.	2007	25	12/2007
	2006	25	12/2006
	2005	6	44 (Exceeded)
	2004	2	27 (Exceeded)
4. Number of laboratory quality standards maintained in certified or participating laboratories for tests such as lipids; newborn screening; those predictive of type 1 diabetes; blood lead, cadmium, and mercury; and nutritional factors.	2007	1001	12/2007
	2006	990	12/2006
	2005	982	904 (Unmet)
	2004	Baseline	866
Data Source: Environmental Health Laboratory – data systems.			
Data Validation: Data systems at CDC's Environmental Health Laboratory monitor laboratory performance under Clinical Laboratory Improvement Amendments (CLIA). CDC also conducts quality assurance activities internally to confirm results and ensure their validity.			
Cross Reference: <u>Measure 1</u> - HHS-1, 2, HP-8.24, 8.25, PART, 500-3; <u>Measure 2</u> - HHS-4, 5, HP-8.28, 500-3; <u>Measure 3</u> - HHS-4, HP-8.26, 500-3; <u>Measure 4</u> - PART, 500-3			

Goal 1, Performance Measure 1:

The wording of this measure has been modified and the targets made more ambitious through the FY 2007 PART process. The previous wording was "Assess exposure of the U.S. population to environmental chemicals, including nutritional indicators."

Currently, CDC can measure at least 300 chemicals or their metabolites in human blood or urine. However, not all of these are yet measured in specimens obtained from participants in the National Health and Nutrition Examination Survey (NHANES). For FY 2004, the exposure results for the U.S. population for 150 chemicals were reported to the National Center for Health Statistics, which administers the NHANES. CDC publicly released exposure data on 148 chemicals in the U.S. population in July 2005 by publishing the *Third National Report on Human Exposure to Environmental Chemicals*.

Goal 1, Performance Measure 2:

The National Environmental Public Health Tracking Program is funding 12 states and one local health department (a total of 17 grants) to conduct data linkage demonstration projects. All states originally funded in FY 2002 completed their demonstration projects in FY 2005. Additional projects were funded in FY 2003 for completion by FY 2006. The wording of this measure was slightly modified, and it will be retired after data are reported for FY 2006.

Goal 1, Performance Measure 3:

Forty-four studies were completed in FY 2005. These studies focused on the health effects of air pollutants such as carbon monoxide, water contaminants such as algal toxins, chemicals, and radiation. They also included 14 disaster-related response activities, including rapid needs assessments, surveillance, mortality assessment, and two special projects (one on Hurricanes Charley, Ivan, Frances, and Katrina; the other on the 2005 Indian Ocean tsunami). (Final publications are still pending in some cases). Many of these studies were responses to specific state requests. The wording of this measure was slightly modified to allow for continuation beyond FY 2006.

Goal 1, Performance Measure 4:

This new measure, developed through the FY 2007 PART process, will ensure the quality of several different tests in a large number of laboratories that participate voluntarily in these quality assurance and standardization programs.

GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS.			
Measure	FY	Target	Result
1. Percentage reduction in asthma hospitalizations in states funded for partial and full implementation per 100,000 people. [O]	2007	Part A Enhanced: 7% Part B: 14%	12/2009
	2006	Part A Enhanced: 6% Part B: 12%	12/2008
	2005	Part A Enhanced: 5% Part B: 10%	12/2007
	2002	Baseline Part A Enhanced	119
	2000	Baseline Part B	147
2. Number of children under age 6 with elevated blood lead levels. [O]	2007	87,125	6/2010
	2006	111,900	6/2009
	2005	136,675	6/2008
	2004		161,500
	2003	Baseline	186,200
3. Prevent the spread of disease and treat malnutrition among refugees in complex humanitarian emergencies where CDC provides assistance. [O]	2006	90% locales	12/2006
	2005	100% locales	100% (Met)
	2004	100% locales	100% (Met)
4. Percentage increase in the capacity of state health departments to anticipate and prevent the spread of illness/disease outbreaks from food- and water-borne illness.	2007	50%	12/2007
	2006	35%	12/2006
	2005	25%	86% (Exceeded)
	2004	Baseline	16%
Data Source: <u>Measure 1</u> - grantee reporting; <u>Measure 2</u> - NHANES; <u>Measures 3 and 4</u> - Data systems are being developed.			
Data Validation: <u>Measure 1</u> - CDC project officers will verify that states are fulfilling the requirements of cooperative agreements through routine monitoring of the grants process. <u>Measure 2</u> - Increased reporting from laboratories electronically, resulting in fewer errors introduced in data during data entry. <u>Measures 3 and 4</u> - Data validation systems are being developed.			
Cross Reference: <u>Measure 1</u> - HHS-1, HP-24.2, PART; <u>Measure 2</u> - HHS-1, HP-8.11, PART; <u>Measure 3</u> - HHS-2, HP-8.29, 8.30; <u>Measure 4</u> - HHS-2, HP-8.27, 8.29, PART			

Goal 2, Performance Measure 1:

The wording of this measure has been modified and the targets made more ambitious through the FY 2007 PART process. The previous wording was "Reduce asthma hospitalizations in states funded by CDC to implement comprehensive asthma control programs." Part A enhanced targets refer to states with partial implementation of the program, while Part B targets refer to states with full implementation of the program.

CDC aims to reduce hospitalizations due to asthma by helping state coalitions create and implement comprehensive asthma-control plans that include science-based interventions, partnerships, and asthma tracking systems. The asthma surveillance data is used to identify and provide interventions to people most in need, thereby preventing hospitalizations and other adverse health effects of asthma. This program effort is being measured by direct target goals set by Healthy People 2010 and driven by HHS' strategic goal to "reduce the major threat to the health and well being of all Americans."

CDC funded 35 state/city/territory grantees in FY 2005 to develop or implement comprehensive asthma control plans. Six of these grantees (Michigan, New York, Oregon, California, Illinois, and Minnesota) are funded to fully implement

their asthma control plans. This measure is based on the HP 2010 goals of reducing hospitalizations for asthma (goal 24.2). Part A enhanced (partial implementation) and B states represent 59 percent of the U.S. population.

Goal 2, Performance Measure 2:

The wording of this measure has been modified and the targets made more ambitious through the FY 2007 PART process. The previous wording was "Reduce the number of children with elevated BLLs."

CDC's *Third National Report on Human Exposure to Environmental Chemicals* quantified the effectiveness of national, state and local efforts to reduce blood lead levels (BLLs) in young children (aged one to five years). The percentage of such children with BLLs over 10 micrograms per deciliter ($\mu\text{g}/\text{dl}$) has decreased from an estimated 4.4 percent in NHANES III (1991–1994) to the 1.6 percent estimated in the *Third Report* (1999–2002). This decline indicates that lead exposure among young children in the general population is diminishing.

The 2001-2002 NHANES estimate is approximately 211,000 (1.07 percent) of children aged one to six years had BLLs above 10 $\mu\text{g}/\text{dL}$, a 51 percent decline in the number of children with elevated BLLs. This figure should be interpreted cautiously because the NHANES estimates are based on small numbers of children with BLLs $\geq 10\mu\text{g}/\text{dL}$, and there is limited experience comparing estimates intervals containing only two years of data instead of the four years preferred by CDC's National Center for Health Statistics.

Goal 2, Performance Measure 3:

The International Emergency and Refugee Health (IERH) program coordinates CDC's response to complex humanitarian emergencies, such as technical assistance to other federal agencies, the United Nations, and other organizations in areas related to the health of refugee populations. Because of early emergency phase interventions, disease outbreaks are assessed to prevent their spread among refugees in complex humanitarian emergencies where CDC provides assistance. CDC coordinated the UNICEF measles vaccination effort in Aceh and completed a mental health survey among mortuary staff workers in Thailand. CDC is also working closely with United Nations and non-governmental partners to monitor and evaluate the effectiveness of post-Tsunami interventions. CDC provides ongoing health response following the South Asia Tsunami including water and sanitation management and health facility assessments. These efforts continue to improve the health and wellbeing of those affected by the disaster.

The target for FY 2006 is decreased to 90 percent from FY 2005's target of 100 percent, as not all requests for assistance necessarily include the IERH program; in such cases, a referral would be provided. Likewise, limitations on staff and other resources may preclude providing the requested services, resulting in less assistance than requested (or perhaps no assistance at all). In some cases, it may be against U.S. Foreign policy to assist or be otherwise inappropriate to assist. This measure will be retired after data are reported for FY 2006.

Goal 2, Performance Measure 4:

The wording of this measure has been modified and the targets made more ambitious through the FY 2007 PART process. The previous wording was "Increase the capacity of state, local and tribal agencies for which CDC provides assistance to prevent the spread of outbreaks from food- and water-borne illness." This measure will track the increased capability of states to prevent and respond to outbreaks from food, water, and air contaminants/vectors.

CDC currently works with 427 state and local environmental health service (EHS) delivery programs to increase their capacity to prevent the spread of outbreaks from food and water borne illness. Some examples are:

- Supported with technical assistance, funds, and training nine states in EHS-NET activities that collect, analyze, and disseminate information on the factors that most likely contribute to food borne illness and outbreaks.
- Provided guidance during technical assistance efforts to 11 states relating to drinking water and recreational water supplies.
- Funded nine state and local health departments to build or enhance environmental health services capacity built on the Ten Essential Public Health Services framework.

GOAL 3: BUILD AND ENHANCE EFFECTIVE PARTNERSHIPS TO IMPROVE ENVIRONMENTAL HEALTH CAPACITY.

Measure	FY	Target	Result
1. Provide assistance to partners.	2006	20	12/2006
	2005	20	20 (Met)
	2004	20	20 (Met)
Data Source: Internal Strategic Planning Documents.			
Data Validation: Data is maintained and verified by Policy Leads in the three NCEH Divisions.			
Cross Reference: HHS-4, 5, HP-8.20, 8.21, 500-3			

Goal 3, Performance Measure 1:

CDC continues to develop active partnerships through direct funding and through earmarks. These organizations include: The National Healthy Homes Training Center and Network, Eastern Kentucky University, State Medicaid Agencies, The World Health Organization, The United Nations High Commissioner on Refugees, World Food Program, The National Environmental Health Association, The Association of Public Health Laboratories, The Immune Deficiency Foundation, Columbia University, The University of California at Berkeley, Mt. Sinai School of Medicine, The Environmental Protection Agency, the National Aeronautics and Space Administration, The United States Geological Survey, The University of Miami, The National Institutes of Health, The National Oceanic and Atmospheric Administration, The Lovelace Respiratory Research Institute (Albuquerque, NM), and The U.S. Coast Guard. This measure will be retired after data are reported for FY 2006.

INJURY PREVENTION AND CONTROL

Efficiency Measure	FY	Target	Result
1. Through the implementation of web-based systems for state and territorial agencies, decrease the time between the submission of an application and the receipt of funds for injury prevention and control efforts. [E]	2007	Maintain FY 2005 Target	12/2008
	2006	Maintain FY 2005 Target	12/2007
	2005	5% faster	12/2006
	2004	Establish baseline	66 days (average)
Data Source: Office of Program Management and Operations.			
Data Validation: Verification with CDC's National Center for Injury Prevention and Control (NCIPC) Extramural Tracking System (NEXT) data system.			
Cross Reference: HHS-8, HP -3, 4			

Efficiency Measure 1:

With an initial investment to develop the system, efficiencies are created when applications are received and processed more quickly. A web-based system also allows retrieving and summarizing grantee information faster and more accurately than what can be collected otherwise. In addition to the time saved, this measure also improves customer service. As more applications become standardized and grantees become more familiar with their format, the grant application process will require less time and provide for more efficient means of tracking and monitoring the status of submissions.

GOAL 1: INCREASE THE CAPACITY OF INJURY PREVENTION AND CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF INJURIES AND VIOLENCE.

Measure	FY	Target	Result
1. Reduce the incidence of rape or attempted rape by increasing the number of school and college aged people reached through educational programs.	2007	3% increase from previous year	12/2008
	2006	3% increase from previous year	12/2007
	2005	3% increase from previous year	12/2006

GOAL 1: INCREASE THE CAPACITY OF INJURY PREVENTION AND CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF INJURIES AND VIOLENCE.			
Measure	FY	Target	Result
	2004	Establish baseline	3,328,735 (Met)
2. Among the states receiving funding from CDC, reduce deaths from residential fire. [O]	2007	1.26 per 100,000	2/2010
	2006	1.27 per 100,000	2/2009
	2005	1.28 per 100,000	2/2008
	2004	1.29 per 100,000	2/2007
	2003	1.30 per 100,000	2/2006
	2002	1.31 per 100,000	1.15 per 100,000 (Exceeded)
	2001	Baseline	1.26 per 100,000
Data Source: <u>Measure 1</u> – Grantee Annual Reports; <u>Measure 2</u> - National Vital Statistics System.			
Data Validation: <u>Measure 1</u> – Data are checked through on-going communication with grantees and through site visits. <u>Measure 2</u> – Data verified through CDC’s National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.			
Cross Reference: <u>Measure 1</u> - HHS-1, HP-15.35, 500-5; <u>Measure 2</u> - HHS-1, HP-15.25, 500-5			

Goal 1, Performance Measure 1:

CDC is developing a measure to track its performance in the rape prevention and education program. A baseline of 3,328,735 school and college aged people reached through programs supported by the Rape Prevention and Education Program has been established by collecting data from grantees through the Rape Prevention and Education Grants System. The language of this measure was modified to clarify its meaning.

Goal 1, Performance Measure 2:

Residential fire deaths, among states receiving funding for residential fire prevention activities, were reduced to 1.15/100,000 people, which exceeds the target for FY 2002. The reporting dates for this measure have been changed as a result of a delay in the release of vital statistics from CDC’s National Center for Health Statistics.

GOAL 2: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.				
Measure	FY	Target	Result	
1. Increase the number of states receiving CDC funding to monitor, identify, and track injuries.		a) TBI Surveillance	a) TBI Surveillance	
	2007	Maintain FY 2006 state funding levels	10/2007	
	2006	Maintain FY 2005 state funding levels	10/2006	
	2005	Maintain FY 2004 state funding levels	Met	
	2004	Disseminate TBI data at state level	Met	
	2003	Revise Central Nervous System (CNS) surveillance guidelines to include protocols for collecting data on mild TBI	Met	
			b) NEISS All Injury Surveillance	b)NEISS All Injury Surveillance
	2007	Maintain FY 2006 activities	12/2007	
	2006	Maintain FY 2005 activities	12/2006	
	2005	Provide national statistics via an Internet-based electronic reporting system made available to the public	Met	

GOAL 2: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.			
Measure	FY	Target	Result
	2004	Publish national statistics on non-fatal injuries treated in emergency departments by leading causes of injury	Met
	2003	Implement an NEISS All Injury Program special study on traumatic brain injury	Met
		c) NVDRS Surveillance	c) NVDRS Surveillance
	2007	Increase the number of states implementing NVDRS to 20.	12/2007
	2006	Maintain FY 2005 state funding levels to continue implementing NVDRS	12/2006
	2005	Maintain FY 2004 state funding levels to continue implementing NVDRS	17 states funded (Met)
	2004	Maintain FY 2003 state funding levels to continue implementing NVDRS	17 states funded (Exceeded)
	2003	Increase the number of states implementing NVDRS from 6 to 8	13 states funded (Exceeded)
Data Source: a) Division of Injury and Disability, Outcomes & Programs; b) Office of Statistics and Programming; c) Division of Violence Prevention			
Data Validation: Verification with NCIPC Extramural Tracking System (NEXT) data system			
Cross Reference: HHS-5, HP-15.1, 15.10, 500-5			

Goal 2, Performance Measure 1:

a) Traumatic Brain Injury (TBI) Surveillance – CDC’s Public Health Injury Surveillance and Prevention Program funds 30 state health departments to conduct injury surveillance, including reporting the number of people who die or are hospitalized with a TBI.

b) National Electronic Injury Surveillance System (NEISS) – NEISS, funded by CDC in collaboration with the U.S. Consumer Product Safety Commission (CPSC), provides injury data from inner city, urban, suburban, and rural children’s hospitals. CDC uses NEISS data to generate national estimates of nonfatal injuries in the U.S. and to guide decisions and policies about injury prevention and control. National statistics on nonfatal injuries treated in emergency departments can be accessed via the internet at <http://www.cdc.gov/ncipc/wisqars/default.htm>, meeting the target that was established for FY 2005.

c) National Violent Death Reporting System (NVDRS) – In FY 2005, CDC funded 17 states to implement NVDRS, gathering and sharing state-level data about violent deaths. This state-based system collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. This information can be used to develop, inform, and evaluate violence prevention programs. CDC met the target established for FY 2005.

GOAL 3: CONDUCT A TARGETED PROGRAM OF RESEARCH TO REDUCE INJURY-RELATED DEATH AND DISABILITY.			
Measure	FY	Target	Result
1. Develop new or improved approaches to prevent and control death and disability due to injuries.	2007	Maintain FY 2005 funding level for research agenda targeted areas; peer review 98% of research projects	9/2007

GOAL 3: CONDUCT A TARGETED PROGRAM OF RESEARCH TO REDUCE INJURY-RELATED DEATH AND DISABILITY.			
Measure	FY	Target	Result
	2006	Maintain FY 2005 funding level for research agenda targeted areas; peer review 98% of research projects	9/2006
	2005	Maintain FY 2004 funding level for research agenda targeted areas; peer review 98% of research projects	Maintained funding for targeted areas, 98% of research projects peer reviewed (Met)
	2004	Maintain FY 2003 funding level for research agenda targeted areas; increase peer-review by 5%	Maintained funding for targeted areas, 93% of research awards peer-reviewed (Exceeded)
	2003	Fund one research project for injury research in targeted areas; increase peer-review by 5%	90% of research awards peer-reviewed (Exceeded)
	2002	Baseline	66% of research awards peer-reviewed; 134 projects funded
Data Source: Office of Extramural Research.			
Data Validation: Verification with NCIPC Extramural Tracking System (NEXT) data system.			
Cross Reference: HHS-4, HP-15, 500-3			


Goal 3, Performance Measure 1:

CDC research focuses on reducing morbidity, disability, death, and lowering costs associated with injuries. CDC's extramural research program supports the following:

- Research centers for broad-based injury control.
- Centers for youth violence prevention.
- Individual, investigator-initiated research that is targeted to specific studies.
- Grants for small business innovative research.

CDC also conducts evaluation research to ascertain the efficacy and effectiveness of interventions and other factors that put people at risk for injury. The extramural program supports a productive and relevant research portfolio and uses a peer review approach that is based on review by the Injury Research Grant Review Committee (IRGRC). IRGRC is composed of experts in injury-related scientific disciplines or current research areas that enable them to evaluate the scientific and technical merits of grant applications. CDC achieved this measure.

OCCUPATIONAL SAFETY AND HEALTH

Efficiency Measure	FY	Target	Result
1. Percent of grant award/funding decisions made available to applicants within nine months of application receipt or deadline date, while maintaining a credible and efficient, two-level peer review system. [E]	2007	69%	12/2007
	2006	66%	12/2006
	2005	Baseline	60%
2. Determine future human capital resources needed to support programmatic strategic goals, focusing on workforce development/training and succession planning. [E] A) Improve CDC NIOSH's supervisor to employee ratio by a specific % over previous year results. B) Increase the number of employees with current mission-oriented Individual Development Plans (IDPs) to a specified % of the CDC NIOSH civil service population. C) Develop succession plans for percentage of key leadership positions for percentage of key leadership positions with anticipated retirement eligible dates for specified FYs.	2006	A) 2.5% over FY 2005 results. B) 65% C) 100% for FY 2008 to FY 2009.	A) 12/2006 B) 12/2006 C) 12/2006
	2005	A) 5% over FY 2004 results. B) 60% C) 100% for FY 2007 to FY 2008.	A) Ratio 1:11.6 (Exceeded) B) 70% (Exceeded) C) 100% (Met)
	2004	Establish Baseline	A) Ratio 1:10.98; B) IDPs 18.6%; C) Succession plans 0% (All Met)
<p>Data Source: <u>Measure 1</u> - IMPAC II, the NIH grant review and administration information system, and NIOSH Office of Extramural Program tracking tools. <u>Measure 2</u> - a) CDC Workforce Information Zone (WIZ), Atlanta Human Resource Center (AHRC); b) Direct report from Divisions to the NIOSH Office of the Deputy Director; c) WIZ, AHRC and formal employee queries by NIOSH Office of the Deputy Director.</p>			
<p>Data Validation: <u>Measure 1</u> - Staff members performing award notification utilize delivery and read receipt notifications. Data is reviewed three times each year by program staff, concurrent with each review council round. <u>Measure 2</u> - a) WIZ is an agency-wide program used to collect and report on human resource actions processed by the AHRC. The Office of the Deputy Director reviews pertinent data in the system monthly to assess progress in improving supervisor to employee ratio; b) Quarterly, the Office of the Deputy Director requests each Division to complete a standardized spreadsheet with basic personnel information and information on active, mission-oriented IDPs; c) Annually, the Office of the Deputy Director reviews the retirement eligibility date of NIOSH employees. Employees with eligibility dates that are current, or within the next five years, and hold a key leadership position are queried as to their retirement plans. If retirement is anticipated in the next five years, the NIOSH Lead Team establishes a succession plan to support the transition and ensure stability within the Institute.</p>			
<p>Cross Reference: <u>Measure 1</u> - HHS-8, PART; <u>Measure 2</u> - HHS-8, -1</p>			

Efficiency Measure 1:

CDC partners with the National Institutes of Health (NIH) Center for Scientific Review to process grant applications. In keeping with the effort to coordinate resources across HHS, CDC utilizes NIH's peer review and management system and computer program (IMPAC II) for receipt and referral of grant applications. By doing so, CDC streamlines services for the extramural community, ensures uniformity of responses to applicants, and achieves cost efficiencies for the Institute. The two-pronged approach to peer review is highly praised in the scientific community and is considered the "gold standard" for quality peer review. IMPAC II is a real-time system that can be monitored at any stage of the approval process. This review system is based on an eight to nine month timeline. This measure was developed through the FY 2006 PART process.

Efficiency Measure 2:

Through this measure, CDC will strive to meet the human capital goals of the President's Management Agenda, which calls for a reduction in layers of government, a reduction in the number of managers in each agency, and the ability to provide employee development and succession planning to enhance the work environment and provide future leadership. Progress is already being made towards each of these goals. This measure will be retired after data are reported for FY 2006.

RESEARCH

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Measure	FY	Target	Result
1. Progress in targeting new research to the areas of occupational safety and health (OSH) most relevant to future improvements in workplace protection.	2007	Evaluate relevance of third 1/5 of CDC NIOSH program activities according to specifications below.	12/2007
	2006	Evaluate relevance of second 1/5 of CDC NIOSH program activities according to specifications below.	12/2006
2. Increase the relevance of occupational safety and health research for future improvements in workplace protection.	2005	Evaluate relevance of first 1/5 of CDC NIOSH program activities with 80% rating 4 or 5 (on a scale of 1 to 5, with 5 being the highest) as judged by independent panels of external customers, stakeholders, and experts.	9/2006
	2004	Finalize arrangements with National Academies (NA) for relevance review.	Met
	2003	Conduct baseline evaluation among safety and health professionals of CDC NIOSH research relevance for practical workplace results.	Met
3. Ensure the quality of occupational safety and health research, as measured by peer review. A) Specified % of internal research programs and % of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion. B) Specified % of new internal research projects and % of new research grants and cooperative agreements are reviewed by external peer-review at project inception.	2006	A) 90% and 100% B) 80% and 100%	A) 12/2006 B) 12/2006
	2005	A) 80% and 90% B) 70% and 100%	A) 89% and 90% (Exceeded and Met) B) 93% and 100% (Exceeded)
	2004	A) 70% and 80% B) 60% and 90%	A) 63% and 82% (Unmet, Exceeded) B) 86% and 100% (Exceeded)
	2003	A) 60% and 70% B) 40% and 90%	A) 62% and data not available (Exceeded) B) 60% and 100% (Exceeded)
4. Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; and measure the success of implemented intervention strategies.	2007	Same target as for FY 2004	A & B: 12/2007 C: 6/2007
	2006	Same target as for FY 2004	A & B: 12/2006 C: 6/2007
	2005	Same target as for FY 2004	A) 150 research and intervention projects were based on tracking information; (Met) B) 11 intervention programs used tracking information to demonstrate the success of the intervention strategy; (Met) C) 6/2006

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.

Measure	FY	Target	Result
	2004	A) Evaluate the role that tracking information had in designing research and intervention projects, B) Identify the role that follow-up tracking information can have in assessing the success of interventions. C) Heightened 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%.	A) 153 research and intervention projects were based on tracking information; B) 21 intervention programs used tracking information to demonstrate the success of the intervention strategy; C) 3% reduction in the prevalence rate of elevated blood lead levels in adults, 16 and older (9.3 adults per 100,000) (All Met)
	2003	A) Establish a baseline by identifying those research and intervention projects that were based upon tracking information B) Identify CDC NIOSH intervention programs that have used tracking information to demonstrate success of the intervention strategy. C) Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by establishing a baseline of the number of persons per 100,000 employed with elevated blood lead levels of 25 µg/dL or greater.	A) 187 (Baseline) B) 21 (Baseline) C) 12.0 (Baseline) (All Met)
5. Percentage of NIOSH programs that will have completed program-specific outcome measures and targets in conjunction with stakeholders and customers.	2007	60%	9/2007
	2006	50%	9/2006
	2005	33%	36% (Exceeded)

Data Source: Measure 1 - National Academies (NA) direct report to NIOSH. Measure 2 - See Measure 1. Measure 3 - NIOSHTIC II database and NIOSH Project Planning and Management (NPPM) system. Measure 4 - a) NPPM system; b) See 4a; c) National prevalence derived from the state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) programs. Measure 5 - See Measure 1.

Data Validation: Measure 1 - NIOSH has contracted with the NA to complete reviews of at least two NIOSH sector programs annually. Upon completion of the reviews, the NA submits a formal report to NIOSH, which includes a quantitative rating of the program, summary of findings, refined outcome measures and suggestions for future improvement. Measure 2 - See Measure 1. Measure 3 - a) Annually, the Office of the Director develops a report on the number of publications produced by select projects using the NIOSHTIC II database and NPPM system. This report is sent to the Divisions for review, to ensure the accuracy and completion of the information; b) Internal Projects – Projects competing for new NORA funds undergo a formal external peer-review process. The NPPM system is used to identify new projects and peer review is verified by the NIOSH Associate Director for Science. External Projects - All external projects are reviewed through the NIH peer review system. The date and details of the reviews are recorded and reviewed by the NIOSH Office of Extramural Programs. Measure 4 - a) Program analysts in each division as well as the Office of the Director review project plans in the NPPM system to assess the use of tracking information in the development and/or completion of projects; b) See Measure 4a; c) NIOSH statisticians check ABLES data quarterly. Annually, the data is compiled and reviewed by the data manager using MS Access for validity of dates, ages, repeated tests on the same individual, and for completeness of data on exposure sources. Independently, a NIOSH project officer uses SAS to compare annual frequency distributions with previous years' data to check for unusual patterns, potential misclassification of exposure sources, and other data problems. The data manager and project officer then reconcile any differences in their annual analyses. Measure 5 - See Measure 1.

Cross Reference: Measure 1 - HHS-4, HP-20, 500-5, 500-3, PART, Measure 2 - HHS-4, HP-20, 500-5, 500-3, Measure 3 - HHS-4, HP-20, 500-5, 500-3, Measure 4 - HHS-4, HP-20.7, 500-5, 500-3, Measure 5 - HHS-4, PART

Goal 1, Performance Measure 1:

CDC has entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria and assembled evaluation panels for the first phase of the review – mining and hearing loss prevention. The development of quantitative evaluation criteria was an extensive process, and took longer than expected. Once completed, the NA evaluation panels employed the criteria to conduct the first phase of the review. To provide the NA panels with ample time to conduct the review, the reporting deadline was extended. NA panels are currently reviewing the mining and hearing loss programs and will provide a formal report with ratings in September 2006.

Goal 1, Performance Measure 2:

CDC conducts research on the full scope of occupational disease and injury, from basic research on mechanisms and etiology of occupational diseases, to applied research on specific ways to prevent disease and injury in the workplace. This measure will be retired after data are reported for FY 2005.

Goal 1, Performance Measure 3:

CDC disseminates its research findings through a variety of publications. In FY 2005, 89 percent of internal research projects and 90 percent of CDC funded research grants and cooperative agreements for occupational safety and health resulted in peer-reviewed publications, exceeding the target. Peer-reviewed publications are valuable resources, especially in the dissemination of research findings to occupational safety and health professionals. Alternative publications are also used, such as CDC numbered documents and CDC Alerts, to direct research findings to a broader audience, including employees and employers. This further promotes the translation of research findings into effective prevention practices adopted in the workplace.

In FY 2005, 93 percent of new internal research projects and 100 percent of new research grants and cooperative agreements were externally peer-reviewed at project inception. All new CDC research grants and cooperative agreements are peer-reviewed through the NIH system. CDC exceeded this portion of the FY 2005 target. This measure will be retired after data are reported for FY 2006.

Goal 1, Performance Measure 4:

CDC supports several state-based surveillance activities and maintains national databases of occupational injuries and fatalities. Linked to this health information is the identification of exposures to hazards that can lead to illness and injury. With this information, specific research initiatives can be undertaken to understand the relationships between exposures and health outcomes. In turn, intervention strategies are developed and implemented to reduce illness and injury.

In FY 2005, 150 research and intervention projects were based on tracking information, and 11 intervention programs used tracking information to demonstrate the effectiveness of the programs' strategies. Due to fewer new research and intervention projects beginning in FY 2005, the number of projects based on tracking information is lower than reported in FY 2004. However, CDC continues to reach its performance target.

Although not included in the target, many CDC projects such as training initiatives and information projects are also initiated in response to surveillance information. CDC continuing education courses, CDC Alerts and Fact Sheets may be developed for occupational safety and health professionals, employers and employees to renew concern and present prevention strategies for identified workplace hazards.

To increase tracking capabilities at the state level, CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to complete a set of occupational health indicators that are designed to provide information about a population's health status with respect to workplace factors. In 2003, the indicators were piloted by 10 states participating in the CDC's States Occupational Surveillance Consortium (SOSC). In the future, a document with data from selected states will be developed to provide a broad view of occupational safety and health at the state level and differences that exist among states.

Goal 1, Performance Measure 5:

As part of the National Academies (NA) comprehensive review of research activities referenced in Performance Measure one, all programs will develop comprehensive outcome-based measures and targets in conjunction with stakeholders and customers. In FY 2005, 36 percent of CDC's programs – mining, construction and agriculture – completed outcome measures and targets. These measures and targets formed the framework for evaluation of the impact of research by NA, and will establish transparent customer-based targets across the entire portfolio.

GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.

Data Validation: HIV data collection systems vary between areas (e.g., name-based code, coded identifier, name-to-code data collection systems). CDC recommends that all states and territories adopt confidential name-based HIV surveillance systems. As of November 2005, 43 states and territories use confidential name-based HIV surveillance while 13 other state and local health departments used code-based or name-to-code methods. The 25 states with mature, stable HIV surveillance systems at baseline are: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, Wyoming. The 30 area comparison group includes the 25 states plus Florida, Iowa, Nebraska, New Mexico, and the U.S. Virgin Islands. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate estimates of trends for that year. All data have been modified to update annual "actual performance" numbers based on the most recent HIV/AIDS surveillance data. Therefore, estimates vary slightly from year to year.

Cross Reference: Measure 1 – HHS-1, PART, PAR, 500-6; Measure 2 - HHS-1, HP-13.17, PAR, 500-6

¹This measure was first reported in FY 2004 and therefore, targets begin in FY 2004. However, actual performance is shown for previous years because the data was available, even though it was not reported in the form of a measure.

Goal 1, Performance Measure 1:

The number of HIV infection cases among persons under 25 years of age diagnosed each year is the best data available to monitor new HIV infections. HIV infections occurring in this group are likely to have been acquired recently and thus are a relatively good proxy measure of HIV incidence. In addition, these data enable CDC to look at yearly trends in reported cases by risk, demographic, and geographic variables. They are from a national surveillance system that collects demographic, clinical, and behavioral information on all AIDS cases diagnosed in the U.S., as well as HIV cases diagnosed in states with HIV reporting requirements. After dramatic reductions from a peak of 150,000 infections per year in the mid-1980's, annual HIV incidence is thought to be level in the U.S. However, recent outbreaks of syphilis among men who have sex with men (MSM) have raised concerns that the incidence of HIV may be rising rather than decreasing. CDC is working to reduce incidence in this and other high risk groups. Recent initiatives to greatly expand HIV testing are expected to have a substantial impact on the proportion of infected persons who are diagnosed. Therefore, in the short term, the number of cases diagnosed and reported to CDC is expected to rise. The FY 2007 target has been adjusted accordingly. In the long-term, helping people learn of their infection and providing them prevention services is expected to decrease the number of new infections. The reporting date for this measure has been changed to allow for complete collection and analysis of data.

Goal 1, Performance Measure 2:

Surveillance data published through 2004 show sharply declining trends in perinatal AIDS cases since the mid-1990s. This decline was strongly associated with increasing zidovudine use in pregnant women who were aware of their HIV status. More recently, improved treatment has also likely delayed onset of AIDS for HIV-infected children. With efforts to maximally reduce perinatal HIV transmission and increase treatment for those infected, cases are likely to remain low. The reporting date for this measure has been changed to allow for complete collection and analysis of data.

DOMESTIC HIV/AIDS PREVENTION

GOAL 2: DECREASE THE NUMBER OF PERSONS AT HIGH RISK FOR ACQUIRING OR TRANSMITTING HIV INFECTION.






Measure	FY	Target	Result
1. Among HIV-infected persons 18 years of age and over, reduce the proportion that had high-risk sex with a negative partner or partner of unknown status. [O]	2007	<11%	11/2008
	2006	<11%	11/2007
	2005	<10%	11/2006
	2004	<10%	13.4% (median) (Unmet)
	2003		17.0% (median)
	2002		13.9% (median)

INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Measure	FY	Target	Result
1. Increase the quality, relevancy, and usefulness of CDC information and recommendations to occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	2006	Same target as for FY 2005	12/2007
	2005	Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.	Bi-annual survey* 12/2006
	2004	Increase the use of CDC information and recommendations by occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	79% (Met)
	2003	Establish baseline on the percentage of occupational safety and health professionals who use occupational safety and health information published within the last 12 months by CDC.	74% (Met)
2. Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation.	2007	80%	12/2007
	2006	80%	12/2006
	2005	75%	80% (Exceeded)
	2004	70%	75% (Exceeded)
	2003	Establish baseline	68% (Met)
3. Increase the percentage of people with occupational safety and health responsibilities who have academic or continuing education training.	2005	Increase number of trained professionals by 6% from baseline.	1,505 full-time academic trainees (7% increase) and 36,884 continuing education trainees (17% increase) (Exceeded)
	2004	Increase number of trained professionals by 3% from baseline.	1,512 full-time academic trainees (8% increase) and 36,917 continuing education trainees (17% increase) (Exceeded)
	2003	Establish baseline	1,405 full-time academic trainees and 31,508 continuing education trainees (Met)
4. Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors. [O] A) Reduction of non-fatal injuries among youth ages 15–17. B) Reduction of fatal injuries among youth 15–17. C) Reduction in the annual number of silicosis deaths among U.S. residents age 15 and older.	2007	A) 15% B) 30% C) 5%	A) 12/2007 B) 12/2007 C) 12/2007
	2006	A) 7%. B) 9% C) 5%	A) 12/2006 B) 12/2006 C) 12/2006
	2005	A) 5% B) 7% C) 5%	A) 21% (Exceeded) B) 23% (Exceeded) C) 18% (Exceeded)
	2004	A) 3% B) 5% C) 5%	A) 9.6% (Exceeded); B) 35.7% (Exceeded); C) 9.0% (Exceeded)

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Measure	FY	Target	Result
	2003	Establish baselines	A) 5.2 (Met) B) 3.5 (Met) C) 180 (Met)
5. Increase workplace use of control and personal protective technologies in targeted sectors. [O] A) Increase the availability of CBRN-certified respirators for use during a CBRN event to a specified % of the professional firefighters. B) Increase the percentage of U.S. pavers with installed engineering controls to a specified %.	2007	A) N/A B) 95%	B) 6/2008
	2006	A) N/A B) 90%	B) 6/2007
	2005	A) 15% B) 80%	A) 46% (Exceeded) B) 80% (Met)
	2004	A) 10% B) 70%	A) 13% (Exceeded) B) 70% (Met)
	2003	A) 3% B) Establish baseline	A) 3% (Met) B) 60% (Met)
6. Reduce occupational illness and injury as measured by: A) Percent reductions in respirable coal dust overexposure. B) Percent reduction in fatalities and injuries in roadway construction. C) Percent of firefighters and first responders' access to chemical, biological, radiological, and nuclear respirators. [O]	2014	A) 50% reduction B) 40% reduction C) 75% reduction	A) 12/2014 B) 12/2014 C) 12/2014
	2003	Baseline	A) >15% B) 154% C) >7%
7. Percentage of: A) Companies employing those with NIOSH training that rank the value added to the organization as good or excellent. B) Professionals with academic or continuing education training. [O]	2009	A) 80% B) Increase of 15%	A) 12/2009 B) 12/2009
<p>Data Source: <u>Measure 1</u> - NIOSH Customer Satisfaction Survey. <u>Measure 2</u> - NIOSH Office of Extramural Programs training grantee annual progress reports, which include performance data. <u>Measure 3</u> - See Measure 2. <u>Measure 4</u> - a) National Electronic Injury Surveillance System (NEISS); b) Census of Fatal Occupational Injuries (CFOI) special research file provided to NIOSH by Bureau of Labor Statistics; c) National Occupational Respiratory Mortality System (NORMS), an interactive query system designed to generate statistics, charts, and maps relating to mortality from occupationally-related lung diseases. <u>Measure 5</u> - a) NIOSH survey of professional firefighters, and the International Safety Equipment Association (ISEA); b) NIOSH and National Asphalt Pavement Association (NAPA) collaboration. <u>Measure 6</u> - a) MSHA and NIOSH data sets that are shared between the agencies - MSHA data is routinely collected as part of the enforcement and compliance requirements, and NIOSH data collected during field investigations, in support of current and future research experiments.; b) See Measure 2b; c) See Measure 5a. <u>Measure 7</u> - See Measure 1.</p>			
<p>Data Validation: <u>Measure 1</u> - The survey is conducted by the NIOSH Education and Information Division, in compliance with the standards of the Data Quality Act. <u>Measure 2</u> - OEP staff review and verify data with grantees via phone or email contact, as needed. <u>Measure 3</u> - See Measure 2. <u>Measure 4</u> - a) The Consumer Product Safety Commission (CPSC) annually visits emergency departments that submit data to NEISS to assess case capture, and review records as they are submitted for completeness and internal consistency. NIOSH receives NEISS data quarterly and reviews the subset of work-related cases that CPSC provides to ensure the cases meet NIOSH definitions of work-relatedness. NIOSH reviews a sample of cases after coding by a contractor to ensure a high level of accuracy for codes that describe source of injury and event/exposure leading to injury; b) NIOSH receives the special CFOI file annually. To avoid duplication of fatalities in the counts, source documents are matched using the decedent's name and other information. To ensure an accurate count of fatal occupational injuries, the census program requires that for each case, the work relationship (that is, whether a fatality is work related) be substantiated by two or more independent source documents or a source document and a follow-up questionnaire; c) NORMS is based on public-use, multiple cause of death data files obtained annually from the National Center for Health Statistics (NCHS). NCHS performs data quality check to remove invalid codes, verify the coding of certain rare causes of death, and ensure age/cause and sex/cause compatibility. To ensure the accuracy of the NORMS results, NIOSH compares the findings to the NCHS control tables. <u>Measure 5</u> - a) NIOSH conducted a telephone survey of a representative sample of professional firefighters and analyzes proprietary data provided by ISEA for each manufacture of NIOSH-approved CBRN respiratory protective devices to assess distribution in the</p>			

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.

Measure	FY	Target	Result
<p>field. NIOSH has also incorporated questions regarding CBRN SCBA availability in the Fire Fighter Fatality Investigation and Prevention Program Evaluation Fire Department Survey, administered to 3,000 fire departments throughout the country in spring 2005; b) In 1997, the partnership between NIOSH and the National Asphalt Pavement Association (NAPA) resulted in a voluntary agreement that equipment manufacturers would incorporate effective fume emission controls on all new highway class pavers. Reports for NAPA and assessments of the average service life (10 years) for highway class pavers enable NIOSH to assess the use of pavers equipped with the recommended engineering controls. <u>Measure 6</u> - a) The MSHA data is collected according to the agency's standard rigorous sampling and handling protocols. The validation of NIOSH data is ensured by following the protocols developed during the generation of the research proposals. The proposals are peer-reviewed and include calibration requirements for the measurement and handling of the dust samples, as well as procedures for analyzing the results and ensuring the meaningfulness of the data points; b) See Measure 2b; c) See Measure 5b. <u>Measure 7</u> - See Measure 1.</p>			
<p>Cross Reference: <u>Measure 1</u> - HHS-4, -4, 5; <u>Measure 2</u> - HHS-4, -5, PART; <u>Measure 3</u> - HHS-4, -5; <u>Measure 4</u> - HHS-1, HP-20.1, 20.2, 20.4, -5; <u>Measure 5</u> - HHS-1, 2 -5, 500-3; <u>Measure 6</u> - HHS-1, PART; <u>Measure 7</u> - HHS-4, -5, PART</p>			

* CDC delayed the next customer survey until 2006, to better measure the impact of this and other new communication tools

Goal 2, Performance Measure 1:

CDC engages in capacity building activities through information dissemination. CDC assessed its capacity building capabilities through information dissemination by conducting a survey questionnaire of four professional associations. CDC mailed the survey in mid-January to a random sample of 300 members from the American Association of Occupational Health Nurses (AAOHN), American College of Occupational and Environmental Medicine (ACOEM), American Industrial Hygiene Association (AIHA), and American Society of Safety Engineers (ASSE), providing a combined sample size of 1,200. From the 688 completed surveys, CDC's final results indicate that 79 percent responded affirmatively to reading or referring to occupational safety and health information provided or published by CDC.

In an effort to further improve dissemination efforts CDC implemented a new tool, "NIOSH eNews". This monthly electronic newsletter is designed to provide stakeholders and researchers with a timely update on what's new in worker safety and health. Currently, more than 25,000 readers subscribe to eNews, enabling them to receive each new issue automatically by e-mail. The electronic format is versatile and interactive allowing readers to access other online resources, as well as provide CDC with comments and feedback on our performance. This measure will be retired after data are reported for FY 2006.

Goal 2, Performance Measure 2:

This measure focuses on the effectiveness of CDC training with respect to entry into the field of occupational safety and health. CDC conducts a competitive training grant program aimed at increasing the number of professionals trained to work in the occupational safety and health field. CDC supports a network of Education and Research Centers (ERCs) and Training Project Grants (TPGs) around the country. In FY 2005, 565 professionals graduated from these programs with specialized training in disciplines that include occupational medicine, occupational health nursing, industrial hygiene, occupational safety, and other closely related occupational safety and health fields of study.

CDC estimates that about half of all U.S. occupational safety and health professionals graduate from CDC-supported programs at the masters and doctoral levels. In FY 2005, CDC exceeded its performance goal with 80 percent of the professionals graduating from CDC-funded programs pursuing careers in occupational safety and health.

Goal 2, Performance Measure 3:

CDC maintains the national cadre of occupational safety and health professionals by training professionals through extramural funding of ERCs and TPGs. Within ERCs, CDC funds more than 1,000 continuing education courses in occupational safety and health each year. Along with its ERCs, CDC also develops training materials for particular groups, specifically miners and young and new workers.

In conjunction with its capacity building efforts, CDC has evaluated this effort and the nation's capacity most recently through the funding of the Institute of Medicine review and report, Safe Work in the 21st Century: Education and Training Needs for the Next Decade's Occupational Safety and Health Personnel. This report will also serve to focus future efforts in CDC's capacity building efforts to achieve future performance targets. This measure will be retired after data are reported for FY 2005.

Goal 2, Performance Measure 4:

CDC translates occupational safety and health surveillance and research findings into technically and economically usable solutions to control workplace hazards and reduce work-related injuries, illnesses, and fatalities.

CDC has a long history of conducting and supporting young worker safety health research and intervention activities, and working with partners to improve young worker safety and health. In 2005, CDC produced previously unavailable data to help guide prevention efforts in the agricultural sector, distributed injury prevention information directly to farm operators, and led a federal interagency working group on childhood agricultural injury prevention. The agriculture sector accounts for more work-related deaths of youth than any other industrial sector. CDC also provided input into the revised child labor regulations that became effective February 14, 2005. Building upon curricula and teaching tools developed by CDC-funded grants and others, CDC is developing a core occupational safety and health curriculum for young workers that engages students and teachers in the exploration of risks to youth in the workplace, their rights and relevant labor laws, common workplace hazards and controls, communication skills, and young workers' role in emergency preparedness and response. In FY 2005, CDC worked with state educational agencies to pilot test this curriculum. CDC is currently revising the curriculum based on this pilot test and will work with partners in FY 2006 to distribute this curriculum to educators.

CDC is also actively working to decrease the incidence of silicosis, an irreversible but preventable disease most closely associated with occupational exposure to silica. In partnership with the DOL, CDC has established and promoted recommended exposure limits for silica and implemented the Silicosis Education Campaign. These efforts provide workers and employers in a variety of industries, including construction and mining, with a guide to working safely with the potentially hazardous compound.

Goal 2, Performance Measure 5:

CDC has issued Chemical, Biological, Radiological and Nuclear (CBRN) Air Purifying Respirators (APR) approvals and implemented standards for upgrading traditional firefighter Self Contained Breathing Apparatus (SCBA) to CBRN protection levels. In addition to developing respirator certification standards and user guidelines, CDC is committed to ensuring that CBRN-protective respirators are available to professional firefighters. Based on a CDC/NIOSH telephone survey of professional firefighters and International Safety Equipment Association data, CDC has increased availability of CBRN-approved respirators to professional firefighters to 46 percent - exceeding the FY 2005 – FY 2007 targets. This increase is due to CDC certification of additional commercial respirators, the approval of seven additional CBRN Air Purifying Respirator models and more accurate reporting. Part A of this measure will be retired, as targets for FY 2005 – 2007 have been exceeded.

More than 350,000 U.S. workers are exposed to fumes generated during the manufacture or use of asphalt. Asphalt fumes are known to cause irritation of the eyes and mucous membranes of the respiratory tract, and research is underway to determine if the fumes are occupational carcinogens. CDC's goal is to facilitate the installation of engineering controls on virtually all U.S. highway-class pavers by 2010. CDC will track the percentage of pavers with engineering controls each year, setting yearly targets to achieve 95 percent by 2010.

Goal 2, Performance Measure 6:

For most program activities, reductions in occupational illnesses and injuries are due to multiple factors of which research is one component. However for some sectors and activities, extenuating circumstances are minimal and efforts are at a stage where future decreases in illness and injuries logically can be attributed to the success of programs without requiring the additional level of analysis. This measure targets three such high risk sectors and activities which represent impact in (a) occupational illness (due to coal dust overexposure), (b) occupational injuries (in roadway construction), and (c) preparedness (firefighter access to CBRN respirators).

Goal 2, Performance Measure 7:

The impact of training can be evaluated as a product of two metrics: the number of trained professionals in occupational safety and health positions, and the value of these trainees to their organizations. In addition, a third metric is used to judge the success of training programs based on the satisfaction of trainees. New surveys will be conducted to augment existing data on the impact of training programs. Follow-up surveys with trainees will determine their level of satisfaction with their education, and surveys of companies hiring trainees will judge the impact they are having in the workplace. In addition, efforts will continue to track the number of professionals with occupational safety and health duties that have academic or continuing education training.

GLOBAL HEALTH

GLOBAL AIDS PROGRAM

In 2005, OMB conducted a PART review of the Emergency Plan. The review was coordinated by the Office of the Global AIDS Coordinator (OGAC), Department of State and included activities by OGAC, the CDC Global AIDS Program, HRSA, and USAID. OMB conducted separate PART reviews of the focus country programs, other bilateral programs, and Global Fund activities. As a result of this review, beginning in the FY 2007 budget cycle, the Global AIDS Program will include performance measures for focus country programs and other bilateral programs that reflect the entire U.S. Government (USG) effort for the Emergency Plan.

In 2006, within the context of the President's Emergency Plan for AIDS Relief (PEPFAR), CDC continues to develop HIV/AIDS prevention, care, and treatment programs in 24 countries and four regional offices that serve 31 additional countries around the world. CDC has assigned 100 staff and has hired over 1,000 locally employed staff in host countries. As a key implementing agency of the Emergency Plan program, CDC has established over 260 new and supplemental cooperative agreements to extend the scope and reach of its activities. A monitoring and evaluation plan for all activities has been developed and all countries submit annual reports. As a part of the USG HIV/AIDS strategy, through the Office of the Global AIDS Coordinator (OGAC), CDC has worked closely with partners including USAID and other government agencies, the World Health Organization, the World Bank, and others to develop a set of common core indicators of progress.

GOAL 1: BY 2010, WORK WITH OTHER COUNTRIES, INTERNATIONAL ORGANIZATIONS, THE U.S. DEPARTMENT OF STATE, USAID, AND OTHER PARTNERS TO ACHIEVE THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS GOAL OF REDUCING PREVALENCE AMONG 15 TO 24 YEARS OF AGE.				
Measure	FY	Target	Result	
1. Initiate, expand, or strengthen HIV/AIDS prevention, care, treatment, and support activities globally. (Includes all GAP funding except that specifically dedicated to the PMTCT).		<i>Surveillance</i>	<i>Surveillance</i>	
	2006	24 countries	3/2007	
	2005	25 countries	25 (Met)	
	2004	25 countries	25 (Met)	
	2003	25 countries	25 (Met)	
	2002	25 countries	25 (Met)	
			<i>Voluntary counseling and testing</i>	<i>Voluntary counseling and testing</i>
	2006	24 countries	3/2007	
	2005	25 countries	25 (Met)	
	2004	25 countries	25 (Met)	
	2003	25 countries	20 (Unmet)	
	2002	25 countries	20 (Unmet)	
			<i>Locally appropriate technical assistance for treatment of STDs, TB, and other opportunistic infections</i>	<i>Locally appropriate technical assistance for treatment of STDs, TB, and other opportunistic infections</i>
	2006	24 countries	3/2007	
	2005	25 countries	3/2006	
	2004	25 countries	23 (Unmet)	
	2003	25 countries	20 (Unmet)	
	2002	25 countries	20 (Unmet)	
Data Source: GAP Planning and Reporting System.				
Data Validation: Data are provided by each country and are checked for accuracy and inconsistencies by the GAP Monitoring and Evaluation Team.				
Cross Reference: 500-6				

Goal 1, Performance Measure 1:

Surveillance: In FY 2005, CDC supported surveillance efforts in 25 countries. In 2006, CDC will continue to support surveillance in 24 countries and four regional offices, with a particular interest in the 15 focus countries. Assistance to additional countries will be provided dependent upon demand and availability of resources to meet the demand.

Voluntary Counseling and Testing: In FY 2005, CDC strengthened voluntary counseling and testing (C&T) programs in all 25 countries by providing technical assistance to ensure the quality and accuracy of HIV testing, strengthening laboratory diagnostic capabilities, identifying methods to target groups at high risk, and enhancing linkages between C&T and health and social services. CDC will continue to support C&T in 24 countries in 2006.

Locally Appropriate Technical Assistance for Treatment of STDs, TB, and Other Opportunistic Infections: In FY 2005, CDC worked to initiate, expand or strengthen locally appropriate technical assistance for treatment of sexually transmitted infections (STIs), TB, and other AIDS-related diseases. Data on the number of countries where CDC provided technical assistance in FY 2005 will be available in March of 2006. CDC will work to support technical assistance for STDs, TB and other opportunistic diseases in 24 countries in FY 2006.

This measure will be retired after data are reported for FY 2006. It has been replaced with new measures developed for PART.

FY 2007 PART Measures

In FY 2005, as the result of the PART review conducted during the FY 2007 budget cycle, CDC added two new goals and accompanying performance measures to reflect the coordinated activities of the Global AIDS Program under the Emergency Plan. These goals reflect CDC's work in the focus countries (Goal 2) and in our other bilateral programs (Goal 3). As a key implementing agency of the Emergency Plan, CDC works closely with other USG agencies and departments in the 15 focus countries to develop one country plan and annual report with indicators for each focus country. This plan and annually reported indicators represent the entire USG effort. The 13 other bilateral countries received more than \$5 million total in U.S. Government (USG) funds in 2005 and also report on standard indicators that reflect the efforts of all USG agencies. The new performance measures draw from these indicators and provide information on the number of individuals receiving services.

GOAL 2: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN 15 FOCUS COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES TO ACHIEVE THE GOALS OF TREATING 2 MILLION HIV-INFECTED PEOPLE AND CARING FOR 10 MILLION PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS BY 2008, AND PREVENTING 7 MILLION NEW HIV INFECTIONS BY 2010.			
Focus Country Performance Measures (Includes all USG activities)			
Measure	FY	Target*	Result
1. Dollars per target reached. [E]	2007	\$189	3/2008
	2006	\$223	3/2007
	2005	\$334	3/2006
	2004	Baseline	\$326
2. Number of individuals provided with general HIV-related palliative care/basic health care and support during the reporting period. [O]	2007	Under development	3/2008
	2006	Under development	3/2007
	2005	1,662,820	1,397,555 (Unmet)
	2004	Baseline	854,800
3. Number of HIV-infected individuals (diagnosed or presumed) who received clinical prophylaxis and/or treatment for TB during the reporting period. [O]	2007	Under development	3/2008
	2006	Under development	3/2007
	2005	337,732	323,144 (Unmet)
	2004	Baseline	241,000
4. The number of people receiving HIV/AIDS treatment in the 15 focus countries.	2007	1,300,000	3/2008
	2006	860,000	3/2007
	2005	470,000	401,233 (Unmet)
	2003	Baseline	66,911

GOAL 2: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN 15 FOCUS COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES TO ACHIEVE THE GOALS OF TREATING 2 MILLION HIV-INFECTED PEOPLE AND CARING FOR 10 MILLION PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS BY 2008, AND PREVENTING 7 MILLION NEW HIV INFECTIONS BY 2010.			
5. Estimated number of HIV infections prevented in the focus countries.	2007	2,800,000	7/2009
	2004	Establish Baseline	7/2006
6. Number of individuals infected and affected by HIV/AIDS, including orphans and vulnerable children, receiving care and support services.	2007	6,700,000	3/2008
	2006	4,300,000	3/2007
	2005	2,600,00	2,940,677 (Met)
	2004	Baseline	1,727,100
7. Number of pregnant women receiving PMTCT services, including counseling and testing during the reporting period.	2007	Under Development	3/2008
	2006	Under Development	3/2007
	2005	2,383,735	1,957,932 (Unmet)
	2004	Baseline	1,271,300
8. Number of pregnant women provided with a complete course of antiretroviral prophylaxis during the reporting period (this is a subset of women receiving PMTCT services, including counseling and testing).	2007	Under Development	3/2008
	2006	Under Development	3/2007
	2005	121,439	122,717 (Met)
	2004	Baseline	125,100
9. Number of individuals who received counseling and testing during the reporting period (counseling includes the provision of test results to clients).	2007	Under Development	3/2008
	2006	Under Development	3/2007
	2005	3,982,958	4,653,257 (Met)
	2004	Baseline	1,791,900
Data Source: Country Operational Plans (COPS) database			
Data Validation: All USG data are validated by the OGAC Strategic Information team following their internal procedures.			
Cross Reference: All measures – PART, 500-6			

*Targets are established for entire USG efforts by the Office of the Global AIDS Coordinator (OGAC).

Efficiency measure:

This measure is the efficiency measure for the focus country measures. The Emergency Plan commits to substantially reduce the per person cost each year for the prevention, care, and treatment outcomes it achieves. The later years of the Emergency Plan will show a great efficiency gain, as focus country investments in infrastructure and delivery systems begin to pay off.

Goal 2, Performance Measure 2:

Palliative care: Palliative care comprises a broad range of services including physical, psychological, spiritual, and social support services. In FY 2005, through the Emergency Plan, the USG provided \$121 million in funding for care for people living with HIV/AIDS in the focus countries. With these resources, palliative care was supported for 1.4 million people.

Goal 2, Performance Measure 3:

TB Treatment or Prophylaxis: Through the Emergency Plan, the USG supported TB care and treatment for approximately 369,000 co-infected people in the focus countries during FY 2005. The priority is diagnosis and treatment of active TB, with support also provided for diagnosis and treatment of latent TB infection.

Goal 2, Performance Measure 4:

People receiving antiretroviral therapy (ART): Baseline 2003 numbers are an aggregate of totals from different population-based studies conducted from 1998-2002 in the 14 original focus countries. The USG provided

approximately \$470 million in Emergency Plan funds for ART in FY 2005. With these resources, over 400,000 people in the focus countries were provided ART through September 2005.

Goal 2, Performance Measure 5:

Prevalence data released by UNAIDS in 2003 indicates that prevalence ranges from a low of 0.4 percent in Vietnam to a high of 37.3 percent in Botswana. The 2003 - 2004 baseline prevalence information will be available at the end of 2005. By the end of 2006, results will be collected for the 2005 - 2006 timeframe. This data will be compared to the baseline data to measure infections averted and will be available at the end of 2007.

Goal 2, Performance Measure 6:

People receiving care: Through the Emergency Plan, the USG works in concert with national strategies in the following three areas, which collectively are considered "Care": 1) support basic needs for orphans and vulnerable children; 2) support care for HIV-positive people; and, 3) support counseling and testing for HIV. In FY 2005, the USG supported the care and support services for almost 3 million people.

Goal 2, Performance Measure 7:

PMTCT services: Expansion of PMTCT services and programs has been a priority since the beginning of the Emergency Plan's implementation. Through September 2005, the USG provided support for PMTCT services for over 1.9 million women. The USG will continue to place emphasis on these programs.

Goal 2, Performance Measure 8:

PMTCT antiretroviral prophylaxis (ARVs): With support from the Emergency Plan, in FY 2005, over 122,000 HIV-positive pregnant women received short-course preventive ARVs, which resulted in approximately 23,000 infections averted among newborns.

Goal 2, Performance Measure 9:

Counseling and Testing: In FY 2005, the USG provided support for HIV counseling and testing services for over 4.6 million people. Approximately \$90 million or about 9 percent of Emergency Plan funds for FY 2005 were committed to counseling and testing.

GOAL 3: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN THE OTHER BILATERAL COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES, INTERNATIONAL AND HOST COUNTRY ORGANIZATIONS TO ACHIEVE THE GOALS OF PREVENTING NEW HIV INFECTIONS, TREATING HIV-INFECTED PEOPLE, AND CARING FOR PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS.			
Other Bilateral Countries Performance Measures (Includes all USG activities)			
Measure	FY	Target*	Result
1. Ratio of Management and Staffing (operational) costs to Total Program Costs in countries receiving \$1 million or more in FY2005 U.S.G. HIV/AIDS funding. [E]	2007	10:100	3/2008
	2006	Establish Baseline	3/2007
2. Number of individuals provided with general HIV-related palliative care/basic health care and support during the reporting period.	2007	Under Development	3/2008
	2006	631,852	3/2007
	2005	607,583	3/2006
	2004	Baseline	407,059
3. Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites).	2007	Under Development	3/2008
	2006	43,859	3/2007
	2005	33,958	3/2006
	2003	Baseline	20,774
4. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results. ¹	2007	Under Development	3/2008
	2006	633,185	3/2007
	2005	623,787	3/2006
	2004	Baseline	145,133

GOAL 3: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN THE OTHER BILATERAL COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES, INTERNATIONAL AND HOST COUNTRY ORGANIZATIONS TO ACHIEVE THE GOALS OF PREVENTING NEW HIV INFECTIONS, TREATING HIV-INFECTED PEOPLE, AND CARING FOR PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS.

Other Bilateral Countries Performance Measures (Includes all USG activities)			
Measure	FY	Target*	Result
5. Number of individuals who received counseling and testing during the reporting period (counseling includes the provision of test results to clients).	2007	Under Development	3/2008
	2006	1,049,628	3/2007
	2005	955,492	3/2006
	2004	Baseline	774,649
6. Number of individuals trained to provide laboratory-related activities. ²	2007	1,370	3/2008
	2006	1,130	3/2007
	2005	Baseline	1,636
7. Percent of young people aged 15-24 that are HIV infected. [0]	2007	Under Development	3/2008
	2006	Under Development	3/2007
	2005	Establish Baseline	3/2006
Data Source: GAP Planning and Reporting System and OGAC.			
Data Validation: All USG data are validated by the OGAC Strategic Information team following their internal procedures.			
Cross Reference: All measures – PART, 500-6			

¹Baseline represents CDC numbers alone. USAID numbers are not available at this time.
²This activity is implemented only by CDC.

Efficiency measure:

This measure is the efficiency measure for the other bilateral countries. The Emergency Plan commits to minimize management and staffing (operational) costs so that more resources can be devoted to direct prevention, treatment, and care programming.

Goal 3, Performance Measure 2:

Palliative care: Palliative care comprises a broad range of services including physical, psychological, spiritual, and social support services. With the resources allocated to these activities, palliative care was supported for 407,059 people.

Goal 3, Performance Measure 3:

People receiving antiretroviral therapy (ART): Through the Emergency Plan, the USG supported ART in the other bilateral countries; data on the number of individuals receiving ART will be available in March of 2006.

Goal 3, Measure 4:

PMTCT: expansion of PMTCT services and programs has been a priority since the beginning of the Emergency Plan's implementation. Through the Emergency Plan, the USG will continue to support counseling and testing for pregnant women, emphasizing the provision of tests results.

Goal 3, Measure 5:

Counseling and Testing: In FY 2005, the USG provided support for HIV counseling and testing services for over 1,636 people in the other bilateral programs. In FY 2006, the USG will continue to provide support to expand and strengthen quality counseling and treatment programs in the other bilateral countries.

Goal 3, Measure 6:

Individuals trained in lab services: In FY 2005, through the Emergency Plan, HHS/CDC trained over 1,600 individuals to provide lab-related activities and strengthen laboratory development in the other bilateral countries.

Goal 3, Measure 7:

Prevalence data: This measure and its baseline are still under development.

GLOBAL IMMUNIZATION PROGRAM

The Global Immunization Program underwent OMB's PART process for the FY 2007 cycle. New performance measures were developed as a result and are included below in the tables and narrative.

Efficiency Measure	FY	Target	Result
1. The portion of the annual budget that directly supports the program purpose in the field. [E]	2007	>=90%	4/2008
	2006	>=90%	4/2007
	2005	>=90%	4/2006
	2004	Baseline	93%
Data Source: Data will be tracked and analyzed through IRIS, GMIS, UFMS, and ICE systems.			
Data Validation: The monthly budget update is reviewed for accuracy by the Division's Associate Director for Management and Operations (ADMO). The ADMO monitors appropriate use of funds by category (polio, measles, and global disease detection) and CAN numbers. The ADMO works with the Polio Eradication Branch and the Global Measles Branch to ensure that funds are completely obligated by the end of the fiscal year. The overall budget is reviewed by the Branch Chiefs, Deputy Division Director, and Division Director quarterly.			
Cross Reference: HHS-8, PART			

Efficiency Measure:

The efficiency measure was developed through the FY 2007 PART process and demonstrates that most of the Global Immunization Program's funding is used to support mission-critical activities directly through CDC's global partners, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Pan American Health Organization (PAHO) and the United Nations Foundation (UNF). Specifically, these funds are used to purchase measles and polio vaccine and/or to provide technical or operational support through these agencies. To continue to meet global goals, CDC needs to maintain this efficiency and support for these activities.

GOAL 4: HELP DOMESTIC AND INTERNATIONAL PARTNERS ACHIEVE WORLD HEALTH ORGANIZATION'S GOAL OF GLOBAL POLIO ERADICATION.			
Measure	FY	Target	Result
1. Purchase doses of oral polio vaccine for mass immunization campaigns in Asia, Africa, and Europe.	2007	500 million doses	6/2008
	2006	500 million doses	6/2007
	2005	500 million doses	6/2006
	2004	500 million doses	500 million doses (Met)
	2003	600 million doses	550 million doses (Unmet)
2. Number of countries in the world with endemic wild polio virus. [O]	2007	0 endemic countries	8/2008
	2006	3 endemic countries	8/2007
	2005	5 endemic countries	8/2006
	2004	Baseline	6 endemic countries ¹
	2003		6 endemic countries
	2002		7 endemic countries

GOAL 4: HELP DOMESTIC AND INTERNATIONAL PARTNERS ACHIEVE WORLD HEALTH ORGANIZATION'S GOAL OF GLOBAL POLIO ERADICATION.
Data Source: <u>Measure 1</u> - UNICEF provides the number of doses of polio purchased with CDC funding in an annual report that is part of the CDC/UNICEF cooperative agreement. <u>Measure 2</u> - WHO provides the polio case data generated from reports submitted by countries.
Data Validation: Case count and surveillance indicators provided weekly by WHO are reviewed and analyzed by the Global Immunization Division.
Cross Reference: <u>Measure 1</u> - HHS-1; <u>Measure 2</u> - HHS-1, PART

¹WHO currently lists six countries as endemic (India, Afghanistan, Pakistan, Nigeria, Niger, and Egypt).

Goal 4, Performance Measure 1:

As planned, CDC purchased slightly less polio vaccine doses in FY 2004 compared to FY 2003, allowing CDC to place greater emphasis on surveillance and operational costs in all endemic and high risk countries.

Goal 4, Performance Measure 2:

Global polio incidence has declined by more than 99 percent from 1988 to 2004. The number of endemic countries has been reduced from 125 polio-endemic countries in 1988 to six countries in 2004. About 250,000 lives have been saved and five million cases of childhood paralysis have been avoided.

In 2005, the American Region of WHO completed its fourteenth year without a reported case of polio due to the wild virus. The Western Pacific Region (includes China, Vietnam, and Cambodia among its 35 countries) and the European Region (51 countries) have achieved regional eradication of polio. However, a large, ongoing polio outbreak in northern Nigeria is likely to postpone the achievement of polio eradication until 2007. As long as polio transmission occurs anywhere in the world, it remains a threat to American children. CDC will continue to fight against polio by collaborating with partners to increase the number and quality of National Immunization Days and intensify implementation of the other strategies to interrupt transmission. CDC will continue to provide scientific assistance to improve tracking to certify that polio eradication has occurred.

Measure two is an adaptation developed as a result of the FY 2007 PART process and serves as both a long-term and annual measure. The ultimate objective is to eradicate polio. The previous goal tracked cases of polio, whereas the new goal tracks number of countries with endemic polio.

GOAL 5: 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.			
Measure	FY	Target	Result
1. Number of global measles-related deaths. [O]	2007	363,400	12/2008
	2006	399,200	12/2007
	2005	435,000	12/2006
	2004	500,000	454,000 (Exceeded)
	2003	621,600	516,000 (Exceeded)
	2002		644,000
	2001		745,000
	2000	Baseline	777,000
2. Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission. [O]	2007	0	6/2008
	2006	0	6/2007
	2005	0	6/2006
	2004		78
	2003		30
	2002		2,502

GOAL 5: 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.

Measure	FY	Target	Result
	2001		392
	2000	Baseline	1,755

Data Source: World Health Organization, Pan American Health Organization

Data Validation: A team of WHO epidemiologists and statisticians annually review the estimates using a standardized methodology. This is supplemented with information obtained in national surveillance and program reviews as well as special studies. In addition, WHO works with partners to examine the quality and accuracy of the data.

Cross Reference: [Measure 1](#) - HHS-1, PART; [Measure 2](#) - HHS-1, PART

The wording of the following measures has changed to reflect modifications approved by OMB through the FY 2007 PART process.

Goal 5, Performance Measure 1:

The previous wording of this measure was, "By 2015, reduce by 90 percent the cumulative global measles-related mortality compared with 2000 estimates (Baseline: 777,000 deaths)."

CDC provided scientific, technical, and programmatic support for measles outbreak investigations in Bangladesh, South Africa, and North Sudan; supported reviews of immunization surveillance in the African and the Western Pacific regions and a national review in the Philippines, and an evaluation of the regional surveillance system for measles, rubella and congenital rubella syndrome in the European region. CDC also contributed funding and or technical assistance to measles immunization campaigns in 16 African countries and to those planned and conducted in Afghanistan, Azerbaijan, Bhutan, Bolivia, Kazakhstan, Nepal, Peru and Turkey. These efforts resulted in recommendations for improved surveillance and control activities and contributed substantially to declines in measles mortality.

Measles has been eliminated from the Western Hemisphere. Measles mortality in the African region has been reduced by 49 percent since 1999. The target for this goal is based on 2000 data estimating 777,000 deaths; by 2015 CDC aims to reduce the global measles-related mortality by 90 percent compared with this estimate from 2000.

The model used to generate the preceding year coverage is based on routine and campaign related performance data that is captured by a Joint WHO/UNICEF reporting form. WHO & UNICEF convene a panel committee to review this data and come to consensus on estimates of disease burden. The panel usually convenes in the first quarter of each calendar year. This year, the panel was not convened till August due to competing and critical public health priorities (re-introduction of polio into West Africa and the Near East) and scheduling conflicts among panel members. WHO final mortality figures for 2004 were released on December 1, 2005 (see Goal five above).

Goal 5, Performance Measure 2:

The previous wording of this measure was, "Eliminate measles transmission in all 47 countries of the Americas."

According to available surveillance information, measles transmission has been interrupted in all countries of the Western Hemisphere since November 2002. However, imported measles cases, with limited secondary spread, continue to occur in several countries, including the U.S. Deaths from measles complications in the Americas have virtually disappeared. Globally, measles caused an estimated 530,000 deaths in 2003 and was the leading cause of death among children under five years of age from a vaccine-preventable disease. This performance measure corresponds with the goal adopted by the Pan American Health Organization (PAHO).

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

LEADERSHIP AND MANAGEMENT

OFFICE OF MINORITY HEALTH

GOAL 1: PREPARE MINORITY MEDICAL, VETERINARY, PHARMACY, AND GRADUATE STUDENTS FOR CAREERS IN PUBLIC HEALTH.			
Measure	FY	Target	Result
1. Increase the number of minority students participating in the Hispanic Health Professions Internship Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, Research Initiatives for Student Enhancement (RISE) and Project IMHOTEP.	2007	87	8/2007
	2006	87	8/2006
	2005	95	101 (Exceeded)
	2004	92	95 (Exceeded)
	2003	65	74 (Exceeded)
Data Source: The data source is based on the number of interns and fellows who are core-funded.			
Data Validation: Data quality assurance is measured by review of quarterly and annual program progress reports.			
Cross Reference: 500-1			

Goal 1, Performance Measure 1:

CDC surpassed the FY 2005 target to enroll 95 students in four summer training programs designed to encourage minority students to pursue graduate careers in public health and to diversify the public health workforce. Demographic data are compiled for all student training programs annually.

The projected number of students targeted for FY 2006 and FY 2007 decreased due to two program announcements which expired at the end of FY 2005. New cooperative agreements were competed under Kennedy Krieger Institute/RISE Morehouse College/IMHOTEP program announcements where a smaller number of students are targeted for support.

GOAL 2: SUPPORT HBCUS, HISPANIC SERVING INSTITUTIONS, AND TRIBAL COLLEGES AND INSTITUTIONS.			
Measure	FY	Target	Result
1. Increase the number of funding mechanisms and the number of minority-serving institutions receiving support.	2007	4 cooperative agreements; 47 schools	8/2007
	2006	4 cooperative agreements; 47 schools	8/2006
	2005	5 cooperative agreements; 75 schools	4 cooperative agreements (Unmet); 76 schools (Exceeded)
	2004	4 cooperative agreements; 69 schools	4 cooperative agreements (Met); 70 schools (Exceeded)
	2003	4 cooperative agreements; 67 schools	4 cooperative agreements (Met); 70 schools (Exceeded)
Data Source: The data source is based on the number of interns and fellows who are core-funded.			
Data Validation: Data quality assurance is measured by review of quarterly and annual program progress reports.			
Cross Reference: 500-1			

Goal 2, Performance Measure 1:

The FY 2005 performance goal to award five cooperative agreements to support Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions, and Tribal Colleges and Institutions was not achieved because the additional cooperative agreement anticipated in August 2005 was not available until October 1, 2005. In FY 2005, a total of 76 schools were reached, exceeding the 2005 target by one school. The targeted number of

institutions projected for FY 2006 and FY 2007 decreased because the Tribal Colleges and Universities cooperative agreement, representing 33 institutions, expired at the end of FY 2005. CDC continues to strengthen its efforts to expand and diversify partnerships with academic institutions and to increase the competence and diversity of the public health workforce.

GOAL 3: FOSTER A STRONGER COLLECTIVE DEPARTMENTAL PERSPECTIVE ON AI/AN ISSUES.			
Measure	FY	Target	Result
1. Working in conjunction with IHS, identify and pursue areas of mutual interest and benefit.	2007	1 Senior Policy Workgroup meeting; disseminate results of the first HP 2010 progress evaluation; and, obtain necessary clearance for an expanded, repeat evaluation.	10/2007
	2006	1 Senior Policy Workgroup meeting.	10/2006
	2005	1 Senior Policy Workgroup meeting.	Unmet
	2004	Implement 6-point Senior Policy Workgroup workplan; establish new CDC AI/AN budget analysis procedures; 1 new CDC – IHS intra-agency agreement with HIS.	Began implementation of workplan and establishment of procedures (Met); Implemented 6 IAA with IHS (Exceeded)
Data Source: Communication between CDC/IHS senior management staff and summaries of workgroup meetings.			
Data Validation: Senior policy workgroup meeting summaries are reviewed by Tribal Liaisons and CDC senior management.			
Cross Reference: 500-1			

Goal 3, Performance Measure 1:

The FY 2005 Senior Policy Workgroup meeting was postponed due to recent senior staff and organizational changes occurring in both agencies. The agencies continued to have multiple teleconferences between senior staff on issues such as closing the gap on infant mortality, pandemic flu planning, and terrorism preparedness and response. In addition, the agencies initiated discussions to strengthen IHS-CDC partnerships through strategic placement of CDC field staff.

PUBLIC HEALTH WORKFORCE DEVELOPMENT

Efficiency Measure	FY	Target	Result
1. Increase the efficiency with which the OMB Clearance package for Epi-Aids is processed, resulting in reduced number of staff hours spent in preparing the package for submission. [E]	2007	50 hours	12/2008
	2006	50 hours	12/2007
	2005	50 hours	12/2006
	2004		22 hours
	2003	Baseline	200 hours
Data Source: Program Analyst monitors completion of Epi-Aid trip reports which includes the OMB reporting form.			
Data Validation: Completion and submission of triennial report to OMB.			
Cross Reference: HHS-8, HP-23			

Efficiency Measure 1:

This measure focuses on increasing the efficiency with which the OMB Clearance package for Epi-Aids is processed. It will result in reduced number of staff hours in preparing the package for submission and tracking the results of Epi-Aids. In 2004, the number of staff hours spent on preparing the package was 22 hours, based on 15 minutes/Epi-Aid to review 90 Epi-Aid reports to ensure the OMB reporting form is included. The OMB Clearance package is prepared and submitted every three years; the next submission is 2006. The wording of this measure was slightly modified to allow for continuation beyond FY 2006. This efficiency measure will be retired after data are reported in FY 2007. This is based on where the Office of Workforce and Career Development is located within the CDC budget submission and also based on the “true effectiveness” of this measure.

GOAL 1: CDC WILL DEVELOP AND IMPLEMENT TRAINING TO PROVIDE FOR AN EFFECTIVE, PREPARED, AND SUSTAINABLE HEALTH WORKFORCE ABLE TO MEET EMERGING HEALTH CHALLENGES.

Measure	FY	Target	Result
1. Number of EIS officers assigned to state or municipal health departments.	2005	50	53 (Exceeded)
	2004	48	48 (Met)
	2003	49	49 (Met)
2. Increase the number of local, state, and federal healthcare professionals who participate in training in epidemiology or public health leadership management.	2007	300	12/2008
	2006	300	12/2007
	2005	300	12/2006
	2004	200	258 (Exceeded)

Data Source: Currently data is based on the number of fellows (EIS, PHPS, PMR) that are core funded.

Data Validation: Program Analyst reviews and validates data through the program's personnel system.

Cross Reference: Measure 1 - HHS-8, HP-23; Measure 2 - HHS-2, 4, HP-23, 500-1

Goal 1, Performance Measure 1:

Exceeding CDC's performance target, 53 Epidemic Intelligence Service (EIS) officers were placed in field assignments in 2005. These placements provide cross-cutting experiences in many subject areas, such as infectious disease, environmental health, injury prevention, maternal/child health, and chronic disease prevention/health promotion. EIS field officers experience a high degree of autonomy and responsibility as vital members of their health department teams. They have the opportunity to take the lead in investigations in their state, to interact with the public, and to produce top-quality scientific presentations and papers. This measure will be retired after data are reported for FY 2005.

Goal 1, Performance Measure 2:

In a response to an August 2003 report that identified gaps at the state and local levels, CDC continues to train professional staff to address these gaps and investigate health problems affecting the nation's population.

- EIS officers participate in domestic and international infectious disease investigations.
- Preventive Medicine Residency combines clinical medical skills with public health practice expertise (e.g., epidemiology, health services management, environmental health).
- Public Health Prevention Service Program focuses on public health program management and provides experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and in state and local health agencies.

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.

Measure	FY	Target	Result
1. Evaluate the impact of training programs conducted by the NLTN on laboratory practices.	2007	Same as FY 2006	12/2007
	2006	90% of the public health and clinical laboratorians attending NLTN courses can correctly handle, process, or identify potential disease agents.	12/2006
	2005	Reduce rejection rates of specimens submitted to state laboratories for newborn screening as a result of training.	Results Inconclusive (Unmet)

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.			
Measure	FY	Target	Result
	<i>2004</i>	Assess the increase in the number of laboratories that adopt specific NCCLS practices for antimicrobial susceptibility testing and reporting.	34% increase (Baseline) (Met)
Data Source: Data for the FY 2005 target is from state neonatal follow-up programs. The data is collected following each course, reviewed, and evaluated by a statistician.			
Data Validation: Data are reviewed by the CDC Training Advisor responsible for the course. For targets after FY 2005, collective data will be checked quarterly.			
Cross Reference: HHS-2, 4, 5, HP-23			

Goal 2, Performance Measure 1:

The National Laboratory Training Network (NLTN) conducted over 200 training courses and trained over 29,000 participants through cost-effective, high quality continuing education in the laboratory sciences in FY 2005. NLTN courses are available in a variety of formats and are developed based on documented training needs and delivered in collaboration with state public health laboratories. Course topics include bioterrorism and chemical terrorism preparedness, safe packaging and shipping of diagnostic and infectious agents, antimicrobial susceptibility testing and newborn screening. Selected courses from the previous year are evaluated to determine outcomes of training.

A report on the effectiveness of the NLTN courses in promoting the adoption of the Clinical and Laboratory Standards Institute (formerly National Committee for Clinical Laboratory Standards - NCCLS) AST standards was completed in October 2004. Use of the NCCLS standards is voluntary, but laboratories that adopt the standards are more likely to produce more accurate testing results.

In 2005, NLTN conducted training nationwide on the proper collection of bloodspot specimens for newborn screening. Proper specimen collection ensures timely analysis and eliminates the need for recalling and resticking the infant.

Training was conducted in three states. Overall the data was statistically inconclusive (e.g., one state's data was not in a useable form; one state showed a slight decrease in needed resticking; and one state's data showed a slight increase). Previous studies, performed in states with high rejection rates, had demonstrated dramatic, statistically significant, improvement after this training. Since all of these states had low rejection rates prior to training, it is concluded that at that rate, training is needed to maintain the acceptable rate, but will not decrease the rate beyond a set target rate. Training efforts need to be targeted to states with very specific rates.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

EFFICIENCY GOAL: PROVIDE DYNAMIC SUPPORT FOR HIGH-PRIORITY STATE AND LOCAL DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.			
Efficiency Measure	FY	Target	Result
1. Eliminate the hours it takes to install GARS (Grants Application and Reporting System) software on grantees machines by establishing a Web-based system. [E]	2005	0 hours	12/2007
	2004	GARS becomes web-based	30% implemented (Unmet)
Data Source: Data logs that track log-ins to the web-based application.			
Data Validation: Information is electronically verified prior to transmission to CDC.			
Cross Reference: HHS-8			

Efficiency Measure 1:

A non-web-based Grants Application and Reporting System (GARS) is burdensome and inefficient for states and CDC. This burden is exacerbated as states face deep budget cuts. State health departments will save 1,952 hours per year on project reporting by using a Web-based GARS (1,952 grantee hours equals an average of four system per grantee times 61 grantees times eight hours per installation). CDC will save 720 hours, for a total saving of 2,672 hours.

The FY 2006 President's Budget proposed elimination of the Preventive Health and Health Services Block Grant. Therefore, CDC implemented only thirty percent of the highest-priority components of the system by December 2005. Given recent passage of a budget that continues the PHHS Block Grant in FY 2006, CDC will now proceed with development and installation of the remaining web-based modules to make GARS fully web-based. Full implementation is scheduled to be completed by December 2007.

BUILDINGS AND FACILITIES

Efficiency Measure	FY	Target	Result
1. Energy and water reduction. [E]	2007	Energy 20%; Water 30%	12/2007
	2006	Energy 20%; Water 30%	12/2006
	2005	Energy 20%; Water 15%	Energy 18% reduction; Water +9% (Unmet)
	2003	Baseline	Energy 8% reduction; Water 19% reduction
2. Deliver leased space below Atlanta's sub-market rate. [E]	2007	10% under market	10/2007
	2006	10% under market	10/2006
	2005	10% under market	-10% (Met)
	2003	Baseline	5% under market
Data Source: <u>Measure 1</u> - CDC-monitored utility meters at Campus or building level, and utility bills; <u>Measure 2</u> - GSA Rent bills, CDC market surveys, and commercially available data sources such as Black's Guide and CoStar.			
Data Validation: <u>Measure 1</u> - Meters are owned and validated by the utility, and are checked monthly; <u>Measure 2</u> - Market surveys are conducted no less than monthly and verified against GSA and commercially available data that serves as "benchmark" data for private industry.			
Cross Reference: <u>Measure 1 and 2</u> - PART			

Efficiency Measure 1:

In response to Executive Order #13123 identifying specific energy reduction goals and applying water management strategies, CDC has initiated monitoring and strategic planning efforts to ensure full compliance with the Executive Order and internal water management standards.

CDC has met 90 percent of its energy goal. CDC is placing considerable emphasis on energy efficient design for its new labs, and this may result in lower future consumption. However, CDC may expect somewhat higher energy usage through the end of the projected construction period [FY 2009] as some older labs remain in service combined with additional electrical usage resulting from actual construction activities. CDC is working with HHS to bring the water metric in line with Executive Order #13123.

Efficiency Measure 2:

To demonstrate the most efficient use of taxpayer dollars, this measure will monitor leased space cost with the expectation of delivering quality space below sub-market rates. CDC used its market presence and sound negotiations to achieve below market lease rates.

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Measure	FY	Target	Result
1. Aggregate of scores for capital projects rated on scope, schedule, budget, and quality.	2007	Greater than or equal to 90%	10/2007
	2006	Greater than or equal to 90%	10/2006
	2005	Greater than or equal to 90%	Met
		<u>Roybal Campus</u> East Campus Consolidated Lab Project, Bldg 23	<u>Roybal Campus</u> East Campus Consolidated Lab Project, Bldg 23
	2007	Continue Construction	6/2007
	2006	Continue design, Begin construction	6/2006

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.

Measure	FY	Target	Result
	2005	Continue design	Met
	2004	Begin design	Met (Pending Project and Funding Authority Approval)
		Epi Tower, Bldg 24	Epi Tower, Bldg 24
	2007	Pending	TBD
	2006	Pending	TBD
	2005	Begin design	Unmet
	2004	Begin design	Unmet (Pending Project and Funding Authority Approval)
		HQ & Emergency Ops Center, Bldg 21	HQ & Emergency Ops Center, Bldg 21
	2005	Complete construction	Met
	2004	Begin construction	Met
	2003	Complete design	Met
		Infrastructure and security upgrades, Bldg 20	Infrastructure and security upgrades, Bldg 20
	2007	Continue construction	06/2007
	2006	Continue construction	06/2006
	2005	Continue construction	Met
		Scientific Communications Center, Bldg 19	Scientific Communications Center, Bldg 19
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Begin construction	Met
		Emerging Infectious Disease Lab, Bldg 18	Emerging Infectious Disease Lab, Bldg 18
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Continue construction	Met
		Chamblee Campus Environmental Health Facility, Bldg 106	Chamblee Campus Environmental Health Facility, Bldg 106
	2007	Complete construction	4/2007
	2006	Complete design; Continue construction	6/2006
	2005	Begin design, Begin construction	Met
	2004	Design target adjusted to FY 2005	Met
		Environmental Toxicology Lab, Bldg 110	Environmental Toxicology Lab, Bldg 110
	2005	Complete construction	Met
	2004	Continue construction	Met

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Measure	FY	Target	Result
	2003	Continue construction	Met
		<u>Cincinnati Campus</u> Lab Consolidation – Site Acquisition	<u>Cincinnati Campus</u> Lab Consolidation – Site Acquisition
	2007	Complete analyses	6/2007
	2006	Continue analyses	6/2006
	2005	Continue analyses	Met (Pending Project and Funding Authority Approval)
	2004	Conduct analyses	Met (Pending Project and Funding Authority Approval)
		<u>Ft. Collins, CO Campus</u>	<u>Ft. Collins, CO Campus</u>
	2006	Complete construction	6/2006
	2005	Continue construction	Met
	2004	Complete design; begin construction	Met
2. Placement of NCID & NCEH laboratorians in CDC standard space (Projects occupied or underway).	2007	NCID 70%; NCEH 100%	10/2007
	2006	NCID 70%; NCEH 100%	10/2006
	2005	NCID 70%, NCEH 100%	70%, 100% (Met)
3. Relationship of work orders (scheduled and unscheduled maintenance).	2007	Scheduled 95%; Unscheduled 5%	10/2007
	2006	Scheduled 95%; Unscheduled 5%	10/2006
	2005	Scheduled 95%, Unscheduled 5%	95%, 5% (Met)
Data Source: <u>Measure 1</u> - Project Management Plans and Facility Project Approval Agreements; <u>Measure 2</u> - Facility Condition Index and periodic employee census counts; <u>Measure 3</u> - "The Management System (TMA)" tracking reports.			
Data Validation: <u>Measure 1</u> - On-site validation in daily or weekly meetings with Project Managers and Contractors verified against approved project management plans and contractual schedule of deliveries and payments; <u>Measure 2</u> - Verification or personnel counts with end-users when the buildings come on line, with additional verification through bi-annual building census. Laboratory "standard" verified through periodic (3-5 year) reviews of Facility Condition Index against published CDC laboratory and construction guidelines (Biosafety in Microbiological and Biomedical Laboratories, and CDC Design and Construction Standards); <u>Measure 3</u> - Tracking performed at the work order level through TMA, with monthly verification by operations & maintenance inspection personnel.			
Cross Reference: <u>Measure 1</u> – PART; <u>Measure 2</u> - PART; <u>Measure 3</u> – PART			

Goal 1, Performance Measure 1:

The aggregate scoring of four vital components (scope, schedule, cost and quality) of capital construction will most accurately assess successful performance and use of appropriated funds. The four combined components provide a comprehensive snapshot of capital construction. Scope, schedule, cost and quality are identified and approved consistent with the Facilities Project Approval Agreement process. The scope component will identify the predefined project needs; the schedule component will reflect the critical milestone dates; the cost component will establish the approved project budget; and the quality component will incorporate the scoring reflecting the use of appropriate building standards and codes.

Goal 1, Performance Measure 2.

The movement of CDC laboratorians into CDC standard space will facilitate CDC's ability to meet its scientific mission. CDC standard space includes standards for bio-safety, CDC design, space planning, and accreditation of laboratory animal care and HHS utilization rate policy. This metric has underlying assumptions concerning the

stability of CDC's growth rates, workforce composition, laboratory standards, and applicable codes. Any significant changes in baseline assumptions would require appropriate upward/downward adjustments to target rates.

By moving select components of the National Center for Infectious Diseases (NCID) into Building 18, the Emerging Infectious Disease Laboratory, CDC met its goal of 70 percent occupancy by NCID for 2005. This building houses the Division of Bacterial and Mycotic Diseases (DBMD), the Division of Viral and Rickettsial Diseases (DBMD), the Division of HIV/AIDS Prevention (DHAP), HIV and Retrovirology Branch, and the Division of Viral Hepatitis (DVH). Building 18 contains unique high containment laboratory space to support research on hazardous pathogens such as Ebola, Avian Flu, and SARS. The facility is also the central receiving, processing and response lab for the CDC Bioterrorism Preparedness and Response Program and Rapid Response/Advanced Technology Lab.


With the occupancy of Building 110, the Environmental Toxicology Laboratory, CDC met 100 percent of its 2005 goal to move the National Center for Environmental Health (NCEH) into CDC standard space. This facility houses the Division of Laboratory Sciences (DLS) whose employees use advanced laboratory science and innovative techniques to prevent disease from exposure to toxic chemicals in the environment; respond to terrorism and public health emergencies involving chemicals; and improve laboratory methods to diagnose and prevent disease. Scientists are working on developing a breakthrough test for botulinum and other toxins. The Radionuclide Laboratory measures select radionuclides that might result from "dirty bombs" or other releases. CDC's award-winning Newborn Screening Quality Assurance Program is the only source in the world for ensuring the accuracy of newborn screening tests responsible for identifying thousands of babies each year who are born with genetic or metabolic disorders. In addition, Building 110 serves as the home of the world reference laboratory for measuring cholesterol, triglycerides, and high and low-density lipoproteins.

Goal 1, Performance Measure 3:

This measure will track the percentage of maintenance projects that are scheduled (i.e., planned) to maintain the facilities, versus the percentage of unscheduled work orders tied to repairs of non-functioning or faulty systems. In general, all facilities are better protected through scheduled maintenance.

TERRORISM

CDC's Strategic National Stockpile (SNS) underwent the OMB PART process for the FY 2007 cycle. As a result of the PART process, CDC's SNS developed new performance measures, including long-term outcome measures, annual outcome and output measures, and an efficiency measure.

EFFICIENCY GOAL: CREATE PROGRAM EFFICIENCIES THAT IMPROVE SERVICES AND CONSERVE RESOURCES FOR MISSION-CRITICAL ACTIVITIES.			
Efficiency Measure	FY	Target	Result
1. Fully automate the application, work plan and semi-annual reporting for cooperative agreement grantees to achieve greater program efficiencies. [E]	2005	62 grantees using system	61 grantees using system (Unmet)
	2003	Baseline	57 grantees using the system, with limited functionality
2. Dollars saved per \$1 invested in the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) for available projects. [E]	2007	\$26	12/2007
	2006	\$24	12/2006
	2005	Baseline	\$22
<p>Data Source: <u>Measure 1</u> - CDC's Coordinating Office of Terrorism Preparedness and Emergency Response has maintained a management information system on CDC's Secure Data Network (SDN) for approximately one year. This system, known as SLPP-MIS, is used to receive, process, monitor, and evaluate cooperative agreements of over \$900 million per year for 62 grantees. <u>Measure 2</u> - CDC's SNS analysis of product Life Cycle Tools.</p>			
<p>Data Validation: <u>Measure 1</u> - There is an internal tracking system component of SLPP-MIS called Enhanced Project Management (EPM) that is utilized by each of the CDC DSLR project officers, as well as senior staff, to track and maintain project issues, comments, progress, and provide reporting functionality on each of the 62 grantees. <u>Measure 2</u> - CDC's SNS coordinates with the FDA and maintains an internal tracking system for identification of products that may be eligible for the SLEP.</p>			
<p>Cross Reference: <u>Measure 1</u> - HHS-8, -3, 4, 500-4; <u>Measure 2</u> - PART, 500-4</p>			

Efficiency Measure 1:

In 2005, all 61 newly funded grantees used the system to fully automate their applications, work plans and semi-annual reporting for the CDC Terrorism Preparedness cooperative agreement, resulting in greater program efficiencies. The Marshall Islands territory did not submit an application and was not provided new funding. Currently, all 62 grantees are using the system for self-reporting. The first semi-annual report was due on May 1, 2005 and the second, November 30, 2005. The benefits of the system and new supporting processes have improved timeliness of applications, ease of processing and production for review as well as elimination of paper processing. Additionally, development of the system addresses the e-government provisions of the President's Management Agenda. This measure will be retired after data have been reported for FY 2005. A new efficiency measure that reflects the entire CDC Terrorism program (not just the Terrorism Cooperative Agreements) is in the development phase.

Efficiency Measure 2:

This efficiency measure was adopted during the PART process to demonstrate the program's improved efficiencies. The return on investment (ROI) is based on each \$1 spent on SLEP costs (testing, shipping, relabeling, etc.). For FY 2005, the baseline in replacement costs is a \$22 return for each \$1 spent. This ROI is calculated based on the total estimated replacement costs divided by the total estimated SLEP costs. For the baseline, CDC used 10 FDA SLEP projects submitted in 2004.

PREVENT

Preparedness goal one (Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally occurring health threats) does not currently have supporting PART or GPRA performance measures.

DETECT

PREPAREDNESS GOAL 2: DECREASE THE TIME NEEDED TO CLASSIFY HEALTH EVENTS AS TERRORISM OR NATURALLY OCCURRING IN PARTNERSHIP WITH OTHER AGENCIES.			
Measure	FY	Target	Result
1. Ensure 100% of applications for registration meet the requirements of the select agent regulations prior to issuing a certificate of registration.	2005	100% compliance	100% Compliance (Met)
2. Inspect entities in accordance with the Select Agent Rule.	2005	525 labs	539 labs (Exceeded)
	2004	300 labs	498 (Exceeded)
3. Increase the number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events including those suggestive of bioterrorism.	2007	3,400	12/2007
	2006	3,200	12/2006
	2005	3,000	3,300 (Exceeded)
	2004	2,100	2,812 (Exceeded)
<p>Data Source: <u>Measures 1, 2</u> - Receipt and processing of applications and all documents (including inspection reports) are captured and indexed by CDC's Division of Select Agents and Toxins (DSAT)'s Electronic Document Management System (EDMS). The system is also used to record the location of each document and to provide data necessary for rapid retrieval and review of the document. <u>Measure 3</u> - CDC's Epi-X network tracks the number of state and local public health professional that use the system.</p>			
<p>Data Validation: <u>Measures 1, 2</u> - Data from the application forms submitted from the public to the CDC Select Agent and Toxins Program are manually entered into a database. The CDC Select Agent and Toxin Program database is a Visual Basic application running on a Microsoft SQL server database that provides an interface for data entry and reporting capabilities. After CDC's Select Agent and Toxin Program determines that the entity has met all safety, security, and record-keeping requirements, it is issued as a registration certificate that is valid for a two to three year period. The dates of registration are captured in the SQL database. Entities that wish to register for select agents or toxins are inspected and are issued a report that cites any deficiencies noted during the inspection event. Dates of inspection and whether the entity addressed all deficiencies satisfactorily are entered into the SQL database. <u>Measure 3</u> - The number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events is captured in the Epi-X application. This number is tracked through the registration process of the application. There are automated system controls in place as well as manual procedures that are frequently conducted to validate that the information being collected is accurate.</p>			
<p>Cross Reference: <u>Measure 1</u> - HHS-4, 5, 500-4; <u>Measure 2</u> - HHS-4, 5, 500-4; <u>Measure 3</u> - HHS-2, 5, 500-4</p>			

Goal 2, Performance Measure 1:

Ensuring the safety and security of select agents and toxins by regulating entities with these materials is paramount to CDC's prevention efforts. Entities must submit registration applications that provide evidence that they can safely and securely use, transfer, and store select agents and toxins. Only after all biosafety and biosecurity requirements under the regulations are satisfied will consideration be given to issue a certificate of registration.

Inspection of 100 percent of all new eligible entities was completed within 180 days of application. During 2005, 30 new applications were received: eight met the requirements and were registered, five entities were suspended, one application was withdrawn, and all other applications have not yet met the requirements of the regulation.

A significant challenge is the requirement of concurrence by the U.S. Department of Agriculture's Animal and Plant Health Inspection Service (APHIS) before issuing a full certificate. Entities believe issuance of a certificate by a single Federal agency indicates compliance with all Federal regulations. Inspections by CDC's public health scientists do not currently include elements of either an animal or plant health inspection. The result is that a full certification cannot be issued to an entity without either an inspection by APHIS or its concurrence with CDC's inspection. In an effort to address inspection/registration challenges, CDC has established ongoing meetings with USDA to develop a joint inspection checklist, a shared database, and improve communication and processes to facilitate concurrence and timely issuance of full certificates of registration, among other activities. This measure will be retired after data have been reported for FY 2005.

Goal 2, Performance Measure 2:

Inspections are an integral part of the Select Agent Program's regulatory activities. After registration applications are thoroughly evaluated and questions answered, an inspection team visits the entity to directly observe and confirm that all requirements are addressed. This includes reviewing safety procedures, the security plan, records for training, access, and transfers, and inventories of the entity's select agents and toxins. Application and registration for the Select Agent Program are currently being automated to enhance program efficiency.

In FY 2005, 539 laboratories were inspected, exceeding the target of 525. Currently, any entity not previously registered with the Select Agent program is being inspected as part of the original registration process. This measure will be retired after data have been reported for FY 2005.

Goal 2, Performance Measures 3:

Epi-X, CDC's secure Web-based communications network for public health officials, links HHS and CDC with state terrorism surveillance and response programs, provides emergency alerts, and creates a forum to share important disease information nationwide. The usefulness of Epi-X has resulted in a substantial increase in the number of users well beyond the original target numbers.

In FY 2005, the number of health professionals using Epi-X was 3,300. The target was exceeded by 300 as a result of CDC's vigorous recruitment effort.

PREPAREDNESS GOAL 3: DECREASE THE TIME NEEDED TO DETECT, CHEMICAL, BIOLOGICAL, RADIOLOGICAL AGENTS IN TISSUE, FOOD, OR ENVIRONMENTAL SAMPLES THAT CAUSE THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. 100% of states have level three chemical lab capacity, and have agreements with and access to (specimens arriving within 8 hours) a level-one chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins.*	2007	100%	12/2007
	2006	100%	12/2006
	2005	25%	50% (Exceeded)
2. Increase the number of labs qualified to provide surge capacity for analysis of chemical agents.	2005	8 labs	10 labs (Exceeded)
	2004	5 labs	5 labs (Met)
3. Maintain at 150 the number of toxic substances likely to be used in chemical terrorism that can be rapidly measured in blood and urine.	2007	150 substances	12/2007
	2006	150 substances	12/2006
	2005	150 substances	150 (Met)
	2004	150 substances	150 (Met)
4. Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents.	2007	100%	12/2007
	2006	80%	12/2006
	2005	75%	80% (Exceeded)
5. Increase the number of labs in LRN.	2005	160 labs	152 (Unmet)
	2004	145 labs	134 (Unmet)
Data Source: The Laboratory Response Network (LRN) delivers accurate and timely identification of agents causing public health treats, including both naturally occurring disease and organisms that could be used in a biologic terrorism attack.			
Data Validation: The data collection and validation activities across the LRN significantly enhances the capacity of laboratories to rapidly detect and identify agents likely to be used in a terrorist attack and provide timely information to health professionals.			
Cross Reference: Measure 1 - HHS-2, PART, 500-4; Measure 2 - HHS-2, 500-4; Measure 3 - HHS-2, 500-4; Measure 4 - HHS-2, PART, 500-4; Measure 5 - HHS-2, 500-4			

*Please note that the nomenclature has changed for chemical laboratories, so level-three labs are now referred to as level-one labs and level-one labs are referred to as level-three labs.

Goal 3, Performance Measure 1:

Level-three laboratories, also called sentinel laboratories, rule out the presence of agents and refer samples to reference labs through the use of specified protocols. As a public health preparedness standard, each state should have the capacity to conduct, rule-out and transfer activities. CDC is training all 62 level-three public health chemical laboratories (i.e., chemical terrorism coordinators in these laboratories) in the proper collection and shipment of human samples following a chemical terrorism event. This training also includes four items: an overview of chemical agents; CDC's responsibilities in responding to chemical terrorism events; a discussion of federal regulations on diagnostic packaging procedures and evidentiary-control measures; and hands-on exercises involving the packaging and shipping of human samples. These public health chemical laboratories will then train internal partners (e.g., hospital laboratories, HAZMAT, doctors, office laboratories) in the proper collection and shipment of human samples after a chemical-terrorism event.

In FY 2005, significant progress was made on this measure as 100 percent of states have level-three lab capacity. Fifty percent of the states are within an eight hour driving distance to a level-one chemical laboratory due to CDC's efforts in increasing the number of level-one laboratories from five to ten in 2005.

CDC has discouraged the development of Memorandums of Understanding (MOUs) between states for specimen analysis, so the actual number of existing agreements is extremely small. Developing MOUs between states may not be the most efficient use of our state laboratory partners' time. At any given time, a level-one laboratory may be overwhelmed with specimens from their own population or those from another state, necessitating transfer of collected specimens to another level-one laboratory. Using this rationale, a given state would have to develop at least multiple MOUs (one with each level-one laboratory) to ensure their specimens would be analyzed by each facility. Using the Emergency Management Assistance Compact (EMAC) may be a better vehicle for level-three laboratories to make sure that specimens from their population are analyzed at a level-one laboratory.

Goal 3, Performance Measure 2:

CDC's Environmental Health Laboratory is working with public health laboratories in states, territories, cities, and counties to provide assistance in expanding their chemical laboratory capacity to respond to chemical terrorism incidents or other emergencies involving chemicals. With CDC funding, laboratories are or will be able to make instrument and equipment purchases, undertake training at the Environmental Health Laboratory or at sites visited by instrument manufacturers, and engage in technology transfer and proficiency testing for methods to measure chemical agents.

As of 2005, ten states are qualified to provide surge capacity testing for various chemical terrorism agents in the event of a large-scale chemical terrorism incident, which exceeds CDC's capacity to respond. This measure will be retired after data have been reported for FY 2005.

Goal 3, Performance Measure 3:

The Rapid Toxic Screen (RTS) is a series of tests to identify various chemical agents in human blood or urine. In a chemical terrorism event, RTS will help determine what chemical agents were used, who has been exposed, and to what extent. In 2005, CDC maintained its capacity to analyze 150 toxic substances in the event of a chemical terrorism incident or other chemical emergency. Maintenance includes ensuring proper operation of analytic instrumentation, running particle samples during proficiency testing challenges and response exercises, and providing for a stockpile of supplies and analytic materials that would allow up to 5,000 samples to be analyzed in the case of a chemical event. CDC also is identifying back-up instrumentation that could be used if our primary response instruments are "down" during an event, and is ensuring that staff is cross-trained allowing for back-up analysts if a primary analyst is unavailable during an incident.

Goal 3, Performance Measures 4 – 5:

Measures four and five relate to the Laboratory Response Network (LRN), which is a consortium of laboratories comprised primarily of state, local and federal public health laboratories, each with different capabilities and levels of expertise.

For performance measure four, CDC made considerable progress regarding increasing proficiency testing. In FY 2005, 80 percent of LRN laboratories passed the six proficiency testing events including one for detection in food that was conducted by the FDA in collaboration with the LRN. Currently, 96 percent of LRN laboratories could test for *Bacillus anthracis*; 93 percent could test for *Yersinia pestis*; and 94 percent for *Francisella tularensis*. Additionally, 82 percent of the labs can test for Ricin, while 75 percent can test for Food-B anthracis. However, strengthening the LRN capacity in this area remains an objective for this measure along with other measures relating to the LRN. In addition to specific agents, rapid diagnostics and rapid testing of potential bioterrorism agents is important to the mission of the LRN. Speed and accuracy in analyzing a potential bioterrorist agent is key to mitigating the effects on morbidity and mortality following an attack.

For performance measure five, CDC is continuing to expand the number of laboratories included in the LRN. Historically, 12 to 15 laboratories had been added to the LRN in each of the past four years. In 2005, the number of labs in the LRN increased from 138 to 152, representing a ten percent increase. The targeted goal of 160 has not yet been achieved. This measure will be retired after data have been reported for FY 2005.

PREPAREDNESS GOAL 4: IMPROVE THE TIMELINESS OF COMMUNICATIONS REGARDING THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. Increase the number of reports of disease outbreaks and other emerging health events posted on Epi-X annually.	2005	1,350	1,467 (Exceeded)
	2004	1,200	1,333 (Exceeded)
2. Increase the number of states and major metropolitan areas with access to Epi-X.	2007	225	12/2007
	2006	150	12/2006
	2005	125	137 (Exceeded)
	2004	100	100 (Met)
3. 100% of LRN labs will report routine public health testing results through standards-based electronic disease surveillance systems and have protocols for immediate reporting by telephone for Category A agents (bacillus anthracis, yersina pestis, francisella tularensis, clostridium botulinum toxin and variola major) for which they conduct testing. [O]	2007	100%	12/2007
	2006	100%	12/2006
	2005	100%	100% (Met)
4. 100% of state and local public health agencies will be in compliance with CDC recommendations for using standards-based, electronic disease surveillance systems for appropriate routine public health information collection, analysis and reporting appropriate public health authorities.	2007	75%	12/2007
	2006	65%	12/2006
	2005	100%	56% (Unmet)
Data Source: Epi-X Application, Laboratory Response Network Laboratories, Public Health Emergency Preparedness & Response Cooperative Agreement recipients.			
Data Validation: <u>Measures 1, 2</u> - The Epi-X application is used to track how many reports are posted to the application annually, as well as how many states and major metropolitan areas have access to the application. This information is routinely analyzed through automated and manual procedures, to ensure it is accurate. <u>Measures 3, 4</u> - While CDC is developing objective measures that define CDC-compliant, standards-based electronic disease surveillance systems, half of the grantee recipients report use of Internet browser-based data entry and receipt of electronic laboratory results (ELR). Additionally, all LRN Labs use established protocols for telephone reporting and have the ability to use a spreadsheet mechanism for reporting through the secure website.			
Cross Reference: <u>Measure 1</u> - HHS-2, 5, 4 -4, 500-4; <u>Measure 2</u> - HHS-2, 5, 4 -4, 500-4; <u>Measure 3</u> - 4 -4, PART, 500-4; <u>Measure 4</u> - HHS-5, 4 -4, PART, 500-4			

Goal 4, Performance Measures 1 – 2:

Measures one and two relate to Epi-X, CDC's secure web-based communications network for public health officials. In FY 2005, CDC increased the availability of Epi-X to 137 states and major metropolitan areas (all 50 states and 87 areas). At the end of 2005, 1,467 reports of disease outbreaks and other emerging health events had been posted on Epi-X, exceeding the target of 1,350. As more users participate in exchanging information via Epi-X, reports and use by public health authorities for the reporting of important public health events will increase. Measure one will be retired after data have been reported for FY 2005.

Goal 4, Performance Measure 3:



Currently, all LRN labs can use established protocols for telephone reporting and, in addition, can use an interim spreadsheet mechanism for reporting through the secure website.

Goal 4, Performance Measure 4:

Currently, the National Electronic Disease Surveillance System (NEDSS) Base System that supports vaccine preventable diseases, hepatitis, meningitis and foodborne diseases is in production in 11 states, while an additional seven states are planning for or considering the latest release. Furthermore, the second generation of NEDSS supporting three additional programs (Adult/Childhood Lead Poisoning, TB and Varicella) will be delivered to multiple states in early 2006. CDC is providing NEDSS grant funding to 57 jurisdictions. In FY 2005, 56 percent of these jurisdictions were in compliance with CDC recommendations. Jurisdictions that have chosen not to implement the NEDSS Base System have either purchased a commercial product or have built their own standards-based electronic

disease surveillance system. The target for FY 2006 was decreased to 65 percent based on the adoption rate of standards-based surveillance systems over the past several years. CDC will continue efforts in this area despite technical challenges faced by state and local public health departments.

INVESTIGATE

PREPAREDNESS GOAL 5: DECREASE THE TIME TO IDENTIFY CAUSES, RISK FACTORS, AND APPROPRIATE INTERVENTIONS FOR THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. Support terrorism preparedness and emergency response training for EIS officers and CEFOs assigned to state and local public health departments.	2005	67	80 (Exceeded)
	2004	48	67 (Exceeded)
	2003	41	41 (Met)
2. Properly equipped public health emergency response teams will be onsite within 4 hours of notification by local public health officials, to assess the public health impact and determine the appropriate public health intervention in response to Category A agents. [O]	2007	70%	12/2007
	2006	50%	12/2006
	2005	25% (16) of grantees	Unmet
3. Increase the number of CDC professionals that are trained responders in the field.	2006	250	12/2006
	2005	150	97 (Unmet)
Data Source: <u>Measure 1</u> - CDC's National Center for Health Marketing; <u>Measure 2</u> - DSLR's SLPP-MIS Application; <u>Measure 3</u> - CDC's Field Services Office			
Data Validation: <u>Measure 1</u> - CDC maintains close contact with state and local public health departments by the assignment of Career Epidemiology Field Officers (CEFOs) to their departments. CEFO Program staff also work to enhance collaboration with internal CDC partners to assure alignment of mutual priorities and integration of joint activities. Through these efforts, CDC is able to validate that it is providing terrorism preparedness and emergency response training that meets the needs of the EIS and Career Epidemiology Field Officers assigned to state and local public health departments. <u>Measure 2</u> - See Efficiency Goal Data Validation. <u>Measure 3</u> - CDC's Field Services Office has developed training curriculum for all emergency responder staff. This curriculum was coordinated with CDC's Office of Workforce and Career Development, as well as CDC's Training and Education Goals and is continuously being validated and revised to meet the needs of CDC's emergency responder staff. The number of responders participating in these training courses is being tracked manually as well as through the web-based system that administers the online courses. Course evaluations are conducted after each training session (classroom and web-based) to determine the effectiveness of the course and identify areas for improvement.			
Cross Reference: <u>Measure 1</u> - HHS-2, 500-4; <u>Measure 2</u> - HHS-2,  , PART, 500-4; <u>Measure 3</u> -  , 1, 500-4			

Goal 5, Performance Measure 1:

In 2005, CDC maintained 80 Epidemiologic Investigation Service (EIS) officers and Career Epidemiology Field Officers (CEFOs) in states and local jurisdictions. CDC ensures they have the knowledge, skills, and tools to respond to terrorism preparedness and emergency response needs through training in areas such as, but not limited to, team leadership, forensic epidemiology, field exercises, incident command structures, legal issues, and agent-specific strategies. In addition, CDC conducted training events for the EIS and CEFOs in the summer of 2005. Since training was established and delivered to all 80 Officers. CDC will retire this measure after data are reported for FY 2005 and replace it with a new measure demonstrating the impact of the training.

Goal 5, Performance Measure 2:

While the FY 2005 performance measure is being reported as unmet, CDC lacks data to determine if this expectation was achieved by state and local public health department grantees. CDC is currently refining the performance measurement processes to better enable state and local health agencies to report on data that measures their progress in moving toward achievement of the CDC preparedness goals. Determination of proper equipment standards, and proficient use of equipment, requires testing of various products, technical reviews, development of written standards/recommendations, coordination, and communication of those standards/recommendations to equipment manufacturers. It is challenging to establish meaningful, aggressive targets because the effort is time intensive and requires extensive coordination and communication.

Goal 5, Performance Measure 3:

CDC's Field Services Office initiated a policy outlining the Public Health Readiness Field Program (PHRFP) describing placement, management, training and funding of field staff positions. An initial step was to develop the

training to prepare new emergency response field staff for responsibilities in the field. Discipline specific competency-based guidelines have been established. A two-week course basic training curriculum ("boot camp") was developed for all emergency response staff. The training plan and curriculum were coordinated with CDC training goals and were integrated into CDC's Office of Workforce and Career Development.

In FY 2005, two course offerings were held in Anniston, AL at the FEMA Noble Trainings Center, in which 97 individuals were trained. A third offering was scheduled to train 70 additional individuals, but was cancelled due to the response to Hurricanes Katrina and Rita. This measure will be retired after data have been reported for FY 2006.

CONTROL

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. Expand and enhance HAN's ability to rapidly provide access to public health guidelines, best practices, and information on the effectiveness of public health interventions.	2007	a) 75% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis c) 80% of state grantees will have a protocol for testing and documenting send/receive capabilities	12/2007
	2006	a) 70% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis. b) N/A c) 75% of state grantees will have a protocol for testing and documenting send/receive capabilities d) N/A	12/2006
	2005	a) 65% of state and 35% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 65% of state grantees will have communication established with identified, key stakeholders c) 60% of state grantees will have a protocol for testing and documenting send/receive capabilities d) Establish interoperable wireless redundant communication systems in 55% of state health departments	a) 57% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet) b) 97% (Exceeded) c) 12/2006 d) 98% (Exceeded)

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
	2004	a) 60% of states and 25% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 50% of state grantees will have communication established with identified, key stakeholders c) 50% of state grantees will have a protocol for testing and documenting send/receive capabilities d) Establish interoperable wireless redundant communication systems in 40% of state health departments	a – d) Unmet
2. 100% of state public health agencies are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC. [O]	2007	90% prepared	12/2007
	2006	80% prepared	12/2006
	2005	70% prepared	76% (Exceeded)
	2004	60% prepared	72% (Exceeded)
3. By 2005, maintain 24/7 communications capability to disseminate information to the public during emergency events. [O]	2005	24/7 capacity	24/7 capacity (Met)
	2004	24/7 capacity	24/7 capacity (Met)
4. 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. [O]	2008	2.3, 60, .17	12/2008
	2003	Baseline	.2, 1.4, .4
5. Number of successful annual exercises and number of active response units for delivering assets in response to multiple events within 12 hours. [O]	2007	1, 7	12/2007
6. The number of successful annual exercises that test response to multiple events with a 12-hour response time. [O]	2007	1	12/2007
	2006	1	12/2006
	2005	Baseline	1
7. Number of trained and ready Technical Advisory Response Units (TARU) for response to multiple events.	2007	7	12/2007
	2006	6	12/2006
	2005	Baseline	5
8. Percentage of inventory discrepancies that are reduced by using quality inventory management systems.	2007	<5%	12/2007
	2006	<5%	12/2006
	2005	Establish Baseline	6 %

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.
<p>Data Source: Measures 1, 3 - Health Alert Network, CDC's Division of the Strategic National Stockpile (SNS); Measure 2 - Completed SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V 10.00.; Measures 4 – 8 – DSNS.</p>
<p>Data Validation: Measures 1, 3 – At CDC, the Health Alert Network is maintained by the National Center for Public Health Informatics (NCPHI). The data that passes through and is captured in HAN is frequently validated by NCPHI staff. Measure 2 – The SNS program maintains a staff Program Services Consultants who provide ongoing technical advice and training assistance to Public health Emergency Preparedness & Response grantees. The consultants also assess the grantee's level of preparedness to receive, distribute and dispense SNS assets. These services improve the grantee's ability to receive, stage, store and distribute the SNS materiel. Measures 4, 5, 6, 7, 8 – DSNS maintains internal tracking systems to monitor its ability to deliver critical medical assets in a national emergency. A new Stockpile Resource Planning (SRP) database and inventory system is used to track and validate stockpiled material.</p>
<p>Cross Reference: Measure 1 - HHS-4, 5, PART, 500-4; Measure 2 - HHS-4, 5, PART, 500-4; Measure 3 - HHS-5, 4, PART, 500-4; Measure 4 - PART, 500-4; Measure 5 - PART, 500-4; Measure 6 - PART, 500-4; Measure 7 - PART, 500-4; Measure 8 - PART, 500-4</p>

Goal 6, Performance Measure 1:

Currently, three basic building blocks for routine and emergency information dissemination are being completed nationwide by HAN:

- continuous high-speed Internet connectivity to support rapid information access.
- broadcast capacity to support emergency communication.
- establishment of redundant communications.

In order to obtain the status of performance for this measure, CDC's National Center for Public Health Informatics sent a test message to the 62 BioTerrorism Cooperative Agreement grantees. Of those, 56.5 percent responded within 30 minutes. Overall, 45 out of 62 (72.5 percent) responded. CDC also used survey results of the 50 states, seven pacific jurisdictions, and four cities/districts for measuring communication established with identified key stakeholders and establishment of interoperable wireless redundant communication systems.

Plans for coming years include continued technical assistance and network testing to ensure timely message translation, dissemination, local response, and feedback. Note that targets b) and d) will be retired after data are reported for FY 2005, and target c) will be measured in 2006 when a template policy has been created for all states.

Goal 6, Performance Measure 2:

CDC describes 12 functions of SNS Preparedness required for the effective management and use of deployed SNS materiel. Based on these functions, grantees are required to develop SNS Preparedness Plans detailing the performance of these functions during an emergency. In an effort to enhance grantee SNS preparedness planning efforts, CDC maintains a staff of program service consultants who provide ongoing technical advice and training assistance to grantees. These consultants also assess the grantees' level of preparedness to receive, distribute and dispense SNS assets. This measure is a CDC challenge. Many jurisdictions lack proper facilities to receive the 50-ton package of SNS material. However, CDC provides technical assistance, education and training to improve the ability of states to receive stage, store and distribute the SNS materiel.

As of December 2005, 76 percent (41 out of 54) of the states and directly-funded cities have met the minimum standards for demonstrating preparedness to use SNS assets and thus received a rating of amber or better.

Goal 6, Performance Measure 3:

CDC has achieved this measure (24/7 Capacity) and therefore it will be retired after data are reported for FY 2005.

Goal 6, Performance Measures 4:

As a result of the PART process, CDC developed this long-term performance measure. CDC will grow and maintain treatment/prophylaxis capability for chemical, biological, radiological/nuclear threats. CDC will report on the measure in FY 2008.

Goal 6, Performance Measures 5 - 7:

As a result of the PART process, CDC developed new performance measures. Measure five is the long-term overarching measure and measures six and seven are annual outcome and output measures, respectively. CDC will

exercise its response to multiple events annually and will also grow its TARU to support multiple responses. Reporting for these measures will begin in FY 2006 and FY 2007.

Goal 6, Performance Measure 8:

As a result of the PART process, CDC developed this performance measure. The new inventory management system will provide the capability to track discrepancies.

RECOVER

Preparedness Goals seven (Decrease the time needed to restore health services and environmental safety to pre-event levels) and eight (Increase the long-term follow-up provided to those affected by threats to the public's health) do not currently have supporting performance measures.

IMPROVE

PREPAREDNESS GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATION FROM AFTER-ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. Evaluate the impact on the performance/preparedness of frontline public health workforce resulting from education and training programs implemented or supported by CDC, including CPHP system.	2005	a) Evaluate impact of programs in 50% of states b) 90% of LHD participants in Phase II of "Project Public Health Ready" achieve certification (denominator = 25 LHDs) c) Implement and evaluate "Project Public Health Ready" in 3 statewide programs d) 90% of states are served by a CPHP e) 50% of LHDs deploy distributed learning technology in public health education and training (denominator: 3,000 LHDs) f) 85% of the 50 State DLCs receive basic competency training	a) 100% (Exceeded) b) 90% (Met) c) 3 (Met) d) 96% (Exceeded) e) 50% (Met) f) 88% (Exceeded)
	2004	a) Evaluate impact in 30% of states b) 10% of LHDs achieve certification under "Project Public Health Ready" (denominator: 13 pilot sites) c) 80% of states served by a CPHP d) 50% of LHDs deploy distributed learning technology in public health education and training (denominator: 3,000 LHDs) e) 50% of the 50 current Distance Learning Coordinators have initiated basic competency training	a) 30% (Met) b) 85% (11 out of 13 pilot test sites) (Met) c) 92% (Exceeded) d) 50% (Met) e) 88% (Exceeded)

PREPAREDNESS GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATION FROM AFTER-ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
	2003	a) Initiate evaluation in 10% of states b) Begin demonstration phase of "Project Public Health Ready" c) 50% of states served by CPHP d) 30% of LHDs deploy distributed learning technology in public health education and training e) 10% increase in DLCs trained in basic core competencies	a) Evaluation framework adapted (Met) b) 12 pilot sites selected (Met) c) 82% (Exceeded) d) 30% (Met) e) 84% of DLCs completed basic courses for core competencies (Met) (Baseline: 0 DLCs)
2. Conduct at least one internal and one external response exercise or training for both radiological and chemical terrorist events; prepare comprehensive annexes to the CDC Emergency Response Plan for radiological and chemical terrorist attacks.	2005	2	2 (Met)
	2004	2	2 (Met)
3. 100% of state public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.	2007	100%	12/2007
	2006	100%	12/2006
	2005	25%	94% of state public health agencies have developed plans for at least one priority agent (Met)
Data Source: <u>Measure 1</u> - Self-reported data as part of required progress reports from the schools and universities that make up the Centers for Public Health Preparedness (CPHP); <u>Measure 2</u> - National Center for Environmental Health Division of Laboratory Science and Office of Terrorism Preparedness and Emergency Response, CDC's Division of State and Local Readiness. <u>Measure 3</u> - Self-reported data as part of required progress reports.			
Data Validation: <u>Measure 1</u> - On a bi-annual basis, CDC reviews self reported progress data from each of the CPHPs. CDC conducts a thorough review of each progress report and validates if the CPHP has achieved or is on target for achieving the objectives agreed to in their application. From this review, CDC attempts to determine the impact that is or will be made on the public health preparedness workforce from the training and education products produced by the CPHPs. <u>Measure 2</u> - This measure only captures the number of internal and external response exercises or trainings for both radiological and chemical terrorism events, not the health impact that will be realized by conducting these exercises or trainings. These exercises are coordinated by CDC's National Center for Environmental Health and they are responsible for validating all data collected during these exercises. <u>Measure 3</u> - See Efficiency Measure Data Validation.			
Cross Reference: <u>Measure 1</u> - HHS-2, 4, 5, 5 -5, 500-4; <u>Measure 2</u> - HHS-2, 500-4; <u>Measure 3</u> - HHS-2, PART, PAR, 500-4			

Goal 9, Performance Measure 1:

The Centers for Public Health Preparedness (CPHPs) began evaluating the impact on the preparedness of frontline public health practitioners resulting from education and training programs implemented. The CPHP network expanded to 41 Centers established in schools and colleges of medicine, nursing, veterinary medicine, pharmacy, biological sciences, public health, and university-based medical and health science centers. CPHPs are now providing preparedness education and other requested services to health agencies in 48 states (96 percent).

In FY 2004 and FY 2005, CDC continued efforts of Phase II of Project Public Health Ready: developing certification criteria for local public health readiness, requiring development of community response plans, providing competency-based education to health and public health workers, and evaluating response through exercises. Additionally, in 2004 and 2005, 88 percent of the 50 Distance Learning Coordinators had initiated competency based training, while the 88 percent also fully received this training in 2005. This measure will be retired after data have been reported for FY 2005.

Goal 9, Performance Measure 2:

The exercises and training components of this measure were achieved in FY 2005. CDC conducted both an internal and external exercise involving chemical terrorism. Both drills exercised CDC assets essential to CDC's response focusing on laboratory sample collection and analysis, epidemiological investigation and reporting, DEOC activation,

and communication activities. CDC also conducted radiological incident trainings for both internal and external partners. This training strengthens the capacity of the public health workforce to respond to such an incident. Additionally, the chemical and radiological annexes to the CDC Emergency Operations System Plan were developed and completed in FY 2003. This measure will be retired after data have been reported for FY 2005.

Goal 9, Performance Measure 3:

In order for state and local public health agencies to test their capabilities for responding to bioterrorism, chemical exposures, and other public health emergencies, CDC recommends that response plans be tested regularly by staff participation in exercises and simulation drills. Lessons learned from both responses to real events and annual exercises can help identify gaps in preparedness planning and should result in improved public health responses.

The FY 2005 target that 25 percent (15 states/territories/grantees) conduct an exercise to evaluate their plans and response systems was exceeded with 94 percent (47/50) of State public health agencies exercising the plan for at least one of these priority agents. In future years, grantees will need to implement corrective actions within 90 days of identifying a deficiency through a drill, exercise, or real event. The FY 2007 target expects that 100 percent of grantees will meet requirements in these areas.

CHANGES AND IMPROVEMENTS OVER PREVIOUS YEAR

From FY 2002 to 2007, CDC reduced the total number of measures included its Performance Plan by 24 percent. In addition, the proportion of outcome measures to the total number of measures increased from 32 percent in FY 2003 to 44 percent in FY 2007.

In addition to these long-term improvements, the FY 2007 Congressional Justification performance budget submission includes several specific changes from the FY 2006 Congressional Justification. These include a new framework to execute the agency's overarching preparedness goals and the addition of several efficiency measures. As a result of the Office of Management and Budget's (OMB) FY 2007 Program Assessment Rating Tool (PART) process, CDC added 27 performance measures to the FY 2007 Annual Plan, many of which were enhancements upon previous GPRA measures. More changes and improvements related to Goals Management are expected in future performance budget submissions.

PREPAREDNESS FRAMEWORK

In FY 2004, CDC developed a new framework to execute the agency's overarching preparedness goals. Following the establishment of this framework, CDC aligned its existing Terrorism performance measures to the appropriate preparedness goals within the new framework. For those goals for which current performance measures do not exist, CDC is leading an effort in coordination with OMB and HHS to develop new outcome-oriented measures. The performance information found in the Detail of Performance Analysis section reflects CDC's new framework for its preparedness goals. Performance measures that do not demonstrate a public health outcome or impact and/or are no longer applicable to the Terrorism program will be retired after data are reported for FY 2005.

EFFICIENCY MEASURES

Consistent with the PMA Standards for Success for Budget and Performance Integration, CDC "has at least one efficiency measure for all PARTed programs." To meet this requirement, CDC added a new efficiency measure for each of the following programs: Breast and Cervical Cancer, Diabetes, Occupational Safety and Health, and STD/TB. In addition, CDC added a new efficiency measure to replace the existing measure for Domestic HIV/AIDS Prevention. CDC had five programs reviewed through PART for the FY 2007 cycle, resulting in six new efficiency measures added to CDC's performance plan. CDC's FY 2007 PART programs include Health Statistics, Environmental Health, Global Immunization, the Strategic National Stockpile, and the Global AIDS Program (in conjunction with the President's Emergency Plan for AIDS Relief program – Focus Countries and Other Bilateral Countries, each with its own efficiency measure).

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SUPPLEMENTAL MATERIAL

STATE AND FORMULA GRANT PROGRAMS

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION <u>FY 2007 DISCRETIONARY STATE/FORMULA GRANTS</u>				
CFDA NUMBER/PROGRAM NAME: PREVENTIVE HEALTH & HEALTH SERVICES BLOCK GRANT				
STATE/TERRITORY	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	Difference +/- 2006
Alabama	\$1,939,544	\$1,610,058	\$0	(\$1,610,058)
Alaska	\$421,611	\$348,579	\$0	(\$348,579)
Arizona	\$1,453,514	\$1,214,052	\$0	(\$1,214,052)
Arkansas	\$1,090,867	\$906,267	\$0	(\$906,267)
California	\$8,377,629	\$7,015,274	\$0	(\$7,015,274)
Colorado	\$1,509,943	\$1,256,918	\$0	(\$1,256,918)
Connecticut	\$1,770,489	\$1,467,009	\$0	(\$1,467,009)
Delaware	\$943,752	\$189,674	\$0	(\$189,674)
District of Columbia	\$227,177	\$776,826	\$0	(\$776,826)
Florida	\$3,651,638	\$3,062,869	\$0	(\$3,062,869)
Georgia	\$3,760,207	\$3,119,625	\$0	(\$3,119,625)
Hawaii	\$953,115	\$787,162	\$0	(\$787,162)
Idaho	\$452,284	\$376,516	\$0	(\$376,516)
Illinois	\$2,881,953	\$2,416,478	\$0	(\$2,416,478)
Indiana	\$2,051,841	\$1,708,985	\$0	(\$1,708,985)
Iowa	\$1,342,075	\$1,113,460	\$0	(\$1,113,460)
Kansas	\$1,111,645	\$923,380	\$0	(\$923,380)
Kentucky	\$1,637,511	\$1,360,525	\$0	(\$1,360,525)
Louisiana	\$3,548,358	\$2,930,359	\$0	(\$2,930,359)
Maine	\$1,090,600	\$900,247	\$0	(\$900,247)
Maryland	\$2,299,500	\$1,908,965	\$0	(\$1,908,965)
Massachusetts	\$3,315,336	\$2,746,938	\$0	(\$2,746,938)
Michigan	\$4,824,062	\$3,999,903	\$0	(\$3,999,903)
Minnesota	\$3,085,873	\$2,552,708	\$0	(\$2,552,708)
Mississippi	\$1,775,906	\$1,469,128	\$0	(\$1,469,128)
Missouri	\$3,041,214	\$2,518,862	\$0	(\$2,518,862)
Montana	\$807,517	\$666,399	\$0	(\$666,399)
Nebraska	\$1,995,155	\$1,644,344	\$0	(\$1,644,344)
Nevada	\$475,101	\$398,162	\$0	(\$398,162)
New Hampshire	\$1,742,043	\$1,434,666	\$0	(\$1,434,666)
New Jersey	\$3,528,870	\$2,930,732	\$0	(\$2,930,732)
New Mexico	\$1,712,200	\$1,412,595	\$0	(\$1,412,595)
New York	\$8,409,860	\$6,979,938	\$0	(\$6,979,938)
North Carolina	\$3,343,956	\$2,777,476	\$0	(\$2,777,476)
North Dakota	\$311,777	\$258,511	\$0	(\$258,511)

FY 2007 BUDGET SUBMISSION				
CENTERS FOR DISEASE CONTROL AND PREVENTION				
FY 2007 DISCRETIONARY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: PREVENTIVE HEALTH & HEALTH SERVICES BLOCK GRANT				
STATE/TERRITORY	FY 2005 Actual	FY 2006 Appropriation	FY 2007 Estimate	Difference +/- 2006
Ohio	\$5,530,333	\$4,585,345	\$0	(\$4,585,345)
Oklahoma	\$1,146,146	\$954,853	\$0	(\$954,853)
Oregon	\$880,899	\$737,067	\$0	(\$737,067)
Pennsylvania	\$5,825,919	\$4,831,756	\$0	(\$4,831,756)
Rhode Island	\$579,671	\$480,033	\$0	(\$480,033)
South Carolina	\$1,500,022	\$1,247,577	\$0	(\$1,247,577)
South Dakota	\$284,128	\$236,289	\$0	(\$236,289)
Tennessee	\$1,983,325	\$1,651,137	\$0	(\$1,651,137)
Texas	\$4,962,387	\$4,158,683	\$0	(\$4,158,683)
Utah	\$1,172,698	\$971,592	\$0	(\$971,592)
Vermont	\$333,283	\$276,021	\$0	(\$276,021)
Virginia	\$2,486,452	\$2,069,772	\$0	(\$2,069,772)
Washington	\$1,232,057	\$1,035,488	\$0	(\$1,035,488)
West Virginia	\$1,095,303	\$906,319	\$0	(\$906,319)
Wisconsin	\$2,389,067	\$1,982,743	\$0	(\$1,982,743)
Wyoming	\$277,275	\$229,583	\$0	(\$229,583)
Subtotal	\$112,563,086	\$93,537,851	\$0	-\$93,537,851
Indian Tribes	\$72,464	\$59,464	\$0	(\$59,464)
Migrant Program	\$0	\$0	\$0	\$0
American Samoa	\$64,860	\$53,497	\$0	(\$53,497)
Guam	\$268,378	\$220,876	\$0	(\$220,876)
Marshall Islands	\$32,121	\$26,642	\$0	(\$26,642)
Micronesia	\$78,511	\$64,941	\$0	(\$64,941)
Northern Mariana Islands	\$49,318	\$40,769	\$0	(\$40,769)
Palau	\$25,794	\$21,245	\$0	(\$21,245)
Puerto Rico	\$1,911,983	\$1,584,793	\$0	(\$1,584,793)
Virgin Islands	\$212,236	\$174,665	\$0	(\$174,665)
Subtotal	\$2,715,666	\$2,246,890	\$0	-\$2,246,890
Total States/Territories	\$115,278,752	\$95,784,741	\$0	-\$95,784,741
Technical Assistance	\$3,247,736	\$3,215,259	\$0	(\$3,215,259)
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments (specify)	-	-	-	-
Subtotal Adjustments	\$3,247,736	\$3,215,259	\$0	-\$3,215,259
TOTAL	\$118,526,488	\$99,000,000	\$0	-\$99,000,000

VACCINES FOR CHILDREN STATE-BY-STATE TABLE

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION <u>FY 2007 MANDATORY STATE/FORMULA GRANTS</u> VACCINES FOR CHILDREN PROGRAM - PROPOSED LAW				
STATE/TERRITORY	FY 2005 Actuals Current Law	FY 2006 Estimate Current Law	FY 2007 Estimate Proposed Law	FY 2007 +/- 2006
Alabama	\$15,891,358	\$22,756,325	\$25,275,551	\$2,519,226
Alaska	\$4,958,014	\$7,099,845	\$7,885,829	\$785,984
Arizona	\$27,254,667	\$39,028,513	\$43,349,142	\$4,320,629
Arkansas	\$11,671,072	\$16,712,902	\$18,563,095	\$1,850,193
California	\$123,844,124	\$177,344,011	\$196,976,780	\$19,632,769
Colorado	\$14,919,182	\$21,364,175	\$23,729,284	\$2,365,109
Connecticut	\$12,256,123	\$17,550,691	\$19,493,631	\$1,942,940
Delaware	\$3,597,771	\$5,151,986	\$5,722,333	\$570,347
District of Columbia	\$3,900,837	\$5,585,974	\$6,204,366	\$618,392
Florida	\$57,091,832	\$81,755,146	\$90,805,804	\$9,050,658
Georgia	\$38,119,138	\$54,586,367	\$60,629,320	\$6,042,953
Hawaii	\$5,159,320	\$7,388,114	\$8,206,011	\$817,897
Idaho	\$8,146,156	\$11,665,244	\$12,956,639	\$1,291,395
Illinois	\$28,338,300	\$40,580,268	\$45,072,684	\$4,492,416
Indiana	\$23,451,983	\$33,583,093	\$37,300,890	\$3,717,797
Iowa	\$7,267,255	\$10,406,664	\$11,558,728	\$1,152,064
Kansas	\$9,282,294	\$13,292,187	\$14,763,691	\$1,471,504
Kentucky	\$12,597,006	\$18,038,834	\$20,035,813	\$1,996,979
Louisiana	\$21,419,162	\$30,672,106	\$34,067,644	\$3,395,538
Maine	\$5,057,655	\$7,242,530	\$8,044,311	\$801,781
Maryland	\$20,319,772	\$29,097,786	\$32,319,041	\$3,221,255
Massachusetts	\$17,912,361	\$25,650,389	\$28,490,001	\$2,839,612
Michigan	\$33,077,261	\$47,366,431	\$52,610,105	\$5,243,674
Minnesota	\$11,119,814	\$15,923,504	\$17,686,307	\$1,762,803
Mississippi	\$16,294,713	\$23,333,927	\$25,917,096	\$2,583,169
Missouri	\$17,341,610	\$24,833,077	\$27,582,209	\$2,749,132
Montana	\$3,489,056	\$4,996,306	\$5,549,420	\$553,114
Nebraska	\$4,540,308	\$6,501,693	\$7,221,459	\$719,766
Nevada	\$12,488,711	\$17,883,756	\$19,863,567	\$1,979,811
New Hampshire	\$4,364,690	\$6,250,209	\$6,942,135	\$691,926
New Jersey	\$28,836,643	\$41,293,892	\$45,865,310	\$4,571,418
New Mexico	\$13,506,257	\$19,340,876	\$21,481,996	\$2,141,120
New York	\$30,061,967	\$43,048,549	\$47,814,214	\$4,765,665
North Carolina	\$30,411,041	\$43,548,420	\$48,369,424	\$4,821,004
North Dakota	\$2,219,924	\$3,178,917	\$3,530,838	\$351,921

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2007 MANDATORY STATE/FORMULA GRANTS VACCINES FOR CHILDREN PROGRAM - PROPOSED LAW				
STATE/TERRITORY	FY 2005 Actuals	FY 2006 Estimate	FY 2007 Estimate	FY 2007 +/- 2006
Ohio	\$29,811,946	\$42,690,520	\$47,416,550	\$4,726,030
Oklahoma	\$20,894,614	\$29,920,957	\$33,233,339	\$3,312,382
Oregon	\$11,696,824	\$16,749,779	\$18,604,054	\$1,854,275
Pennsylvania	\$19,139,348	\$27,407,427	\$30,441,550	\$3,034,123
Rhode Island	\$4,467,116	\$6,396,882	\$7,105,045	\$708,163
South Carolina	\$18,239,070	\$26,118,234	\$29,009,639	\$2,891,405
South Dakota	\$3,186,669	\$4,563,290	\$5,068,467	\$505,177
Tennessee	\$22,882,207	\$32,767,177	\$36,394,649	\$3,627,472
Texas	\$119,631,273	\$171,311,235	\$190,276,149	\$18,964,914
Utah	\$13,345,434	\$19,110,578	\$21,226,204	\$2,115,626
Vermont	\$3,212,452	\$4,600,211	\$5,109,475	\$509,264
Virginia	\$20,276,848	\$29,036,319	\$32,250,769	\$3,214,450
Washington	\$24,981,369	\$35,773,164	\$39,733,412	\$3,960,248
West Virginia	\$5,410,994	\$7,748,510	\$8,606,304	\$857,794
Wisconsin	\$12,373,480	\$17,718,746	\$19,680,290	\$1,961,544
Wyoming	\$2,882,556	\$4,127,802	\$4,584,768	\$456,966
Indian Tribes	-	-		
Migrant Program	-	-		
Chicago	\$21,592,460	\$30,920,268	\$34,343,279	\$3,423,011
Houston	\$841,091	\$1,204,437	\$1,337,774	\$133,337
New York City	\$44,865,602	\$64,247,261	\$71,359,718	\$7,112,457
Philadelphia	\$11,137,188	\$15,948,384	\$17,713,940	\$1,765,556
San Antonio	\$10,859,704	\$15,551,028	\$17,272,596	\$1,721,568
American Samoa	\$382,942	\$548,371	\$609,078	\$60,707
Guam	\$1,064,893	\$1,524,920	\$1,693,736	\$168,816
Marshall Islands	\$0	\$0	\$0	\$0
Micronesia	\$0	\$0	\$0	\$0
Northern Mariana Islands	\$698,390	\$1,000,090	\$1,110,805	\$110,715
Palau	\$0	\$0	\$0	\$0
Puerto Rico	\$18,711,559	\$26,794,835	\$29,761,143	\$2,966,308
Virgin Islands	\$1,059,966	\$1,517,866	\$1,685,899	\$168,033
Total States/Cities/Territories	\$1,123,853,372	\$1,609,350,998	\$1,787,513,300	\$178,162,302
Technical Assistance	-			-
State Penalties	-	-		-
Contingency Fund	-	-		-
Other Adjustments ¹	\$379,273,628	\$348,612,002	\$358,931,700	\$10,319,698
Subtotal Adjustments	\$379,273,628	\$348,612,002	\$358,931,700	\$10,319,698
TOTAL RESOURCES	\$1,503,127,000²	\$1,957,963,000³	\$2,146,445,000	\$188,482,000

¹ Adjustments include costs associated with vaccine stockpile purchases, storage and rotation, special projects and program support services.

² Funding for FY 2005 reflects a one-time shift in funding as the VFC grant period moves from a calendar year to a fiscal year basis. Also, funding for VFC in FY 2005 reflects obligations. FY 2006 funding includes carryover of \$60 million from FY 2005.

³ FY 2006 funding includes carryover of \$60 million from FY 2005.

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)			
	FY 2005 Actual	FY 2006 Estimate	FY 2007 Estimate
Ceiling FTE			
Infectious Diseases	2,259	2,266	2,266
Health Promotion ¹	791	793	820
Health Information and Service	599	600	600
Environmental Health and Injury Prevention	399	400	400
Occupational Safety and Health	1,221	1,225	1,225
Global Health	87	87	87
Public Health Research	7	7	7
Public Health Improvement and Leadership	964	967	967
Preventive Health & Health Services Block Grant (PHHSBG) ¹	27	27	0
Business Services Support	1,083	1,086	1,086
Terrorism	529	529	529
Agency for Toxic Substances and Disease Registry	365	429	429
TOTAL, CEILING FTE	8,331	8,416	8,416
Statutory Exempt FTE			
Infectious Diseases	53	53	53
Health Promotion	2	2	2
Environmental Health and Injury Prevention	1	1	1
Global Health	20	20	20
Terrorism ²	250	500	549
Total, Statutory Exempt FTE	326	576	625
TOTAL CDC/ATSDR FTE	8,657	8,992	9,041

¹ PHHSBG is eliminated in the FY 2007 President's Budget. As a result, FTE levels for Health Promotion include those from PHHSBG in FY 2007.

² FTE levels for Terrorism include proposed increases for assigning additional FTEs to the state and local health departments in support of Homeland Security related activities. This increase will provide better technical assistance, better coordinated exercises and training across state boundaries, will create regional partnerships, will improve response capabilities, and help states achieve the new preparedness goals.

DETAIL OF POSITIONS

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION PROGRAM ADMINISTRATION DETAIL OF POSITIONS			
	2005 Actual	2006 Estimate	2007 Estimate
Executive Level			
Executive level I	-	-	-
Executive level II	-	-	-
Executive level III	-	-	-
Executive level IV	-	-	-
Executive level V	-	-	-
<i>Subtotal</i>	-	-	-
Total-Executive Level Salary	-	-	-
<i>Total - SES</i>	29	29	29
Total - SES Salary	\$4,265,446	\$4,436,064	\$4,613,506
GS-15	417	417	417
GS-14	1,222	1,222	1,222
GS-13	2,039	2,039	2,039
GS-12	1,129	1,129	1,129
GS-11	727	727	727
GS-10	38	38	38
GS-9	507	507	507
GS-8	84	84	84
GS-7	403	403	403
GS-6	97	97	97
GS-5	83	83	83
GS-4	35	35	35
GS-3	26	26	26
GS-2	2	2	2
GS-1	0	0	0
<i>Subtotal</i>	6,809	6,809	6,809
Total - GS Salary	\$523,739,428	\$535,785,435	\$547,572,715
Average GS grade	11.9	11.9	11.9
Average GS salary	76,919	78,688	80,419
Average Special Pay Categories			
Average Comm. Corps Salary ¹	92,557	95,427	97,526
Average Wage Grade Salary	48,339	49,451	50,539

¹ Includes special pays and allowances.

NEW POSITIONS REQUESTED

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION NEW POSITIONS REQUESTED			
	FY 2006 Estimate	FY 2007 Estimate	FY 2007 +/- FY 2006
Exempt (Terrorism)	500	549	49
Non-Exempt (Terrorism)	529	529	0
Total	1,029	1,078	49

PERFORMANCE BUDGET CROSSWALK

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION PERFORMANCE BUDGET CROSSWALK (DOLLARS IN THOUSANDS)				
Performance Program Area (PPA)	Budget Activity	FY 2005 Actual	FY 2006 Appropriation ⁵	FY 2007 Estimate
Infectious Diseases ²	Infectious Diseases ²	\$1,679,332	\$1,693,217	\$1,685,684
Health Promotion ¹	Health Promotion ¹	\$1,024,204	\$963,426	\$929,208
Health Information and Service	Health Information and Service	\$228,674	\$222,903	\$261,674
Environmental Health and Injury Prevention ¹	Environmental Health and Injury Prevention ¹	\$289,432	\$289,021	\$279,309
Occupational Safety and Health ³	Occupational Safety and Health ³	\$251,241	\$255,272	\$250,194
Global Health ^{1,4}	Global Health ^{1,4}	\$317,153	\$381,251	\$381,103
Public Health Research	Public Health Research	\$31,000	\$31,000	\$31,000
Public Health Improvement and Leadership (PHIL) ¹	Public Health Improvement and Leadership (PHIL) ¹	\$247,389	\$264,823	\$190,165
Prev. Health & Health Services Block Grant (PHHSBG)	Prev. Health & Health Services Block Grant (PHHSBG)	\$118,526	\$99,000	\$0
Buildings and Facilities	Buildings and Facilities	\$269,708	\$158,400	\$29,700
Business Services Support ^{1,3}	Business Services Support ^{1,3}	\$319,152	\$298,616	\$303,854
Terrorism	Terrorism	\$1,622,757	\$1,632,257	\$1,657,161
Agency for Toxic Substance and Disease Registry ⁶	Agency for Toxic Substance and Disease Registry	\$76,041	\$74,905	\$75,004
FY 2006 Pandemic Influenza One-Time Funding (DoD) ⁵			\$77,000	
<i>OPDIV Total Request²</i>		\$6,474,609	\$6,441,091	\$6,074,056

¹FY 2005 funding levels reflect a technical reprogramming among several budget activities, shown comparably in FY 2006 and FY 2007.

²FY 2007 Reflects the Proposed Law transfer of \$100 million from the Section 317 Program to the Vaccines for Children program.

³The FY 2007 Estimate carries forward FY 2006 Conference language to move management and administrative costs (\$34.8 million) from Occupational Safety and Health to Business Services Support. Funding for FY 2005 is shown on a comparable basis.

⁴Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$439.0 million in FY 2005), as part of the President's Emergency Plan for AIDS Relief.

⁵The FY 2006 Appropriation includes a 1.0% across-the-board rescission for all relevant programs, projects, and activities. FY 2006 funding also reflects \$77 million in one-time costs related to pandemic influenza planning that are not carried forward into FY 2007.

⁶ FY 2006 funding for ATSDR includes a rescission of 0.476% for Interior, Environment, and Related Agencies.

SUMMARY OF FULL COST

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLARS IN MILLIONS)			
Performance Program Area	FY 2005	FY 2006	FY 2007
INFECTIOUS DISEASES	\$1,886.4	\$1,847.3	\$1,816.4
Infectious Diseases Control	\$293.8	\$282.0	\$292.9
Goal 1	\$23.3	\$22.4	\$23.3
<i>Measure 1</i>	\$10.9	N/A	N/A
<i>Measure 2</i>	\$0.8	\$0.8	\$0.8
Goal 2	\$3.5	\$3.4	\$3.5
<i>Measure 1</i>	\$0.7	N/A	N/A
<i>Measure 2</i>	\$2.2	\$2.1	\$2.2
Goal 3	\$37.5	\$36.1	\$37.5
<i>Measure 1</i>	\$2.1	N/A	N/A
<i>Measure 2</i>	\$6.5	N/A	N/A
<i>Measure 3</i>	\$17.8	\$17.2	\$17.9
Goal 4	\$3.0	\$2.9	\$3.0
Goal 5	\$23.2	\$22.2	\$23.1
<i>Measure 1</i>	\$1.2	N/A	N/A
<i>Measure 2</i>	\$0.6	N/A	N/A
<i>Measure 3</i>	\$3.0	\$2.9	\$3.0
Goal 6	\$3.8	\$3.6	\$3.8
<i>Measure 1</i>	\$2.9	N/A	N/A
<i>Measure 2</i>	\$0.7	\$0.6	\$0.7
Goal 7	\$4.4	\$4.3	\$4.4
<i>Measure 1</i>	\$4.4	\$4.3	\$4.4
Goal 8	\$6.8	\$6.5	\$6.7
<i>Measure 1</i>	\$6.8	\$6.5	\$6.7
HIV/AIDS, STD and TB Prevention	\$989.5	\$978.2	\$1,056.6
<i>HIV/AIDS, Research and Domestic</i>	\$682.1	\$672.8	\$756.5
Goal 1	\$670.5	\$661.4	\$743.7
<i>Measure 1</i>	\$662.3	\$653.3	\$734.6
<i>Measure 2</i>	\$8.2	\$8.1	\$9.1
Goal 2	\$296.7	\$292.7	\$329.1
<i>Measure 1</i>	\$216.4	\$213.4	\$240.0
Goal 3	\$165.6	\$163.4	\$183.7
<i>Measure 1</i>	\$154.6	\$152.5	\$171.5
<i>Measure 2</i>	\$11.0	\$10.8	\$12.2
Goal 4	\$42.1	\$41.5	\$46.7
<i>Measure 1</i>	\$3.3	\$3.3	\$3.7
Goal 5	\$160.6	\$158.4	\$178.1
<i>Measure 1</i>	\$45.8	\$45.2	\$50.8
<i>Sexually Transmitted Diseases</i>	\$164.4	\$163.3	\$160.5
Goal 6	\$95.4	N/A	N/A
<i>Measure 1</i>	\$16.1	N/A	N/A
<i>Measure 2</i>	\$31.6	N/A	N/A
Goal 7	\$57.5	N/A	N/A
<i>Measure 1</i>	\$51.0	N/A	N/A
<i>Measure 2</i>	\$6.6	N/A	N/A
Goal 8	\$11.5	N/A	N/A
<i>Measure 1</i>	\$11.5	N/A	N/A
Goal 9	N/A	\$91.5	\$89.9
<i>Measure 1</i>	N/A	\$29.4	\$28.9
<i>Measure 2</i>	N/A	\$32.7	\$32.1
<i>Measure 3</i>	N/A	\$31.0	\$30.5
Goal 10	N/A	\$62.1	\$61.0
<i>Measure 1a</i>	N/A	\$24.5	\$24.1
<i>Measure 1b</i>	N/A	\$19.6	\$19.3
<i>Measure 2</i>	N/A	\$11.4	\$11.2
<i>Measure 3</i>	N/A	\$6.5	\$6.4

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLARS IN MILLIONS)			
Performance Program Area	FY 2005	FY 2006	FY 2007
INFECTIOUS DISEASES	\$1,886.4	\$1,847.3	\$1,816.4
<i>Tuberculosis</i>	\$143.0	\$142.0	\$139.6
Goal 11	\$143.0	\$142.0	\$139.6
<i>Measure 1</i>	\$143.0	\$142.0	\$139.6
<i>Measure 2</i>	\$99.4	\$98.7	\$97.0
<i>Measure 3</i>	\$12.9	\$12.8	\$12.6
<i>Measure 4</i>	\$27.9	\$27.7	\$27.2
Immunization	\$603.0	\$587.1	\$467.0
Goal 1	\$200.5	\$195.2	\$224.1
<i>Measure 1</i>	\$140.2	\$136.5	\$193.8
<i>Measure 2</i>	\$18.1	\$17.6	\$8.9
<i>Measure 3</i>	\$42.2	\$41.1	\$21.5
Goal 2	\$20,051.3	\$195.2	\$224.1
<i>Measure 1</i>	\$200.5	\$195.2	\$224.1
Goal 3	\$24.1	\$23.5	\$18.7
<i>Measure 1</i>	\$12.1	\$11.7	\$9.3
<i>Measure 2</i>	\$12.1	\$11.7	\$9.3
Goal 4	\$30.2	\$29.4	\$23.3
<i>Measure 1</i>	\$30.2	\$29.4	\$23.3
HEALTH PROMOTION	\$1,095.2	\$1,029.7	\$981.4
Chronic Disease Prevention, Health Promotion, and Genomics	\$953.5	\$884.4	\$858.1
Goal 1	\$47.7	\$44.2	\$42.9
<i>Measure 1</i>	\$28.6	\$26.5	\$25.7
<i>Measure 2</i>	\$19.1	\$17.7	\$17.2
Goal 2	\$47.7	\$44.2	\$42.9
<i>Measure 1</i>	\$47.7	\$44.2	\$42.9
Goal 3	\$162.1	\$159.2	\$154.5
<i>Measure 1</i>	\$85.8	\$79.6	\$77.2
<i>Measure 2</i>	\$19.1	\$17.7	\$17.2
<i>Measure 3</i>	\$19.1	\$17.7	\$17.2
<i>Measure 4</i>	\$19.1	\$17.7	\$17.2
<i>Measure 5</i>	\$19.1	\$17.7	\$17.2
Goal 4	\$85.8	\$79.6	\$77.2
<i>Measure 1</i>	\$28.6	\$35.4	\$34.3
<i>Measure 2</i>	\$19.1	\$17.7	\$17.2
<i>Measure 3</i>	\$19.1	\$17.7	\$17.2
Goal 5	\$114.4	\$106.1	\$103.0
<i>Measure 1</i>	\$114.4	\$106.1	\$103.0
Goal 6	\$143.0	\$79.6	\$77.2
<i>Measure 1</i>	\$57.2	\$53.1	\$51.5
Goal 7	\$47.7	\$44.2	\$42.9
<i>Measure 1</i>	\$47.7	\$44.2	\$42.9
<i>Measure 2</i>	\$47.7	\$44.2	\$42.9
Goal 8	\$38.1	\$35.4	\$34.3
<i>Measure 1</i>	\$19.1	\$17.7	\$17.2
<i>Measure 2</i>	\$19.1	\$17.7	\$17.2
Birth Defects, Developmental Disabilities, Disability and Health	\$141.8	\$145.3	\$123.2
Goal 1	\$62.4	\$63.9	\$54.2
<i>Measure 1</i>	\$12.8	\$13.1	\$11.1
<i>Measure 2</i>	\$8.5	\$8.7	\$7.4
<i>Measure 3</i>	\$19.8	\$20.3	\$17.3
Goal 2	\$79.4	\$81.4	\$69.0
<i>Measure 1</i>	\$8.4	\$8.6	\$7.3
<i>Measure 2</i>	\$32.0	\$32.8	\$27.9
HEALTH INFORMATION AND SERVICE	\$293.1	\$294.0	\$309.3
Health Statistics	\$152.4	\$146.0	\$138.3
Goal 1	\$152.4	\$146.0	\$138.3
<i>Measure 1</i>	\$129.5	\$124.1	\$117.6
Health Marketing	\$57.6	\$63.6	\$55.9
Goal 2	\$11.5	\$12.7	\$160.1
<i>Measure 1</i>	\$2.3	\$2.5	\$7.3

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLARS IN MILLIONS)			
Performance Program Area	FY 2005	FY 2006	FY 2007
ENVIRONMENTAL HEALTH AND INJURY PREVENTION	\$337.7	\$337.5	\$312.1
Environmental Health	\$183.3	\$176.7	\$160.1
Goal 1	\$33.0	\$31.8	\$28.8
<i>Measure 1</i>	\$11.0	\$10.6	\$9.6
<i>Measure 2</i>	\$7.3	\$7.1	\$6.4
<i>Measure 3</i>	\$14.7	\$14.1	\$12.8
Goal 2	\$83.1	\$80.1	\$72.5
<i>Measure 1</i>	\$33.0	\$31.8	\$28.8
<i>Measure 2</i>	\$44.0	\$42.4	\$38.4
<i>Measure 3</i>	\$3.7	\$3.5	\$3.2
<i>Measure 4</i>	\$2.4	\$2.3	\$2.1
Goal 3	\$16.5	\$15.9	\$14.4
<i>Measure 1</i>	\$16.5	\$15.9	\$14.4
Injury Prevention and Control	\$154.4	\$160.7	\$152.0
Goal 1	\$88.0	\$91.6	\$86.6
<i>Measure 1</i>	\$52.5	\$54.6	\$51.7
<i>Measure 2</i>	\$3.1	\$3.2	\$3.0
Goal 2	\$20.1	\$20.9	\$19.8
<i>Measure 1</i>	\$20.1	\$20.9	\$19.8
Goal 3	\$46.3	\$48.2	\$45.6
<i>Measure 1</i>	\$46.3	\$48.2	\$45.6
OCCUPATIONAL SAFETY AND HEALTH	\$394.9	\$318.3	\$306.4
Occupational Safety and Health	\$394.9	\$318.3	\$306.4
Goal 1	\$296.2	\$238.7	\$229.8
<i>Measure 1</i>	N/A	\$47.7	\$137.9
<i>Measure 2</i>	\$59.2	N/A	N/A
<i>Measure 3</i>	\$209.3	\$121.0	N/A
<i>Measure 4</i>	\$27.6	\$22.3	\$21.4
<i>Measure 5</i>	N/A	\$47.7	\$70.5
Goal 2	\$98.7	\$79.6	\$76.6
<i>Measure 1</i>	\$19.7	\$19.1	N/A
<i>Measure 2</i>	\$19.7	\$19.1	\$18.4
<i>Measure 3</i>	\$19.7	N/A	N/A
<i>Measure 4</i>	\$19.7	\$22.3	\$39.8
<i>Measure 5</i>	\$19.7	\$19.1	\$18.4
<i>Measure 6</i>	N/A	N/A	N/A
<i>Measure 7</i>	N/A	N/A	N/A
GLOBAL HEALTH	\$335.2	\$394.9	\$386.8
Global Health - GAP	\$130.9	\$128.3	\$126.0
Goal 1	\$130.9	\$128.3	N/A
<i>Measure 1</i>	\$130.9	\$128.3	N/A
Global Health - Immunization	\$146.1	\$146.4	\$145.7
Goal 2	\$24.8	\$24.9	\$24.8
<i>Measure 1</i>	\$13.2	\$13.2	\$13.1
<i>Measure 2</i>	\$11.7	\$11.7	\$11.7
Goal 3	\$11.0	\$11.0	\$10.9
<i>Measure 1</i>	\$9.5	\$9.5	\$9.5
<i>Measure 2</i>	\$1.5	\$1.5	\$1.5
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP	\$151.5	\$173.1	\$90.8
Workforce and Career Development	\$81.9	\$80.2	\$80.6
Goal 1	\$70.9	\$66.1	\$66.5
<i>Measure 1</i>	\$3.4	N/A	N/A
<i>Measure 2</i>	\$67.5	\$66.1	\$66.5
Goal 2	\$10.9	\$10.7	\$10.8
<i>Measure 1</i>	\$10.9	\$10.7	\$10.8
PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT	\$119.8	\$99.0	-

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLARS IN MILLIONS)			
Performance Program Area	FY 2005	FY 2006	FY 2007
TERRORISM	\$1,662.6	\$1,666.3	\$1,682.5
<i>PREVENT</i>	-	-	-
Goal 1	\$33.3	\$33.3	\$33.6
<i>Measure 1</i>	\$33.3	N/A	N/A
<i>Measure 2</i>	\$33.3	\$33.3	\$33.6
<i>DETECT</i>	-	-	-
Goal 2	\$332.5	\$249.9	\$235.5
<i>Measure 1</i>	\$33.3	\$83.3	\$100.9
<i>Measure 2</i>	\$49.9	\$50.0	N/A
<i>Measure 3</i>	\$49.9	\$33.3	\$33.6
<i>Measure 4</i>	\$66.5	\$83.3	\$100.9
<i>Measure 5</i>	\$133.0	N/A	N/A
Goal 3	\$249.4	\$200.0	\$252.4
<i>Measure 1</i>	\$33.3	N/A	N/A
<i>Measure 2</i>	\$83.1	\$33.3	\$50.5
<i>Measure 3</i>	\$33.3	\$50.0	\$84.1
<i>Measure 4</i>	\$99.8	\$116.6	\$117.8
<i>INVESTIGATE</i>	-	-	-
Goal 4	\$216.1	\$166.6	\$168.2
<i>Measure 1</i>	\$99.8	N/A	N/A
<i>Measure 2</i>	\$49.9	\$66.7	\$168.2
<i>Measure 3</i>	\$66.5	\$100.0	N/A
<i>CONTROL</i>	-	-	-
Goal 5	\$282.6	\$333.3	\$387.0
<i>Measure 1</i>	N/A	\$83.3	\$84.1
<i>Measure 2</i>	\$199.5	\$249.9	\$302.8
<i>Measure 3</i>	\$83.1	N/A	N/A
<i>IMPROVE</i>	-	-	-
Goal 6	\$14,015.8	\$83.3	\$84.1
<i>Measure 1</i>	\$23.8	N/A	N/A
<i>Measure 2</i>	\$33.3	N/A	N/A
<i>Measure 3</i>	\$83.1	\$83.3	\$84.1
TOTAL*	\$6,276.5	\$6,160.1	\$5,885.7

*Total funding for CDC does not include \$77 million in one-time funding for the FY 2006 Pandemic Influenza supplemental, funded through the Department of Defense.

CDC's Full Cost estimates for FY 2005 – FY 2007 were estimated by adding program management cost to the budget activities across CDC using the All Purpose Table. Program management costs included CDC's Leadership & Management and Business Services Support activities as well as Buildings & Facilities activities. Program management costs were allocated, where appropriate, across performance program areas based on the proportion of total program level cost represented by each program and performance program area. The full cost of each performance program area was then distributed by performance measures. These distributions are based on professional judgments, supported to the extent possible by financial and other statistical data. In many cases, performance measures are aggregated in the distributions of cost because of the interdependence of the activities and goals represented by the measures. The cost distributions by performance measures are presented for "active" measures in a given year. That is, measures that are to be deleted are included only for the applicable year(s) before their deletion; new measures are included beginning with the first year in which performance data are expected.

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2005)

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FINANCING BY PROGRAM AND ORGANIZATION – FY 2005 (DOLLARS IN THOUSANDS)													
	ATSDR	CCID ²	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD ²	OWCD	BSS	Total
Infectious Diseases		1,679,332											1,679,332
Health Promotion			1,024,204										1,024,204
Health Information and Service				228,674									228,674
Environmental Health and Injury					289,432								289,432
Occupational Safety and Health						251,241							251,241
Global Health							317,153						317,153
Public Health Research										31,000			31,000
Public Health Improvement & Leadership		5,773	37,329	546	9,399			7,403	163,746	3,273	19,920		247,389
Prev. Hlth./Hlth. Services Block Grant			118,526										118,526
Building & Facilities										269,708			269,708
Business Services Support												319,152	319,152
Terrorism								1,622,757					1,622,757
Total, CDC	0	1,685,105	1,180,059	229,220	298,831	251,241	317,153	1,630,160	163,746	303,981	19,920	319,152	6,398,568
Agency for Toxic Substances & Disease Registry	76,041												76,041
Vaccines For Children ³		1,503,127											1,503,127
Total, CDC/ATSDR¹	76,041	3,188,232	1,180,059	229,220	298,831	251,241	317,153	1,630,160	163,746	303,981	19,920	319,152	7,977,736

¹Total for CDC/ATSDR does not include User Fees (\$2,226).

²Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were recently reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director and are funded at \$22.8 million.

³Funding for Vaccines for Children in FY 2005 reflects obligations.

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2006)

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FINANCING BY PROGRAM AND ORGANIZATION – FY 2006 (DOLLARS IN THOUSANDS)													
	ATSDR	CCID ²	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD ²	OWCD	BSS	Total
Infectious Diseases		1,693,217											1,693,217
Health Promotion			963,426										963,426
Health Information and Service				222,903									222,903
Environmental Health and Injury					289,021								289,021
Occupational Safety and Health						255,272							255,272
Global Health							381,251						381,251
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									237,251	7,851	19,721		264,823
Prev. Hlth./Hlth. Services Block Grant			99,000										99,000
Building & Facilities										158,400			158,400
Business Services Support												298,616	298,616
Terrorism								1,632,257					1,632,257
Pandemic Influenza - FY 2006 One-Time Costs		50,000		27,000									77,000
Total, CDC	0	1,743,217	1,062,426	249,903	289,021	255,272	381,251	1,632,257	237,251	197,251	19,721	298,616	6,366,186
Agency for Toxic Substances & Disease Registry	74,905												74,905
Vaccines For Children ³		1,957,963											1,957,963
Total, CDC/ATSDR¹	74,905	3,701,180	1,062,426	249,903	289,021	255,272	381,251	1,632,257	237,251	197,251	19,721	298,616	8,399,054

¹Total for CDC/ATSDR does not include User Fees (\$2,226).

²Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director and are funded at \$22.8 million.

³FY 2006 funding includes carryover of \$60 million from FY 2005 for Vaccines for Children.

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2007)

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FINANCING BY PROGRAM AND ORGANIZATION – FY 2007 (DOLLARS IN THOUSANDS)													
	ATSDR	CCID ³	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD ³	OWCD	BSS	Total
Infectious Diseases ¹		1,685,684											1,685,684
Health Promotion			929,208										929,208
Health Information and Service				261,674									261,674
Environmental Health and Injury					279,309								279,309
Occupational Safety and Health						250,194							250,194
Global Health							381,103						381,103
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									162,550	7,867	19,748		190,165
Prev. Hlth./Hlth. Services Block Grant													0
Building & Facilities										29,700			29,700
Business Services Support												303,854	303,854
Terrorism								1,657,161					1,657,161
Total, CDC	0	1,685,684	929,208	261,674	279,309	250,194	381,103	1,657,161	162,550	68,567	19,748	303,854	5,999,052
Agency for Toxic Substances & Disease Registry	75,004												75,004
Vaccines For Children		2,146,445											2,146,445
Total, CDC/ATSDR²	75,004	3,832,129	929,208	261,674	279,309	250,194	381,103	1,657,161	162,550	68,567	19,748	303,854	8,220,501

¹The FY 2007 President's Budget reflects the Proposed Law transfer of \$100 million from the Section 317 Program to the Vaccines For Children program.

²Total for CDC/ATSDR does not include User Fees (\$2,226).

³Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and recently approved by Congress in FY 2005. These activities are now managed in the Office of the Director and are funded at \$22.5 million.

MECHANISM TABLE – BUDGET ACTIVITY

FY 2007 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION MECHANISM TABLE - BY BUDGET ACTIVITY⁴ (DOLLARS IN THOUSANDS)				
Budget Activity	FY 2005	FY 2006	FY 2007	FY 2007 +/- FY 2006
Infectious Diseases¹	\$1,679,332	\$1,693,217	\$1,685,684	(\$7,533)
Intramural Research and Program Assistance	\$304,393	\$306,021	\$301,333	(\$4,688)
Extramural Programs	\$1,340,947	\$1,352,034	\$1,346,330	(\$5,704)
PHS Evaluation Transfers	\$33,992	\$35,162	\$38,021	\$2,859
Health Promotion	\$1,024,204	\$963,426	\$929,208	(\$34,218)
Intramural Research and Program Assistance	\$136,834	\$128,401	\$120,137	(\$8,264)
Extramural Programs	\$866,272	\$814,866	\$787,272	(\$27,594)
PHS Evaluation Transfers	\$21,098	\$20,159	\$21,799	\$1,640
Health Information and Service	\$228,674	\$222,903	\$261,674	\$38,771
Intramural Research and Program Assistance	\$132,054	\$129,661	\$141,844	\$12,183
Extramural Programs	\$93,848	\$91,479	\$117,923	\$26,444
PHS Evaluation Transfers	\$2,772	\$1,763	\$1,907	\$144
Environmental Health and Injury Prevention	\$289,432	\$289,021	\$279,309	(\$9,712)
Intramural Research and Program Assistance	\$77,904	\$77,624	\$75,241	(\$2,383)
Extramural Programs	\$205,641	\$205,349	\$197,529	(\$7,820)
PHS Evaluation Transfers	\$5,887	\$6,048	\$6,539	\$491
Occupational Safety and Health	\$251,241	\$255,272	\$250,194	(\$5,078)
Intramural Research and Program Assistance	\$151,574	\$154,006	\$151,225	(\$2,781)
Extramural Programs	\$99,667	\$101,266	\$98,969	(\$2,297)
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
Global Health	\$317,153	\$381,251	\$381,103	(\$148)
Intramural Research and Program Assistance	\$75,200	\$91,122	\$89,463	(\$1,659)
Extramural Programs	\$235,898	\$283,574	\$284,552	\$978
PHS Evaluation Transfers	\$6,055	\$6,555	\$7,088	\$533
Public Health Research	\$31,000	\$31,000	\$31,000	\$0
Intramural Research and Program Assistance	\$0	\$0	\$0	\$0
Extramural Programs	\$31,000	\$31,000	\$31,000	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
Public Health Improvement & Leadership	\$247,389	\$264,823	\$190,165	(\$74,658)
Intramural Research and Program Assistance	\$142,457	\$152,522	\$109,519	(\$43,003)
Extramural Programs	\$104,522	\$111,888	\$80,200	(\$31,688)
PHS Evaluation Transfers	\$410	\$413	\$446	\$33
Prev. Health & Health Services Block Grant	\$118,526	\$99,000	\$0	(\$99,000)
Intramural Research and Program Assistance	\$1,600	\$1,336	\$0	(\$1,336)
Extramural Programs	\$116,926	\$97,664	\$0	(\$97,664)
PHS Evaluation Transfers	\$0	\$0	\$0	\$0

**FY 2007 BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
MECHANISM TABLE - BY BUDGET ACTIVITY⁴
(DOLLARS IN THOUSANDS)**

Budget Activity	FY 2005	FY 2006	FY 2007	FY 2007 +/- FY 2006
Building and Facilities	\$269,708	\$158,400	\$29,700	(\$128,700)
Intramural Research and Program Assistance	\$269,708	\$158,400	\$29,700	(\$128,700)
Extramural Programs	\$0	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
Business Services Support	\$319,152	\$298,616	\$303,854	\$5,238
Intramural Research and Program Assistance	\$319,152	\$298,616	\$303,854	\$5,238
Extramural Programs	\$0	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
Terrorism	\$1,622,757	\$1,632,257	\$1,657,161	\$24,904
Intramural Research and Program Assistance	\$300,372	\$299,631	\$285,167	(\$14,464)
Extramural Programs	\$1,322,385	\$1,330,126	\$1,369,494	\$39,368
PHS Evaluation Transfers ²	\$0	\$2,500	\$2,500	\$0
FY 2006 Pandemic Influenza One-Time Funding (DoD)	\$0	\$77,000	\$0	(\$77,000)
Intramural Research and Program Assistance	\$0	\$46,200	\$0	(\$46,200)
Extramural Programs	\$0	\$30,800	\$0	(\$30,800)
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
CDC Budget Authority Total ¹	\$6,398,568	\$6,366,186	\$5,999,052	(\$367,134)
Intramural Research and Program Assistance	\$1,911,248	\$1,843,540	\$1,607,483	(\$236,057)
Extramural Programs	\$4,417,106	\$4,450,046	\$4,313,269	(\$136,777)
PHS Evaluation Transfers	\$70,214	\$72,600	\$78,300	\$5,700
Agency for Toxic Substances and Disease Registry	\$76,041	\$74,905	\$75,004	\$99
Intramural Research and Program Assistance	\$63,213	\$62,269	\$62,307	\$38
Extramural Programs	\$12,828	\$12,636	\$12,697	\$61
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
Vaccines for Children ^{1,5}	\$1,503,127	\$1,957,963	\$2,146,445	\$188,482
Intramural Research and Program Assistance	\$54,864	\$71,466	\$71,466	\$0
Extramural Programs	\$1,448,263	\$1,886,497	\$2,074,979	\$188,482
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
PHS Evaluation Transfers (non-add)	\$265,100	\$265,100	\$265,100	\$0
Intramural Research and Program Assistance	\$148,456	\$148,456	\$148,456	\$0
Extramural Programs	\$116,644	\$116,644	\$116,644	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
CDC/ATSDR Program Level Total ^{1,3}	\$7,977,736	\$8,399,054	\$8,220,501	(\$178,553)
Intramural Research and Program Assistance	\$2,029,325	\$1,977,275	\$1,741,256	(\$236,019)
Extramural Programs	\$5,878,197	\$6,349,179	\$6,400,945	\$51,766
PHS Evaluation Transfers	\$70,214	\$72,600	\$78,300	\$5,700

¹ FY 2007 reflects the Proposed Law transfer of \$100 million from the Section 317 program to the Vaccines for Children program.

² Beginning in FY 2006, Terrorism became part of CDC's budget authority, thereby subjecting the budget activity to the PHS Evaluation Transfer in FY 2006 and FY 2007.

³ Funding levels do not include total amount for user fees (\$2,226).

⁴ The intramural/extramural split for CDC's budget activities is an estimate and will be updated for each fiscal year in the report to Congress, due in March 2006.

⁵ Funding for VFC in FY 2005 reflects obligations. FY 2006 funding includes carryover of \$60 million from FY 2005.

PRESIDENT'S MANAGEMENT AGENDA

OVERVIEW

Included in this section are CDC's key program management activities to address key aspects of the President's Management Agenda (PMA). The activities below briefly describe CDC's progress in these areas and outline some important initiatives designed to further improve the agency's program management.

CDC has been actively pursuing goals and improvements related to the PMA for several years. For example, CDC decreased its proportion of administrative positions by six percent from 1997 to 2001. CDC has historically focused on keeping the agency market-based and efficient by having approximately 6,000 service contractor staff engaged to conduct commercially-oriented responsibilities. In addition, CDC established its Fiscal Management Excellence Initiative in 2000, which has further enhanced improvements in fiscal performance. CDC is organized to effectively address and lead PMA issues. For example, CDC has established a Management Council to help concentrate management attention on the PMA.

PROGRESS ON PRESIDENT'S MANAGEMENT AGENDA

CDC made major achievements in addressing the President's Management Agenda (PMA) objectives. CDC has consolidated or restructured nearly 40 major human capital or business services improvements and more than doubled its supervisory ratio, thereby making the agency more efficient and effective. CDC has maintained its reasoned strategic planning approach in Competitive Sourcing for FY 2002 - FY 2005. Another major, successful effort is implementing HHS' Unified Financial Management System (UFMS) which integrates the Department's financial management structure and provides HHS leaders with a more timely and coordinated view of critical financial management information. Furthermore, CDC has made extraordinary progress in Expanded Electronic Government initiatives, such as consolidating IT infrastructure services, having a leadership role in the establishment of a multi-department architecture for the President's Biosurveillance Initiative, and being actively engaged in HHS' modernization efforts. CDC's efforts to integrate budget and performance have taken on increased significance as the agency continues work to implement a new strategy and organization under the Futures Initiative. Recently, the agency announced modernizations to enhance health impact, support the capacity to respond to public health emergencies, and to directly engage CDC's customers, the American public.

STRATEGIC MANAGEMENT OF HUMAN CAPITAL INITIATIVE

CDC's significant growth in its workforce over the past years is attributable to an ever-expanding public health mission. From FY 1996 to present, the number of employees has grown from 6,406 to 9,132 - an increase of nearly 43 percent. This trend clearly reflects the agency's expanded disease prevention and control responsibilities. CDC's workforce is comprised of individuals working in over 170 job series with an emphasis on scientific and medical occupations. Approximately two-thirds of CDC employees work in the Atlanta headquarters area. However, the agency has a major presence (defined here as more than 50 employees) in such diverse geographical areas as Cincinnati, OH; Morgantown, WV; Hyattsville, MD; Pittsburgh, PA; Washington, D.C.; Spokane, WA; Durham, NC; and Fort Collins, CO. CDC's overseas presence will be up to 250 employees this year.

WORKFORCE RESTRUCTURING

CDC continues to promote and enhance its Strategic Management of Human Capital initiatives in support of the PMA. These initiatives include reducing layering, eliminating administrative positions through consolidation, further improving our supervisory ratio, and supporting the transition of our workforce toward providing more frontline public health functions.

CDC had already consolidated most of its program support offices to eliminate duplication prior to the PMA. Centralized offices included equal employment opportunity, procurement, human resources, facilities operations, security and emergency preparedness, and others. This consolidation resulted in substantial savings and efficiencies. CDC has undertaken a wide range of additional administrative consolidations and business improvements.

Administrative Consolidations

- CDC more than doubled its supervisory ratio from 1:5.5 in 2002 to over 1:12.6 in January 2006. This documents the overall success in flattening organizations, reducing management layers, and consolidating and/or restructuring administrative functions.
- CDC consolidated 13 information technology (IT) infrastructure functions, services, staff and fiscal resources into the new Information Technology Services Office (ITSO). This consolidation reduced operating costs by 30 percent and staff by 29 percent.

- A complex and innovative approach to administrative/management consolidation was used to functionally merge the Office of the Director (OD) in both ATSDR and NCEH into one unit. FTE savings of 18 percent (35 FTEs) have already been realized.
- CDC is effectively completing its Business Services Consolidation Plan. This is an overarching strategy, approved by HHS in July 2003, to reduce administrative positions, centralize reporting and supervisory relationships, and establish agency-wide shared services.
- CDC consolidated the agency's medical and professional inquiry hotlines. CDC awarded a performance-based contract for consolidated public and professional health information services reducing over 40 hotlines to one. This will expand services (24x365, multilingual, hearing impaired) and save about \$35 million over seven years.
- CDC completed the evaluation and detailed planning for budget execution services consolidation in FY 2004. In October 2004, CDC consolidated budget execution services across the agency. This action successfully resulted in a 20 percent reduction of staff working in budget execution services, or a decrease of 61 FTEs. Comprehensive Service Level Agreements are in place.
- CDC consolidated graphics services across the agency in FY 2005. This action resulted in fiscal and staff savings, including savings expected from more efficient use of equipment, that can be redirected to mission direct activities.
- CDC completed the evaluation and detailed planning for the consolidation of professional training services. Implementation of consolidated professional training services across the agency is expected to be complete in FY 2006 - 2007. CDC has been working with HHS to implement the HHS Learning Management System.
- CDC completed the evaluation and detailed planning for consolidation of travel services in 2005 with associated fiscal and staff savings for redirection to mission direct activities. CDC is currently working according to HHS' timeline to implement e-travel services by the end of FY 2006.
- CDC, with HHS' guidance, completed the restructuring of its human resources office to the HHS Atlanta Human Resources Center (AHRC). This human resources office restructuring eliminated 76 FTEs, reflecting a 30 percent staff reduction. Despite this reduction, the time from AHRC's receipt of a hiring request to the day the job offer is made was reduced by 47 percent between 2003 and 2004.
- CDC consolidated administrative functions in approximately 30 CDC/OD offices, reducing staffing from a baseline of 83 FTEs to 63, or a savings of 24 percent. This action resulted in savings that can be redirected to mission direct activities.
- As a result of these human capital and other CDC business services improvements, the agency has reduced its number of mission support (i.e., administrative) staff by approximately 900 as of the end of 2005. This reduction of mission support staff will allow the redirection of administrative staff positions to front line public health efforts.

Business Process Improvements

CDC Has recently engaged in and continues to move forward with restructuring and efficiencies. For example, the CDC Director's span of direct reports was reduced from 23 to 15. In addition, in September 2004, CDC abolished two major program offices. Staff from the two associated Office of the Directors have been redeployed within the Coordinating Center for Health Information and Service, the Office of Workforce and Career Development, or in other CDC programs.

CDC successfully implemented a state-of-the-art financial system, UFMS in April 2005. UFMS is part of a multi-year effort initiated by former Secretary Thompson. CDC went "live" with UFMS' General Ledger and Accounting for Pay System in October 2004. The grants interface (Grants Solution) was also implemented in the first quarter of FY 2005.

CDC is improving procurement and grants operations. Operational improvement opportunities have been identified that will result in increased employee productivity through workforce alignment, process redesign, and operational performance management. This effort has already resulted in new contract cycle time being reduced by 42 percent between FY 2003 and FY 2005.

CDC evaluated vaccine purchase processes and will streamline CDC's purchase of over half of the nation's childhood vaccines through its Vaccine Management Improvement Project.

The Office of Personnel Management approved CDC/ATSDR's plan to offer Voluntary Separation Incentive Payments (VSIPs), or buyouts, to staff who worked in mission support functions in FY 2005. Under the VSIP authority, 336 mission support staff separated during FY 2005. CDC's plan was to use the VSIPs to help implement

major reorganizations and business services consolidations which resulted in significant business efficiencies and redeployment of positions to front line public health efforts.

CDC has effectively used Voluntary Early Retirement Authority (VERA) to reduce mission support staff and restructure efficiencies accordingly. In FY 2003, 73 staff accepted VERA. In FY 2004 and FY 2005, 39 and 93 staff, respectively, retired early under VERA.

Delayering Actions

CDC has completed delayering the agency to no more than four management layers. In total, CDC abolished over 200 "Sections" in response to this initiative. This "Section" delayering has contributed to a 33 percent decrease in the official number of organizational units at CDC since 2001. This agency-wide approach resulted in compressing the distance between citizens and decision-makers.

FY 2006 ACTIVITIES

- CDC will continue to flatten the agency by further improving its supervisory ratio.
- CDC/ATSDR will continue efforts to redirect more mission support staff to mission direct positions.
- CDC will strategically retrain and redeploy employees impacted by initiatives such as competitive sourcing, consolidations, and reduction of mission support positions.

COMPETITIVE SOURCING INITIATIVE

COMPETITIVE SOURCING PLAN

CDC developed a long range Competitive Sourcing plan to guide the program and the resulting competitions each year. This plan reflects consideration of where and how competitive sourcing can best further the CDC's mission, human capital plans and maximize our savings potential. CDC has continually met the plans' goals and maintained "green" PMA scorecard performance ratings.

COMPETITIONS

In FY 2003, CDC completed five studies of its Facilitates Planning and Management Office. CDC prevailed in all five studies, indicating that through rigorous and complex analysis of work, CDC was performing at a cost to the taxpayer less than that of comparable service providers.

In FY 2004, CDC conducted six A-76 competitions involving a range of CDC staff. The specific competitions included: (1) Animal Care, (2) Laboratory, Glassware and Associated Laundry services, (3) Office Automation, (4) Printing (5) Materials Management and (6) Library Services. Again, except for the small printing streamlined study, five of the competitions resulted in in-house decisions. The Library Services performance decision was not announced until FY 2005. This record indicates that through rigorous and complex analysis of commercial work, CDC performs at a cost to the taxpayer less than that of other service providers.


In FY 2005, three new standard competitions were announced for Computer Clerk Support, Statistical Support, and Writer and Editor Services. All three competitions resulted in in-house decisions. These FY 2005 competitions included approximately 150 FTEs. In addition to the standard competitions, the CDC Information Technology Services Office was approved by OMB as a "restructuring" alternative to A-76 competitions. The organization will achieve comparable savings over the next five years.

Preliminary planning is underway and public announcements will be made during FY 2006.

COMPETITIVE SOURCING SAVINGS

CDC savings that accrue from competitive sourcing are reinvested in mission-direct, public health activities. For example, reductions in FTEs associated with mission support functions will be redirected to activities such as epidemiology, laboratory science, medical officials, and pandemic preparedness teams. Information technology savings are used to fund projects that support Health IT, science and other core mission activities such as linking public health and electronic medical records. Similarly, as CDC's mission continually expands with new and re-emerging diseases and health risks, savings are effectively invested in meeting urgent challenges such as avian influenza, tsunami response teams, and hurricane disaster relief efforts. Moreover, new requirements are resulting from opening the new CDC laboratory facilities and Global Communications Center as part of our facilities modernization program. This will help make our health protection tools and information accessible to the global community.

PERFORMANCE GOALS AND MEASURES

GOAL 1: PROVIDE VARIOUS STANDARDIZED AND INTEGRATED MEANS FOR ACCESS TO CDC INFORMATION RESOURCES BY HEALTH PRACTITIONERS AND THE PUBLIC.			
Measure	FY	Target	Result
1. Increase the cost efficiency of providing IT infrastructure services across CDC. [E]	2005	\$7,245/user/year	\$6,157/user/year (Exceeded)
	2003		\$8,454/user/year
Data Source: CDC's Information Technology Services Office (ITSO) key performance measure for cost per customer served.			
Data Validation: Independent validation and verification by HHS and contractor.			
Cross Reference:  -2			

Goal 1, Performance Measure 1:

CDC is improving service contracting effectiveness by increasing use of performance-based contracting for service contracts in alignment with administration and HHS goals. This measure will be retired after data are reported for FY 2005.

IMPROVED FINANCIAL PERFORMANCE INITIATIVE

UNITED FINANCIAL MANAGEMENT SYSTEM (UFMS)

Unified Financial Management System (UFMS) - UFMS is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has reached a major milestone in April 2005 with the move to production for the Center for Disease Control (CDC) and the Food and Drug Administration (FDA). CDC's FY 2007 budget includes \$1.6 million for this purpose.

Accounting Operations - Operations and Maintenance (O & M) activities for UFMS commenced in FY 2005. The Program Support Center will provide the O & M activities needed to support UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post deployment services include supplemental functional support, training, change management and technical helpdesk services. Ongoing business operation services involve core functional support, training and communications, and help desk services. Ongoing technical services include the operations and maintenance of the UFMS production and development environments, ongoing development support, and backup and disaster recovery services. CDC's FY 2007 budget includes \$3.5 million for this purpose.

Automating Administrative Activities - HHS agencies have been working to implement automated solutions for a wide range of administrative activities. As UFMS development and implementation move toward completion, there are added opportunities to improve efficiency through automating the transfer of information from administrative systems to the accounting system. CDC's FY 2007 budget includes \$1.7 million to support coordinated development of these improved automated linkages and administrative systems.

With the implementation of UFMS, CDC continues to pursue an aggressive strategy to upgrade fiscal management activities by bridging UFMS to the analytical and reporting tools necessary to respond to complex financial management requirements. These analytical and reporting tools position CDC to respond to current, future and contingency financial management requirements. To accomplish this strategy, CDC planned a multi-phased approach to UFMS. In October 2004, CDC implemented core UFMS Phase I. Core UFMS Phase I Implementation entailed deploying the UFMS General Ledger and Accounting for Pay Systems. In addition, CDC deployed the UFMS Interim Grants Solution in December 2004. This covered more than 50 percent of the dollar and transaction volume of the agency. In April 2005, CDC completed the full UFMS financial and accounting implementation of Phase I which is the cornerstone for future UFMS development and follow-up activities.

Phase II of UFMS started in FY 2005 with continuation into FY 2006 and FY 2007. Phase II will entail multiple tasks to include exploring the possibility of moving CDC to a fully project centric environment, modification of CDC feeder systems to support this environment, and development of a CDC data warehouse that will merge programmatic and financial information for meaningful management reporting. To this end, CDC commissioned and completed a

business case to identify timelines, accurate cost estimates, preferred functional and technical solutions and a strategic plan to accomplish these efforts. The business case is currently under consideration. Other activities that will be included in Phase II include piloting the MarkView Invoice Imaging system for UFMS and integrating a number of other departmental business system with the UFMS core financials. These systems include eTravel, Sunflower property management, IMPAC II for grants processing, and iProcure/Prism for acquisitions. In addition to Phase II development, CDC will also need to plan for Phase I support. This will include continued funding to the HHS UFMS effort, post implementation support, and maintenance and support of non-Oracle systems.

FINANCIAL MANAGEMENT IMPROVEMENT

CDC successfully began issuing quarterly financial statements in FY 2003 and accelerating the closing of accounting records at the end of the fiscal year. The use of automated tools has expedited the financial data consolidation process and streamlined financial statement preparation. CDC continues to prepare timely quarterly statements and to implement reviews, checks, reconciliations, and functions analysis to ensure the accuracy and completeness of financial statements. CDC is also proceeding with its Financial Management Excellence Initiative to further improve financial operations by following guidelines set by PricewaterhouseCoopers and the U.S. General Accounting Office in their respective November, 2000 reports. For example, 123 CDC staff members have graduated from CDC's Financial Management Certificate Program.

ACCOUNTABILITY

CDC participated in the HHS "top down" audit approach in FY 2003 through FY 2005 for which HHS received clean opinions. Additionally, CDC received five consecutive clean audit opinions from FY 1998 through FY 2002 evidenced in the independent auditors' report in the CDC/ATSDR Chief Financial Officer's annual reports for the applicable years. CDC also performs management control reviews and risk assessments under the Federal Managers' Financial Integrity Act and reports results to HHS in an annual report.

As part of the Corrective Action Plan, CDC has developed procedures for preparing interim and year-end financial statements and has significantly improved timeliness of its reporting over the past two years.

In a continued effort to ensure the reliability and integrity of financial information and that the objectives for which funds are being expended adhere to Congressional Intent, a CDC base "Quality Assurance and Data Validation Team" has been established to regularly conduct internal financial assessments on randomly sampled data at the commitment and post obligation levels. Additionally, this team will monitor compliance with laws, rules, and regulations.

EXPANDED E-GOVERNMENT INITIATIVE

CDC's request includes funding to support the PMA's Expanding E-Government and Departmental enterprise information technology initiatives. Operating Division funds will be combined to create an Enterprise Information Technology (EIT) Fund to finance specific information technology initiatives identified through the HHS strategic planning process and approved by the HHS IT Investment Review Board. These enterprise information technology initiatives promote collaboration in planning and project management and achieve common HHS-wide goals. Examples of HHS enterprise initiatives funded by the EIT Fund are Enterprise Architecture, Capital Planning and Investment Control, Enterprise E-mail, Grants Management Consolidation, and Public Key Infrastructure.

ENTERPRISE ARCHITECTURE

CDC has made great strides in its Enterprise Architecture (EA) development. Recent accomplishments include ongoing work of CDC's Enterprise Architecture Board (EAB) made up of Agency-wide representatives; the development of CDC's Health Alerts Domain's as-is environment, to-be environment, transition strategy, and sequencing plan; the completion of CDC's Federal Health Architecture (FHA) Service Component Reference Model (SRM), Technical Reference Model (TRM), and TRM inventory; and actively contributing to HHS' EA Model Working Group, EA Review Board meetings, and EA Program Team meetings. The resulting effort has raised CDC to GAO Enterprise Architecture Management Maturity Framework (EAMMF) Stage 3 and CDC anticipates achieving OMB Enterprise Architecture Assessment Framework (EAAF) Level 3 soon.

SECURITY

CDC is participating in the HHS Secure One program by building a strong information security program which is comprised of a mature Certification and Accreditation (C&A) and security assessment program, information security awareness training, policy development, test and evaluation, and security operations activities. CDC completed Business Continuity Planning and testing for all of the 23 Federal Information Security Management Act (FISMA) critical systems as of March 2005 and Business Continuity activities continue on an ongoing basis. CDC has

developed a robust Plan of Action and Milestone program to manage, mitigate, and validate remediation of system and enterprise weaknesses.

HHS MODERNIZATION

Government-Wide E-Gov Projects

CDC is actively engaged in eight of the federal E-Gov initiatives, namely Federal Health Architecture, CHI, e-Vitals, e-Grants, e-Travel, Geospatial Information One Stop, SAFECOM, and GovBenefits, with an initial 16 CDC programs represented covering \$4.4 billion. CDC has actively advanced e-commerce using FedBizOpps to post all contract opportunities electronically. CDC has migrated to HHS' enterprise-wide grants management system for research grants using NIH's eRA (IMPAC II) system and will migrate other grants to the same system in FY 2006. CDC is co-chairing the FHA surveillance working group and actively participating in the interoperability working group. CDC met the October 2003 goal for the Government Paperwork Elimination Act to make all information collections and disseminations available electronically.

IT Infrastructure Consolidation

CDC consolidated the agency's IT infrastructure functions, services, staff, and fiscal resources in accordance with OMB and HHS instructions. CDC has reduced costs by 30 percent and reduced staff by 29 percent in line with the overall agency reduction in mission support staffing. The 13 functions defined as IT infrastructure are: desktop computing support, directory services, e-mail, helpdesk support, infrastructure software, IT security, networking, data center services, office automation, remote access, server management, videoconferencing, and telecommunications.

Citizen-Centered Service

This past year, CDC launched its newly redesigned web site. Key improvements include making the site more citizen-centered including improvements in use, navigation, searching, interactivity, personalization, and enriching and expanding content in a consumer-oriented presentation. CDC has one of the most frequently visited Web sites in the government as the authoritative trusted source of public health information for health care providers, public health officials, the media, and the public. CDC's web site attracts 10 million different visitors per month on average. The SARS outbreak resulted in over 17 million different visitors in April 2003.

CDC consolidated all of its more than 40 health information hotlines and clearinghouses into one consolidated consumer response service at 1-800-CDC-INFO. The service went live in March 2005 with the initial conversion of HIV/AIDS, STDs, and immunization hotlines. The new service handles public inquiries 24 hours per day, every day, in bilingual and services hearing impaired callers. The contact center handled nearly 500,000 calls during the first nine months of operation and is continually growing as new health topics are added to the contact service.

BUDGET AND PERFORMANCE INTEGRATION INITIATIVE

CDC's efforts to integrated budget structure and performance have increased in significance as the agency implemented a new strategy and organization. The agency continues to modernize to enhance health impact, support the capacity to respond to public health emergencies, and directly engage CDC's customers, the American public.

Across CDC, integration efforts are reflected in the development of the agency's Performance Budget. This document aggregates performance information, required under the Government Performance and Results Act (GPRA), with budget information. The Performance Budget reflects:

- an emphasis on outcome-oriented measures that demonstrate the focus of CDC's programs.
- efficiency measures for all programs, per OMB instruction via the Program Assessment Rating Tool (PART) review.
- full costs calculated at the goal and performance measure level.
- plans to address program deficiencies identified during PART reviews.
- coordination across CDC throughout the development of the FY 2007 Performance Budget and other integration activities.

SENIOR AGENCY MANAGER MEETINGS

In FY 2005, senior agency managers from CDC's Financial Management Office (FMO), Office of Strategy and Innovation (OSI), and Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) collaborated on the FY 2005 spend plan process. The spend plan process was formulated to fund programs based

on performance rather than allocation and is intended to map program success and methods used to budget and track resources contributing to health impacts.

The FY 2005 spend plan proposals were aligned to agency goals established at each of the management levels. Each spend plan proposal submitted was comprised of seven key components, including a preparedness goal, theme, priorities, project narrative, milestones and risks, activities, and a budget. FY 2005 spend plan priorities were developed based on interaction with and guidance from CDC leadership, HHS, and subject matter experts. The priorities represented areas in which the terrorism preparedness and emergency program needed to concentrate in FY 2005. COTPER and OSI reviewed and evaluated projects and provided recommendations on funding. Projects recommended for funding were then submitted to FMO for a detailed review of the project budget, and finally, submitted to the Executive Leadership Board and HHS for final approval.

In summary, the spend plan team reviewed submissions from seven different CDC coordinating Centers and Offices and successfully determined which programs fit the priorities outlined. Of the 176 Spend plan proposals submitted, 111 spend plan proposals were funded.

Additionally, in FY 2005, senior managers from CDC's OSI, FMO, COPTER, Procurement and Grants Office (PGO), and the Management Information Systems Office (MISO) collaborated to develop FY 2006 joint planning activities for budget, goals, and extramural awards. This collaborative effort created a single planning process supported by IRIS, budget and performance integration, and CDC's newly created health impact web-based system that will link resources to performance. CDC's health impact system is a tool which will allow staff to track projects, performance, budget, and health impact through a uniform electronic system across the agency.

PART

In FY 2004 through FY 2006, 12 CDC programs (317 Immunization Program, Breast and Cervical Cancer, Diabetes, Domestic HIV/AIDS Prevention, HAN, ATSDR, State and Local Preparedness, B&F, Epidemic Services and Response, Occupational Safety and Health, Infectious Diseases, and STD/TB) participated in a PART review by OMB. In addition, five programs (Environmental Health, Global AIDS, in conjunction with the President's Emergency Plan for AIDS Relief, Global Immunization, Health Statistics and the Strategic National Stockpile) were evaluated during the FY 2007 budget cycle. These programs have developed performance measures which are reported on in each submission of the performance budget. Many of the performance measures are outcome-oriented and support the direction of the Futures Initiative. Programs also develop improvement plans which address PART recommendations and provide a framework for enhancing the program. Many programs reviewed by PART have already seen improvements in strategy, program management and results. For example:

- CDC has initiated a business improvement project to revamp the entire vaccine distribution process which will strengthen the efficiency and accountability of vaccine management systems. Once fully implemented, the new systems will automate and integrate vaccine ordering and management by centralizing distribution of all public purchased vaccines.
- Breast and Cervical Cancer performance targets were increased in accordance with data submitted by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Federal Advisory Committee. This review was solicited as an independent verification of the effectiveness of the program in general, and a report of the first 12 years of the Breast and Cervical Cancer program was prepared and endorsed.
- CDC's Diabetes program completed a management analysis to determine how resources (i.e. human capital, time and funds) are being used to achieve National Program Objectives (NPO). The analysis successfully captured the internal and external influence, interaction and impact of resources.
- CDC's Domestic HIV/AIDS Prevention program developed a template for project officers' use to analyze progress reports from state health departments, Community-Based Organizations and providers. CDC is phasing-in the implementation of the Program Evaluation and Monitoring System (PEMS) which will allow CDC to augment qualitative data from grantee annual progress reports with quantitative data to show client and program effectiveness.
- CDC's Environmental Health program and ATSDR initiated an intramural review program to evaluate all of its activities and projects with the goal of identifying shortcomings and making recommendations for improvement. This program is conducted by the Peer Review Subcommittee of their Board of Scientific Counselors, an independent organization whose charter is to provide guidance to the program. The subcommittee will evaluate the entire Environmental Health program within the next five years.
- CDC has entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria. To conduct the first phase of review, a NA evaluation panel was assembled and employed the criteria to review mining and hearing loss prevention. NA panels are in

the process of reviewing the mining and hearing loss programs and will provide a formal report with ratings in September 2006.

- ATSDR implemented a new long-term outcome measure for documenting the effectiveness of its interventions at sites that pose the most urgent public health hazards. ATSDR now evaluates its interventions at each site to determine their impact on public health. As a result, this new measure has focused the agency's leadership, its Cooperative Agreement Partners, and EPA on achieving public health outcomes.
- Critical tasks and performance measures were developed for the Public Health Emergency Preparedness Cooperative Agreement Program and were incorporated into the grant guidance for FY 2005.
- CDC's Occupational Safety and Health program initiated a contract with the National Academy of Sciences to conduct a comprehensive evaluation of the impact and relevance of occupational safety and health research.
- CDC's Infectious Diseases program has a website to post performance data on the grantee profile pages, including funding, activities funded, links to the grantees home page, grantee contact information and Congressional summaries (available for a limited number of grantees).
- CDC's TB program began to award state health department cooperative agreements for a new project cycle utilizing a new funding formula based on the burden of the disease.

Efficiency Measures

All CDC PART programs have at least one efficiency measure. These efficiency measures, along with their targets and actual performance, can be found in the Detail of Performance Analysis sections of this document.

FULL COST

CDC continues to report the full costs calculated at the goal and performance measure level in the Performance Budget. The full cost table has been changed to include the allocation of costs to Buildings and Facilities and Public Health Improvement and Leadership.