



**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**
Fiscal Year
2015

Centers for Disease Control
and Prevention

*Justification of
Estimates for
Appropriation Committees*

MESSAGE FROM THE DIRECTOR

I am pleased to present our budget request for fiscal year 2015. The Centers for Disease Control and Prevention is the nation's health protection agency. We work 24/7 to protect Americans from health and safety threats, both foreign and domestic. Our programs promote quality of life and prevent the leading causes of disease, injury, disability, and death.

We are committed to maximizing the impact of every dollar entrusted to our agency. This budget request maintains critical investments in FY 2014 and continues our efforts to increase public health capacity at local, state, national, and international levels. Our efforts align with the Administration's priorities and support Department of Health Human Services goals to help people live healthy, safe, and productive lives.

Our FY 2015 budget request includes increased investment to:

- Increase **global health security**
- Attack the growing problem of **antibiotic resistance**
- Reduce deaths due to **prescription painkiller abuse and overdose**
- Sustain progress in **ending the transmission of polio**
- Continue to improve our disease fighting tools through **advanced molecular detection**

Performance improvement is a critical aspect of our work. We regularly measure how our programs serve the public and meet public health aims. As such, this request includes data for how we measure success for each of our programs.

I am confident this budget supports CDC's ability to carry out its critical mission and sustain key efforts to preserve and protect the lives of Americans.

Sincerely,



Thomas R. Frieden, MD, MPH

Director, Centers for Disease Control
and Prevention

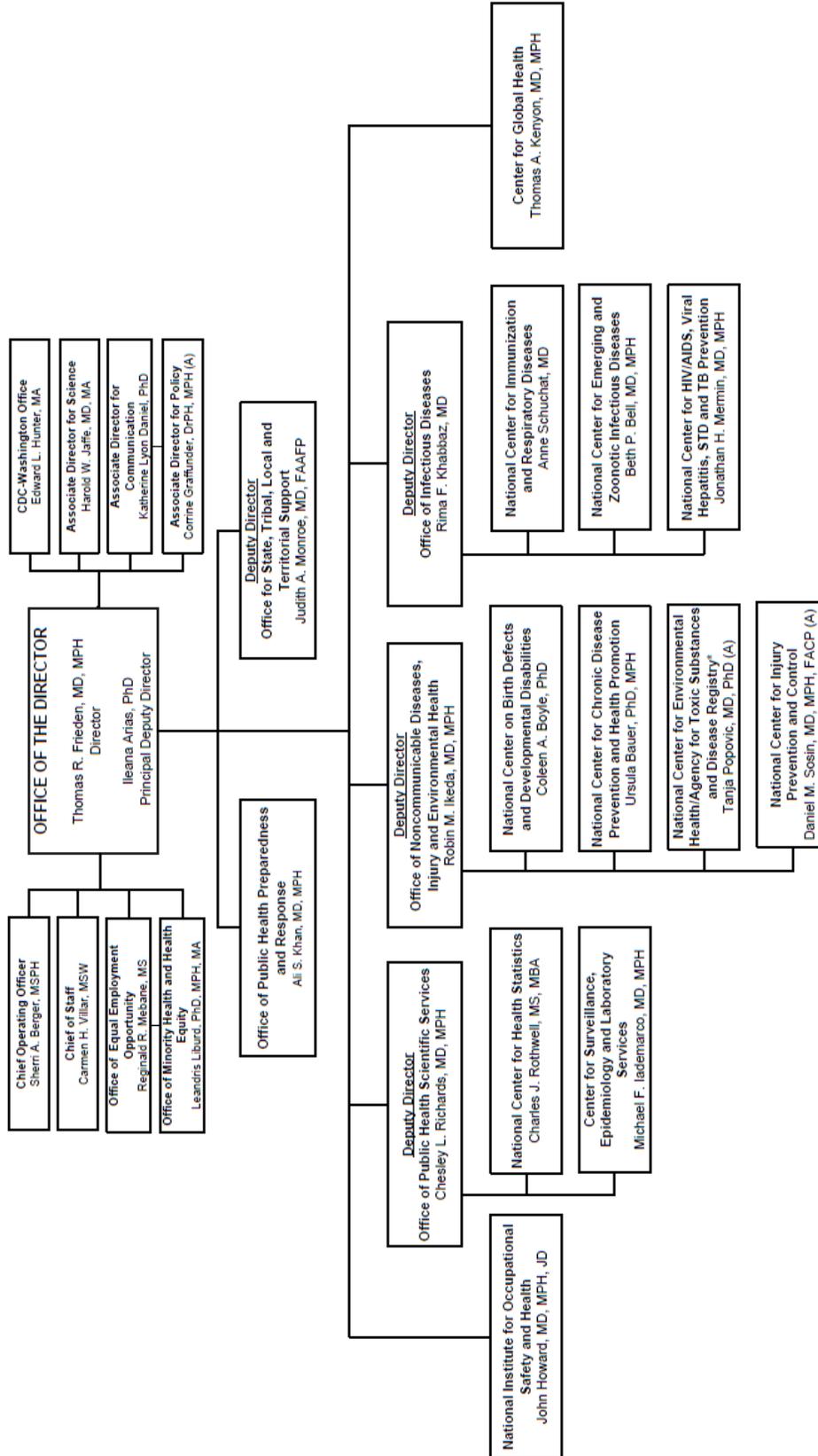
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CDC ORGANIZATIONAL CHART

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



*ATSDR is an OPDIV within DHHS but is managed by a common director's office.

(A) serving as an acting official

APPROVED 12/16/2013

Names Updated 1/26/2014

EXECUTIVE SUMMARY

INTRODUCTION AND MISSION

About

The Centers for Disease Control and Prevention (CDC) is an operating division of the U.S. Department of Health and Human Services. Since 1946, CDC has served as a public health leader in United States and throughout the world. Today, CDC has more than 10,000 full-time employees. In addition to staff at its Atlanta, Georgia headquarters, CDC scientists and health experts are assigned to all 50 states and more than 50 countries.

Mission

CDC works 24/7 to protect America from health, safety and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

CDC increases the health security of our nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise.

Goals

- Protect Americans from infectious diseases
- Prevent the leading causes of disease, disability, and death
- Protect Americans from natural and bioterrorism threats
- Ensure global disease protection
- Keep Americans safe from environmental and work-related hazards
- Monitor health and ensure laboratory excellence

Approach

Science is the foundation of CDC's work. CDC uses proven methods to prevent the leading causes of injury, disease, disability, and health. CDC programs also maintain high standards of quality and ethical practice. As a result, CDC programs promote long, productive, healthy lives for all people.



For more information, visit <http://www.cdc.gov/budget>.

OVERVIEW OF THE BUDGET REQUEST

The fiscal year (FY) 2015 President's Budget request for CDC and ATSDR includes a total funding level of \$11,117,194,000 in discretionary budget authority, mandatory funding, Public Health Service (PHS) Evaluation funds, and the Affordable Care Act Prevention and Public Health Fund (PPHF). This is an overall increase of \$310,719,000 above the FY 2014 Enacted level. The CDC program level request of \$6,606,361,000 (excluding mandatory programs except the Prevention Fund) for FY 2015 is a decrease of \$242,614,000 compared to the FY 2014 Enacted level.

The FY 2015 budget request proposes strategic new investments and identifies targeted reductions that will allow CDC to advance its core public health mission in the most cost-effective manner.

In FY 2015, CDC's Working Capital Fund (WCF) will have replaced the Business Services Support (BSS) direct appropriation, which previously funded CDC's Business Service Offices. To support the Working Capital Fund (WCF), estimates in this budget request continue to include realignment of BSS funding to budget lines. Increases in this request include funding to support estimated WCF costs.

The funding amounts and programmatic approaches described below are changes compared to the FY 2014 Enacted level.

New Initiatives

Global Health Security (+\$45.0 million)

The FY 2015 budget request includes an increase of \$45.0 million to expand Global Health Security activities. The increase will allow CDC to partner with up to 10 additional countries in 2015 to create sustainable emergency management programs to manage emerging threats, enhance early detection, and effectively respond to global epidemics and other public health emergencies. New funding will also accelerate the development of new diagnostics tests and build capacities to test for new pathogens globally. Despite improved technologies and knowledge, dangerous gaps remain in the global workforce, tools, training, surveillance capabilities, and coordination that are crucial to protect against the spread of infectious disease. Although every country is required to fully implement the International Health Regulations (IHR), fewer than 20 percent of World Health Organization (WHO) Member States reported in 2012 that they have fully achieved the IHR core capacities, and one of the goals of the Global Health Security Agenda is to close this gap.

The new Global Health Security program will build upon, expand, and accelerate successful CDC efforts to prevent avoidable catastrophes, detect threats early, and mobilize effective responses to contain outbreaks. This initiative will use current CDC platforms in innovative ways and add significant new components to CDC's work. Activities will include development of essential public health systems (i.e., core laboratory, surveillance, and information exchange systems) as well as the building of local technical capacities in other countries. After establishing a new baseline, external investments will be reduced, as other nations assume greater financial responsibility to sustain their own GHS activities.

Detect and Protect against Antibiotic Resistance (+\$30.0 million)

The FY 2015 budget request includes an increase of \$30.0 million to detect and protect against antibiotic resistance. Each year, CDC estimates that over 2 million illnesses and about 23,000 deaths are caused by antibiotic resistance. The Detect and Protect against Antibiotic Resistance (AR) initiative enhances surveillance and laboratory capacity at local, state, and national levels to characterize domestic AR threats and protect patients from danger. Most critically, the initiative will invest in direct action by implementing proven evidence-based interventions that reduce the emergence and spread of AR pathogens and improve appropriate antibiotic

use. The initiative leverages existing CDC detection and protection programs to prevent the spread of the most deadly and costly antibiotic resistant pathogens such as Carbapenem-resistant Enterobacteriaceae (CRE), cephalosporin-resistant gonorrhea, and drug-resistant Salmonella, and in the related pathogen *C. difficile*.

Prescription Drug Overdose Prevention (+\$15.6 million)

The FY 2015 budget request includes an increase of \$15.6 million to expand the existing Core Violence and Injury Prevention Program (Core VIPP) to additional states with the highest burden of prescription drug abuse. [Prescription Drug Overdose](#)¹ (PDO) represents a growing public health concern, as evidenced by the more than 60 people who die every day in the United States from these overdoses, most of which involve prescription opioid pain relievers. PDO deaths have increased four-fold between 1999 and 2010, and now outnumber deaths from all illicit drugs—including cocaine and heroin—combined. Abuse of opioid pain relievers claimed over 16,600 lives in 2010, resulted in over 400,000 emergency department visits in 2011, and cost health insurers an estimated \$72 billion annually in medical costs. Currently, 16 of the 20 states funded through Core VIPP address prescription drug abuse. To curb the devastating effects of this epidemic, increased investment in FY 2015 will equip more states to focus intensely on implementing PDO-specific interventions.

Increases

Vaccines for Children – Mandatory Funding (+\$514.1 million)

The FY 2015 budget request includes an increase in mandatory funding for the Vaccines for Children (VFC) Program. This estimate includes an increase for vaccine purchase, based on price and forecast changes for vaccines, and an increase for grantee operations to strengthen vaccine storage and handling activities. Taken together with CDC's Section 317 Immunization activities, these programs provide vaccines and the necessary program support to reach uninsured and underinsured populations. These resources will help support a comprehensive immunization program, based on strong science—from establishing and implementing vaccine policy to monitoring the effectiveness, impact, coverage, and safety of routinely recommended vaccines.

Surveillance, Epidemiology, and Public Health Informatics (+\$27.9 million)

The FY 2015 budget request includes an increase for Surveillance, Epidemiology, and Public Health Informatics. This increase will restore and expand activities that support public health scientific services across CDC. The FY 2015 budget expands CDC's capacity to monitor key health indicators, purchase 12 months of 2003 electronic birth records enhanced data, and phase in electronic death and birth records. Within the total, \$5.0 million is included for public health systems research.

Public Health Workforce Capacity (+\$15.0 million)

The FY 2015 budget request includes an increase for Public Health Workforce Capacity. This increase will be used to restore activities that support a prepared, diverse, and sustainable public health workforce through programs that recruit new talent through on-the-job fellowships, increase access to high-quality workplace training (including e-learning), and work with academia to improve education about population health. With this request, CDC will support approximately 600 fellows from the Public Health Associate Program (PHAP), Epidemic Intelligence Service (EIS), and other important fellowship programs.

National Healthcare Safety Network (+\$14.0 million)

This funding increase extends the National Healthcare Safety Network (NHSN) to more than 3,000 additional sites, including initiating efforts in ambulatory surgery centers and other non-hospital settings. Funds will also

¹ <http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/index.html>

enable CDC to continue to provide data for national healthcare-associated infection (HAI) elimination and targeted HAI prevention intervention.

World Trade Center – Mandatory Funding (+\$13.7 million)

The FY 2015 budget request includes an increase in mandatory funding for the World Trade Center Health Program. Funds support the treatment of cancer, as well as the increase in enrollment, including responders from the Shanksville, Pennsylvania and Pentagon sites, who became eligible to enroll in the WTC Health Program in May 2013.

National Violent Death Reporting System (+\$12.2 million)

With the increased funds proposed for FY 2015, CDC will complete expansion of the National Violent Death Reporting System to all 50 states and to Washington, D.C. The *Now Is The Time Initiative* stated that we need better data to help Americans understand how and when firearms are used in violent deaths and to inform future research and prevention strategies. For the first time, prevention researchers, practitioners, and policymakers will be able to gauge the magnitude, trends, and characteristics of violent deaths at the national, state, and local levels.

Polio Eradication (+\$10.0 million)

The FY 2015 budget request includes an increase to support the Global Polio Eradication Initiative (GPEI) and partner efforts towards the goal to stop all wild poliovirus transmission and any new vaccine derived polioviruses by December 2014, and the goal of certifying the end of all wild poliovirus transmission and any new vaccine-derived polioviruses by December 2018. CDC is the lead scientific agency for U.S. global polio eradication efforts. CDC contributed substantially to the more than 99 percent decline in global polio cases from more than 350,000 cases reported annually in 1988 to 403 cases reported in 2013, only 160 of which came from the remaining endemic countries.

Cancer Screening Demonstration Project (+\$10.0 million)

The FY 2015 budget request includes an increase to support a new cancer demonstration project to facilitate the transition from the existing screening programs to a more population based model. CDC will develop and implement innovative strategies to increase population-level screening rates for recommended breast, cervical and colorectal cancer screenings. Programs would use funding to leverage their connections to the clinical care system and enhance efforts to expand population-based, public health activities, facilitate more organized cancer screening efforts that link people to care, and improve screening rates for all recommended populations.

Gun Violence Prevention Research (+\$10.0 million)

This increase will support research into the causes and prevention of gun violence, focusing on those questions with the greatest potential for public health impact. This activity is in alignment with *Now is the Time*², which calls for research on gun violence prevention to equip Americans with needed information about this public health issue. These activities will be informed by the research agenda Consensus Report developed by the Institute of Medicine and the National Research Council in 2013 (*Priorities for Research to Reduce the Threat of Firearm-Related Violence*)³, which sets forth questions addressing youth access to firearms, improved understanding of risk factors, and examining risks and benefits of firearm ownership.

² <http://www.whitehouse.gov/issues/preventing-gun-violence>

³ <http://www.iom.edu/Reports/2013/Priorities-for-Research-to-Reduce-the-Threat-of-Firearm-Related-Violence.aspx>

Food Safety (+\$10.0 million)

This funding increase will address the critical unmet needs in the nation's food safety system, focusing on the following three priority areas in food safety at CDC and at state health departments, all of which are important provisions of the Food Safety Modernization Act (FSMA):

- Apply advanced DNA technology for faster, better foodborne disease control and prevention
- Detect, investigate and stop foodborne outbreaks
- Provide information to help guide food safety policy

Domestic HIV/AIDS Prevention and Research (+\$7.4 million)

The FY 2015 budget request includes an increase for domestic HIV prevention, with an increase of \$4.4 million to improve HIV surveillance timeliness, quality and efficiency as well as support projects that identify and share best practices for HIV testing and other prevention activities. The \$3.0 million provided in PHS Evaluation funds will evaluate the effectiveness of CDC's core school HIV prevention activities. Additionally, CDC will dedicate \$8.0 million of its total HIV resources to help grantees increase their capacity to seek health insurer reimbursement for covered infectious disease testing. Overall, HIV/AIDS prevention investments will continue to align activities with the National HIV/AIDS Strategy and to promote high-impact prevention that focuses resources on effective, scalable, and sustainable prevention strategies along the HIV continuum of care for persons living with HIV and populations at highest risk for HIV.

Rape Prevention and Education (+\$5.6 million)

The FY 2015 budget request includes an increase of \$5.6 million in PHS Evaluation funds for the Rape Prevention and Education (RPE) program. In 2014, evaluation activities will build the evidence base in sexual violence prevention and will scale up evidence-based efforts throughout the RPE program. In FY 2015, the increase from the PHS Evaluation Funds for RPE will continue these efforts and support other evaluation activities to improve sexual violence prevention nationwide.

Energy Employees Occupational Illness Compensation Program Act (EEOICPA) – Mandatory Funding (+\$5.4 million)

The FY 2015 budget request includes an increase in mandatory funding for EEOICPA. Funds provide compensation to Department of Energy employees or survivors of employees who have been diagnosed with a radiation-related cancer, beryllium-related disease, or chronic silicosis because of their work in producing or testing nuclear weapons.

Decreases and Eliminations**Preventive Public Health and Health Services Block Grant (-\$160.0 million)**

The FY 2015 budget request continues the elimination of the Preventive Health and Health Services Block Grant (PHHSBG) program, which was proposed in FY 2014. These activities may be more effectively and efficiently implemented through the State [Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health](http://www.cdc.gov/chronicdisease/about/statepubhealthactions-prevcd.htm)⁴ program, which provides resources to states to coordinate activities across categorical funding streams. When the PHHSBG was first authorized in 1981, there were minimal resources within CDC's budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity, and many states did not receive funding from CDC to support prevention of chronic

⁴ <http://www.cdc.gov/chronicdisease/about/statepubhealthactions-prevcd.htm>

disease. However, since 1981, categorical programs at CDC have grown and can better address these public health threats. Elimination of this program provides an opportunity to find savings, while expanding core public health activities and for other CDC priorities such as food safety and the reduction of healthcare-associated infections.

Cancer Prevention and Control (-\$53.0 million)

The FY 2015 budget request includes a decrease of \$42.0 million for the National Breast and Cervical Cancer, Early Detection Program, and Colorectal Cancer Screening Program. As the Affordable Care Act (ACA) increases access to cancer screening services began in 2014, the public health need to provide these clinical services will diminish. The ACA will increase access to cancer screening services for many low-income, underserved women through expanded insurance coverage, similar to the populations covered by CDC’s National Breast and Cervical Cancer Early Detection Program. Through the ACA, most health plans are required to cover mammograms and other cancer screenings without co-pays or deductibles. The law also requires new health plans to cover prevention counseling for women who are at a greater risk for breast cancer and, starting in 2014, it ensures that no one can be denied health insurance because of a pre-existing condition. The budget directs limited public health resources to other CDC priorities such as healthcare-associated infections and food safety and reduces funding for direct screenings such as breast, cervical, and colorectal screenings that are already covered by insurance. The request redirects \$11.0 million proportionally from other cancer activities to the Cancer Screening Demonstration Project. The new demonstration proposed in 2015 will work to enhance population-based activities that address known barriers to screening, recruit people in need of screening, help navigate people through the health care system, and assure delivery of quality screening.

Immunization Program (-\$51.5 million)

The FY 2015 budget includes a decrease for the Immunization Program. This decrease will be targeted to vaccine purchases. Health insurance expansion will further increase access to immunizations and is expected to decrease the number of uninsured and underinsured individuals in need of Section 317 vaccine for routine immunizations. Since September 2010, new health plans have been required to cover vaccines routinely recommended by the Advisory Committee on Immunization Practices without charging a deductible, copayment, or coinsurance. This request dedicates \$8.0 million to expand the capacity of public health departments to bill health insurers for immunization services. For FY 2015, CDC’s priorities for the Immunization Program are to preserve core public health immunization infrastructure at the local, state, and federal levels; to maintain an adequate amount of vaccine purchase to provide a vaccination safety net for uninsured adults and for response to vaccine-preventable disease outbreaks and other vaccine urgent needs; and to make strategic investments to enhance the immunization infrastructure and evidence base and improve efficiency.

Racial and Ethnic Approaches to Community Health (-\$51.0 million)

The FY 2015 budget request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program. The newly funded Partnerships to Improve Community Health, funded at \$80 million, will build on past program successes and lessons learned from CDC’s community-based programs. This effort will also adopt best practices and lessons learned from the REACH program into its strategy in program planning and implementation.

State and Local Preparedness and Response Capability (-\$45.8 million)

The FY 2015 budget request includes a decrease of \$45.8 million from State and Local Preparedness and Response Capability. This reduction will decrease grants funded through the Public Health Emergency Preparedness (PHEP) cooperative agreement. Since 2002, PHEP cooperative agreements provided nearly \$9 billion to public health departments across the nation to upgrade their ability to effectively respond to a wide range of public health threats. In FY 2015, CDC’s continued support of public health departments through PHEP

will focus on capability sustainment. This decrease also eliminates \$8.1 million for Academic Centers for Public Health Preparedness. CDC will continue to support research and training for public health preparedness through the research agenda of the OPHPR Science Office.

Occupational Safety and Health – Education and Research Centers (-\$27.5 million)

The FY 2015 budget request eliminates the Education Research Centers (ERCs). Originally created almost 40 years ago, the ERC program has addressed the limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. The ERCs’ reach and impact have grown substantially across the nation since the program’s inception, increasing awareness of the importance of coursework specializing in these areas. Although the budget does not include funding for the federal portion of these grants, CDC will continue to provide scientific and programmatic expertise to the ERCs as requested.

National Occupational Research Agenda –Agricultural, Forestry and Fishing Sector (-\$24.0 million)

The FY 2015 budget request reflects elimination of the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupational Research Agenda (NORA). Although this program has made positive contributions, it has been proposed for elimination in a limited-resource environment.

Buildings and Facilities (-\$14.0 million)

The FY 2015 budget request includes a funding decrease for Buildings and Facilities. The \$10.0 million in FY 2015 will support critical repairs and improvements through a combination of proposed budget authority and prior multi-year appropriations. The FY 2015 request will support the sustainment of the repairs and improvement (R&I) program to ensure continued condition improvement and reduction of deferred maintenance for CDC assets.

Environmental and Health Outcome Tracking Network (-\$11.0 million)

The FY 2015 budget request maintains core tracking network activities and functions. CDC will reduce the number of states receiving tracking network cooperative agreements and will reduce or eliminate funding to national partners in FY 2015. CDC will focus on capacity building for existing grantees to ensure that public health actions based on these data continue.

Workplace Wellness (-\$10.0 million)

The FY 2015 budget request eliminates the Workplace Wellness program. These programs were of limited duration and will have completed their work in FY 2014. CDC will integrate lessons learned from these projects into on-going chronic disease prevention programs.

Strategic National Stockpile (-\$8.0 million)

The FY 2015 budget request includes a decrease to the Strategic National Stockpile (SNS). This level will prioritize replacement of expiring items that rank the highest on formulary priorities, based on an annual review of the SNS and result in efficiencies from improved procurement. CDC works to continually improve our capability to deliver SNS assets to affected areas during public health emergencies. For example, access to existing Defense Logistics Agency (DLA) contract pricing and its procurement system is expected to yield reduced procurement costs and has already decreased delivery times for MCM orders by 75%. CDC has always sought to maximize the effectiveness of resources and investments, and is even more focused on doing so in the current fiscal environment.

National Public Health Institutes (-\$7.5 million)

The FY 2015 budget request includes a decrease which eliminates dedicated funding to assist other nations in setting up and strengthening National Public Health Institutes. The funding for this new program is available through 2015. These activities are similar to existing CDC global health activities that will be substantially expanded in 2014 and 2015.

Hospitals Promoting Breastfeeding (-\$5.5 million)

The FY 2015 budget request includes a decrease to the Hospitals Promoting Breastfeeding program. CDC plans to support a new funding opportunity to provide decentralized technical assistance through multiple organizations to assist hospitals in improving maternity care practices in their locales. This decentralized model will focus on overcoming local, state, and regional barriers to breastfeeding and will capitalize on local knowledge, experiences, and challenges in a way that cannot be accomplished by a single national entity. CDC also continues to support breastfeeding as a strategy to reduce obesity and funds activities proven to increase breastfeeding through the State Public Health Actions to Prevent Chronic Disease and The Partnerships to Improve Community Health grant programs.

Realignments

Influenza Planning and Response

The FY 2015 budget includes \$15.0 million for Influenza Planning and Response, reflecting a realignment of funding to CDC previously funded through pandemic influenza balances, to sustain critical international influenza activities.

ALL PURPOSE TABLE

(dollars in thousands)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Immunization and Respiratory Diseases Total	718,169	784,548	748,066	(36,482)
Budget Authority	602,593	611,384	607,942	(3,442)
<i>PHS Evaluation Transfer</i>	12,864	12,864	12,864	0
<i>ACA/PPHF</i>	90,883	160,300	127,260	(33,040)
PHSSEF	11,829	N/A	N/A	N/A
HIV/AIDS, Viral Hepatitis, STI and TB Prevention Total	1,095,371	1,120,566	1,127,942	7,376
Budget Authority	1,091,680	1,120,566	1,124,942	4,376
<i>PHS Evaluation Transfer</i>	3,691	0	3,000	3,000
Emerging and Zoonotic Infectious Diseases Total	341,396	390,447	445,299	54,852
Budget Authority	297,222	338,447	393,549	55,102
<i>ACA/PPHF</i>	44,174	52,000	51,750	(0,250)
Chronic Disease Prevention and Health Promotion Total	1,002,550	1,187,962	1,077,957	(110,005)
Budget Authority	769,517	741,962	608,253	(133,709)
<i>ACA/PPHF</i>	233,033	446,000	469,704	23,704
Birth Defects, Developmental Disabilities, Disability and Health Total²	133,539	132,337	132,337	0,000
Budget Authority	133,539	132,337	61,541	(70,796)
<i>ACA/PPHF</i>	0	0	70,796	70,796
Environmental Health Total	142,379	179,811	168,811	(11,000)
Budget Authority	121,639	166,811	131,811	(35,000)
<i>ACA/PPHF</i>	20,740	13,000	37,000	24,000
Injury Prevention and Control Total	138,943	150,839	194,304	43,465
Budget Authority	138,943	150,839	188,699	37,860
<i>PHS Evaluation Transfer</i>	0	0	5,605	5,605
Public Health Scientific Services Total	492,508	482,957	525,809	42,852
Budget Authority	193,238	397,266	377,723	(19,543)
<i>PHS Evaluation Transfer</i>	247,769	85,691	95,086	9,395
<i>ACA/PPHF</i>	51,501	0,000	53,000	53,000
Occupational Safety and Health Total	323,059	332,860	280,590	(52,270)
Budget Authority	212,335	220,860	0	(220,860)
<i>PHS Evaluation Transfer</i>	110,724	112,000	280,590	168,590
Global Health Total	362,792	416,801	464,301	47,500
Public Health Preparedness and Response	1,278,870	1,371,198	1,317,375	(53,823)
Cross-Cutting Activities and Program Support Total	250,619	298,649	123,570	(175,079)
Budget Authority	228,034	138,649	123,570	(15,079)
<i>ACA/PPHF</i>	22,585	160,000	0,000	(160,000)
Total CDC - BA (adjusted for ACL transfer)	5,430,402	5,807,120	5,399,706	(407,414)
Total CDC - BA and PHS Eval (adjusted for ACL transfer)	5,805,450	6,017,675	5,796,851	(220,824)
Program Level - BA, PHS Eval, PHSSEF & PPHF (adjusted for ACL transfer)	6,280,195	6,848,975	6,606,361	(242,614)
PHS Evaluation Transfers	375,048	210,555	397,145	186,590
Prevention and Public Health Fund Transfer	462,916	831,300	809,510	(21,790)
Public Health and Social Services Emergency Fund (Transfer)	11,829	0	0	0,000
Mandatory Funding Sources				
Vaccines for Children ³	3,607,256	3,562,470	4,076,617	514,147
Energy Employees Occupational Illness Compensation Program Act (EEOICPA) ⁴	50,984	49,933	55,358	5,425
World Trade Center (Mandatory) ⁵	230,680	268,180	281,941	13,761
Affordable Care Act (Mandatory)	0	0	20,000	20,000
Agency for Toxic Substances and Disease Registry	72,228	74,691	74,691	0,000
User Fees	2,114	2,226	2,226	0
Total CDC/ATSDR adjusted for proposed ACL transfer	10,243,457	10,806,475	11,117,194	310,719

¹The FY 2013 level has been made comparable to FY 2014 and FY 2015 to reflect BSS transfers to implement the Working Capital Fund and EZID/Global Health funding shift.

²The FY 2013 Birth Defects Total has been comparably adjusted to reflect transfer of \$6.7 million to ACL.

³The FY 2013 level reflects an estimated funding level. The FY 2014 and FY 2015 levels represent anticipated transfers from Medicaid.

⁴The FY 2014 amount reflects mandatory sequestration reduction.

⁵The FY 2013 through FY 2015 amounts reflect the Federal government's estimated net obligations.

PREVENTION AND PUBLIC HEALTH FUND

CDC’s FY 2015 request from the Affordable Care Act Prevention and Public Health Fund (PPHF) is a total of \$809,510,000 of the \$1,000,000,000 available. This request is an overall decrease of \$21,790,000 below the FY 2014 Enacted level of PPHF. Strategic use of PPHF dollars will help our nation achieve the joint goals of improving the health of Americans and restraining the growth in public and private healthcare costs.

Investments through PPHF will continue to support the vital work of state, local, and tribal public health agencies throughout the United States and in U.S. territories. PPHF helps sustain public health activities at a time when agencies are facing fiscal challenges. PPHF likewise helps advance the field overall by supporting innovative evidence-based public health interventions. Such interventions inform and improve the way public health work is accomplished and promote healthier and more productive communities.

CDC’s strategic approach to investing PPHF dollars is to ensure every dollar spent attains the greatest possible impact. To achieve this end, some PPHF program dollars will be invested jointly with programs and activities also supported through CDC’s regular appropriation to maximize the benefit of limited resources. In FY 2015, PPHF will support programs and activities throughout CDC that:

- Improve public health agencies’ capacities to detect and respond to health threats
- Prevent the leading causes of death
- Improve the collection, analysis, and sharing of health information to inform implementation of prevention programs

The activities listed in the following tables are described in greater detail in the program narratives found within the Narrative by Activity section of this FY 2015 Congressional Justification.

Improving Public Health Detection and Response

(dollars in millions)	FY 2013 Enacted ¹	FY 2014 Enacted	FY 2015 Request
Epidemiology and Laboratory Capacity (ELC) / Emerging Infections Program (EIP)	\$39.985	\$40.000	\$40.000
Environmental and Health Outcome Tracking Network	\$23.885	\$0.000	\$24.000
Public Health Workforce	\$23.050	\$0.000	\$15.000
Healthcare-Associated Infections	\$11.750	\$12.000	\$11.750
National Public Health Improvement Initiative	\$37.039	\$0.000	\$0.000
Improving Public Health Detection and Response	\$135.709	\$52.000	\$90.750

¹FY 2013 column incorporates permissive transfer amounts.

CDC is requesting \$90,750,000 from PPHF to support investments that strengthen federal, state, local, tribal, and territorial public health threat detection and response capacity, our nation’s first line of defense against health threats. Investments supported by PPHF include the Epidemiology and Laboratory Capacity cooperative agreement and the Emerging Infections Program. These efforts augment state and local capacity to detect and respond to infectious diseases, including those caused by influenza, pertussis, rotavirus, foodborne pathogens, as well as healthcare-associated infections (HAIs), which now affect one out of every 20 hospital patients. PPHF funds also will support the Environmental and Health Outcome Tracking Network in tracking and reporting environmental hazards and related health problems to inform decisions on where to focus resources and interventions. Investing in these areas will bolster our nation’s public health workforce and improve efficiencies and performance of federal, state, and local public health laboratories across the country.

CDC will invest PPHF dollars to support activities that build upon substantial progress already achieved. With regard to preventing HAIs, for instance, funds will be used to widely implement practices that save lives, reduce treatment costs, and prevent costly hospital readmissions, thereby working to fulfill the joint goals of PPHF.

Preventing the Leading Causes of Death and Disabilities

(dollars in millions)	FY 2013 Enacted¹	FY 2014 Enacted	FY 2015 Request
Cancer Prevention and Control	\$0.000	\$104.000	\$169.204
Immunization	\$108.100	\$160.300	\$127.260
Tobacco	\$83.000	\$105.000	\$105.000
Diabetes	\$0.000	\$73.000	\$73.000
Heart Disease and Stroke	\$0.000	\$73.000	\$73.000
Birth Defects	\$0.000	\$0.000	\$70.796
Lead Prevention	\$0.000	\$13.000	\$13.000
New Cancer Demonstration Project	\$0.000	\$0.000	\$10.000
Million Hearts®	\$4.600	\$4.000	\$4.000
Healthy Weight Task Force/Early Child Care Collaboratives	\$4.000	\$4.000	\$4.000
Nutrition/Physical Activity	\$8.823	\$35.000	\$4.000
Hospitals Promoting Breastfeeding	\$2.500	\$8.000	\$2.500
Community Transformation Grants (CTGs)	\$146.300	\$0.000	\$0.000
National Prevention Strategy	\$0.922	\$0.000	\$0.000
Racial Ethnic Approaches to Community Health Grant Program (REACH)	\$0.000	\$30.000	\$0.000
Workplace Wellness	\$0.000	\$10.000	\$0.000
Viral Hepatitis	\$10.000	\$0.000	\$0.000
Preventive Health and Health Services Block Grant	\$0.000	\$160.000	\$0.000
Preventing the Leading Causes of Death Total	\$368.245	\$779.300	\$655.760

¹FY 2013 column incorporates permissive transfer amounts.

CDC is requesting \$655,760,000 from PPHF to support cancer prevention and control, tobacco use prevention and cessation, immunization, and other activities that address the leading causes of death and disability. PPHF will be used to address certain risk factors such as poor nutrition, lack of physical activity, and lack of access to vital community and clinical preventive services for diabetes, heart disease, and related chronic diseases, including behavioral interventions, disease screening, and treatment. By targeting these risk factors, CDC seeks to prevent heart attacks, strokes, cancers, and other chronic diseases which are responsible for 70% of deaths and 75% of U.S. healthcare costs.

In FY 2015, the Immunization Program will remain responsible for the essential public health workforce and systems at the national, state, and local levels that protect all Americans, regardless of health insurance status, from disability and death from vaccine-preventable diseases. CDC will conduct scientific studies that provide the evidence base for national immunization policy, including burden of disease, vaccine effectiveness and safety, economic analyses, and program feasibility. The Immunization Program will continue to be responsible for providing federally purchased vaccines to protect uninsured Americans from preventable diseases and will also provide funding to immunization awardees and support scientific and programmatic expertise to further develop, enhance, and maintain Immunization Information Systems.

The focus on reducing cardiovascular disease and other leading causes of death is specifically supported by the diabetes and heart disease programs, cancer prevention and control programs, the Million Hearts® initiative, and tobacco programs. Preventing tobacco use, which accounts for over 440,000 deaths each year, not only saves lives but also reduces direct health care costs and improves productivity. In FY 2015, CDC will continue to implement strategic, comprehensive communications efforts that will result in significant reductions in initiation and prevalence of tobacco use.

Using Information For Action

(dollars in millions)	FY 2013 Enacted¹	FY 2014 Enacted	FY 2015 Request
Prevention Research Centers	\$6.456	\$0.000	\$25.000
Healthcare Statistics/ Healthcare Surveillance	\$28.514	\$0.000	\$20.000
Community Guide	\$7.378	\$0.000	\$8.000
Vital Statistics	\$0.000	\$0.000	\$5.000
Public Health System Research	\$0.000	\$0.000	\$5.000
Using Information for Action Total	\$42.348	\$0.000	\$63.000

¹FY 2013 column incorporates permissive transfer amounts.

CDC is requesting \$63,000,000 from PPHF to support investments in systems for gathering, analyzing, and communicating health data to inform implementation of effective prevention practices. CDC will use PPHF resources to maintain and expand data collection on our nation’s health, wellness, and disease burden, with particular emphasis on certain populations at increased risk of illness.

Expanded collection and analysis of data, including local-level data, will improve the collective understanding of the nation’s health status. Such knowledge can then be used by decision makers and practitioners to address risk factors for poor health, implement best practices to advance public health, and improve health outcomes. For instance, surveys that pose questions about health insurance coverage, access to care, and burden of care can track the impact of Affordable Care Act implementation on healthcare access and utilization of services to inform future decisions on implementation activities. Similarly, data collection on fitness and dietary behavior can better inform obesity and chronic disease prevention activities currently underway.

OVERVIEW OF PERFORMANCE

As the nation's prevention agency and a leader in improving health around the world, CDC is committed to reducing the leading causes of death, disability and injury. CDC staff work 24/7 around the world to save lives, protect people, and save money through prevention. To achieve maximum public health impact, CDC conducts research; implements strategic, evidence-based programs; and monitors results through ongoing data collection.

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

– Dr. Tom Frieden, Director, CDC

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

- Strengthen public health and clinical linkages
- Improve health security at home and around the world
- Better prevent the leading causes of illness, injury, disability, and death

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

Strengthen Public Health and Clinical Linkages

- Healthcare facilities monitor and prevent healthcare-associated infections (HAI) through CDC's National Healthcare Safety Network (NHSN). As of August 2013, over 12,400 healthcare facilities, including nearly all US hospitals, participate in NHSN for quality improvement. The number of acute care hospitals reporting multi-drug resistant organisms such as *Clostridium difficile* and Methicillin-resistant *Staphylococcus aureus* (MRSA) more than doubled to 4,000 in FY 2013. Since 2008, the combination of CDC data systems, guidelines and programs has contributed to significant reductions of HAIs in healthcare settings, including:
 - 44% reduction in central line-associated bloodstream infections
 - 31% reduction in healthcare-associated invasive MRSA infections
 - 20% reduction in surgical site infections
- In FY 2013, results from CDC laboratory training workshops indicate that nearly 64% of public health and clinical laboratory workshop participants improved laboratory policies or practices and implemented new or modified testing protocols, a six percentage point increase from FY 2012 baseline. Noted improvements include enhanced laboratory biosafety and biosecurity as well as more accurate and timely test results for improved community and patient health.
- CDC has made significant progress in developing health information technology standards for Early Hearing Detection and Intervention (EHDI) Information Systems to use in electronic health exchanges with clinical electronic health records. Since 2011, CDC has consistently demonstrated the successful electronic exchange of hearing screening results and patient demographics between clinical electronic health records and public health entities, most recently at the 2013 Healthcare Information and Management Systems Society Interoperability Showcase. Additionally, the Office of the National Coordinator for Health Information Technology selected CDC's EHDI as a candidate to move forward with potential pilot implementation of its Structured Data Captured Initiative, which will facilitate innovative data collection so any researcher, clinical trial sponsor and/or reporting entity can access and interpret the data in electronic format.
- In 2012, CDC developed and commercialized a new laboratory technique that can distinguish old HIV infections from new infections. This will enable the public health community to identify where the highest rates of new infections are occurring, align prevention activities accordingly, and evaluate impact and prevention efforts. Surveillance studies using this technology are presently being conducted in parts of Asia and Africa
- CDC developed and validated an immunohistochemistry test for the diagnosis of leishmaniasis, which showed improved sensitivity and specificity when compared to existing molecular methods in tissue biopsy. Leishmaniasis is a parasitic disease that is found in parts of the tropics, subtropics, and southern Europe. It causes skin sores and can affect internal organs such as the spleen, liver, and bone marrow

Improve Health Security at Home and Around the World

- CDC led the establishment of the African Centre for Integrated Laboratory Training (ACILT), a regional center for excellence, in South Africa. The training center is the first of its kind and has increased the pool of well-trained, competent and motivated laboratory workers needed in the fight against HIV, TB and malaria. From 2008 to June 2013, ACILT has provided 96 course offerings to 1,255 participants from 39 countries in Africa, Asia, and the Caribbean regions, thereby enhancing the technical skills of bench scientists, policy makers, strategic planners, bio-safety professionals and quality managers.

- CDC and World Health Organization developed an innovative, task-based training and mentoring program, Strengthening Laboratory Management Toward Accreditation (SLMTA), to establish high quality laboratories in resource-limited settings. As of December 2013, 499 laboratories in 37 countries were implementing SLMTA and 1,644 laboratory managers received SLMTA training. Laboratory rankings demonstrate marked improvement. Several have already achieved full accreditation, which directly translates into improved patient care.
- Through coordinated action between a number of CDC divisions and other partners, public health officials swiftly detected and controlled the 2012 multi-state outbreak of fungal meningitis due to a contaminated medication. Tennessee public health officials quickly identified the outbreak, notified both state and national partners, and organized all specimens to be sent to CDC partially due to enhanced capacity as a result of CDC funds. The CDC's HAI laboratories identified other microorganisms from sealed medication vials and consulted with the CDC fungal experts to develop innovative diagnostic and treatment guidance. Over 80 of CDC's Epidemic Intelligence Service "disease detectives" provided critical assistance with identifying cases, tracking down and communicating with those exposed to the contaminated medication, and developing treatment guidelines for an infection rarely seen in humans. Through excellent preparedness and rapid response, the outbreak was contained to 749 cases and 61 deaths; it is estimated that without these efforts, at least 100 more deaths would have occurred.
- Rapid detection found a small outbreak of Listeria infections related to cheese in the Midwest in June 2013, which was controlled within just six days, the fastest response yet. The cheese had a long shelf life and was distributed nationally. As Listeria is a rare but serious foodborne illness, had the product not been recalled, a large nationwide outbreak of severe illnesses and deaths likely would have occurred.
- CDC developed an innovative method of linking illnesses to food commodities based on outbreak-associated illnesses for 1998–2008. As published in March 2013, by estimating annual US foodborne illnesses, hospitalizations, and deaths attributable to each of 17 food commodities, CDC found that 46% of illnesses were linked to produce, and more deaths were linked to poultry than to any other commodity. CDC's findings can be used by regulators and industry to design, target and implement more informed measures to prevent food contamination.
- To reduce the overall healthcare costs and burden to U.S. states, CDC implemented a pilot program conducting cost-effective overseas health interventions for refugees prior to their arrival in the United States. Between 2012 and 2013, CDC achieved an 11% increase in the number of refugees receiving vaccinations overseas and a 14% increase in the number of refugees receiving recommended presumptive treatment for parasite infections.
- CDC distributed more than 1,220 radiation emergency tool kits in FY 2013 to public health professionals and clinicians. Recent evaluation research has found that the toolkits were valuable resources for planning (pre-event) and just-in-time (intra-event) use. Since the creation of the toolkits in 2005, CDC has provided more than 28,000 kits to professionals across the nation and internationally to assist clinicians in developing plans and response capacity for radiation emergencies.
- CDC's Occupational Safety and Health program developed a portable tool and methods for detecting and simultaneously measuring worker exposure of up to seven fumigants within 11 minutes. This improves worker protection over currently used methods that require several different types of detectors and sensors to measure multiple chemicals. It can be used to protect shipyard workers, customs agents, and emergency responders.

- CDC's has contributed significantly to the near elimination of polio. The number of polio cases has declined by more than 40% between CY 2012 and CY 2013. CDC and partner prevention strategies have resulted in the absence of Type 3 poliovirus in Asia, and the virus has not been found in Africa since November 2012.
- In 2012, CDC's international Field Epidemiology Training Program residents conducted more than 400 outbreak investigations, over 190 planned investigations, and approximately 440 surveillance system evaluations. Through CDC's Global Disease Detection Centers, CDC responded to 209 disease outbreaks, including anthrax, viral hemorrhagic fever, and cholera.
- CDC's National Stockpile program deployed life-saving pharmaceuticals, medical supplies, and medical equipment to New York and New Jersey in support of the response to Hurricane Sandy. This included seven, 250-bed Federal Medical Stations and 26 support personnel. CDC also provided emergency medical supplies to California in response to botulism and smallpox incidents.

Better Prevent the Leading Causes of Illness, Injury, Disability, and Death

- CDC has expanded its HIV testing efforts, especially focusing on communities that have a high burden of HIV infection among African Americans and Latinos. In 2011, CDC supported more than 3.3 million HIV tests in the United States, and 18,000 people were newly identified as HIV positive. Preliminary data for 2012 indicate that more than 3.2 million tests were conducted, identifying more than 14,000 previously undiagnosed cases of HIV infection.
- Per capita cigarette consumption among adults in the United States declined from 1,507 to 1,196 between 2008 and 2012, indicating that current smokers are smoking fewer cigarettes.
- In FY 2012, CDC's Tips I campaign generated 207,519 additional calls (a 132 percent increase) to 1-800-QUIT NOW compared to corresponding weeks in 2011, resulting in an estimated 1.6 million new quit attempts among U.S. adult smokers, of whom at least 100,000 will likely quit for good.
- CDC supports the operations of the First Lady's Let's Move Salad Bars to Schools, an initiative that includes members from the public, private, and non-profit sectors. From January 2011 to October 2013, the initiative provided over 2,700 new salad bars to schools across the country, making fresh fruits and vegetables more easily accessible to over 1.3 million children.
- From July 1, 2012 to June 30, 2013 the WISEWOMAN Program provided 47,121 cardiovascular disease (CVD) screenings. During this period the WISEWOMAN Program reported 9,920 cases of high blood pressure, 6,538 cases of high cholesterol, 4,009 cases of diabetes, and 6,898 smokers among participants.
- The Diabetes Prevention and Control Alliance, a CDC grantee, is working with stakeholders in Colorado such as the Colorado Prevention Alliance, the Colorado Business Group on Health, the State Department of Personnel Administration, and major health plans, to get the National DPP lifestyle change intervention approved as a covered benefit for state employees. As a result of their efforts, 44,011 Colorado state employees are now eligible to participate in the program based on their risk for prediabetes and insurance provider.
- CDC's Breast and Cervical Cancer Early Detection Program provided breast and cervical cancer screening to 540,897 low-income, uninsured and underinsured women in 2012, diagnosing 5,905 women with breast cancer and 4,471 women with invasive cervical cancer or high-grade premalignant lesions.

- CDC’s Division of Reproductive Health supports State Perinatal Quality Collaboratives (PQC) to improve pregnancy outcomes for women and newborns using continuous quality improvement methods. From September 2008 to March 2013, the Ohio State PQC experienced an estimated 31,600 babies who would have been delivered at 36-38 weeks but were delayed to 39 weeks or more, preventing an estimated 950 Neonatal Intensive Care Unit admissions and 45 infant deaths with an estimated cost savings of \$19 million. From September 2010 to January 2013, the New York PQC decreased elective deliveries during 36-38 weeks gestation by 85%, including a 91% decrease in labor inductions, and an 84% decrease in C-sections
- Early success indicators for CDC’s Stopping Elderly Accidents, Deaths & Injuries—an innovative falls prevention pilot project in Colorado, New York and Oregon—show that in one medical group in New York, 85% of older adults are being screened for fall risk. This is a 45% increase over pre-pilot screenings.
- Since 2013, CDC’s Heads Up Public Service Announcements featuring professional athletes highlighting concussions and other serious brain injuries that occur both on and off the sports field has reached over 65 million viewers including parents, youth, and teens.
- Data from CDC’s National Center for Health Statistics document the success of CDC and its partners in improving the health of mothers and babies. According to data compiled by NCHS, the U.S. infant mortality rate declined 12% from 2005 through 2011, following a plateau from 2000 through 2005. NCHS data also show from 2007 through 2011, teen birth rates fell at least 15% for all but two states and by 30% or more in seven states. The U.S. cesarean delivery rate has not increased since 2009, documenting the success of efforts to reduce nonmedically-indicated cesarean delivery and labor induction prior to 39 weeks following clinical guidelines released by the American College of Obstetricians and Gynecologists.

Other CDC Accomplishments

- CDC’s National Public Health Improvement Initiative is increasing the capacity of state, tribal, local, and territorial public health departments and agencies to utilize performance and quality improvement practices that lead to more efficient and effective organizations, operations, programs, and services for better health outcomes. Examples of early successes reported in FY 2013 include:
 - Efficiency: Alabama decreased clinic wait times by 40%; North Carolina increased productivity for call handling in vital statistics by 97%; and South Carolina realized an annual savings of \$140,000 in prompt payment discounts by improving its invoice payment system.
 - Effectiveness: Oklahoma decreased the percentage of early elective deliveries (births) by 66%, North Carolina is increasing newborns screened for hearing loss by 1 month of age and newborns that complete diagnostic hearing evaluation by 3 months of age, with \$4,170,000 in projected savings based on two years of birth cohorts; and Virginia increased enrollment in its Plan First program by 300%.
- CDC.gov continues to maintain high customer satisfaction scores as measured by the American Customer Satisfaction Index. As of December 2013, CDC.gov's satisfaction score of 82 ranks it as a "top performer" among 100 participating federal websites

- In July 2013, CDC's "Solve the Outbreak" iPad application, which allows virtually anyone to become a disease detective, won the Advanced Distributed Learning (ADL) Challenge for "Best Government Learning App". Solve the Outbreak, the innovation through which users assume the role of an officer in the agency's Epidemic Intelligence Service (EIS), came out ahead of 18 other competitors in the category.
- CDC's Chamblee Building 107 construction project diverted 93% of its construction waste from landfill, exceeding the 50% target required by Executive Order 13423.
- CDC's efforts to provide transportation alternatives and flexible work schedules resulted in the agency receiving a "Gold" award for the University of South Florida's Center for Urban Transportation Research's 2012 Best Workplace for CommutersSM Race to Excellence. Best Workplaces for CommutersSM, a program designed to encourage sustainable transportation innovation, singled out 23 employers nationwide across four categories. The awards recognize organizations who have taken exemplary steps to offer transportation options such as vanpool and transit benefits or telework and compressed workweek for their employees.

Agency Performance Management

CDC conducts continuous quality improvement through priority and goal setting, performance measurement, and program evaluation. In recent years, CDC has established a performance management system which is critical to continuous improvement.

CDC's Quarterly Program Review (QPR) is a systematic process for monitoring program priorities, measurable outcomes, strategies, and progress. The QPR process includes written materials and formal meetings between program staff and CDC senior leaders. CDC's QPR process yields useful information on a regular basis that enables leadership and management to make timely decisions regarding program design and allows for potential shifts in program strategy or resource allocation.

Agency use of evaluation and evidence

CDC fully supports the use of evidence and evaluation. CDC supports scientific advances and the use of evidence and data to support program design and budget decisions. CDC continues to focus on the development and use of evidence to enhance all aspects of the Agency's mission.

CDC builds evidence regarding effective programs through its own evaluation, through systematic reviews of existing literature (Community Guide), through the use of rigorous methods to develop vaccination recommendations (ACIP's GRADE), and by finding innovative ways to make data accessible for public health decision making (Data Warehouse, Sortable Stats, Prevention Status Reports).

CDC promotes evidence-based prevention interventions in our grant announcements, shares best practices through websites, searchable databases and other means, and is exploring additional strategies for promoting the use of evidence in practice such as performance-based grant making and recognition awards (Million Hearts).

CDC is increasing its internal capacity to oversee and conduct program evaluation by expanding and enhancing the evaluation training available to employees through CDC University, developing an evaluation fellowship to expand program evaluation expertise, and by putting standard program evaluation guidelines and recommendations into place.

Alignment to Administration Priorities and Initiatives

CDC is committed to supporting the national priorities set by the Administration. For example, CDC has supported the implementation of the President's National HIV/AIDS Strategy (NHAS) goals of reducing the

number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities through domestic HIV programs.

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

In support of The President's plan to prevent gun violence, [*Now is the Time*](#)^[1], CDC asked the Institute of Medicine (IOM), in collaboration with the National Research Council (NRC), to convene a committee that would follow the IOM/NRC process to engage diverse stakeholders and identify the most pressing research questions on gun violence, including those questions with the greatest potential public health impact. Beginning in FY 2015, CDC will conduct research into the causes and prevention of gun violence based on the committee's recommendations. CDC will continue to support analyses of surveillance and other data to document the public health burden of firearm injuries in the US. A recent Morbidity and Mortality Weekly Report examined rates of firearm homicides and firearm suicides in the Nation's 50 largest Metropolitan Statistical Areas.

CDC is committed to HHS Sustainability Efforts in construction of new facilities designed and built to meet Guiding Principles. Moreover, Guiding Principle compliance is embedded in Repairs & Improvements projects for existing facilities across CDC.

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

CDC is a co-founding partner of The Million Hearts initiative, a national public-private initiative designed to prevent one million heart attacks and strokes by January 2017. CDC provides leadership and communications support for the initiative, which includes a number of complementing public and private strategies

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

CDC actively supports the HHS Action Plan to Reduce Racial and Ethnic Health Disparities by helping to eliminate persistent health disparities in the leading causes of death and disability through effective and scalable public health interventions. The efforts include:

- National Tobacco Control Networks, which help advance the science and practice of tobacco control related to specific populations in the United States.
- The Motor Vehicle Injury Tribal Initiative, which works with grantees to design, implement, and evaluate programs to reduce motor vehicle-related injuries and deaths among members of their communities.
- The Minority HIV/AIDS Research Initiative, which works directly with highly-affected minority communities to enroll study participants directly in research on HIV education, prevention, testing and linkage to care.

^[1] <http://www.whitehouse.gov/issues/preventing-gun-violence>

CDC leads key activities for 19 measures in the FY 2015 HHS performance plan.

These include:

- Improving health care quality and patient safety
- Strengthening public health surveillance and epidemiology
- Enhancing support of the public health infrastructure at the state, tribal, local, and territorial levels
- Addressing obesity through childhood nutrition, food labeling, and physical fitness
- Protecting Americans in public health emergencies
- Increasing impact in global health
- Preventing and controlling tobacco use
- Enhancing food safety
- Mitigating and preventing infectious and chronic diseases

Building on CDC's contributions to the FY 2012-2013 Agency Priority Goals (Priority Goals), CDC plays a significant role in three FY 2014-2015 Priority Goals, contributing our expertise in surveillance and promotion of evidence-based practices in accomplishing these goals:

- Preventing tobacco consumption
- Reducing healthcare associated infections
- Improving food safety in the United States

BUDGET EXHIBITS

APPROPRIATIONS LANGUAGE - COMPARISON TO FY 2014 CONSOLIDATED APPROPRIATIONS ACT

Centers For Disease Control and Prevention

Immunization and Respiratory Diseases

For carrying out titles II, III, XVII, and XXI, and section 2821 of the PHS Act, titles II and IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act, with respect to immunization and respiratory diseases, [~~\$571,536,000~~]~~\$607,942,000~~: *Provided*, That in addition to amounts provided herein, \$12,864,000 shall be available from amounts available under section 241 of the PHS Act to carry out the National Immunization Surveys.

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

For carrying out titles II, III, XVII, *and* XXIII [, and XXVI] of the PHS Act with respect to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis prevention, [~~\$1,072,834,000~~]~~\$1,124,942,000~~. *Provided, That in addition to the amounts provided herein, \$3,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the evaluation of HIV school health activities.*

Emerging and Zoonotic Infectious Diseases

For carrying out titles II, III, and XVII, and section 2821 of the PHS Act, titles II and IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act, with respect to emerging and zoonotic infectious diseases, [~~\$287,300,000~~]~~\$393,549,000~~: *Provided*, That of the [funds provided for the Advanced Molecular Detection initiative, the CDC Director shall establish and publish a five-year program implementation plan within 90 days of enactment.] *amounts available to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under federal or state quarantine law, up to \$1,000,000 shall remain available until expended.*

Chronic Disease Prevention and Health Promotion

For carrying out titles II, III, XI, XV, XVII, and XIX of the PHS Act with respect to chronic disease prevention and health promotion, [~~\$711,650,000~~]~~\$608,253,000~~: *Provided*, That funds appropriated under this account may be available for making grants under section 1509 of the PHS Act for [not less than]*up to* 21 States, tribes, or tribal organizations: *Provided further*, That [of the funds available under this heading, \$5,000,000 shall be available to conduct an extension and outreach program to combat obesity in counties with the highest levels of obesity: *Provided further*, That of the funds provided under this heading, \$80,000,000 shall be available for a program consisting of three-year grants of no less than \$100,000 per year to non-governmental entities, local public health offices, school districts, local housing authorities, local transportation authorities or Indian tribes to implement evidence based chronic disease prevention strategies: *Provided further*, That applicants for grants described in the previous proviso shall determine the population to be served and shall agree to work in collaboration with multi-sector partners.] *the proportional funding requirements under section 1503(a) of the PHS Act shall not apply to funds made available under this heading.*

Birth Defects, Developmental Disabilities, Disabilities and Health

For carrying out titles II, III, XI, and XVII of the PHS Act with respect to birth defects, developmental disabilities, disabilities and health, [~~\$122,435,000~~]~~\$61,541,000~~.

Public Health Scientific Services

For carrying out titles II, III, and XVII of the PHS Act with respect to health statistics, surveillance, *health* informatics, and workforce development, [\$347,179,000]\$377,723,000: *Provided*, That in addition to amounts provided herein, [\$85,691,000]\$95,086,000 shall be available from amounts available under section 241 of the PHS Act to carry out public health scientific services.

Environmental Health

For carrying out titles II, III, and XVII of the PHS Act with respect to environmental health, [\$147,555,000]\$131,811,000.

Injury Prevention and Control

For carrying out titles II, III, and XVII of the PHS Act with respect to injury prevention and control, [\$142,311,000]\$188,699,000: *Provided*, That in addition to the amounts provided herein, \$5,605,000 shall be available from amounts under section 241 of the PHS Act to carry out the evaluation of Rape Prevention and Education programs.

National Institute for Occupational Safety and Health

For carrying out titles II, III, and XVII of the PHS Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 [, and 514] of the Federal Mine Safety and Health Act, section 13 of the Mine Improvement and New Emergency Response Act, and sections 20, 21, and 22 of the Occupational Safety and Health Act, with respect to occupational safety and health, [\$180,300,000: *Provided*, That in addition to amounts provided herein, \$112,000,000] \$280,590,000 shall be available from amounts available under section 241 of the PHS Act.

Energy Employees Occupational Illness Compensation Program

For necessary expenses to administer the Energy Employees Occupational Illness Compensation Program Act, \$55,358,000, to remain available until expended: *Provided*, That this amount shall be available consistent with the provision regarding administrative expenses in section 151(b) of division B, title I of Public Law 106–554.

Global Health

For carrying out titles II, III, and XVII of the PHS Act with respect to global health, [\$383,000,000]\$464,301,000, of which [\$114,250,000]\$128,735,000 for international HIV/AIDS shall remain available through September 30, [2015, and of which \$7,500,000 shall remain available through September 30, 2015, to support national public health institutes] 2016: *Provided*, That funds may be used for purchase and insurance of official motor vehicles in foreign countries.

Public Health Preparedness and Response

For carrying out titles II, III, and XVII of the PHS Act with respect to public health preparedness and response, and for expenses necessary to support activities related to countering potential biological, nuclear, radiological, and chemical threats to civilian populations, [\$1,323,450,000, of which \$535,000,000 shall remain available until expended for the Strategic National Stockpile: *Provided*, That in the event the Director of the CDC activates the Emergency Operations Center, the Director of the CDC may detail CDC staff without reimbursement for up to 30 days to support the work of the CDC Emergency Operations Center, so long as the Director provides a notice to the Committees on Appropriations of the House of Representatives and the Senate within 15 days of the use of this authority and a full report within 30 days after use of this authority which includes the number of staff and funding level broken down by the originating center and number of days detailed: *Provided further*, That in the previous proviso the annual reimbursement cannot exceed \$3,000,000 across CDC: *Provided further*, That of the funds provided for the Strategic National Stockpile, up to \$2,000,000 shall be used to support a comprehensive

IOM evaluation of the distribution system.] \$1,317,375,000: *Provided, That of the amounts available for the Strategic National Stockpile, \$542,817,000 shall remain available until expended: Provided further, That the Director of the Centers for Disease Control and Prevention, or the Administrator of the Agency for Toxic Substances and Disease Registry, may detail staff without reimbursement for up to 180 days, to support an activation of the Emergency Operations Center at the Centers for Disease Control and Prevention.*

CDC-Wide Activities and Program Support

(Including Transfer of Funds)

For carrying out titles II, III, XVII, and XIX, and section 2821 of the PHS Act and for cross-cutting activities and program support that supplement activities funded under the headings “Immunization and Respiratory Diseases”, “HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention”, “Emerging and Zoonotic Infectious Diseases”, “Chronic Disease Prevention and Health Promotion”, “Birth Defects, Developmental Disabilities, Disabilities and Health”, “Environmental Health”, “Injury Prevention and Control”, “National Institute for Occupational Safety and Health”, “Energy Employees Occupational Illness Compensation Program”, “Global Health”, “Public Health Preparedness and Response”, and “Public Health Scientific Services”, [\$517,570,000, of which \$380,000,000 shall be available until September 30, 2015, for business services and transfer to the Working Capital Fund,] and *for carrying out section 4001 of Public Law 111-148, \$123,570,000, of which [\$24,000,000]\$10,000,000 shall be available until September 30, 2018, for [acquisition of real property,] equipment, construction and renovation of facilities: Provided, That paragraphs (1) through (3) of subsection (b) of section 2821 of the PHS Act shall not apply to funds appropriated under this heading and in all other accounts of the CDC: Provided further, That funds appropriated under this heading and in all other accounts of CDC may be used to support the purchase, hire, maintenance, and operation of aircraft for use and support of the activities of CDC: Provided further, That employees of CDC or the Public Health Service, both civilian and commissioned officers, detailed to States, municipalities, or other organizations under authority of section 214 of the PHS Act, or in overseas assignments, shall be treated as non-Federal employees for reporting purposes only and shall not be included within any personnel ceiling applicable to the Agency, Service, or HHS during the period of detail or assignment: Provided further, That CDC may use up to \$10,000 from amounts appropriated to CDC in this Act for official reception and representation expenses when specifically approved by the Director of CDC: Provided further, That in addition, such sums as may be derived from authorized user fees, which shall be credited to the appropriation charged with the cost thereof: Provided further, That with respect to the previous proviso, authorized user fees from the Vessel Sanitation Program shall be available through September 30, [2015] 2016: Provided further, That of the funds made available under this heading and in all other accounts of CDC, up to \$1,000 per eligible employee of CDC shall be made available until expended for Individual Learning Accounts: Provided further, That [to facilitate the implementation of the permanent Working Capital Fund (“WCF”) authorized under this heading in division F of Public Law 112–74, on or after enactment of this Act, unobligated balances of amounts appropriated for business services for fiscal year 2013 shall be transferred to the WCF: Provided further, That on or after enactment of this Act, CDC shall transfer amounts available for business services to other CDC appropriations consistent with the benefit each appropriation received from the business services appropriation in fiscal year 2013: Provided further, That once the WCF is implemented in fiscal year 2014, assets purchased in any prior fiscal year with funds appropriated for or reimbursed to business services may be transferred to the WCF and customers billed for depreciation of those assets: Provided further, That CDC shall, consistent with the authorities provided in 42 U.S.C. 231, ensure that the WCF is used only for administrative support services and not for programmatic activities: Provided further, That CDC shall notify the Committees on Appropriations of the House of Representatives and the Senate not later than 15 days prior to any transfers made with funds provided under this heading.] *the Director may transfer funds between any of the accounts of CDC with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.**

APPROPRIATIONS LANGUAGE ANALYSIS – COMPARISON TO FY 2014 CONSOLIDATED APPROPRIATIONS ACT

Language Provision	Explanation
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention	
For carrying out titles II, III, XVII, and XXIII [, and XXVI] of the PHS Act	Title XXVI of the PHS Act does not contain authorities for this CDC account.
<i>Provided</i> , That in addition to the amounts provided herein, \$3,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the evaluation of HIV school health activities.	Language added to reflect the transfer of PHS Evaluation funds (PHS Act sec. 241) to support HIV school health.
Emerging and Zoonotic Infectious Disease	
<i>Provided</i> , That of the [funds provided for the Advanced Molecular Detection initiative, the CDC Director shall establish and publish a five-year program implementation plan within 90 days of enactment.]	This program planning language is no longer needed in FY 2015. The beginning words not marked for deletion, “Provided, That of the”, now begin the proviso which is shown in the row below.
<i>...amounts available to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under federal or state quarantine law, up to \$1,000,000 shall remain available until expended.</i>	Isolating and quarantining travelers with highly contagious diseases such as multi-drug resistant tuberculosis protects the health security of travelers and U.S. communities. Under its regulatory authority, CDC issues federal isolation orders under Title III of the Public Health Service Act. To ensure prompt and effective isolation when necessary, CDC has Memorandums of Agreement with 182 hospitals for transportation, evaluation, diagnosis, care, and treatment of travelers who pose a significant risk to public health. The availability of \$1,000,000, as an initial set-aside, until expended, will ensure resources to address state and local expenditures for federal isolation orders. It can take several months to years to receive the final invoices for review and negotiation to ensure the government makes fiscally-responsible payments to these partners. Cases are extremely variable in terms of frequency (five in the past five years) and cost (from \$2,000 to over \$500,000 per case).
Chronic Disease Prevention and Health Promotion	
<i>Provided</i> , That funds appropriated under this account may be available for making grants under section 1509 of the PHS Act for [not less than]up to 21 States, tribes, or tribal organizations	CDC requests that 21 grants under section 1509 of the PHS Act be a ceiling, not a floor.
<i>Provided further</i> , That [of the funds available under this heading, \$5,000,000 shall be available to conduct an extension and outreach program to combat obesity in counties with the highest levels of obesity: <i>Provided further</i> , That of the funds provided under this heading, \$80,000,000 shall be available for a program consisting of three-year grants of no less than \$100,000 per year to non-governmental entities, local public health offices, school districts, local housing authorities, local transportation authorities or Indian tribes to implement evidence based chronic disease prevention strategies: <i>Provided further</i> , That applicants for grants described in the previous proviso shall determine the population to be served and shall agree to	This FY 2014 Enacted appropriations language, establishing a \$5,000,000 program to combat obesity in high-burden counties as well as a separate \$80,000,000 chronic disease prevention program, is no longer needed in FY 2015. The beginning words not marked for deletion, “ <i>Provided further</i> , That”, now begin the proviso which is shown in the row below.

Language Provision	Explanation
work in collaboration with multi-sector partners.]	
...the proportional funding requirements under section 1503(a) of the PHS Act shall not apply to funds made available under this heading.	Currently, the National Breast and Cervical Cancer Early Detection Program (NBCEDP) authorization requires that States spend at least 60% of funds on direct services, but provides waiver authority for no more than five States. In the FY 2014 President’s Budget, CDC requested language to allow for waivers for up to ten States so that these States could tailor Program activities to meet the needs of their specific populations as the Affordable Care Act is implemented over time. This language proposed for FY 2015 broadens this request so that no NBCEDP grantee would need a waiver to spend less than 60% of funds on direct services. This language supports all grantees as they look to best adapt to Affordable Care Act implementation.
Public Health Scientific Services	
For carrying out titles II, III, and XVII of the PHS Act with respect to health statistics, surveillance, <i>health</i> informatics, and workforce development,	Added a small specification to clarify the purpose.
Injury Prevention and Control	
<i>Provided, That in addition to the amounts provided herein, \$5,605,000 shall be available from amounts under section 241 of the PHS Act to carry out the evaluation of Rape Prevention and Education programs.</i>	Language added to reflect the transfer of PHS Evaluation funds (PHS Act sec. 241) to support the evaluation of the Rape Prevention and Education program.
National Institute for Occupational Safety and Health	
For carrying out titles II, III, and XVII of the PHS Act, sections 101, 102, 103, 201, 202, 203, 301, and 501[, and 514] of the Federal Mine Safety and Health Act	Section 514 of the Federal Mine Safety and Health Act does not contain any active authority for this CDC account.
Global Health	
[2015, and of which \$7,500,000 shall remain available through September 30, 2015, to support national public health institutes] 2016	No funding is provided for national public health institutes in the FY 2015 President’s Budget.
Public Health Preparedness and Response	
[\$1,323,450,000, of which \$535,000,000 shall remain available until expended for the Strategic National Stockpile: <i>Provided, That in the event the Director of the CDC activates the Emergency Operations Center, the Director of the CDC may detail CDC staff without reimbursement for up to 30 days to support the work of the CDC Emergency Operations Center, so long as the Director provides a notice to the Committees on Appropriations of the House of Representatives and the Senate within 15 days of the use of this authority and a full report within 30 days after use of this authority which includes the number of staff and funding level broken down by the originating center and number of days detailed: <i>Provided further, That in the previous proviso the annual reimbursement cannot exceed \$3,000,000 across CDC: <i>Provided further, That of the funds provided for the Strategic National Stockpile, up to \$2,000,000 shall be used to support a comprehensive IOM evaluation of the distribution system.] \$1,317,375,000</i></i></i>	<ol style="list-style-type: none"> 1. “of which \$535,000,000 shall remain available until expended for the Strategic National Stockpile” is replaced by the Strategic National Stockpile proviso proposed in the next row. 2. “<i>Provided, That in the event the Director of the CDC activates the Emergency Operations Center....</i>” This proviso is replaced by the Emergency Operations Center proviso proposed in the second row below. 3. “<i>Provided further, That in the previous proviso...</i>” This proviso is also replaced by the same Emergency Operations Center proviso proposed in the second row below. 4. “<i>Provided further, That of the funds provided for the Strategic National Stockpile...</i>” This IOM evaluation language is not needed in FY 2015.
<i>Provided, That of the amounts available for the Strategic National Stockpile, \$542,817,000 shall remain available until expended</i>	The language has been reformatted, but the intent remains the same as the Strategic National Stockpile no-year funding language it replaces shown in the row above.

Language Provision	Explanation
<p><i>Provided further, That the Director of the Centers for Disease Control and Prevention, or the Administrator of the Agency for Toxic Substances and Disease Registry, may detail staff without reimbursement for up to 180 days, to support an activation of the Emergency Operations Center at the Centers for Disease Control and Prevention.</i></p>	<p>CDC works year-round to ensure the security, safety, and health of the United States from foreign and domestic threats, whether man-made or naturally-occurring. CDC participates with international, state, and local partners to respond to urgent and emergent public health issues, including those outside of nationally-declared emergencies, by providing life-saving responses to chemical, biological, radiological, and nuclear threats, as well as other disasters, outbreaks, and epidemics. To achieve this goal during an activation of the Emergency Operations Center, CDC relies on all employees, including Agency for Toxic Substances and Disease Registry employees, to potentially assist in responding to urgent and emergent public health issues. To best meet this goal, CDC requests authority to deploy or otherwise utilize CDC staff to support such responses, regardless of appropriation line from which those staff are resourced. There will be a time limit of 180 days per employee to work on the emergency.</p>
<p>CDC-Wide Activities and Program Support</p>	
<p>[\$517,570,000, of which \$380,000,000 shall be available until September 30, 2015, for business services and transfer to the Working Capital Fund,]</p>	<ol style="list-style-type: none"> 1. The FY 2014 appropriation of “\$517,570,000” is replaced by the FY 2015 proposed amount shown in the row below. 2. With the Working Capital Fund fully established in FY 2015, this business services language is no longer needed.
<p>and for carrying out section 4001 of Public Law 111-148, \$123,570,000</p>	<ol style="list-style-type: none"> 1. This CDC account carries out this section of P.L. 111-148. 2. “\$123,570,000” is the appropriation amount proposed for FY 2015.
<p>of which [\$24,000,000]\$10,000,000 shall be available until September 30, 2018, for[acquisition of real property,] equipment, construction and renovation of facilities</p>	<p>CDC does not request authority for acquisition of real property in FY 2015.</p>
<p><i>Provided further, That [to facilitate the implementation of the permanent Working Capital Fund (“WCF”) authorized under this heading in division F of Public Law 112–74, on or after enactment of this Act, unobligated balances of amounts appropriated for business services for fiscal year 2013 shall be transferred to the WCF: <i>Provided further, That</i> on or after enactment of this Act, CDC shall transfer amounts available for business services to other CDC appropriations consistent with the benefit each appropriation received from the business services appropriation in fiscal year 2013: <i>Provided further, That</i> once the WCF is implemented in fiscal year 2014, assets purchased in any prior fiscal year with funds appropriated for or reimbursed to business services may be transferred to the WCF and customers billed for depreciation of those assets: <i>Provided further, That</i> CDC shall, consistent with the authorities provided in 42 U.S.C. 231, ensure that the WCF is used only for administrative support services and not for programmatic activities: <i>Provided further, That</i> CDC shall notify the Committees on Appropriations of the House of Representatives and the Senate not later than 15 days prior to any transfers made with funds provided under this heading.]</i></p>	<p>These provisos related to the FY 2014 implementation of the Working Capital Fund are no longer needed in FY 2015.</p> <p>The beginning words not marked for deletion, “<i>Provided further, That</i>”, now begin the proviso which is shown in the row below.</p>

Language Provision	Explanation
<p><i>... the Director may transfer funds between any of the accounts of CDC with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.</i></p>	<p>CDC requests this limited transfer authority in order to improve the provision of services and activities between accounts following Congressional notification.</p>

AMOUNTS AVAILABLE FOR OBLIGATION ^{1,2,3}

	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
Discretionary Appropriation:			
FY 2013 Enacted Amount ¹	\$5,657,023,000	\$5,807,120,000	\$5,399,706,000
OMB 0.2% Rescission	(\$11,314,000)	\$0	\$0
Sequestration	(\$284,581,000)	\$0	\$0
Transfer from Other Accounts	\$83,428,000	\$0	\$0
Transfer to Other Accounts	(\$7,802,000)	\$0	\$0
Subtotal, adjusted Appropriation	\$5,436,754,000	\$5,807,120,000	\$5,399,706,000
Mandatory and Other Appropriations:			
Transfers from Other Accounts ³	\$462,916,000	\$831,300,000	\$809,510,000
Receipts from CRADA ⁴	\$901,997	\$704,442	\$704,442
Receipts from Royalties ⁴	\$1,948,268	\$1,521,558	\$1,521,558
Appropriation (EEOICPA)	\$50,958,000	\$49,933,000	\$55,358,000
Subtotal, adjusted Mandatory and Other Appropriations	\$516,724,265	\$883,459,000	\$867,094,000
Recovery of prior year Obligations	\$45,795,656	\$0	\$0
Unobligated balance start of year	\$159,968,011	\$155,856,826	\$172,892,863
Unobligated balance expiring	\$6,489,780	\$0	\$0
Unobligated balance end of year	(\$155,856,826)	(\$172,892,863)	(\$162,969,306)
Total Obligations	\$6,009,874,886	\$6,673,189,870	\$6,277,347,822

¹ Excludes Vaccine for Children and World Trade Center Health Program.

² Excludes the following amounts for reimbursements: FY 2013 \$810,611,000; FY 2014 \$810,611,000; and FY 2015 \$810,611,000

³ Includes Prevention and Public Health Fund

⁴ FY 2013 amount represents anticipated receipts. FY 2014 and FY 2015 amounts are estimates assuming level receipts. FY 2014 and FY 2015 actual may vary.

SUMMARY OF CHANGES

	Dollars	FTEs
FY 2014 Enacted (Program Level)	\$6,848,975	10,846
FY 2015 President's Budget (Program Level)	\$6,606,361	10,846
Net Change	(\$242,614)	0

	FY 2014 FTE	FY 2014 Enacted	FTE Change	FY 2015 +/- FY 2014
Increases:				
Immunization and Respiratory Diseases				
Influenza/Influenza Planning and Response	---	\$172,558	---	\$15,000
HIV/AIDS, Viral Hepatitis, STI and TB Prevention				
Domestic HIV/AIDS Prevention and Research	---	\$788,809	---	\$7,376
Emerging and Zoonotic Infectious Diseases				
Core Infectious Diseases (includes Antibiotic Resistance Initiative)	---	\$218,647	---	\$31,102
National HealthCare Safety Network	---	\$18,071	---	\$14,000
Food Safety	---	\$40,089	---	\$10,000
Chronic Disease Prevention and Health Promotion				
New Cancer Demonstration Project (PPHF)	---	\$0	---	\$10,000
Injury Prevention and Control				
Injury Prevention Activities	---	\$29,023	---	\$15,623
NVDRS	---	\$11,333	---	\$12,237
Gun Violence Prevention Research	---	\$0	---	\$10,000
Rape Prevention - PHS Evaluation Transfer	---	\$0	---	\$5,605
Public Health Scientific Services				
Surveillance, Epidemiology, and PH Informatics	---	\$275,156	---	\$17,852
Public Health Workforce Capacity (PPHF)	---	\$0	---	\$15,000
Public Health Systems Research (PPHF)	---	\$0	---	\$5,000
Vital Statistics (PPHF)	---	\$0	---	\$5,000
Global Health				
Global Public Health Protection (includes Global Health Security Initiative)	---	\$215,909	---	\$45,000
Polio Eradication	---	\$150,928	---	\$10,000
Total Increases	N/A	\$1,920,523	N/A	\$228,795
Decreases:				
Immunization & Respiratory Diseases				
Immunization Program Level	---	\$611,990	---	-\$51,482
Chronic Disease Prevention, Health Promotion, & Genomics				
B&C Cancer and Colorectal Cancer	---	\$250,679	---	-\$41,960
REACH	---	\$51,005	---	-\$51,005
Workplace Wellness	---	\$10,000	---	-\$10,000
Hospitals Promoting Breastfeeding	---	\$8,000	---	-\$5,500
Environmental Health				
Environmental and Health Outcome Tracking Network	---	\$35,000	---	-\$11,000
Occupational Safety & Health				
Educational and Research Centers	---	\$27,519	---	-\$27,519
Agriculture, Forestry, Fishing (AgFF)	---	\$24,000	---	-\$24,000
Global Health				
National Public Health Institutes (non-add)	---	\$7,500	---	-\$7,500
Public Health Preparedness & Response				
State and Local Preparedness and Response Capability	---	\$662,849	---	-\$45,823

	FY 2014 FTE	FY 2014 Enacted	FTE Change	FY 2015 +/- FY 2014
Strategic National Stockpile	---	\$550,817	---	-\$8,000
Cross-Cutting Activities and Program Support	---		---	
Preventive Health and Health Services Block Grants	---	\$160,000	---	-\$160,000
Building and Facilities	---	\$24,000	---	-\$14,000
All Other Decreases	---		---	
All Other Decreases	---		---	-\$13,620
Total Decreases	N/A	\$2,423,359	N/A	(\$471,409)
Transfers				
	---	\$0	---	\$0
Built-In:				
1. Annualization of Jan - 2014 Pay Raise	---	---	---	\$2,966
2. FY 2015 Pay Increases	---	---	---	\$8,652
3. Changes in Day of Pay	---	---	---	\$0
4. Rental Payments to GSA and Others	---	---	---	\$554
Total Built-In	10,846	\$0	0	\$12,172
1. Absorption of Current Services	---	---	---	(\$12,172)
Total	---	---	---	(\$12,172)
Total Increases (Program Level)	10,846	\$1,920,523	0	\$228,795
Total Decreases (Program Level)	N/A	\$2,423,359	0	(\$471,409)
NET CHANGE - L/HHS/ED Program Level	10,846	\$6,848,975	0	(\$242,614)
Other Program Level Changes				
1. Vaccines for Children	---	\$3,562,470	---	\$514,147
2. World Trade Center	---	\$268,180	---	\$13,761
3. Energy Employees Occupational Illness Compensation Act (EEOICPA)	---	\$49,933	---	\$5,425
4. User Fees	---	\$2,226	---	\$0
Total - Program Level Net Increase	10,846	\$3,882,809	0	\$533,333
NET CHANGE: BUDGET AUTHORITY & PROGRAM LEVEL	10,846	\$10,731,784	0	\$290,719

BUDGET AUTHORITY BY ACTIVITY

(dollars in millions)

Budget Activity/Description	FY 2013 Actual ¹	FY 2014 Base ¹	FY 2015 President's Budget
Immunization and Respiratory Diseases - BA	\$602,593	\$611,384	\$607,942
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	\$1,091,680	\$1,120,566	\$1,124,942
Emerging and Zoonotic Infectious Diseases - BA	\$297,222	\$338,447	\$393,549
Chronic Disease Prevention and Health Promotion - BA	\$769,517	\$741,962	\$608,253
Birth Defects, Developmental Disabilities, Disability and Health - BA	\$133,539	\$132,337	\$61,541
Environmental Health - BA	\$121,639	\$166,811	\$131,811
Injury Prevention and Control - BA	\$138,943	\$150,839	\$188,699
Public Health Scientific Services - BA	\$193,238	\$397,266	\$377,723
Occupational Safety and Health - BA	\$212,335	\$220,860	\$0
Global Health - BA	\$362,792	\$416,801	\$464,301
Public Health Preparedness and Response - BA	\$1,278,870	\$1,371,198	\$1,317,375
Cross-Cutting Activities and Program Support - BA	\$228,034	\$138,649	\$123,570
Total CDC, Budget Authority -	\$5,430,402	\$5,807,120	\$5,399,706
Total CDC, FTEs	11134	11134	11134

¹ FY 2013 Actual and FY 2014 Base have been made comparable to reflect BSS realignment and EZID/Global Health reorganization.

AUTHORITIES AND ENABLING LEGISLATION

(dollars in thousands)¹

Enabling Legislation Citation ²	Enabling Legislation Status	Allocation Methods	FY 2014 Appropriations Act	FY 2015 President's Budget
Immunization and Respiratory Diseases				
PHSA Title II, §§ 301, 307, 310, 311, 317, 317N, 317S, 319, 319C, 319E, 319F, 322, 325, 327, 340C, 352, Title XVII*, 2102(a)(6), 2102(a)(7), 2125, 2126, 2127, 2821; Immigration and Nationality Act §§ 212 (8 U.S.C. 1182), 232 (8 U.S.C. 1222); Social Security Act § 1928 (42 U.S.C. 1396s)	Permanent Indefinite	Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; Contracts; and Other	\$784,548	\$748,066
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention				
PHSA Title II, §§ 301, 306(a-l), 306(n)*, 307, 308(d), 310, 311, 317, 317E(a-f), 317E(g)*, 317N(a-b), 317N(c)*, 317P(a-c), 318(a-d), 318(e)*, 318(f), 318B*, 322, 325, 327, 352, Title XVII*, 2315, 2320, 2341; Title II of P.L. 103-333; Section 212 of the Consolidated Appropriations Act, 2014 (P.L. 113-76, Division H)	Permanent Indefinite	Direct Federal/Intramural, Competitive Grant/Cooperative Agreements, Formula Grants/Cooperative Agreements, Contracts, and Other	\$1,120,566	\$1,127,942
Emerging and Zoonotic Infectious Diseases				
PHSA §§ 252, 264, 301, 304, 307, 308(d), 310, 311, 317, 317P, 317R, 317S, 319, 319D, 319E*, 319F, 319G, 321, 322, 325, 327, 352, 353, 361–369, 1102, Title XVII*, 2821*; P.L. 96–517; P.L. 111-5; Immigration and Nationality Act §§ 212, 232 (8 U.S.C. 1182, 8 U.S.C. 1222, 8 U.S.C. 1252)	Permanent Indefinite	Direct Federal/Intramural, Contracts, and Competitive Grants/Cooperative Agreements	\$390,447	\$445,299
Chronic Disease Prevention and Health Promotion				
PHSA Title II §§ 301, 307, 310, 311, 317*, 317D*, 317H, 317K*, 317L*, 317M, 330E, 399B*–399D, 399E, 399Q*, 399V-3*–399Z*, 1501*–1509*, Title XVII*; Fertility Clinic Success Rate And Certification Act of 1992 (P.L. 102-493); Comprehensive Smoking Education Act of 1984, P.L. 98-474 (15 U.S.C. 1335(a) and 15 U.S.C. 1341); Comprehensive Smokeless Tobacco Health Education Act of 1986 (P.L. 99-252); The Patient Protection and Affordable Care Act of 2010, § 4201* (P.L. 111-148)	Permanent Indefinite	Direct Federal Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; and Competitive Contracts	\$1,187,962	\$1,077,957
Birth Defects and Developmental Disabilities				
PHSA Title II §§ 301, 304, 307, 308(d), 310, 311, 317, 317C(a)*, 317J*, 317K*, 317L*, 317Q, 327, 352, 399M, 399Q*, 399S, 399T, 399V-2, 399AA, 399BB, 399CC; 1102, 1110, 1112, 1114, Title XI, Title XVII*; The Prematurity Research Expansion And Education For Mothers Who Deliver Infants	Permanent Indefinite	Direct Federal/Intramural, Competitive Grants, Cooperative Agreements and Contracts	\$132,337	\$132,337

(dollars in thousands)¹

Enabling Legislation Citation ²	Enabling Legislation Status	Allocation Methods	FY 2014 Appropriations Act	FY 2015 President's Budget
Early Act §§ 3,5 (42 U.S.C. 247b-4f* and 42 U.S.C. 247b-4g).				
Public Health Scientific Services				
PHSA Title II §§ 241, Title III 301, 304, 306*, 307, 308, 310, 317, 317G, 318, 319, 319A, 353, 391, 399V, 778, 1102, Title XVII*, 2315, 2341, 2521*; P.L. 107-347, Title V (44 U.S.C. 3501 note); Intelligence Reform and Terrorism Prevention Act of 2004 § 7211* (P.L. 108-458); Food, Conservation, And Energy Act of 2008 § 4403 (7 U.S.C. 5311a); P.L. 101-445 § 5341 (7 U.S.C. 5341); The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)	Permanent Indefinite	Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Contracts	\$482,957	\$525,809
Environmental Health				
PHSA Title II §§ 301, 307, 310, 311, 317*, 317A*, 317B*, 317I*, 327, 352, 361, 366, 1102; Title XVII*	Permanent Indefinite	Direct Federal/Intramural, Contracts, Competitive Grants/Cooperative Agreements	\$179,811	\$168,811
Injury Prevention and Control				
PHSA Title II §§ 214, 215, 301, 304, 307, 308, 310, 311, 317, 319, 319D*, 327, 352, 391*, 392*, 393*, 393A*, 393B*, 393C*, 393D*, 394*, 394A*, 399P*, 1102; Title XVII*, Bayh-Dole Act of 1980 (P.L. 96-517); Safety of Seniors Act of 2007 (P.L. 110-202); Traumatic Brain Injury Act of 2008 (P.L. 110-206); Family Violence Prevention and Services Act §§ 303 (42 U.S.C. 10403)*, 314 (42 U.S.C. 10414)*	Permanent Indefinite	Direct Federal/Intramural; Competitive Cooperative Agreements/Grants, including Formula Grants; and Competitive Contracts	\$150,839	\$194,304
Occupational Safety and Health				
PHSA Title II §§ 301, 304, 306, 307, 308(d), 310, 311, 317, 317A, 317B, 319, 327, 352, 399MM, 1102, Title XVII, 2695; Occupational Safety and Health Act of 1970 §§20–22, P.L. 91-596 as amended by P.L. 107-188 and 109-236 (29 U.S.C. 669–671); Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164 and P.L. 109-236 (30 U.S.C. 811–813, 842, 843–846, 861, 951–952, 957, 962, 963, 964); Black Lung Benefits Reform Act of 1977 § 19, P.L. 95-239 (30 U.S.C. 902); Bureau of Mine Act, as amended by P.L. 104-208 (30 U.S.C. 1 note, 3, 5); Radiation Exposure Compensation Act, §§ 6 and 12 (42 U.S.C. 2210 note); Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (42 U.S.C. §§7384, et seq.); Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 §§ 3611, 3612, 3623, 3624, 3625, 3626, 3633	Permanent Indefinite	Direct Federal/Intramural, Competitive Grant/Cooperative Agreements, Contracts, Other	\$332,860	\$280,590

(dollars in thousands)¹

Enabling Legislation Citation ²	Enabling Legislation Status	Allocation Methods	FY 2014 Appropriations Act	FY 2015 President's Budget
of P.L. 106-398; National Defense Authorization Act for Fiscal Year 2006, P.L. 109-163; Toxic Substances Control Act, P.L. 94-469 as amended by 102-550, (15 U.S.C. 2682, 2685); Ryan White HIV/AIDS Treatment Extension Act of 2009 § 2695, P.L. 111-87 (42 U.S.C. 300ff-131); James Zadroga 9/11 Health and Compensation Act (2010), P.L.111-347				
Global Health				
PHSA Title II §§ 301, 304, 307, 310, 319*, 327, 340C, 361–369*, Title VII*, 2315, 2341; Foreign Assistance Act of 1961 §§ 104, 627, 628; Federal Employees International Organization Service Act § 3 (5 USC 3343); International Health Research Act of 1960 § 5; Agriculture Trade Development and Assistance Act of 1954 § 104; 38 U.S.C. § 3968; Foreign Employees Compensation Program (22 U.S.C. 3968); Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L.110-293); PEPFAR Stewardship & Oversight Act of 2013 (P.L. 113-56); Section 212 of the Consolidated Appropriations Act, 2012 (P.L. 112-74, Division F)	Permanent Indefinite	Direct Federal/Intramural, Competitive Grants/Cooperative Agreements, Direct Contracts, Interagency Agreements	\$416,801	\$464,301
Public Health Preparedness and Response				
PHSA Title II §§ 301, 307, 310, 311, 319, 319C-1*, 319D*, 319F*, 319F-2*, 319G*, 351A*, 361, Title XVII*, 2801, 2812*	Permanent Indefinite	Direct, Federal Intramural, Cooperative Agreements, including Formula Grants/Cooperative Agreements; and Contracts	\$1,371,198	\$1,317,375
CDC-Wide Activities and Program Support				
PHSA Title II §§ 301, 304, 306*, 307, 308, 310, 311, 317, 317F*, 319, 319A, 319D*, 322, 325, 327, 352, 361–369, 391*, Title XVII*, 2821*	Permanent Indefinite	Direct Federal/Intramural, Contracts, Competitive Grants/Cooperative Agreements	\$298,649	\$123,570

¹ FY 2013 Actual and FY 2014 Base have been made comparable to reflect BSS realignment and EZID/Global Health reorganization.

² Expired/Expiring noted with *

APPROPRIATIONS HISTORY TABLE

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2006 ^{2,4}	3,910,963,000	5,945,991,000	6,064,115,000	5,884,934,000
2006 Rescission	--	--	--	(58,848,000)
2006 Supplemental ⁵	--	--	--	275,000,000
2006 Supplemental ⁶	--	--	--	218,000,000
2006 Section 202 Transfer to CMS	--	--	--	(4,002,000)
2007 ^{4,5,7}	5,783,205,000	6,073,503,000	6,095,900,000	5,736,913,000
2008 ⁴	5,741,651,000	6,138,253,000	6,156,169,000	6,156,541,000
2008 Rescission ⁴	--	--	--	(106,567,000)
2009	5,618,009,000	6,202,631,000	6,313,674,000	6,283,350,000
2009 American Reinvestment & Recovery Act ⁸				300,000,000
2009 H1N1 Influenza Supplemental, HHS ⁹	473,000,000	--	--	473,000,000
2010 H1N1 Influenza Supplemental, CDC ⁹	200,000,000	--	--	200,000,000
2010 Public Health Prevention Fund ¹⁰	--	--	--	191,800,000
2010	6,312,608,000	6,313,032,000	6,733,377,000	6,390,387,000
2011	6,265,806,000	--	6,527,235,000	5,648,970,000
2011 Public Health Prevention Fund	610,900,000	--	--	610,900,000
2012	5,817,412,000	--	5,765,915,000	5,655,670,000
2012 Public Health Prevention Fund	752,500,000	--	848,000,000	809,000,000
2013 Enacted	4,991,523,000	--	5,713,698,000	5,657,023,000
2013 OMB 0.2% Rescission				(\$11,314,000)
2013 Sequestration	--	--	--	(284,581,000)
2013 Public Health Prevention Fund	903,210,000	--	858,000,000	462,916,000
2014	5,216,509,000	--	5,757,052,000	5,792,542,000
2014 Public Health Prevention Fund	755,110,000	0	839,000,000	831,300,000
2015	5,399,706,000	--	--	--
2015 Public Health Prevention Fund	809,510,000	--	--	--

¹ Does not include funding for ATSDR

² FY 2004, FY 2005, FY 2006, funding levels for the Estimate reflect the proposed Law for Immunization.

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

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

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

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

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

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

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

¹⁰ The Affordable Care Act passed on March 23, 2010, after the FY 2010 appropriation. The amounts here reflect CDC's request and final amount allotted from the PPH Fund to CDC from HHS.

APPROPRIATIONS NOT AUTHORIZED BY LAW

(dollars in millions)			Appropriations in	
Program	Last Year of Authorization	Authorization Level	Last Year of Authorization	Appropriations in FY 2014 ¹
Sexually Transmitted Diseases Grants	FY 1998	Such Sums...	\$113.671	\$157.719
WISEWOMAN	FY 2003	Such Sums...	\$12.419	\$21.740
National Center for Health Statistics	FY 2003	Such Sums...	\$125.899	\$155.397
Safe Motherhood/Infant Health Promotion	FY 2005	Such Sums...	\$44.738	\$45.589
Oral Health Promotion	FY 2005	Such Sums...	\$11.204	\$15.790
Asthma Prevention	FY 2005	Such Sums...	\$32.422	\$27.596
Lead Poisoning Prevention	FY 2005	Such Sums...	\$36.474	\$15.528
Injury Prevention and Control	FY 2005	Such Sums...	\$138.237	\$150.839
Birth Defects, Developmental Disability, Disability and Health	FY 2007	Such Sums...	\$122.242	\$132.337
Breast and Cervical Cancer ²	FY 2012	\$275.000 in FY 2012	\$204.779	\$207.269

¹ FY 2014 Appropriations amounts include BSS realignments, so FY 2014 amounts are not directly comparable to the amounts provided under "Appropriations in Last Year of Authorization."

² Breast and Cervical Cancer appropriation includes WISEWOMAN funding.

NARRATIVES BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$602.593	\$611.384	\$607.942	-\$3.442
PHS Evaluation Transfer	\$12.864	\$12.864	\$12.864	\$0.000
ACA/PPHF	\$90.883	\$160.300	\$127.260	-\$33.040
PHSSEF Transfer	\$11.829	\$0.000	\$0.000	\$0.000
Total Request	\$718.169	\$784.548	\$748.066	-\$36.482
FTEs	626	626	626	0
Immunization Program Level	\$552.043	\$611.990	\$560.508	-\$51.482
-Immunization Program - BA	\$448.296	\$438.826	\$420.384	-\$18.442
-National Immunization Survey - PHS Evaluation Transfer	\$12.864	\$12.864	\$12.864	\$0.000
-Immunization Program - PPHF	\$90.883	\$160.300	\$127.260	-\$33.040
Influenza/Influenza Planning and Response	\$166.126	\$172.558	\$187.558	+\$15.000
-Influenza Planning and Response - BA	\$154.297	\$172.558	\$187.558	+\$15.000
-Influenza Planning and Response – PHSSEF Transfer	\$11.829	\$0.000	\$0.000	\$0.000

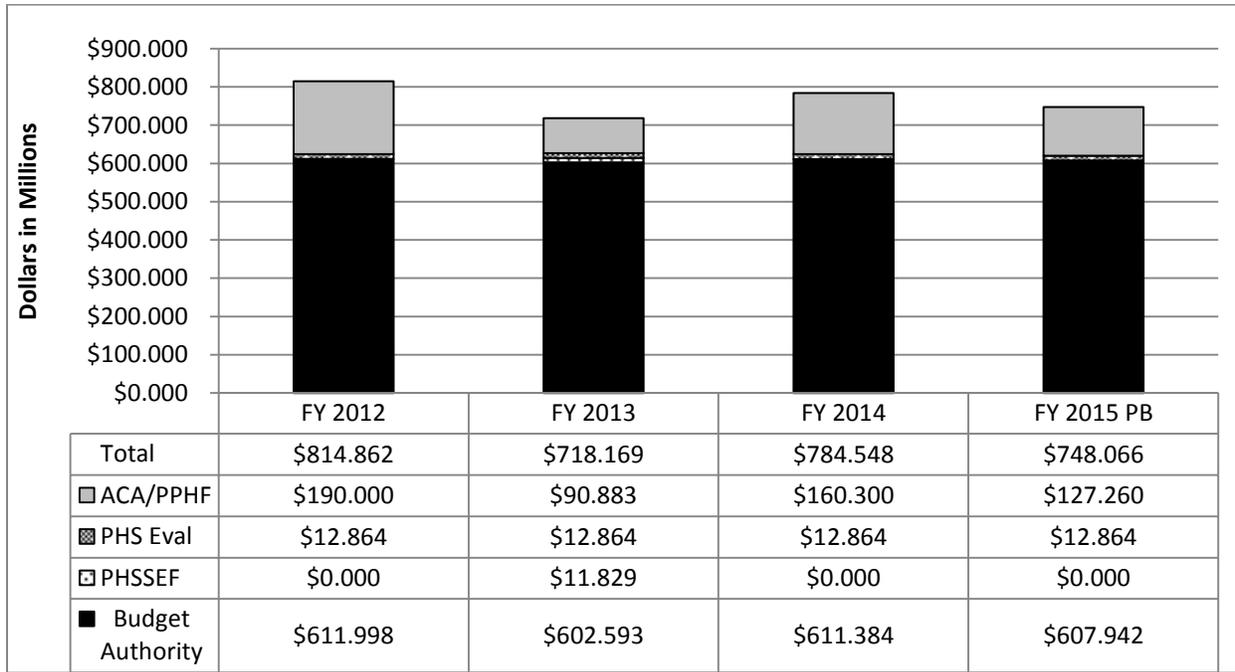
¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

CDC prevents disease, disability, and death of children, adolescents, and adults through immunization and control of respiratory and related diseases. Through the discretionary Section 317 Immunization Program and mandatory Vaccines for Children (VFC) Program, CDC improves access to immunization services for underinsured and uninsured populations in the United States and supports the scientific evidence base for vaccine policy and practices. CDC also provides critical epidemiology and laboratory capacity to detect, prevent, and respond to vaccine-preventable, respiratory, and related infectious disease threats as well as preparedness planning for pandemic influenza.

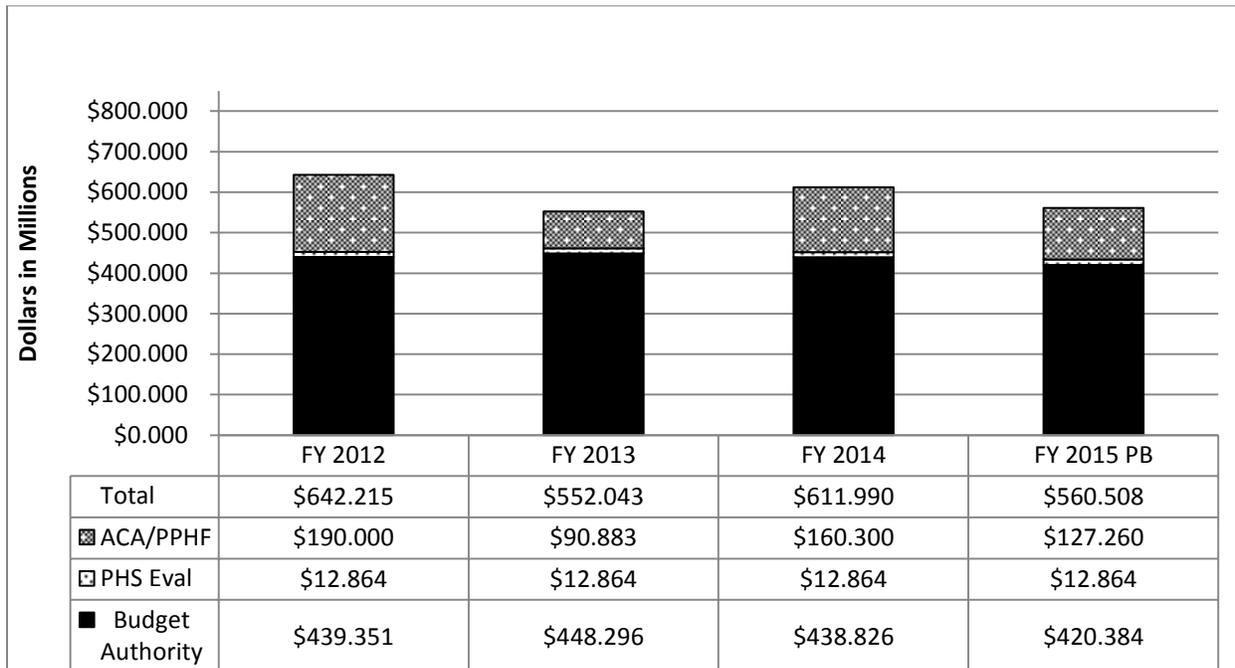
CDC's FY 2015 request of **\$748,066,000** for immunization and respiratory diseases, including \$127,260,000 from the Affordable Care Act Prevention and Public Health Fund (PPHF) and \$12,864,000 in PHS Evaluation funding, is \$36,482,000 below the FY 2014 Enacted level. The reductions to the 317 Immunization Program reflect an expectation of increased insurance coverage for immunization services through public and private health insurance expansion.

Figure: Immunization and Respiratory Diseases Funding History¹



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Figure: 317 Immunization Program Funding History¹



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Table: Immunization Program Funding History¹

Immunization Program ¹	
Fiscal Year	Dollars (in millions)
2005	\$493.032
2006	\$517.199
2007	\$512.804
2008	\$527.359
2009	\$557.359
2009 (ARRA)	\$300.000
2010	\$561.459
2011	\$488.576
2011 (ACA/PPHF)	\$100.000
2012	\$452.215
2012 (ACA/PPHF)	\$190.000
2013	\$461.160
2013 (ACA/PPHF)	\$90.883
2014	\$451.690
2014 (ACA/PPHF)	\$160.300

¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Immunization Program Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$448.296	\$438.826	\$420.384	-\$18.442
PHS Evaluation Transfer	\$12.864	\$12.864	\$12.864	\$0.000
ACA/PPHF	\$90.883	\$160.300	\$127.260	-\$33.040
Total	\$552.043	\$611.990	\$560.508	-\$51.482

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's national immunization recommendations currently provide guidance for the prevention of 17 vaccine-preventable diseases (VPDs) across the lifespan. The Section 317 Program plays a fundamental role in the achievement of national immunization goals and aims to achieve and sustain high vaccination coverage rates to prevent death and disability from VPDs. The Section 317 Program provides funds to support the essential public health functions and to ensure program effectiveness and scientifically sound immunization policy. A strong public health infrastructure at the national, state, and local levels is vital to sustaining high vaccination coverage levels, low incidence of VPDs, and for maintaining public health preparedness for a response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. The Section 317 Program also purchases routinely recommended vaccines to protect at-risk and vulnerable populations not eligible for VFC and to meet urgent public health needs such as controlling VPD outbreaks. The flexibility of the Section 317 Program is critical—allowing states to use their Section 317-purchased vaccine to meet their unique needs and priorities and fulfilling needs in responding to VPD outbreaks. The Affordable Care Act health insurance-related provisions will improve access to immunization services by requiring new private health plans and most public insurance to cover routinely recommended vaccines without cost-sharing. However, these health insurance provisions do not address the public health functions that must be in place to ensure safe and effective national immunization policies and programs—making the Section 317 Immunization cooperative agreements critical in FY 2015 and beyond.

Budget Request

CDC's FY 2015 request of **\$560,508,000** for the Immunization Program, including \$127,260,000 from the Affordable Care Act Prevention and Public Health Fund and \$12,864,000 in PHS Evaluation funding, is \$51,482,000 below the FY 2014 Enacted level. This decrease will be targeted to vaccine purchases. Health insurance expansion will further increase access to immunizations and is expected to decrease the number of uninsured and underinsured individuals in need of Section 317 vaccine for routine immunizations. Since September 2010, new health plans have been required to cover vaccines routinely recommended by the Advisory Committee on Immunization Practices (ACIP) without charging a deductible, copayment, or coinsurance. This request includes \$8,000,000 to expand the capacity of public health departments to bill health insurers for immunization services.

For FY 2015, CDC's priorities for the Section 317 Immunization Program are to:

- Preserve core public health immunization infrastructure at the local, state, and federal levels
- Maintain an adequate amount of vaccine purchase to provide a vaccination safety net for uninsured adults, and for response to VPD outbreaks and other vaccine urgent needs
- Make strategic investments to enhance the immunization infrastructure and evidence base and improve efficiency

Preserving Core Public Health Immunization Infrastructure

In FY 2015, the Section 317 Immunization Program will remain responsible for the essential public health workforce and systems at the national, state, and local levels that protect all Americans, regardless of health insurance status, from disability and death from VPDs.

In FY 2015, CDC will conduct scientific studies that provide the evidence base for national immunization policy, including burden of disease, vaccine effectiveness and safety, economic analyses, and program feasibility.

- For example, CDC's vaccine effectiveness research provided critical scientific evidence of waning immunity that informed the ACIP's recommendation for a booster dose of meningococcal conjugate vaccine at age 16 to assure protection through the high-risk college years.

In addition, CDC collects, analyzes, and reports scientific data about the effectiveness and safety of vaccines as they are used in the real-world setting and with larger populations to ensure the effectiveness and safety of our national vaccine programs and policies, and inform changes. This includes:

- Implementing vaccine safety priority studies by strengthening vaccine safety surveillance for rare vaccine adverse events
- Improving adverse-event reporting through electronic reporting
- Developing vaccine safety profiles for each newly licensed vaccine in collaboration with other federal agencies

Ongoing monitoring of immunization coverage rates is critical to identify and reach populations at greater risk for VPDs. The National Immunization Survey (NIS) is essential to assess national progress, document programmatic achievements, and identify disparities in immunization coverage rates. The NIS documented increases in adolescent vaccination rates from 2010 to 2012 for all three routinely recommended adolescent vaccines, and also identified the need for targeted efforts to improve human papillomavirus (HPV) vaccination coverage among adolescent girls. Based on this information, CDC provided FY 2013 funding from the PPHF to 11 immunization programs to conduct several activities to increase HPV vaccination, including using Immunization Information Systems (IIS) for reminder/recall for girls 11-18 years of age and a comprehensive communications campaign. In FY 2015, CDC will fund the NIS to monitor progress and inform programmatic strategies.

CDC supports efforts to communicate the benefits of vaccine to the public—through science-based communications campaigns and tools—as an aid in making informed vaccine decisions to protect themselves and their loved ones. CDC also conducts outreach to educate healthcare providers about current immunization policy and clinical best practices to help them protect their patients and communities from VPDs. CDC developed and will maintain a [dynamic provider toolkit](#)⁵ for conversations with parents about vaccination which includes evidence-based strategies, print materials, and web-based tools.

CDC will implement health information technologies to give healthcare providers the necessary immunization information to make sure their patients get the vaccines they need, when they need them, and CDC will manage vaccine supply disruptions and shortages to ensure the best public health outcomes until restoration of vaccine supply. Funds will also be used to respond to disease outbreaks by:

- Rapidly identifying and investigating cases
- Conducting surveillance and laboratory testing
- Implementing targeted vaccination efforts and other measures to control the spread of disease and prevent future outbreaks

⁵ <http://www.cdc.gov/vaccines/hcp.htm>

Maintaining an Adequate Amount of Vaccine Purchase

In FY 2015, the Section 317 Immunization Program will continue to be responsible for providing federally purchased vaccines to protect uninsured Americans from preventable diseases —and thus protecting communities from the dangers of low vaccination rates. CDC estimates, that although it is expected these populations will begin to decrease as implementation of expanded health insurance coverage provisions begin, there will continue to be a need for Section 317-purchased vaccines to serve uninsured adults and to provide rapid vaccination response to disease outbreaks and other urgent public health needs. It will be important to maintain a safety net for immunization services. And, unlike the federal VFC Program which has very specific eligibility requirements, Section 317 vaccine can be used to vaccinate non-VFC-eligible populations, such as adults or the fully-insured, in a public health emergency. A recent example where it became necessary to use Section 317 vaccine to vaccinate some privately-insured children was responding to pediatric influenza vaccine supply shortages in 2012-2013. The shortage was due to pediatricians not buying an adequate supply of privately-purchased pediatric influenza vaccines.

In FY 2015, CDC will work collaboratively with its awardees and partners to sustain record-high childhood immunization coverage rates and increase immunization coverage rates for children and adults by improving access to immunizations. Specifically, CDC will work to establish access points at complementary venues such as schools, pharmacies, and retail-based clinics; expand the network of VFC providers through recruitment efforts; purchase and deliver vaccine for at-risk populations; and ensure those with insurance have access to immunization services through an in-network provider.

Making Strategic Investments

In some communities, such as rural areas, health departments serve as a critical access point. Since 2009, CDC invested funding to expand immunization infrastructure to assist public health clinics that serve fully-insured patients with billing for immunization services in order to preserve access to life-saving immunizations for fully-insured populations. The purpose of billing is to expand access to fully-insured individuals in areas where there is not adequate in-network provider coverage. As of FY 2013, 35 awardees are developing and/or implementing billing systems in targeted areas of their jurisdictions. In FY 2015, CDC will support awardees in this area. However, while expanded billing capacity in public health departments may help to maintain and improve access to immunization services for the fully-insured, it does not replace the need for Section 317 vaccine that provides a critical public health safety net for vaccinating the uninsured and responding to VPD outbreaks and other public health emergencies.

Anticipating the evolving role of public health, CDC strategically directed immunization resources to prepare for the new healthcare environment. CDC made investments in IIS that inform and support clinical decision-making and allow interfacing with electronic health records (EHRs) and vaccine ordering systems—helping more than 95% of 56 awardees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions. In FY 2015, Section 317 will provide funding to immunization awardees and support scientific and programmatic expertise to further develop, enhance, and maintain IIS capable of identifying individuals in need of immunization, measuring vaccination coverage rates, producing reminder and recall notices, and interfacing with EHRs. CDC's immunization services program and the public health informatics program (refer to the public health scientific services section) collaborate to support Section 317 awardees in enhancing their IIS to be compliant with standards and requirements set by the national Electronic Health Records – Meaningful Use (EHR-MU) program.

Immunization Summary Table

(dollars in millions)		FY 2013	FY 2014	FY 2015	2015
		Final ¹	Enacted	President's Budget	+/-2014
	Immunization Infrastructure ²	\$218.201	\$241.080	\$241.080	\$0.000
	Vaccine Purchase ²	\$121.937	\$123.480	\$85.980	-\$37.500
	Extramural Program Operations	\$161.623	\$188.824	\$176.698	-\$12.126
	Intramural Program Operations	\$50.282	\$58.606	\$56.750	-\$1.856
	Total	\$552.043	\$611.990	\$560.508	-\$51.482

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² See 317 Immunization Grant Table for more information.

Table: Advancing Public Health Immunization Priorities

Funding Category	FY 2015 Section 317 Funding
Immunization Infrastructure	Will be awarded to support essential public health immunization workforce and systems at the state and local levels to recruit and educate networks of immunization providers, provide continual quality assurance, promote public awareness of new and expanded vaccine recommendations, manage vaccine shortages, and respond to VPD outbreaks. These awards only include core infrastructure/operations funding that goes to all awardees.
Vaccine Purchase	Will be allocated through direct assistance to provide federally purchased vaccines to vaccinate non-VFC-eligible uninsured populations and to meet urgent public health needs such as VPD outbreaks.
Extramural Program Operations	Will support national immunization policies and programs, including disease surveillance, vaccine coverage assessment, post-marketing evaluation of vaccine effectiveness and safety, immunization information technologies, centralized vaccine ordering and distribution systems, payor of last resort, public awareness campaigns and resources, and provider education and tools. Some of these funds go to awardees for work beyond the scope of core grants.
Intramural Program Operations	Will provide national public health expertise in immunization and VPDs that supports national, state, and local vaccination program efforts, including expertise in epidemiology and surveillance, laboratory methods and science, immunology, immunization policy, health communications science, vaccine management, and program implementation.

Supporting State and Territorial Immunization Programs

In FY 2015, CDC will provide infrastructure funding to 64 awardees—including all 50 states, Washington, D.C., five large cities, five territories, and three Pacific Freely Associated States—through a non-competitive, formula-based, discretionary cooperative agreement program that provides financial assistance for state and local

immunization operations. Through population-based awards and collaboration, the Section 317 Program established a comprehensive immunization system providing:

- Public sector vaccine ordering and distribution
- Continual quality assurance
- Provider recruitment and enrollment in the VFC Program
- Provider education and public awareness focused on new and expanded vaccine recommendations
- Management of vaccine shortages

In addition, CDC will provide its 64 awardees with direct assistance for vaccine purchased from the federal contracts. As part of the new five-year funding cycle that began in FY 2013, CDC adopted a vaccine use policy that Section 317–purchased vaccines cannot be used for routine vaccination of fully insured individuals. Assuring that public funds are not subsidizing insured benefits allows CDC to target its resources more effectively to meet public health priorities. In alignment with the vaccine use policy and to assure that public funds are not subsidizing insured benefits, the FY 2015 budget continues to allocate vaccine direct assistance based on the estimated number of uninsured adults within each awardee’s jurisdiction. Beginning in FY 2014, vaccine direct assistance will be allocated to the 64 Section 317 Immunization Programs based on a formula that takes into account the percentage of uninsured adults ages 19 to 64 years in their jurisdictions. The final allocation to awardees is adjusted as necessary to minimize large fluctuations. This will support an orderly transition to the new vaccine allocation formula, limit disruption to the Section 317 Immunization Program, and ensure that all awardees receive some amount of discretionary Section 317 vaccine to provide a safety net. For the FY 2014 allocation of vaccine direct assistance to U.S state and city awardees, CDC used the 2012 U.S. Census data for uninsured adults ages 19 to 64 years as its base population and allocated vaccine to each awardee based on their proportion of the uninsured adult population. The allocation of vaccine to the five U.S. Territories and three Pacific Freely Associated States was not changed.

CDC provides national public health expertise in VPDs that supports the 64 awardees, including expertise in:

- Epidemiology and surveillance
- Laboratory methods and science
- Immunology
- Immunization policy
- Health communications science
- Vaccine management
- Program implementation

Table: Section 317 Immunization Cooperative Agreements^{1, 2}

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final	Enacted	President’s Budget	2015 +/-2014
Number of Awards	64	64	64	0
- New Awards	0	0	0	0
- Continuing Awards	64	64	64	0
Average Award	\$5.315	\$5.696	\$5.110	-\$0.586
Range of Awards	\$0.572–\$37.773	\$0.624–\$40.527	\$0.600–\$36.500	N/A
Total Awards	\$340.138	\$364.560	\$327.060	-\$37.500

¹This table includes Section 317 budget authority and Prevention and Public Health Funds. It does not include funds from the former program implementation line.

²Immunization operations awards and vaccine direct assistance are included in the table. In FY 2013, CDC awarded a new five-year cooperative agreement for Section 317 immunization funding.

Influenza Planning and Response Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$154.297	\$172.558	\$187.558	+\$15.000
PHSSEF Transfer	\$11.829	\$0.000	\$0.000	\$0.000
Total	\$166.126	\$172.558	\$187.558	+\$15.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's influenza planning and response activities ensure a comprehensive response for seasonal influenza as well as the ability to respond to an influenza pandemic. CDC's influenza program works to detect, respond to, and prevent influenza disease that can cause mild to severe illness, and at times can lead to death. Some people, such as older adults, young children, and people with certain health conditions, are at higher risk for serious influenza complications. Over a period of 30 years, between 1976 and 2006, estimates of influenza-associated deaths in the United States ranged from a low of about 3,000 to a high of about 49,000 people. On average, influenza causes more than 200,000 hospitalizations annually, and a [study](#)⁶ published in 2007 estimated more than \$10 billion annually in direct medical costs for hospitalizations and outpatient visits from seasonal influenza-related complications. Not only can influenza infections be severe, but also, influenza seasons are unpredictable—requiring constant vigilance from CDC and its domestic and international public health partners. CDC provides leadership and a cutting-edge scientific and programmatic foundation for the diagnosis, prevention, and control of influenza domestically and internationally. CDC's annual seasonal influenza activities improve preparedness by:

- Strengthening surveillance and diagnostic capacity
- Improving public awareness and provider knowledge about influenza and the importance of vaccination, other prevention measures, and early treatment
- Enhancing our international, Federal, State, and local partnerships to respond quickly to influenza epidemics

Prevention of seasonal influenza requires an annual reassessment of virus strains contained in the vaccine; the assessment is based on CDC surveillance data. The vaccine must be produced and administered annually to account for seasonal variations. Since 2010, the Advisory Committee on Immunization Practices (ACIP) has recommended influenza vaccine for all Americans six months and older. To implement this recommendation, CDC works to educate providers and raise public awareness. CDC makes special efforts to reach high-risk individuals, such as pregnant women, and provides further outreach to subspecialty medical providers to increase vaccination of persons at especially high risk of severe illness or death from influenza. CDC also promotes vaccination at non-traditional venues, such as retail pharmacies, to increase access to vaccine services outside of clinic settings and hours.

Budget Request

CDC's FY 2015 request of **\$187,558,000** for influenza planning and response is \$15,000,000 above the FY 2014 Enacted level, reflecting a realignment of funding to CDC previously funded through pandemic influenza balances, to sustain critical international influenza activities.

⁶ <http://download.thelancet.com/flatcontentassets/H1N1-flu/epidemiology/epidemiology-14.pdf>

Influenza Prevention

In FY 2015, CDC will support efforts to prevent influenza through vaccination. CDC focuses on increasing demand with healthcare providers for influenza vaccination each season through investments in health communication with providers and the general public, targeted outreach to high-risk populations, and partnerships with pharmacists as a means to extend the reach of influenza vaccination. Annual vaccination campaigns help reach the Healthy People 2020 influenza vaccination goals, including those for minority and high-risk populations, and they also help build capacity for vaccination efforts in the event of an influenza pandemic.

To complement national efforts, resources will be available to all 64 immunization awardees to increase demand for seasonal influenza, including school-located vaccination clinics, and to improve influenza coverage rates among priority populations (school-aged children, high-risk adults, and racial and ethnic groups). CDC will measure vaccination coverage, with particular attention to racial and ethnic minority populations with historically low coverage rates. These surveys guide outreach efforts that result in improvement of influenza vaccination rates, particularly among children.

Detection and Monitoring of Influenza

Detection and monitoring of influenza involves a network of laboratories at the state level and internationally that are routinely testing samples to:

- Determine severity of the [influenza season](#)⁷
- Identify viruses that are causing disease and may pose a pandemic threat
- Determine the effectiveness of the influenza vaccine and other interventions

Ongoing work to improve laboratory and surveillance methods ensures that CDC can adequately respond to unusual cases. To build capacity for influenza surveillance, CDC continues to train public health laboratory workers at state laboratories that have similar responsibilities during foodborne outbreaks.

In FY 2015, CDC will serve as a World Health Organization (WHO) Collaborating Center to rapidly detect, identify, and characterize emerging influenza viruses so vaccine-candidate viruses used to produce vaccines for seasonal and novel viruses are rapidly selected. CDC receives and characterizes approximately 11,000 influenza virus specimens each year. The number of influenza virus specimens received and characterized fluctuates by year depending on the severity and burden of the disease. Worldwide characterization of these specimens is essential to the production of each season's influenza vaccine. It also aids in informing vaccine policies and recommendations as well as decisions regarding potential vaccines for novel viruses with pandemic potential. Effective influenza control depends on shortening the time between identification of novel influenza viruses and delivery of effective vaccines.

CDC will work with domestic and international partners in the intersection of human and animal health to improve surveillance, conduct swift outbreak responses, and complete threat assessments for emerging influenza viruses with pandemic potential. Pandemics emerge when a virus that is predominantly transmitted among animals develops the ability to be transmitted among humans. Each human case of infection with an animal influenza virus represents the potential for a pandemic. CDC will conduct research to understand better the complex factors that determine how and when these novel influenza viruses develop the ability to be transmitted from person to person.

Because novel influenza viruses can emerge anywhere in the world, CDC will support the international monitoring of influenza and evaluate countries' core capacities to conduct surveillance, perform laboratory testing, and prepare to respond to influenza pandemics. CDC's influenza program funds WHO regional offices as

⁷ <http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>

well as partner nations through cooperative agreements. CDC will continue this support by funding 36 countries, with emphasis on countries that continue to experience animal outbreaks and human cases of H5N1 and H7N9 influenza. Core activities funded through these agreements include:

- Helping establish, expand, and maintain influenza surveillance and laboratory capacity
- Helping develop global and local pandemic plans and influenza prevention policies
- Supporting targeted research projects to address critical needs
- Building the evidence base for decisions on influenza vaccine program expansion

CDC's international support resulted in twice as many countries reporting to WHO FluNet since 2005 when the number of countries from which specimens were processed was 59; as of 2013, 121 countries report to WHO FluNet. CDC will work on expanding virus sample sharing among countries so that vaccines and diagnostic tests for viruses with pandemic potential can be produced.

Domestically, CDC will support the capability of state and local health departments to conduct influenza laboratory testing. CDC will provide training and consultation to maintain the number of public health laboratories able to perform testing for resistance to antiviral medications and to participate in CDC evaluations of new influenza diagnostic tests.

Supporting State/Municipality/Territorial Laboratory Capacity

The Epidemiology and Laboratory Capacity for Infectious Diseases cooperative agreement (ELC) assists states and eligible local public health agencies to strengthen their basic epidemiologic and laboratory capacity to address infectious disease threats. CDC funds 50 states, five municipalities, and one territory through the ELC to conduct influenza surveillance and diagnostic activities with funding from the Influenza Planning and Response budget line.

In FY 2015, public health departments will be funded to improve detection of novel human influenza virus infections, such as the H3N2v and H7N9 influenza virus. Rapid and thorough investigations determined the H3N2v virus caused 308 human cases in the United States in 2012. Collaboration between the state and local health authorities and CDC is essential for risk assessment and response to similar novel viruses. In addition, these funds support seasonal influenza surveillance consisting of eight different systems. This network of systems provides data on:

- Influenza viruses
- Outpatient influenza-like illness
- Influenza-associated hospitalizations
- Influenza-associated deaths
- Geographic distribution of the viruses

The network also forms the foundation for pandemic influenza surveillance.

CDC provides ELC awardees with the reporting websites and other materials necessary to report influenza surveillance data throughout the year from public health laboratories, outpatient influenza-like illness surveillance sites, and vital statistics offices. CDC updates awardees on the current influenza season and any pertinent developments in influenza surveillance during monthly conference calls, yearly in-person meetings, and individually as needed. Awardees also rely on CDC's epidemiologic, laboratory, and programmatic assistance during investigations of outbreaks or unusual cases of influenza (e.g., pediatric deaths, human infections with novel influenza A viruses, and antiviral resistant influenza infections or outbreaks).

Table: Influenza Planning and Response ELC Grants¹

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President's Budget	2015 +/-2014
Number of Awards	56	56	56	0
- New Awards	0	0	0	0
- Continuing Awards	56	56	56	0
Average Award	\$0.107	\$0.107	\$0.107	\$0.000
Range of Awards	\$0.016–\$0.232	\$0.016–\$0.232	\$0.016–\$0.232	N/A
Total Grant Awards	\$6.000	\$6.000	\$6.000	\$0.000

¹This table only reflects Influenza Planning and Response funding that goes out through the ELC, which also funds other infectious disease activities.

Response to Influenza Pandemics

In FY 2015, CDC will work to ensure the availability and effectiveness of medical countermeasures and equipment in the event of an influenza pandemic. Scientific experts will update or develop guidance that will inform purchasing countermeasure requirements. Examples of countermeasures include antiviral drugs, respirators or masks, and ventilators to assist patients with breathing. CDC will also develop and evaluate solutions to lessen the impact of an influenza pandemic through non-pharmaceutical interventions or actions that people and communities can take to help slow the spread of influenza. In addition, CDC is developing a nationwide system of triage call centers that would be activated during a severe pandemic to provide advice to ill individuals and thereby reduce the burden on hospitals, healthcare facilities, and public health departments. CDC is also collaborating with the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), and national associations that represent pharmacies, pharmacists, and pharmaceutical distributors on efforts to improve antiviral distribution and dispensing at the local level during a pandemic.

Domestically, CDC will sustain the nation’s ability to respond to influenza pandemics by ensuring well-trained staff are in place for pandemic response. CDC will also provide scientific and programmatic expertise to help CDC’s Public Health Emergency Preparedness (PHEP) Cooperative Agreement Program and HHS’ Hospital Preparedness Program (HPP) Cooperative Agreement awardees meet all hazard requirements of the Pandemic and All Hazards Preparedness Act of 2006 and the Pandemic and All Hazards Preparedness Reauthorization Act of 2013. CDC collaborates with awardees to determine their jurisdictional priorities for capability development and sustainment, along with related performance measures. The pandemic influenza capabilities include Public Health Surveillance & Epidemiological Investigation, Public Health Laboratory Testing, Medical Countermeasure Dispensing, and Emergency Operations Coordination. In addition, CDC will support planning efforts among health departments, hospitals, and emergency responders. Coordination among these groups will result in more integrated emergency response plans prior to a public health disaster to ensure a rapid, efficient, and effective response at the community level. CDC will test its response capabilities with federal, state, and local partners in FY 2015 with a functional exercise that implements an incident management system to test its response plans and evaluate improvements made based on lessons from previous responses and exercises.

Affordable Care Act Prevention and Public Health Fund

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President's Budget	2015 +/-2014
	ACA/PPHF	\$90.883	\$160.300	\$127.260	-\$33.040

The following activities are included:

Immunization – \$127,260,000

In FY 2015, CDC's request of \$127,260,000 will support immunization activities and advance modernization of CDC's immunization infrastructure and evidence base. CDC will also use these funds to support vaccine purchase, state operations, and communications.

State Table: Section 317^{1,2,3}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$5,833,752	\$6,214,445	\$5,443,956	(\$770,489)
Alaska	\$1,863,849	\$2,009,077	\$1,841,630	(\$167,447)
Arizona	\$7,439,410	\$7,982,561	\$7,192,406	(\$790,156)
Arkansas	\$2,506,084	\$2,766,976	\$2,760,734	(\$6,242)
California	\$37,773,438	\$40,526,849	\$36,500,080	(\$4,026,769)
Colorado	\$5,215,590	\$5,596,400	\$5,042,506	(\$553,894)
Connecticut	\$4,275,620	\$4,553,272	\$3,984,026	(\$569,245)
Delaware	\$1,112,984	\$1,222,815	\$1,199,913	(\$22,902)
Florida	\$17,029,018	\$18,255,314	\$16,389,941	(\$1,865,373)
Georgia	\$10,410,735	\$11,122,048	\$9,853,597	(\$1,268,450)
Hawaii	\$1,706,822	\$1,874,057	\$1,834,944	(\$39,113)
Idaho	\$2,020,287	\$2,181,699	\$2,013,527	(\$168,172)
Illinois	\$8,632,443	\$9,260,330	\$8,335,560	(\$924,770)
Indiana	\$6,743,642	\$7,181,727	\$6,284,441	(\$897,285)
Iowa	\$3,473,622	\$3,735,236	\$3,392,997	(\$342,239)
Kansas	\$2,721,914	\$2,967,477	\$2,834,611	(\$132,866)
Kentucky	\$4,625,939	\$4,957,720	\$4,446,514	(\$511,206)
Louisiana	\$3,243,068	\$3,508,628	\$3,260,191	(\$248,437)
Maine	\$1,955,193	\$2,141,652	\$2,079,792	(\$61,860)
Maryland	\$4,678,669	\$5,068,235	\$4,731,341	(\$336,893)
Massachusetts	\$6,419,074	\$6,861,085	\$6,090,417	(\$770,668)
Michigan	\$10,019,759	\$10,707,937	\$9,499,061	(\$1,208,876)
Minnesota	\$6,066,385	\$6,462,180	\$5,660,699	(\$801,481)
Mississippi	\$3,177,308	\$3,444,030	\$3,222,467	(\$221,563)
Missouri	\$5,828,585	\$6,224,851	\$5,508,117	(\$716,734)
Montana	\$1,258,699	\$1,362,957	\$1,270,498	(\$92,459)
Nebraska	\$1,514,099	\$1,669,130	\$1,656,712	(\$12,418)
Nevada	\$3,360,632	\$3,576,504	\$3,121,200	(\$455,304)
New Hampshire	\$1,820,095	\$1,971,282	\$1,839,019	(\$132,264)
New Jersey	\$6,995,636	\$7,542,446	\$6,919,705	(\$622,740)
New Mexico	\$3,316,702	\$3,554,566	\$3,187,984	(\$366,582)
New York	\$10,648,034	\$11,425,742	\$10,295,774	(\$1,129,968)
North Carolina	\$9,513,696	\$10,140,830	\$8,905,326	(\$1,235,505)
North Dakota	\$1,226,769	\$1,325,557	\$1,226,020	(\$99,536)
Ohio	\$7,545,709	\$8,240,110	\$7,917,307	(\$322,803)
Oklahoma	\$4,572,731	\$4,887,083	\$4,336,344	(\$550,738)
Oregon	\$4,146,886	\$4,451,616	\$4,017,721	(\$433,895)
Pennsylvania	\$10,325,708	\$10,993,573	\$9,609,931	(\$1,383,642)
Rhode Island	\$2,444,430	\$2,573,801	\$2,150,399	(\$423,402)
South Carolina	\$3,991,840	\$4,327,064	\$4,049,123	(\$277,941)
South Dakota	\$1,967,913	\$2,086,848	\$1,795,298	(\$291,550)
Tennessee	\$5,700,561	\$6,156,546	\$5,683,800	(\$472,746)
Texas	\$26,586,167	\$28,275,887	\$24,613,711	(\$3,662,176)
Utah	\$2,622,318	\$2,866,876	\$2,765,492	(\$101,384)
Vermont	\$1,651,286	\$1,755,316	\$1,524,789	(\$230,527)
Virginia	\$6,524,259	\$7,037,689	\$6,468,471	(\$569,218)
Washington	\$11,164,084	\$11,683,913	\$9,513,226	(\$2,170,687)
West Virginia	\$2,495,875	\$2,659,060	\$2,330,460	(\$328,601)
Wisconsin	\$4,741,318	\$5,136,778	\$4,797,633	(\$339,145)
Wyoming	\$1,025,361	\$1,111,413	\$1,039,834	(\$71,578)

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Cities				
Chicago	\$4,413,665	\$4,753,587	\$4,343,778	(\$409,808)
District of Columbia	\$1,889,359	\$2,024,612	\$1,814,968	(\$209,644)
Houston ⁴	\$2,093,920	\$2,313,468	\$2,313,468	\$0
New York City	\$11,293,512	\$12,018,910	\$10,488,686	(\$1,530,224)
Philadelphia	\$2,334,242	\$2,513,544	\$2,295,238	(\$218,306)
San Antonio	\$1,614,984	\$1,784,315	\$1,784,315	\$0
Territories				
American Samoa	\$571,757	\$624,324	\$599,698	(\$24,626)
Guam	\$1,443,584	\$1,562,581	\$1,454,627	(\$107,954)
Marshall Islands	\$2,602,083	\$2,729,450	\$2,244,218	(\$485,232)
Micronesia	\$3,289,921	\$3,438,943	\$2,785,374	(\$653,569)
Northern Mariana Islands	\$990,066	\$1,076,144	\$1,016,998	(\$59,145)
Puerto Rico	\$4,131,722	\$4,425,048	\$3,958,418	(\$466,630)
Republic Of Palau	\$657,388	\$686,369	\$553,117	(\$133,252)
Virgin Islands	\$877,964	\$969,518	\$967,849	(\$1,670)
Subtotal States	\$301,933,998	\$323,639,188	\$290,439,246	(\$33,199,941)
Subtotal Cities	\$23,639,682	\$25,408,436	\$23,040,454	(\$2,367,981)
Subtotal Territories	\$14,564,484	\$15,512,377	\$13,580,300	(\$1,932,077)
Total States/Cities/Territories	\$340,138,164	\$364,560,000	\$327,060,000	(\$37,500,000)
Total Resources ⁵	\$340,138,164	\$364,560,000	\$327,060,000	(\$37,500,000)

¹CFDA NUMBER: 93.268, Discretionary

²This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial awardees). For a more comprehensive view of grant and cooperative agreement funding to awardees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

³Includes vaccine direct assistance and immunization infrastructure/operations grant funding.

⁴Immunization infrastructure/operations grant funding only; vaccine direct assistance for Houston is included with Texas.

⁵FY 2013 does not include American Recovery and Reinvestment Act funding.

State Table: Vaccines for Children^{1,2}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$56,480,869	\$55,503,655	\$63,908,549	\$8,404,894
Alaska	\$9,635,069	\$9,528,889	\$10,832,058	\$1,303,169
Arizona	\$76,815,180	\$75,503,701	\$86,910,216	\$11,406,515
Arkansas	\$38,776,731	\$38,113,053	\$43,873,392	\$5,760,339
California	\$395,749,600	\$388,903,954	\$447,793,221	\$58,889,267
Colorado	\$38,751,336	\$38,112,510	\$43,835,247	\$5,722,737
Connecticut	\$36,126,110	\$35,556,976	\$40,855,428	\$5,298,452
Delaware	\$10,160,517	\$10,019,996	\$11,483,108	\$1,463,112
Florida	\$190,047,629	\$186,741,648	\$215,047,267	\$28,305,619
Georgia	\$112,149,029	\$110,227,374	\$126,890,299	\$16,662,925
Hawaii	\$13,271,873	\$13,134,327	\$14,981,736	\$1,847,409
Idaho	\$17,253,847	\$16,972,510	\$19,516,241	\$2,543,731
Illinois	\$82,440,747	\$81,061,867	\$93,264,053	\$12,202,185
Indiana	\$56,168,536	\$55,232,545	\$63,541,335	\$8,308,790
Iowa	\$25,459,312	\$25,055,898	\$28,793,121	\$3,737,223
Kansas	\$25,100,585	\$24,691,598	\$28,391,760	\$3,700,162
Kentucky	\$45,329,520	\$44,543,423	\$51,291,412	\$6,747,989
Louisiana	\$59,606,211	\$58,567,700	\$67,447,683	\$8,879,983
Maine	\$13,332,807	\$13,159,597	\$15,064,023	\$1,904,426
Maryland	\$57,260,228	\$56,278,931	\$64,786,777	\$8,507,846
Massachusetts	\$60,097,368	\$59,105,102	\$67,982,329	\$8,877,227
Michigan	\$87,070,772	\$85,611,128	\$98,503,215	\$12,892,087
Minnesota	\$35,413,642	\$34,837,939	\$40,056,548	\$5,218,609
Mississippi	\$38,407,046	\$37,748,990	\$43,455,389	\$5,706,399
Missouri	\$54,529,466	\$53,596,597	\$61,696,442	\$8,099,845
Montana	\$7,945,902	\$7,831,514	\$8,981,951	\$1,150,436
Nebraska	\$15,702,174	\$15,449,711	\$17,759,728	\$2,310,017
Nevada	\$30,580,333	\$30,090,034	\$34,586,935	\$4,496,901
New Hampshire	\$7,844,209	\$7,746,415	\$8,861,166	\$1,114,751
New Jersey	\$65,262,420	\$64,206,747	\$73,816,621	\$9,609,873
New Mexico	\$37,809,847	\$37,188,752	\$42,769,390	\$5,580,637
New York	\$81,509,311	\$80,258,276	\$92,167,058	\$11,908,782
North Carolina	\$97,830,488	\$96,174,862	\$110,681,705	\$14,506,842
North Dakota	\$5,817,870	\$5,737,555	\$6,575,123	\$837,568
Ohio	\$96,605,322	\$94,905,164	\$109,320,757	\$14,415,593
Oklahoma	\$55,506,364	\$54,578,319	\$62,793,436	\$8,215,117
Oregon	\$29,694,871	\$29,232,996	\$33,579,977	\$4,346,981
Pennsylvania	\$75,883,810	\$74,685,452	\$85,818,970	\$11,133,518
Rhode Island	\$11,489,779	\$11,329,972	\$12,985,749	\$1,655,777
South Carolina	\$54,678,305	\$53,770,769	\$61,854,097	\$8,083,328
South Dakota	\$8,884,996	\$8,750,693	\$10,045,956	\$1,295,263
Tennessee	\$67,475,729	\$66,311,935	\$76,347,913	\$10,035,978
Texas	\$341,895,457	\$335,953,207	\$386,867,770	\$50,914,564
Utah	\$23,743,669	\$23,373,740	\$26,850,393	\$3,476,653
Vermont	\$6,444,135	\$6,380,466	\$7,273,156	\$892,690
Virginia	\$56,399,837	\$55,415,767	\$63,820,043	\$8,404,276
Washington	\$77,036,739	\$75,834,244	\$87,117,426	\$11,283,182
West Virginia	\$18,964,144	\$18,656,407	\$21,450,226	\$2,793,819
Wisconsin	\$39,461,011	\$38,805,384	\$44,639,993	\$5,834,609
Wyoming	\$4,852,621	\$4,792,896	\$5,481,439	\$688,543
Cities				

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Chicago	\$47,140,519	\$46,388,826	\$53,315,232	\$6,926,406
District of Columbia	\$9,540,336	\$9,412,395	\$10,780,655	\$1,368,261
Houston ³	\$716,881	\$758,914	\$790,173	\$31,259
New York City	\$119,356,770	\$117,328,255	\$135,039,035	\$17,710,780
Philadelphia	\$25,348,430	\$24,977,664	\$28,655,812	\$3,678,149
San Antonio	\$654,962	\$693,364	\$721,923	\$28,559
Territories				
American Samoa	\$1,444,466	\$1,422,920	\$1,631,131	\$208,210
Guam	\$2,610,984	\$2,589,453	\$2,938,030	\$348,577
Northern Mariana Islands	\$1,377,466	\$1,362,275	\$1,552,269	\$189,994
Puerto Rico	\$45,776,691	\$45,032,857	\$51,778,116	\$6,745,258
Virgin Islands	\$2,179,170	\$2,190,369	\$2,446,898	\$256,528
Subtotal States	\$2,954,753,375	\$2,905,271,184	\$3,342,647,824	\$437,376,640
Subtotal Cities	\$202,757,897	\$199,559,418	\$229,302,831	\$29,743,413
Subtotal Territories	\$53,388,776	\$52,597,874	\$60,346,443	\$7,748,568
Total States/Cities/Territories	\$3,210,900,049	\$3,157,428,477	\$3,632,297,098	\$474,868,621
Other Adjustments ⁴	\$396,115,671	\$405,041,523	\$444,319,902	\$39,278,379
Total Resources⁵	\$3,607,015,720	\$3,562,470,000	\$4,076,617,000	\$514,147,000

¹CFDA Number: 93.268, Mandatory

²This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

³Funding for Houston only includes funding for operations, not the cost of vaccines. Funding for Texas includes the cost of vaccines for Houston.

⁴Other adjustments include vaccine that is in inventory at the centralized distribution center but has not been ordered by immunization providers, funds for centralized vaccine distribution activities, developing a new centralized vaccine ordering system, pediatric stockpile, influenza stockpile, stockpile storage and rotation, and program support services.

⁵Total resources for FY 2013 reflect Actuals; total resources for FY 2014 and FY 2015 are based on the OMB-approved FY 2015 VFC PB 10 Year Table.

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

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget	2015 +/-2014
	Budget Authority	\$1,091.680	\$1,120.566	\$1,124.942	+\$4.376
	PHS Evaluation Transfer	\$3.691	\$0.000	\$3.000	+\$3.000
	Total Request	\$1,095.371	\$1,120.566	\$1,127.942	+\$7.376
	FTEs	1,204	1,204	1,204	0
HIV/AIDS, Viral Hepatitis, STI, and TB					
	- Domestic HIV/AIDS Prevention and Research	\$768.635	\$788.809	\$796.185	+\$7.376
	- PHS Evaluation Transfer (non-add)	\$3.691	\$0.000	\$3.000	+\$3.000
	- Viral Hepatitis	\$31.368	\$31.410	\$31.410	\$0.000
	- Sexually Transmitted Infections	\$154.861	\$157.719	\$157.719	\$0.000
	- Tuberculosis	\$140.507	\$142.628	\$142.628	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

CDC prevents and controls HIV, viral hepatitis, sexually transmitted infections, and TB in the United States to address CDC’s overarching goal of protecting Americans from infectious diseases. These efforts aim to achieve the objectives of the [National HIV/AIDS Strategy](#)⁸; the [HIV Continuum of Care Initiative](#)⁹; the [HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis](#)¹⁰; and the [National Prevention Strategy](#).¹¹ CDC focuses on the populations most affected, including racial and ethnic minorities such as African Americans and Latinos, men who have sex with men (MSM) of all races, persons born outside the United States, and young sexually active adults. CDC’s strategic role is to monitor these infections and related risk factors; implement effective prevention and control programs; and conduct prevention research, demonstration projects, and evaluation efforts to refine prevention approaches. Because HIV, viral hepatitis, STI, and TB share many social, environmental, behavioral, and biological determinants, CDC’s programs open a broader dialogue that includes positive messages about prevention and wellness, rather than only disease incidence or avoidance. CDC also incorporates social determinants of health, which consider socioeconomic status, healthcare service access and quality, and key structural, contextual, and environmental factors in the planning of interventions and programs.

CDC’s FY 2015 request of **\$1,127,942,000** for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections (STI), and Tuberculosis (TB) prevention, including \$3,000,000 in Public Health Service Evaluation Transfer funds, is \$7,376,000 above the FY 2014 Enacted level. Overall, HIV/AIDS prevention investments will continue to align activities with the *National HIV/AIDS Strategy* and to promote high-impact prevention that focuses resources on effective, scalable and sustainable prevention strategies along the HIV continuum of care for persons living with HIV and populations at highest risk for HIV. In FY 2015, \$4.3 million in additional funding will be used to improve CDC’s HIV surveillance timeliness, quality and efficiency as well as support projects that identify and share best practices for HIV testing, earlier diagnostic identification of HIV, and other HIV prevention activities. The \$3 million in PHS Evaluation transfer funds will evaluate the effectiveness of CDC’s core school HIV prevention activities by comparing local education agencies and schools where programmatic efforts are focused with those not receiving such attention. Additionally, CDC will dedicate \$8 million of its total HIV resources to help grantees increase their capacity to seek health insurer reimbursement for covered infectious disease testing.

⁸ <http://www.whitehouse.gov/administration/eop/onap/nhas>

⁹ <http://aids.gov/federal-resources/policies/care-continuum/>

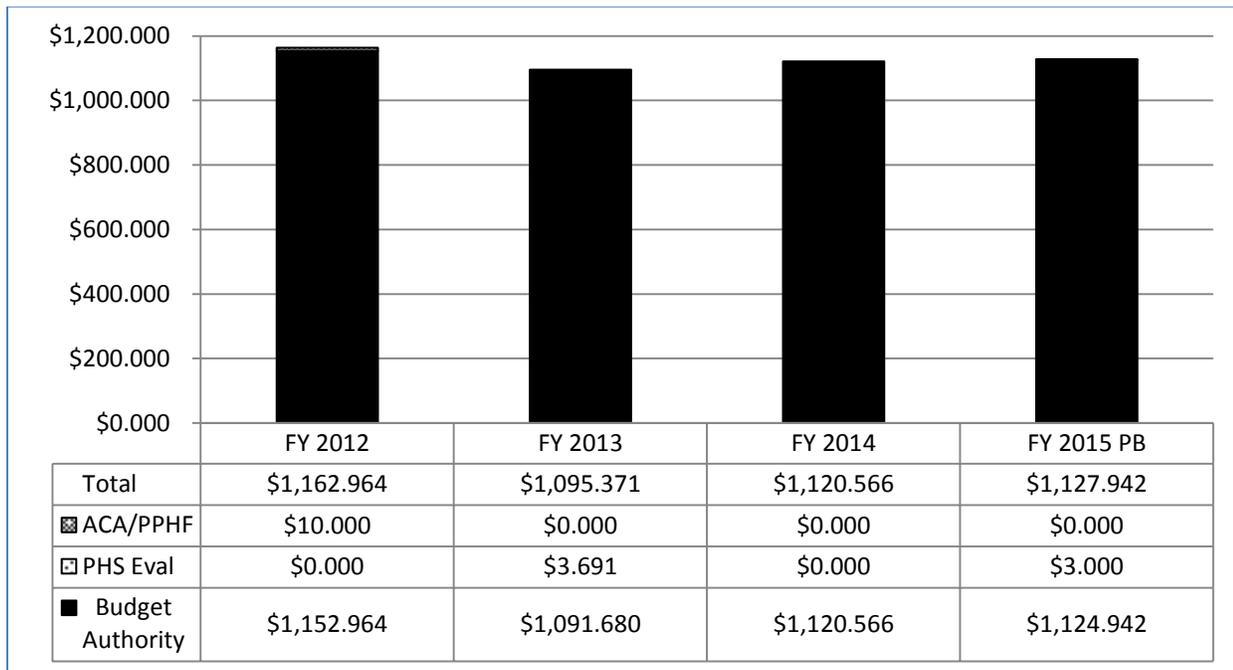
¹⁰ <http://www.cdc.gov/hepatitis/HHS-ActionPlan.htm>

¹¹ <http://www.surgeongeneral.gov/initiatives/prevention/strategy/>

CDC is improving program collaboration and service integration (PCSI) across HIV, viral hepatitis, STI, and TB prevention programs. Through PCSI, CDC strengthens collaborative work across disease areas and integrates services at the individual, or client, level, resulting in improved efficiency, cost effectiveness, and health outcomes. CDC will publish information on best practices and maintain support of PCSI by encouraging HIV, viral hepatitis, STD and TB grantees to address related infections and to develop capacities that can be shared across programs. CDC will also continue to support HIV, STD, viral hepatitis and TB control activities in six Pacific Islands jurisdictions through a single cooperative agreement with each jurisdiction in order to reduce administrative strain on these small areas.

CDC will leverage the Affordable Care Act to improve the prevention and control of HIV and AIDS, viral hepatitis, STIs, and TB in the United States, and will continue to complement the Act’s provisions by continuing critical public health services at the state and local levels. These include surveillance, monitoring, partner services and contact investigations, laboratory services, provider training, operational research, and outreach to populations unlikely to access clinical care.

Figure: Funding History (dollars in millions)¹



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Domestic HIV/AIDS Prevention and Research Budget Request

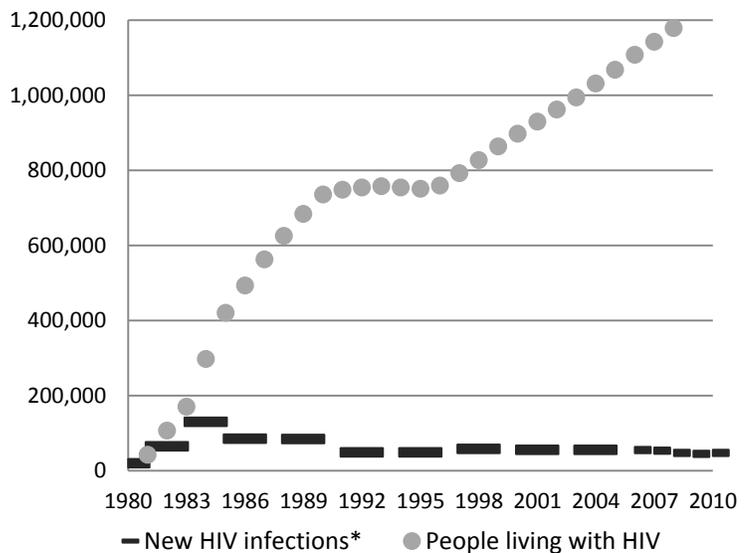
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	
			President Budget	2015 +/-2014
HIV Prevention by Health Departments	\$377.419	\$398.238	\$398.238	\$0.000
Surveillance, Research and Programs to Support HIV Prevention	\$360.788	\$359.410	\$363.786	+\$4.376
- PHS Evaluation Transfer (non-add)	\$3.691	\$0.000	\$0.000	\$0.000
HIV Adolescent and School Health	\$30.428	\$31.161	\$34.161	+\$3.000
- PHS Evaluation Transfer (non-add)	\$0.000	\$0.000	\$3.000	+\$3.000
Total	\$768.635	\$788.809	\$796.185	+\$7.376

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC is the nation’s lead HIV prevention agency and is at the forefront of stopping new infections. More than 1.1 million Americans now live with HIV, a total that has risen slowly since the advent of better, life-prolonging treatments. Some populations bear a disproportionate burden of HIV. For example, 39% of new HIV infections occur among adolescents and young adults (ages 13 to 29). The rising number of persons living with HIV increases the demand for CDC prevention services. CDC’s HIV prevention efforts are driven by the *National HIV/AIDS Strategy* (NHAS). The NHAS guides federal agencies in making the most of recent advancements in HIV prevention and treatment, as well as in using prevention and treatment resources most effectively. The three overarching goals of the NHAS are reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities. More information can be accessed at the [National HIV/AIDS Strategy \(on the White House website\)](#).¹²

Figure: HIV Prevalence and Incidence, 1980-2010



*For 1980 to 2005, new HIV infections were estimated using back-calculation methodology. In 2006, new HIV infections were estimated using original incidence surveillance methodology. Estimates from 2007-2010 were estimated using updated incidence surveillance methodology.

CDC uses a high-impact approach to HIV prevention that incorporates the NHAS action steps and maximizes the effectiveness of current HIV prevention methods. CDC’s approach is based on targeting the best combination of scientifically-proven, cost-effective, and scalable interventions to the populations that need it most. It also includes general HIV prevention education for young Americans. CDC’s approach to HIV prevention includes:

- Surveillance and epidemiology to characterize the HIV epidemic and related risk factors
- Prevention interventions such as HIV testing, condom distribution, counseling and education for HIV-positive and high-risk HIV-negative persons, partner services, linkage to care, retention and re-engagement in care, and adherence to HIV treatments

¹² <http://www.whitehouse.gov/administration/eop/onap/nhas>

- HIV education for school-aged youth
- Training and capacity building for organizations providing HIV education and other prevention services
- Operational research and evaluation

Budget Request

CDC's FY 2015 request of **\$796,185,000** for domestic HIV/AIDS prevention and research, including \$3,000,000 in Public Health Service (PHS) Evaluation Transfer funds for evaluation of school HIV prevention activities, is \$7,376,000 above the FY 2014 Enacted level.

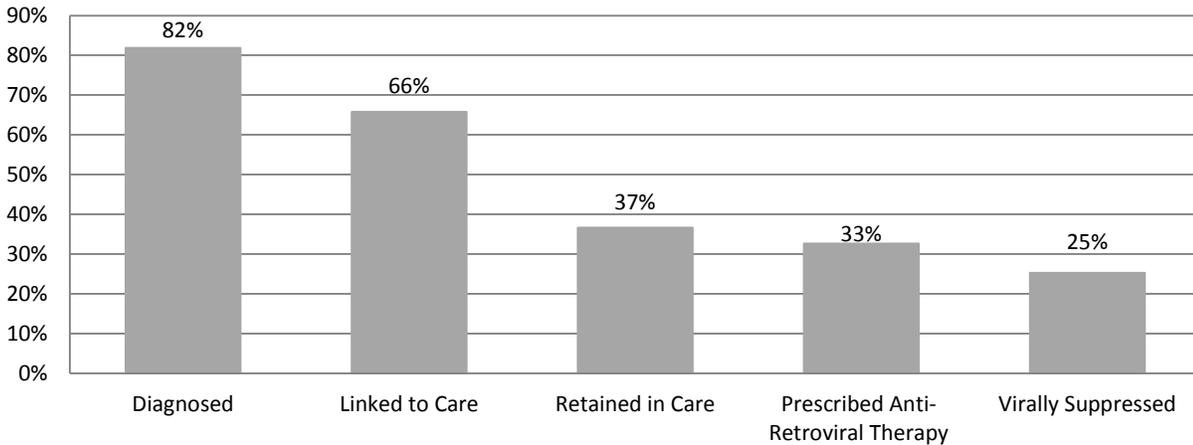
To better monitor progress and improve performance under the *National HIV/AIDS Strategy*, in FY 2015 CDC will increase support by over \$4 million for HIV surveillance activities and projects that identify best practices for health services and care delivery. CDC will also invest \$8 million of existing funding to help HIV prevention grantees increase their capacity to seek reimbursement for covered services. CDC will continue to support High-Impact Prevention (HIP) approaches led by health departments and Community High-Impact Prevention (CHIP) efforts led by capacity-building grantees and community-based organizations. Both HIP and CHIP focus CDC resources on implementing effective, scalable and sustainable prevention strategies for persons living with HIV and populations at highest risk for HIV. Building on the progress achieved through CDC's high-impact approaches, new activities in FY 2015 include:

- Issuing a new FY 2015 community-based organizations (CBOs) funding opportunity announcement (FOA) that shifts awarded programs to supporting all aspects of the continuum of care and funding the most effective interventions to achieve better outcomes
- Offering grantees technical assistance on the most cost effective ways to allocate their available resources through the Capacity Building Assistance FOA launched in FY 2014
- Developing materials for health departments and CBO grantees to use in identifying the comparative cost-effectiveness of various prevention interventions
- Assessing the extent to which resources are allocated by health departments in alignment with epidemiological burden
- Providing tools and resources to enable health departments to better use surveillance data to link, retain, and re-engage persons living with HIV in care.

In addition, CDC will continue efforts to partner with state, local and territorial education agencies to monitor youth health behavior, implement HIV and other disease prevention programs and provide expert guidance to schools and youth organizations on school health services, prevention programs and safe and supportive school environments. This request includes an additional \$3 million in PHS Evaluation transfer funds to evaluate CDC's efforts in providing school-based health prevention activities by expanding efforts to assess youth health risk behaviors and access to school health care services.

Given the estimated lifetime costs of treating a single person with HIV infection is \$402,000, HIV prevention is cost-saving to society. One recent analysis by CDC researchers estimated a savings of more than \$125 billion in direct medical costs resulting from approximately 350,000 infections averted between 1991 and 2006 (Farnham PG, Holtgrave DR, Sansom SL, Hall HI. Medical costs averted by HIV prevention efforts in the United States, 1991-2006. *J Acquir Immune Defic Syndr* 2010; 54:565-67). Fortunately, we know better than ever before how to prevent HIV among high-risk populations and preserve the health of those infected. For example, in addition to evidence that HIV testing can lead to earlier treatment and longer, healthier lives for those infected, recent data have shown that people who begin taking antiretroviral drugs early are much less likely to transmit HIV, with up to a 96% reduction in transmission risk. However, a recent CDC analysis indicates that only 25% of those living with HIV know of their infection, are receiving care and are on treatment, and have a suppressed viral load, which means common laboratory tests can no longer detect the virus in the person's system.

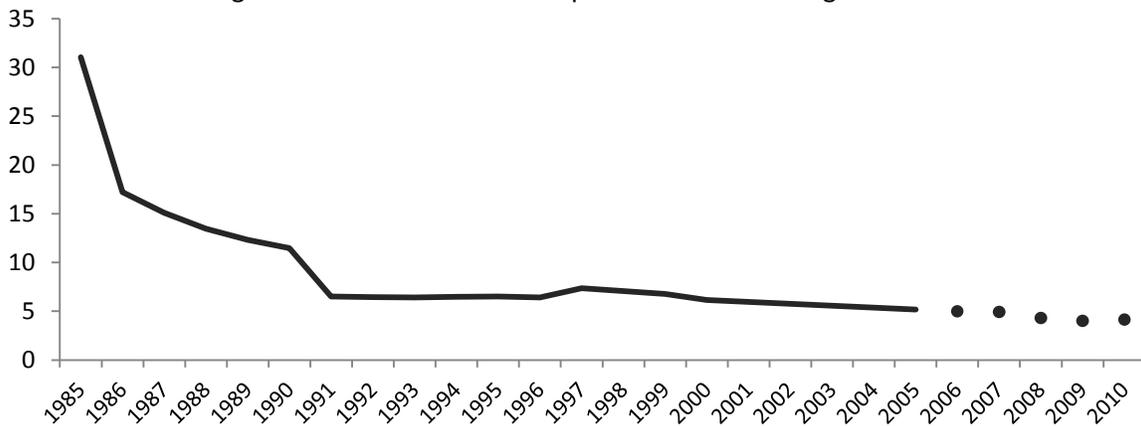
Figure: Percentage of HIV-Infected Individuals Engaged in Selected Stages of the Continuum of HIV Care, 2009



HIV Prevention by Health Departments

CDC's FY 2015 request of **\$398,238,000** for HIV Prevention by Health Departments is level with the FY 2014 Enacted level. CDC's HIV Prevention by Health Departments cooperative agreements serve as the foundation for HIV prevention nationwide. These programs are a chief contributor to HIV prevention successes in the United States, including reductions in perinatal HIV infections, reductions in HIV transmission rates and increases in individual knowledge of HIV status. In FY 2014 CDC funded 61 state and local health departments under a five-year cooperative agreement ending in FY 2017.

Figure: HIV Transmission Rate per 100 Persons Living with HIV



1985-2005 transmission rates based on incidence determined through back calculation methodology

- 2006-2010 transmission rates based on direct measure of incidence

For its main cooperative agreement funding state and local health departments, CDC has prioritized increasing the number of persons who are aware of their HIV status and improving the proportion of persons who are linked to care, retained in care, prescribed antiretroviral drugs, and whose HIV infection is suppressed. This has meant supporting strategies most likely to yield the greatest benefit and shifting resources so that the largest awards go to the jurisdictions with the greatest need as determined by the number of persons living with HIV.

This funding shift is being phased in over the five years of the cooperative agreement. By 2015, 85% of the funding shift will have been implemented. Funding under this cooperative agreement is awarded in three categories: A, B, and C.

Category A funds 61 health departments. Grantees are required to spend 75% of their funding on a limited set of activities with demonstrated potential to substantially reduce new infections:

- HIV testing
- Comprehensive prevention with persons living with HIV
- Condom distribution
- Policy initiatives to address structural barriers

Category A grantees are required to focus testing efforts on populations with relatively high rates of HIV, and meet minimum targets for linking persons testing positive to care and providing them with partner services. Grantees may use the remaining 25% to support other proven HIV interventions for persons at highest-risk of acquiring the infection. These could include using social media to raise awareness and encourage testing and risk reduction behaviors, as well as activities to support pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) services. In these prevention methods people take antiretroviral drugs to try to reduce the chance of becoming HIV- infected before (PrEP) or after (nPEP) having sex or sharing drug injection equipment with partners that might have HIV.

Table: Category A - Core HIV Prevention Programs

Activity	Examples
HIV testing	New Jersey implemented a two-test rapid testing algorithm in 33 sites in the most heavily impacted cities in New Jersey. Under this algorithm, persons testing positive with a rapid test are immediately offered a second rapid test, reducing the possibility of a false positive result. Persons can then be referred to care based upon two sequential positive rapid tests
Prevention with positives	The State of Washington developed a process for ensuring all persons testing positive for HIV, regardless of where they were tested, receive linkage to care services
Condom distribution	In New York City, free condoms are distributed in 94% of all venues identified as popular among men who have sex with men (MSM). In 2012, over 17 million condoms were distributed
Policy initiatives	Nevada proposed a change to the state’s Administrative Code that would require mandatory reporting of all HIV-related laboratory tests, which is necessary to measure progress along the continuum of care

In FY 2015 CDC will continue to support Category A grantees by evaluating grantees performance against minimum targets and providing feedback and assistance to support continuous programmatic improvement. Grantee performance plans will remain consistent with HHS efforts to streamline data collection and reduce reporting burden for grantees.

Category B is a continuation of CDC’s Expanded Testing Initiative. Under Category B, 34 health departments in jurisdictions with large populations disproportionately affected by HIV are funded to conduct additional HIV testing, primarily in health care settings. CDC-funded health department HIV testing activities include:

- Education for health care providers on innovative approaches to reaching populations most at risk
- Professional training on implementing clinical processes that support routine screening
- Scientific and programmatic expertise on developing infrastructure to support linkage to care for persons who test positive

- Oversight to ensure testing services are implemented according to recommendations

Category B funding also supports the purchase of test kits and outreach activities to promote testing, conducting testing at non-clinical venues, and overcoming obstacles for individuals who do not access clinical services and engage in care. Similar to Category A, Category B grantees are required to focus their testing efforts on populations with relatively high rates of HIV and meet minimum targets for linking persons testing positive to care and providing them with partner services.

Table: Category B - Expanded HIV Testing Program

Activity	Examples
HIV testing in health care settings	Pennsylvania provided health care facilities throughout the state access to an online resource center and to testing initiative materials to help them implement routine, opt-out HIV screening
HIV testing in non-health care settings	Florida partnered with the AIDS Healthcare Foundation to use their mobile medical units to conduct targeted HIV and STD testing in 12 counties with high HIV incidence

CDC will direct these grantees to use part of their awards to strengthen their capacity to seek reimbursement for HIV preventive services that may be covered under health insurance policies. These services include testing for HIV and related co-infections in healthcare settings. CDC will work with health departments to help them to determine when prevention services may be reimbursable, and will provide information about setting up billing systems. Category B-funded grantees will use the results of business case assessments for billing, including identification of technical assistance and staffing needs, to determine priority clinics for implementation. Additionally, these health departments will explore billing for testing and other clinical services with their funded community-based organizations. Grantees will also work closely with community health centers, emergency departments and in-patient hospital settings to integrate HIV testing into their daily practice flows. Such integration is a prerequisite to implementation of sustainable testing practices that are not dependent on program resources. CDC will provide assistance in the form of trainings, written resources, and subject matter expertise, as well as facilitate the exchange of materials and tools between grantees (publications, manuals and other resources).

Category C supports innovative demonstration projects at 30 funded health departments aimed at developing methods to improve the practice of HIV prevention, such as the following examples.

Table: Category C – Demonstration Projects to Implement and Evaluate High-Impact Prevention

Activity	Examples
Structural, behavioral, and biomedical interventions	Vermont will conduct a computerized assessment of HIV and Hepatitis C knowledge for clients at a community-based organization providing substance abuse services. Clients will then complete a novel intervention to enhance knowledge and reduce risk behaviors
HIV testing	Illinois uses peer-led events to improve testing, linkage to care, risk reduction services, and partner services for two populations at high risk, men who have sex with men (MSM) and transgender persons of color
Linkage to and retention in care	New Jersey is evaluating the effectiveness of patient navigators as a means of ensuring 100% of all newly diagnosed persons are linked to care within two business days
Advanced use of technology	To remind persons at highest risk for HIV to test regularly, and ensure medication adherence among persons living with HIV, Oregon has established a reminder system that uses texts, emails and phone calls

Activity	Examples
Use of HIV surveillance data	Alaska uses statewide HIV surveillance data to identify and re-engage in care persons living with HIV. For example, health department staff can identify patients for whom key laboratory tests are missing and can work with the patient to schedule a health care visit, accompanying the patient if necessary

CDC will continue to support HIV prevention activities for six Pacific Island jurisdictions. With available funding, CDC will prepare a new Health Department FOA for FY2015 that specifically addresses the HIV epidemic in the men who have sex with men (MSM) population. Additionally, CDC will continue supporting Program Collaboration and Service Integration (PCSI) through its cooperative agreements by encouraging grantees to use their programs to address related infections—including viral hepatitis, other STDs, and TB—and to develop capacities that can be shared across programs.

Table: HIV Prevention by Health Departments Grant Table^{1,2,3,4}

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	61	61	61	0
- New Awards	0	0	0	0
- Continuing Awards	61	61	61	0
Average Award	\$5.476	\$5.844	\$5.844	\$0.000
Range of Awards	\$0.592-\$32.959	\$0.674-\$38.341	\$0.742-\$37.366	N/A
Total Awards	\$334.048	\$356.465	\$356.465	\$0.000

¹ CDC supports Category A, B, and C awards for health departments under a single HIV prevention funding opportunity announcement.

² Awards described here do not include funding for Pacific Island jurisdictions as these are funded under another cooperative agreement.

³ Totals do not include funding under Direct Assistance, which is a financial assistance mechanism that is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial health agencies that are recipients of grants and cooperative agreements.

⁴ FY 2015 information may be adjusted to reflect new FOA to address HIV among men who have sex with men (MSM).

Surveillance, Research and Programs to Support HIV Prevention

CDC's FY 2015 request of **\$363,786,000** for Surveillance, Research and Programs to Support HIV Prevention is \$4,376,000 above the FY 2014 Enacted level.

The *National HIV/AIDS Strategy* requires special efforts to identify and reach people who are most at-risk for acquisition or transmission of HIV. CDC advances this imperative through national HIV surveillance, support of community-based prevention programs, capacity building to improve prevention activities of the health departments and community-based organizations, research, social marketing, and program collaboration and service integration. CDC works through national, regional, and other organizations to:

- Build HIV prevention capacity in directly funded community-based organizations, health departments and indirectly CDC-funded community-based organizations across the nation; and
- Mobilize broader efforts to address HIV in communities disproportionately affected by HIV.

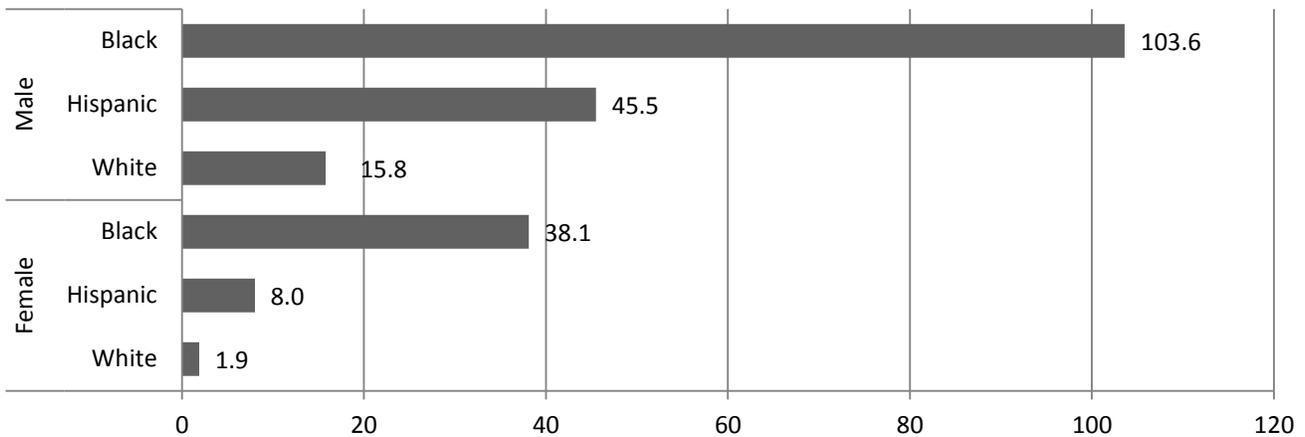
Surveillance—The *National HIV/AIDS Strategy* (NHAS) emphasizes identifying and targeting prevention efforts, including HIV testing, towards populations at greatest risk for acquiring and transmitting HIV. CDC surveillance activities are essential to this effort. The [Continuum of Care Initiative](http://aids.gov/federal-resources/policies/care-continuum/)¹³, announced by the President in 2013, depends on quality surveillance data to improve the delivery of services to people living with HIV across the

¹³ <http://aids.gov/federal-resources/policies/care-continuum/>

entire continuum of care: diagnosis, linkage to care, retention in care, starting and staying on antiretroviral therapy, and suppressing viral load. Surveillance data are used at the local level to inform a feedback loop with providers in order to improve performance on the continuum of care.

- Through its National HIV Surveillance System (NHSS), CDC provides funding and scientific support to health departments across the nation to track new HIV diagnoses and deaths. NHSS enables collection of state- and national-level data on new diagnoses, number of persons living with HIV (prevalence), and estimates of new infections (incidence).
- Through the National HIV Behavioral Surveillance system, CDC collects data from three high risk populations—men who have sex with men, persons who inject drugs, and high risk heterosexuals—on behavioral risks for HIV, HIV testing behaviors, access to and use of prevention services, and HIV results.
- CDC’s Medical Monitoring Project produces nationally representative data on clinical and behavioral outcomes among adults receiving medical care for HIV infection.

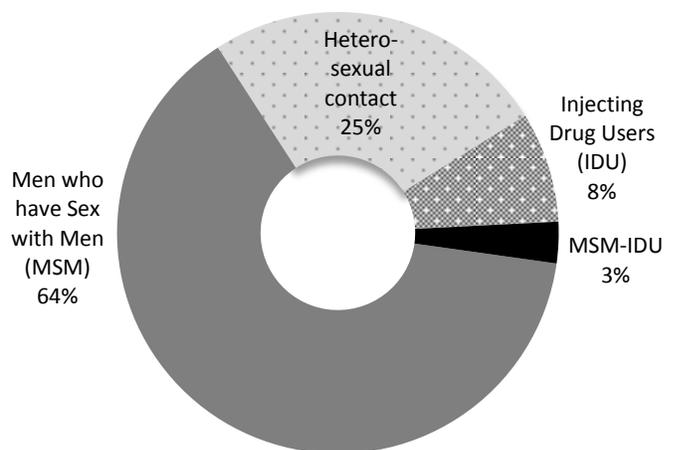
Figure: Estimated Rate of New HIV Infections, 2010
(per 100,000 individuals)



CDC publishes regular surveillance reports and analyses to guide national, state and local prevention and testing programs, social marketing campaigns, and health education efforts directed towards affected populations. For example, NHSS data show that African Americans have substantially higher rates of new HIV infection than whites or Hispanics or Latinos, and that two-thirds of new HIV infections occur among men who have sex with men (MSM).

Similarly, using data derived from both the NHSS and the Medical Monitoring Project, CDC has demonstrated that [African Americans and young people are among those groups least likely to receive ongoing care and effective treatment](#)¹⁴: only 34% of

Figure: Estimated New HIV Infections by Route of Transmission, 2010



¹⁴ <http://www.cdc.gov/hiv/policies/npr/>

HIV-infected African Americans are retained in care, and only 21% are virally suppressed (compared to national figures of 37% and 25%, respectively).

CDC’s surveillance systems also inform other federal programs. For example, the Health Resources and Services Administration (HRSA) and the Department of Housing and Urban Development use CDC’s data to guide the allocation of over \$2 billion in federal funding for HIV care, treatment, and housing programs.

In FY 2015, CDC will continue to fund and assist health departments with HIV surveillance. To improve the timeliness, quality, and efficiency of HIV surveillance data used to monitor the *National HIV/AIDS Strategy*, CDC will increase investments in activities such as promoting the use of standard formats for the electronic reporting of laboratory results, timely shipment of specimens for incidence testing, and more quickly obtaining and matching death records. CDC will also increase investments in identifying effective models for the surveillance-to-program data feedback loop. In addition, CDC will continue to fund surveys of HIV-related behaviors among high-risk populations, and collect data on clinical and behavioral outcomes for persons living with HIV receiving medical care.

Table: HIV Surveillance Grant Table¹

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	59	59	59	0
- New Awards	59	0	0	0
- Continuing Awards	0	59	59	0
Average Award	\$0.975	\$1.039	\$1.039	\$0.000
Range of Awards	\$0.112-\$5.289	\$0.122-\$5.442	\$0.122-\$5.442	N/A
Total Awards	\$57.523	\$61.281	\$61.281	\$0.000

¹Totals do not include funding under Direct Assistance.

Community High Impact Prevention (CHIP) —The NHAS emphasizes investing in prevention at the community level. CHIP focuses resources on effective and sustainable prevention activities tailored to persons at highest risk in the communities most effected by HIV. CHIP has two components:

- Supporting community-based organizations (CBOs)
- Building HIV prevention capacity with health care providers and directly-funded health departments, as well as directly- and indirectly-funded CBOs

Through CHIP’s first component, CDC supports CBOs to implement the best combination of effective approaches with the greatest potential. CDC began to implement CHIP in 2014 by directing CBO grantees to focus more on HIV testing, linkage to and retention in care, and other effective interventions and support services for persons living with HIV and for persons at highest risk for acquiring HIV. In FY 2015, a new funding opportunity announcement will continue this shift of supporting all aspects of the continuum of care to achieve better outcomes.

Also in FY 2015, CDC will continue to separately fund 34 CBOs that serve young men of color who have sex with men, young transgender persons of color, and their partners. Although men who have sex with men (MSM) are a small proportion of the population, they represent the majority of persons diagnosed with HIV. Funded organizations are required to meet minimum testing targets and targets for linking persons testing HIV-positive to care.

Table: HIV Prevention Projects for Community-Based Organizations Grant Table^{1,2}

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	131	131	TBD	N/A
- New Awards	0	0	TBD	N/A
- Continuing Awards	131	131	TBD	N/A
Average Award	\$0.304	\$0.304	TBD	N/A
Range of Awards	\$0.234-\$0.495	\$0.254-\$0.537	TBD	N/A
Total Awards	\$39.871	\$39.820	TBD	N/A

¹Reflects funding for CDC’s principal grant program for community-based organizations. In separate programs, CDC also directly funds community-based organizations in Puerto Rico and the Virgin Islands and others that focus on young MSM and transgendered persons.

²The current funding cycle ends in FY 2014. Funding for CBOs will continue in FY 2015 under a new funding announcement that is currently in development and will reflect changes as discussed earlier in the narrative.

As part of CHIP’s second component, in FY 2015 CDC will provide over \$25 million in capacity-building assistance funding to support CBOs and health departments to implement interventions for persons living with HIV and persons at high risk for acquiring HIV. Capacity building is a key strategy for ensuring the availability of quality, sustainable HIV prevention programs. In FY 2014, a new funding cycle began and will continue through FY 2018. Capacity-building grantees provide assistance on effective strategies to improve HIV prevention including:

- Sustainable, high-impact HIV testing and screening programs
- Comprehensive prevention for persons living with HIV that includes linkage to and retention in care and prevention services
- Tools that assist CBOs in using their data to better target and manage patients with the goal of improving viral load suppression rates.

Table: HIV Capacity-Building Assistance Grant Table

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	28	25	25	0
- New Awards	0	25	0	-25
- Continuing Awards	28	0	25	+25
Average Award	\$0.665	\$0.924	\$1.034	+\$0.110
Range of Awards	\$0.252-\$1.299	\$0.312-\$1.610	\$0.349-\$1.802	N/A
Total Awards	\$18.633	\$23.095	\$25.850	+\$2.755

¹FY 2014 figures are based on projected funding for a combined program announcement for the Capacity Building Assistance program and the STD/HIV Prevention Training Centers.

Research—To achieve the prevention goals put forward in the *National HIV/AIDS Strategy* and improve performance along the continuum of care, CDC supports research to identify, adapt, and translate HIV prevention interventions for persons at highest risk and develops recommendations and guidance based on the latest science. For example, in 2013 CDC published the Bangkok Tenofovir Study, providing the first evidence that a daily oral dose of antiretroviral drugs traditionally used to treat HIV infection can be used as a biomedical intervention to reduce HIV acquisition among uninfected persons who inject drugs. In conjunction with this release, CDC published [Interim Guidance for Pre-exposure Prophylaxis \(PrEP\) for the Prevention of HIV Infection: PrEP for Injecting Drug Users](#).¹⁵ In 2015, CDC will increase support for projects that identify and document best practices for HIV testing and other HIV prevention activities, such as treatment adherence among persons living

¹⁵ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6223a2.htm>

with HIV. CDC will also invest in laboratory, behavioral, and epidemiologic studies supporting earlier identification of HIV and development and implementation of new methods for preventing transmission.

Communications Campaigns—CDC raises awareness about the HIV epidemic in the United States and promotes HIV prevention and testing through the [Act against AIDS initiative](#)¹⁶. This initiative seeks to combat HIV-related stigma and normalize testing and other risk reduction behaviors, particularly for populations most affected by HIV. For example, the [Testing Makes Us Stronger](#)¹⁷ campaign encourages HIV testing among African-American gay and bisexual men in six cities: Atlanta, Baltimore, Houston, New York City, Oakland, and Washington, D.C. Since 2011, this campaign has generated more than 552 million media impressions, including those garnered through the campaign's website and [Facebook page](#)¹⁸. Similarly, since its launch in 2013, [Reasons/Razones](#)¹⁹, a national, bilingual campaign to encourage HIV testing among Latino gay and bisexual men, has generated high levels of social media engagement, including almost 200,000 views of its public service announcement on YouTube²⁰.

Program Collaboration and Service Integration (PCSI) - In FY 2015, CDC will continue to support PCSI by encouraging grantees in its major HIV, STD, TB and viral hepatitis programs to provide services that can be integrated at the patient, or client, level and to develop capacities that can be shared across programs. For example, [CDC's NCHHSTP Atlas](#)²¹ provides an interactive platform for accessing data on HIV/AIDS, viral hepatitis, STD and TB. This interactive tool provides CDC an effective way to disseminate data, while allowing users to observe trends and patterns by creating detailed reports, maps, and other graphics. County level data were added to the Atlas in 2013. CDC has also published data on best PCSI practices, and developed integrated guidelines for services for at risk populations that will achieve efficiencies in program management and implementation. For example, CDC has encouraged its HIV grantees to strengthen collaboration between programs to improve surveillance. CDC will provide funding and scientific guidance to 24 state and local health departments to ensure the provision of HIV testing, linkage to care, and other related services to TB patients, a group with high rates of HIV. CDC will also fund 59 state and local health departments to address HIV through sexually-transmitted disease (STD) programs.

HIV Adolescent and School Health

CDC's FY 2015 request of **\$34,161,000** for HIV Adolescent and School Health, including \$3,000,000 in Public Health Service (PHS) Evaluation Transfer funds for evaluation of school HIV prevention activities, is \$3,000,000 above the FY 2014 Enacted level.

The *National HIV/AIDS Strategy* identifies the education of all Americans about the threat of HIV and how to prevent it as a critical step in reducing new infections in the United States. CDC's primary strategy to achieve this mandate is supporting school-based education programs to prevent HIV, STD, and teen pregnancy among adolescents. In 2010, persons aged 15–24 years comprised 26% of all new HIV infections; among those infected, 82.8% were male and 17.2% female. The risk for acquiring HIV infection during adolescence and early adulthood starts with initiation of sexual behavior or injection drug use. Youths, particularly those at highest risk, need effective school-based, school-linked, and community-based interventions that make them aware of their risk for HIV and help delay initiation of sexual activity, increase condom use for those who are sexually active, and decrease other behaviors, such as alcohol and drug use, that contribute to HIV risk.

¹⁶ <http://www.cdc.gov/actagainstaids/>

¹⁷ <http://hivtest.cdc.gov/stronger/>

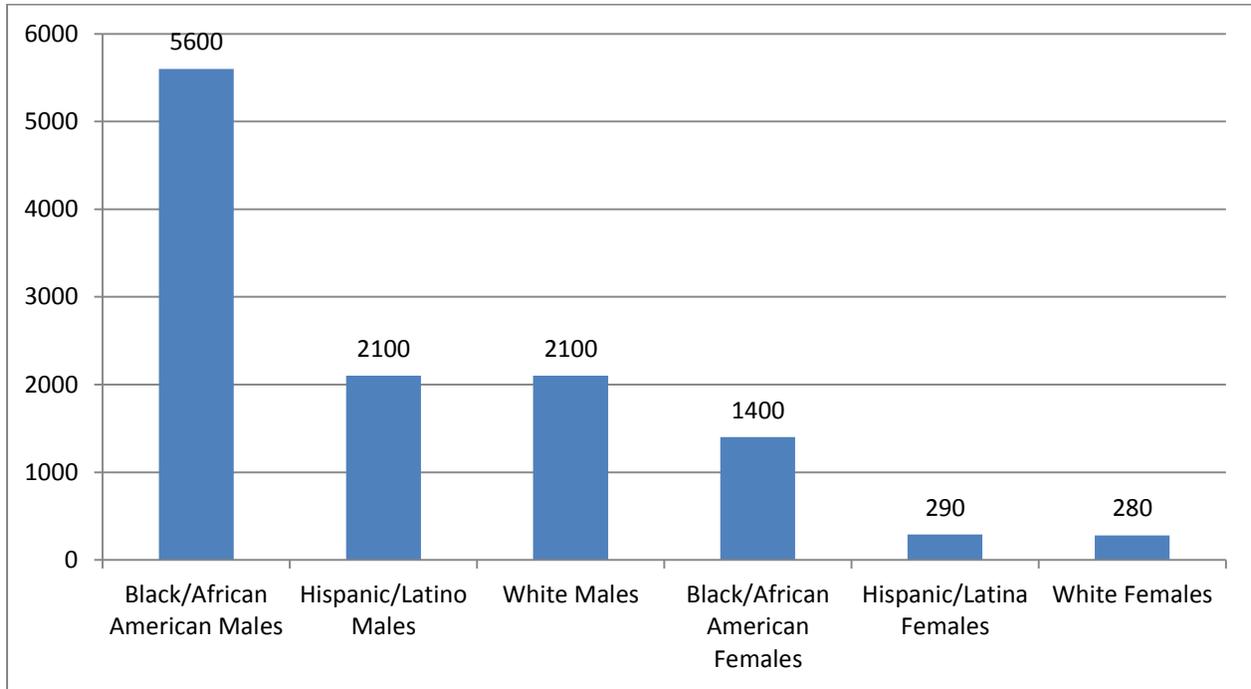
¹⁸ <https://www.facebook.com/testingmakesusstronger>

¹⁹ <http://hivtest.cdc.gov/reasons/>

²⁰ http://www.youtube.com/watch?v=arkOjDaOE_c

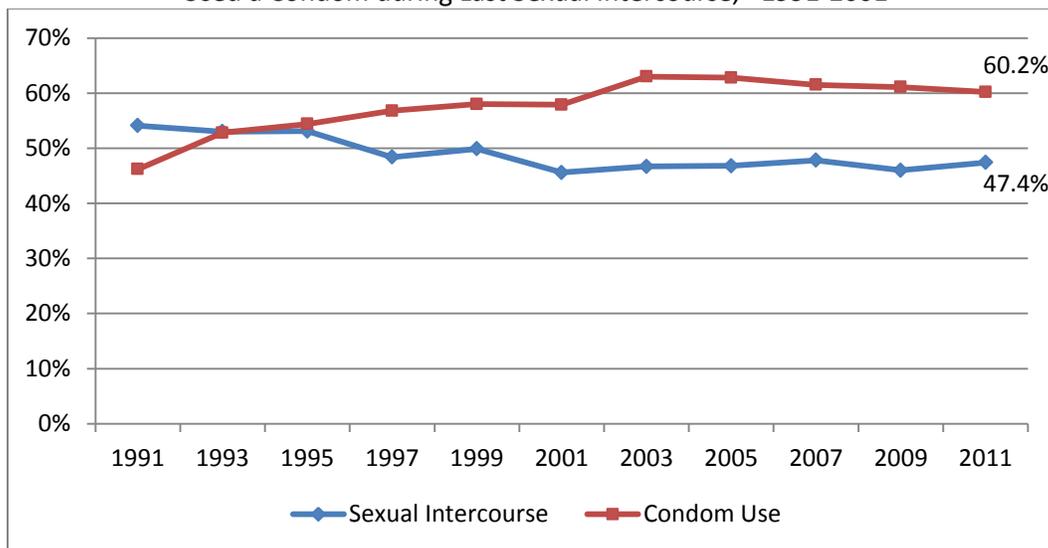
²¹ <http://www.cdc.gov/nchhstp/atlas/>

Figure: Number of new HIV Infections among youth by sex and race/ethnicity—United States, 2010



The HIV Adolescent and School Health program is unique in the federal government because it funds cooperative agreements with state, territorial, and local education agencies to help adolescents develop healthy behaviors and avoid HIV and STDs while creating healthy school environments for all students. This program has contributed to the success of protecting the health of adolescents through decreases in sexual risk behaviors, as shown in the graph below. Further, this program protects the health of adolescents by encouraging access to health services to youth. For example, HIV-related school health practices improved between 2000 and 2006, with study results showing the percentage of middle schools and high schools where health services staff provided HIV counseling, testing, and referrals increasing from 11.8% to 39.1%.

Figure: Percentage of High School Students Who Ever Had Sexual Intercourse and Used a Condom during Last Sexual Intercourse,* 1991-2011



*Among students who were currently sexually active, National Youth Risk Behavior Surveys, 1991-2011

The current evaluation system for school HIV prevention activities measures the performance of schools in providing sexual health education, sexual health care services, and safe and supportive environments. In FY 2015, CDC proposes new activities to evaluate the effectiveness of its core school HIV prevention activities. These new activities will expand CDC's evaluation system by incorporating the ability to assess youth sexual risk behaviors and access to sexual health care services. Evaluation activities will compare local education agencies and schools where programmatic efforts are focused with those not receiving such attention. These expanded evaluation activities will benefit school HIV prevention by:

- Establishing a feedback loop with state and local education agencies on the relationship between programmatic efforts and student outcomes
- Sharing with practitioners in the field findings and subsequent guidance on how to achieve *National HIV/AIDS Strategy* aims through effective HIV prevention for students
- Using the information collected to conduct additional rigorous evaluation of school HIV prevention activities.

For Adolescent and School Health grantees, there are two major activities:

School-based Surveillance Systems - CDC monitors six types of health-risk behaviors that contribute to the leading causes of death and disability through the Youth Risk Behavior Surveillance System. Additionally, CDC provides [national data on school-based health policies, programs, and practices](#)²²; such data are not monitored elsewhere in the government. The data are used by CDC, the U.S. Department of Education, other federal agencies, state and local health departments and education agencies, and many non-governmental organizations.

School-based Prevention Programs - CDC funds education agencies to implement activities for youth at disproportionate risk of infection, including young men who have sex with men, homeless youth, and youth in alternative schools. Due to reduced funding levels for school-based efforts, CDC has limited funding to only those states and cities with high rates of HIV infection. These 19 state education agencies and 17 local education agencies will provide young people with the skills and knowledge needed to avoid infection with HIV and other STDs, thereby reducing disease transmission. Three of these sites will additionally provide school-centered HIV/STD prevention for young men who have sex with men. School-based prevention program grantees will:

- Increase implementation of evidence-based sexual health education programs in schools
- Create more supportive school environments for adolescents at highest risk for HIV
- Increase HIV counseling and testing among adolescents

In addition, six non-governmental organizations are funded to provide capacity-building assistance to assist states and localities with identifying best practices that may best fit a jurisdiction's epidemiologic and educational context and with supporting programmatic evaluation requirements.

To support these grantees, CDC disseminates evidence-based guidance, supports evaluation research, and develops and maintains a publicly-accessible library of toolkits and guidance to help state, territorial, and local education agencies.

²² <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>

Table: HIV Prevention for Adolescent and School Health Grant Table¹

(dollars in millions)	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	42	42	42	0
- New Awards	42	0	0	0
- Continuing Awards	0	42	42	0
Average Award	\$0.221	\$0.400	\$0.400	\$0.000
Range of Awards	\$0.100-\$0.650	\$0.300-\$0.400	\$0.300-\$0.300	N/A
Total Awards	\$9.287	\$16.800	\$16.800	\$0.000

¹ Reflects funding to state and local education agencies.

² A new funding cycle began in FY 2013 and is aligned with the academic calendar in order to streamline budgeting and expenditure tracking for education agencies. Due to this alignment of funding cycles as well as cost extensions from the previous cooperative agreement, average award funding for project year one (FY 2013) will be substantially less than for FY 2014 and beyond. The first year of the project is a programming planning year; additional funding will be provided in FY 2014 for implementation.

Viral Hepatitis Budget Request

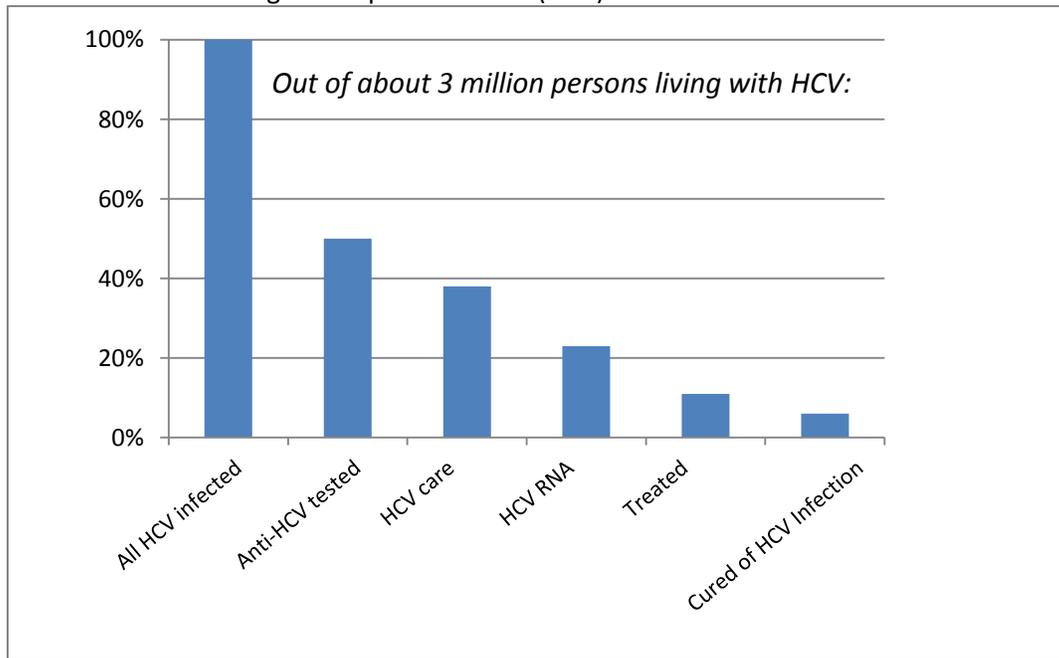
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015 +/-2014
			President Budget	
Budget Authority	\$31.368	\$31.410	\$31.410	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

An estimated 3.5 - 5.3 million Americans are living with chronic viral hepatitis infection, but between 45% and 65% of them are unaware of their infection status and therefore are not receiving any medical care for their condition. This low level of awareness contributes to increases in mortality related to viral hepatitis, particularly hepatitis C. In addition, approximately 75,000 new viral hepatitis infections occur each year. From 2007-2011, reports to CDC of new cases of hepatitis C rose by 44%, particularly among adolescents and young adults in suburban and rural areas. To prevent new infections and disease among those infected and to improve the viral hepatitis continuum of care, CDC partners with state and local health departments, universities, medical centers and other clinical care providers, community-based organizations, and others. CDC activities are aligned with the [HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis](#).²³ Through CDC's implementation of effective vaccination strategies, the annual incidence of hepatitis A virus infection has decreased more than 95% since 1995, and the annual incidence of hepatitis B virus infection, particularly among children aged 15 years and younger, has had a similar decline in the past decade. The 2011 rates of 0.4 new hepatitis A cases and 0.9 new hepatitis B cases per 100,000 members of the nation's population both represent the lowest rates of new cases recorded to date. To achieve the national goal for eliminating mother-to-child transmission of hepatitis B, CDC supports state and local prevention programs to assure that infants exposed to hepatitis B receive recommended prevention services; currently, state and local programs provide services to approximately half of the estimated 24,000 newborns exposed to hepatitis B. While there is no vaccine available to prevent the transmission of hepatitis C virus infection, screening programs can help identify infected persons that can benefit from care and treatment.

Figure: Hepatitis C Virus (HCV) Continuum of Care



²³ <http://www.cdc.gov/hepatitis/HHS-ActionPlan.htm>

Budget Request

CDC's FY 2015 request of **\$31,410,000** for Viral Hepatitis is level with the FY 2014 Enacted level. This funding is used to identify populations most at risk for viral hepatitis, characterize sources of hepatitis transmission, and monitor both the disease burden and the impact of CDC prevention efforts through epidemiologic studies and surveillance activities. CDC conducts laboratory research to assess the performance of new screening tests and monitor the circulation of variant hepatitis strains that may not be prevented by current vaccines or responsive to therapies. CDC conducts research necessary to update vaccination, treatment and other prevention recommendations for the identification and management of persons living with chronic hepatitis B virus and hepatitis C virus (HCV) infections. In July of 2012, CDC issued [new recommendations for HCV screening](#)²⁴ of persons born between 1945 and 1965; in June 2013, the U.S. Preventive Services Task Force similarly revised its [HCV testing recommendations](#).²⁵ [With full implementation of this updated testing policy, CDC estimates that 121,000 deaths from hepatitis C can be averted.](#) CDC is also working to improve the continuum of hepatitis C testing, care and treatment; and will leverage the use of newly FDA-licensed safe and curative therapies for new prevention opportunities. Implementation of these recommendations, and improvements in the care continuum for hepatitis C, will increase the proportions of persons who are made aware of their infection and then cured of it. Additionally, more effective diagnosis and treatment of HCV will lead to reduced HCV transmission to others.

In order to reduce viral hepatitis-related illness and death, CDC seeks to:

- Conduct hepatitis surveillance and detect outbreaks
- Support targeted implementation of one-time testing for Asian-Americans, persons born during 1945-1965, and others at risk for viral hepatitis and linkage of infected individuals to preventive care and treatment services
- Link those persons found to be living with viral hepatitis to appropriate medical care and treatment
- Develop interventions to prevent HCV transmission among adolescent and young adult persons who inject drugs.
- Update CDC recommendations for hepatitis A and hepatitis B vaccination to reduce the incidence of hepatitis A and hepatitis B
- Increase and improve case management of infants born to hepatitis B virus (HBV)-infected mothers, infants who are at highest risk for developing chronic HBV infections.
- Raise awareness about viral hepatitis among at-risk persons and educate healthcare providers about viral hepatitis prevention, care and treatment.

CDC helps its public health partners conduct public health surveillance and investigate outbreaks of hepatitis. CDC detects and responds to outbreaks of hepatitis A and hepatitis B among the large proportion of the U.S. population who remain unvaccinated and vulnerable to these infections. Through these efforts, potentially exposed persons are identified, screened, and referred for treatment if indicated. In a 2012 multi-state HCV outbreak, though genetic testing CDC's viral hepatitis laboratory identified that a single strain was transmitted to 43 patients by an infected healthcare worker. CDC then helped to identify more than 11,000 persons from 17 healthcare facilities in eight states (Arizona, Georgia, Kansas, Maryland, Michigan, New Hampshire, New York, and Pennsylvania), ensuring these people were notified about potential exposure and recommended HCV testing. Similarly, in 2013 CDC helped to quickly identify both the source of a new hepatitis outbreak and the means by which it was spread, facilitating a rapid response that contained and greatly minimized the scope of the outbreak. A total of 162 people in 10 states - Arizona (23), California (79), Colorado (28), Hawaii (8), New Hampshire (1), New Jersey (1), New Mexico (11), Nevada (6), Utah (3), and Wisconsin (2) - were confirmed to

²⁴ <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6104a1.htm>

²⁵ <http://www.uspreventiveservicestaskforce.org/uspstf12/hepc/hepcfinalrs.htm>

have become ill from hepatitis A after eating a contaminated frozen fruit mix product purchased at a national discount buyers club.

In FY 2015 CDC will continue to fund active hepatitis surveillance—investigating case reports to ascertain demographic and infection risk information about patients and disease transmission trends in the community—in a limited number of sites. These jurisdictions will serve as sentinel sites to provide “early warning” viral hepatitis data for the nation as a whole. In addition, CDC will fund prevention research to better inform its programs, focusing on studies of young persons at risk for hepatitis C and studies of ways to improve HBV and HCV screening and linkage to care. CDC will also continue to support improvements in effectiveness and efficiencies that can be gained through program collaboration and service integration (PCSI), by encouraging grantees to utilize their programs to address related infections, such as HIV and other STDs, and to develop capacities that can be shared across programs, including HIV, STD and TB. Also, CDC will continue to analyze the long-term effectiveness of hepatitis A virus and HBV vaccines, assess ways to improve vaccine coverage, evaluate the role of vaccination in preventing transmission among populations not currently recommended to receive these vaccinations, and monitor and assess new efforts to improve diagnosis of HBV and HCV infections.

CDC will continue to fund viral hepatitis coordinators in 48 states, the District of Columbia, Los Angeles, New York City, and Philadelphia. Grantees promote the implementation of CDC recommendations for hepatitis vaccination, screening, and linkage to care in the healthcare provider community, raise awareness of the health disparities caused by viral hepatitis, implement strategies to improve hepatitis A and hepatitis B vaccination, HBV and HCV testing and treatment to reduce morbidity, mortality and transmission caused by these infections. As an example, these coordinators work to incorporate viral hepatitis prevention, testing and linkage to care into appropriate clinical care settings, including CDC-funded HIV, STI and immunization programs serving populations at risk. CDC funds a technical assistance provider with expertise in viral hepatitis to provide ongoing support for the viral hepatitis coordinators through conference calls, educational materials, advice and other means. Additionally, CDC will continue projects begun in 2014 that support the development and evaluation of viral hepatitis prevention programs in a limited number of systems. These viral hepatitis prevention programs will improve the health of communities by reducing new infections, improving systems of care, and combatting hepatitis-related health disparities.

Table: Viral Hepatitis Cooperative Agreement Grant Table¹

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	52	52	52	0
- New Awards	52	0	0	0
- Continuing Awards	0	52	52	0
Average Award	\$0.097	\$0.108	\$0.108	\$0.000
Range of Awards	\$0.020-\$0.250	\$0.020-\$0.250	\$0.020-\$0.250	N/A
Total Awards	\$5.036	\$5.231	\$5.231	\$0.000

¹Reflects funding for viral hepatitis prevention coordinators. This table excludes funding for a technical center and for sentinel surveillance, which is conducted in a small number of areas.

Sexually Transmitted Infections Budget Request

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$154.861	\$157.719	\$157.719	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

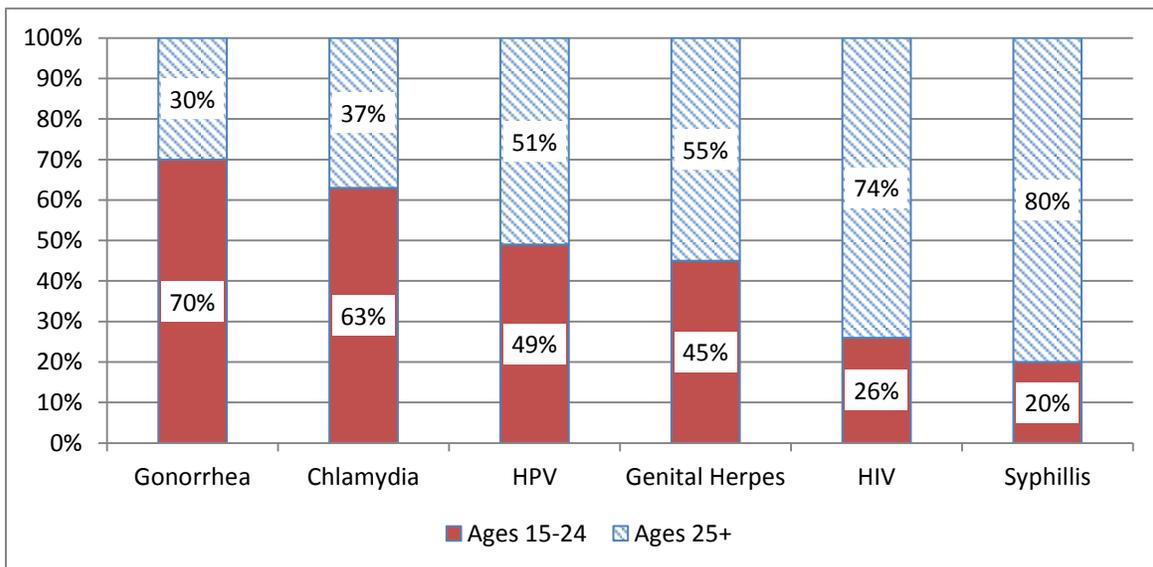
Sexually transmitted infections (STIs), also known as sexually transmitted diseases (STDs), can lead to harmful, associated medical conditions that include poor reproductive outcomes such as pelvic inflammatory disease and infertility, and increased risk of HIV infection. There are about 20 million new STI every year, costing the U.S. healthcare system \$16 billion in direct medical care costs alone. CDC funds all state and fifteen territorial or local health departments to prevent STI and their sequelae. Notable CDC accomplishments include preventing 32 million cases of gonorrhea and thereby saving \$3.7 billion in medical costs over a 33-year period ending in 2003, and annual prevention of 21,000 cases of pelvic inflammatory disease and 4,000 cases of tubal factor infertility that together result in potential healthcare cost savings of \$45 to \$77 million each year.

Budget Request

CDC's FY 2015 request of **\$157,719,000** for Sexually Transmitted Infections is level with the FY 2014 Enacted level. CDC will concentrate on the following four priority areas to guide STD prevention and maximize long term impact.

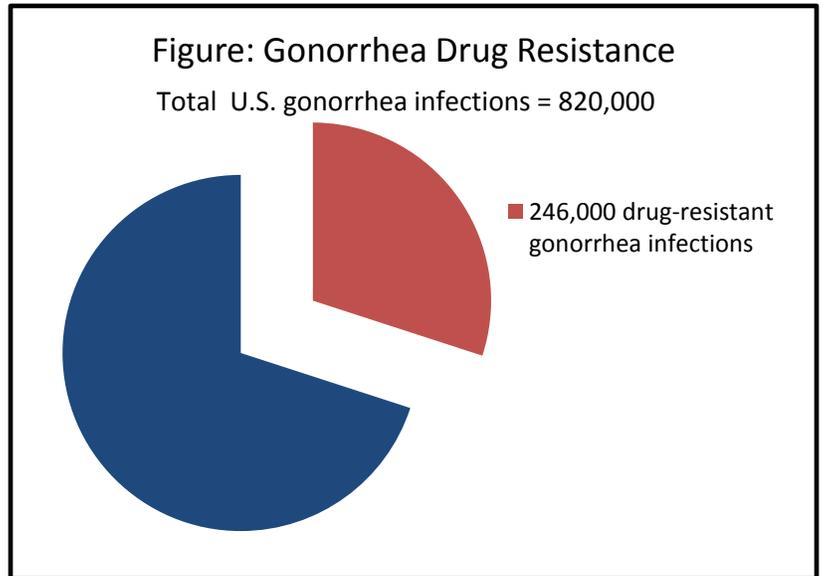
Adolescents and young adults— CDC will work with partners to address the high proportion of STD incidence in adolescents and young adults. For example, CDC and the National Chlamydia Coalition are working with the National Committee for Quality Assurance to develop strategies to improve chlamydia screening, identify evidence-based methods for improving chlamydia HEDIS rates and promote the exchange of best practices related to chlamydia screening. CDC will also prevent reinfection with chlamydia and gonorrhea and increase options available to treat partners of infected women by providing programmatic assistance to STD prevention programs implementing Expedited Partner Therapy.

Figure: Young people account for a substantial portion of new STIs



Men who have sex with men—CDC will fund state and local health departments to implement local prevention efforts to reduce STD risk among the most vulnerable MSM populations. CDC will assist health departments in conducting internet-based partner services to reach partners possibly exposed to STDs. CDC initiated several new studies as part of the agency’s efforts to prevent STD transmission and STD-related HIV transmission in MSM. One study will determine human papillomavirus (HPV) prevalence and HPV vaccine uptake in MSM at two locations. Another ongoing study through CDC’s STD Surveillance Network aims to verify the effectiveness of antibiotic treatment of gonorrhea in MSM using laboratory confirmation of a patient’s cure. CDC is also working with partners to develop and implement training materials and curricula for clinicians working in HIV care settings accessed by MSM to ultimately improve sexual risk behavior assessments and STD screening rates of MSM, including non-genital testing.

Multi-drug resistant gonorrhea—Gonorrhea is a very complex bacterium that continuously evolves to become resistant to each antibiotic recommended for treatment. CDC will monitor trends in gonorrhea resistance through our Gonococcal Isolate Surveillance Project, a sentinel laboratory surveillance system. CDC will also update and promote treatment guidelines accordingly and support investigation of new treatments in conjunction with the National Institutes of Health. Targeted protection activities to tackle drug resistant gonorrhea in the community are described in the Antibiotic Resistance Initiative, found under the Emerging and Zoonotic Infectious Diseases budget request.



Congenital syphilis— Untreated syphilis during pregnancy can result in infant death in up to 40 percent of cases. CDC will strengthen partnerships with healthcare providers, HRSA's Maternal and Child Health Bureau, and Title V-funded programs (Maternal and Child Health Block Grant) to ensure pregnant women receive syphilis testing and timely treatment to prevent babies from being born with this preventable, costly, and debilitating disease.

CDC will educate and train healthcare providers in the areas of sexual and reproductive health. The agency trains physicians on STD treatment guidelines that highlight special populations, including MSM, adolescents, and incarcerated populations. CDC will also continue development of guidelines for screening and treatment of STDs, STD diagnostics, and laboratory practice. Eleven sites will receive CDC funding to participate in the STD Surveillance Network, a sentinel clinic and population-based system to monitor STD-related trends.

CDC's current STD prevention activities complement the delivery of STD clinical preventive services and are not duplicative of services covered by the Affordable Care Act. CDC awards the majority of its STD funds to state and local health departments through cooperative agreements. A new five-year cooperative agreement cycle begins in January 2014. This new cycle includes important updates and refinements to the program, including a phased-in funding formula to better align prevention resources with need, and a restructuring of program components to allow grantees more flexibility to meet the needs in their jurisdictions. Through the STD program cooperative agreement and the consolidated Pacific Islands program, CDC provides funding and guidance to all 50 states, as well as 15 territorial and local STD prevention programs, to strengthen assessment (including surveillance and evaluation) and assurance capacity. Ultimately, these cooperative agreements will increase identification and treatment of STD cases and reduce STD rates in the U.S. population.

The STD cooperative agreement supports and improves the ability of public health departments to:

- Design, implement, and evaluate state and local STD prevention programs.
- Assess and ensure appropriate screening and treatment safety net services at the community level by:
 - Working with community partners to assure low-income women and their partners have access to infertility prevention services and promote interventions that prevent STD-related infertility.
 - Screening for and preventing chlamydia, gonorrhea and syphilis among uninsured and underinsured and highly-affected populations, such as adolescents and MSM.
- Enhance STD surveillance, including by taking advantage of the advances in electronic health records and health information exchanges.
- Focus on integration of screening for congenital syphilis during antenatal visits.
- Monitor antibiotic resistance of gonorrhea.
- Conduct contact investigations of exposed sexual partners and outreach services, which may include non-reimbursable testing of exposed partners in non-clinical settings in order to prevent the spread of STDs.
- Create and deliver relevant health promotion information to providers and the general public.
- Address related infections, such as HIV and viral hepatitis, and develop capacities that can be shared across programs, including HIV, viral hepatitis, and TB, which can lead to improvements in effectiveness and efficiencies and furthers program collaboration and service integration (PCSI).

Table: Sexually Transmitted Disease Prevention Cooperative Agreement Grant Table^{1,2}

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted ³	President Budget ³	2015 +/-2014
Number of Awards	59	59	59	0
- New Awards	0	59	0	-59
- Continuing Awards	59	0	59	+59
Average Award	\$1.607	\$1.604	\$1.604	\$0.000
Range of Awards	\$0.173-\$6.278	\$0.176-\$6.369	\$0.180-\$6.463	N/A
Total Awards	\$94.797	\$94.638	\$94.638	\$0.000

¹ Awards include funding to address HIV co-infection.

² Awards do not include funding provided under Direct Assistance.

³ FY 2014 and FY 2015 amounts do not include Gonococcal Isolate Surveillance Project awards.

Tuberculosis Budget Request

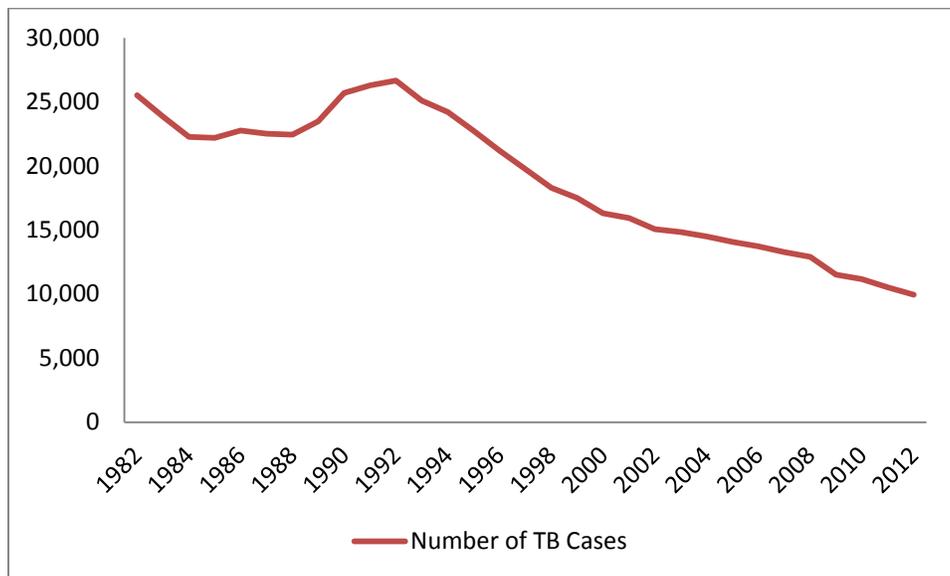
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015
			President Budget	+/-2014
Budget Authority	\$140.507	\$142.628	\$142.628	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC works 24/7 to protect the United States from tuberculosis (TB), particularly from those threats posed by global and drug-resistant TB, providing TB funding to all 50 states, ten large cities and eight territories. CDC's TB program reversed a deadly TB resurgence during the late 1980s and early 1990s caused by decreased funding for TB programs, changes in demographics, and the HIV epidemic. This resurgence resulted in an additional 52,000 TB cases that would otherwise not have occurred had we stayed on the long-term downward trend without the resurgence. Thanks to a concerted federal, state, and local response, TB incidence is now at its lowest level since national reporting began in 1953. Annual new TB cases have decreased 63% between 1992 and 2012. The United States now has among the lowest TB incidence rates in the world. Despite lower numbers of TB cases, however, the rate of decline in TB has slowed, reflecting the difficulty of preventing TB in vulnerable populations and the constant need for vigilance against this age-old disease.

Figure: Reported TB Cases United States, 1982 – 2013*



*Updated as of September 2013.

TB is spread through the air from person to person. People can experience latent TB, which has no symptoms and is not infectious; however, latent TB can become reactivated and infectious, causing infectious disease. Inappropriate or interrupted TB treatment can lead to drug resistance. Given these challenges and that TB is still endemic in many other countries, intensive TB prevention and control programs are needed to protect communities. Key strategies for TB control and elimination include increasing the percentage of persons newly diagnosed with drug-sensitive TB who complete treatment within 12 months (treatment is longer for persons with drug-resistant cases), increasing the percentage of culture-positive TB patients who receive testing for drug susceptibility, and increasing the percentage of newly-infected contacts of persons with smear-positive TB who complete treatment for TB infection.

Budget Request

CDC's FY 2015 request of **\$142,628,000** for TB is level with the FY 2014 Enacted level. This budget supports efforts necessary to prevent and control TB in the United States.

To maintain TB control and ultimately eliminate TB from the United States, CDC funds health departments in all 50 states, 10 large cities, Washington, DC, Puerto Rico, the Virgin Islands and other territories through cooperative agreements for TB control and laboratory support. Funding levels are set using a formula that considers case numbers, complexity, laboratory workload, and training needs; full implementation of formula funding will be achieved in the new cycle beginning in FY 2015. Five of these grantees also serve as regional training and technical assistance centers. Grantee activities include:

- Investigating and reporting of every case of TB, which allows them to halt the spread of the disease
- Identifying people who have TB disease
- Testing the bacteria for drug-resistance
- Ensuring that people who are sick are completely cured
- Identifying other potentially-infected contacts
- Offering treatment to prevent future cases

In addition to funding cooperative agreements, CDC provides national leadership in responding to challenges to TB elimination by directly engaging in a range of TB prevention and control activities. For example, CDC's TB experts work across the nation responding to TB outbreaks. For every case of TB identified, state and local TB programs need to evaluate family and community members who may have come in contact with the sick person, provide testing, and assure TB treatment if needed to ensure the disease is not spreading. State and local health departments may invite CDC staff to visit their jurisdictions to assist with these investigations. From May 2012 to May 2013, CDC responded to eight requests to assist with local TB outbreaks among vulnerable populations such as homeless persons, American Indians, excessive alcohol users, persons in corrections facilities, and adults with mental illness. Two of these outbreaks involved drug-resistant TB. A total of 33,873 people needed to be evaluated for TB due to their exposure in these eight outbreaks alone.

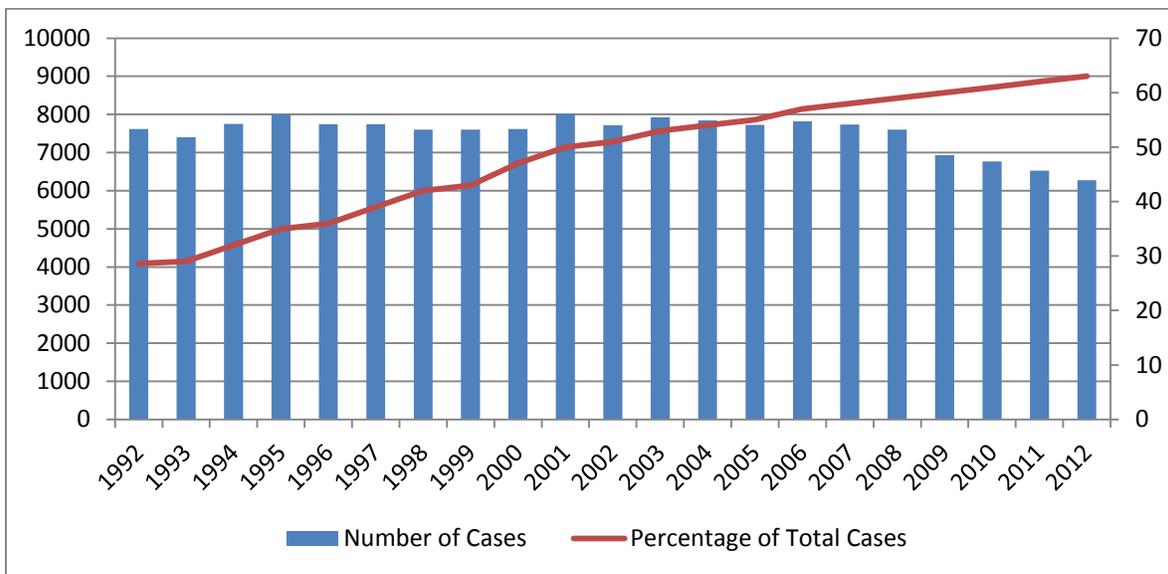
CDC-funded research improves the evidence base for the prevention and treatment of TB. In clinical research, CDC is studying ways to improve TB treatment, including therapy for children and in persons with HIV infection, diabetes, other co-morbidities, and drug-resistant TB. CDC continues to develop better TB diagnostic tools and address the significant limitations of current therapies, including harmful side effects. CDC's programmatic research is developing more efficient means to control TB in the future by evaluating programmatically relevant research – epidemiologic, behavioral, economic, laboratory, and operational – concerning the identification, diagnosis, prevention and control of active TB disease and latent TB infection. The agency publishes TB prevention and treatment guidelines, such as the recent release of guidelines for the use and safety monitoring of Bedaquiline Fumarate, the newest drug for the treatment of multidrug-resistant TB. Moreover, CDC develops and conducts innovative laboratory tests to serve state TB programs' diagnostic needs. For example, CDC developed and implemented the Molecular Detection of Drug Resistance Service, a national clinical referral service which provides rapid laboratory confirmation of multidrug-resistant and extensively drug-resistant TB. This service enables CDC and state health departments to rapidly confirm drug-resistant tuberculosis and provide guidance on selection of an effective drug, thereby protecting others from acquiring infection.

Many physicians in the United States have never seen a TB case during their training, and are unfamiliar with TB diagnosis and treatment. Misdiagnosis and failure to appropriately treat TB result in prolonged transmission among families and communities, as well as months of debilitating illness for the patient. To combat this problem, CDC supports five regional training and medical consultation centers to provide training and health education about TB diagnosis, treatment and other aspects of TB control, such as contact investigations. These

centers offer medical consultation to physicians who are treating TB patients, particularly those with complicated or drug-resistant cases.

CDC supports the international community in preventing global and drug resistant TB, which in the long run reduces the TB burden at home. The majority (63%) of U.S. TB cases are among persons born outside this country, reflecting the higher TB prevalence in other countries. CDC is working in more than 30 countries in partnership with the World Health Organization, PEPFAR, the U.S. Agency for International Development, and ministries of health around the world to build TB control program and laboratory capacity. For example, we are participating in introducing and evaluating GeneXpert, a rapid test that uses nucleic acid amplification technology to identify patterns in TB DNA that are associated with drug resistance. By using this test instead of culture-based methods, TB programs are able to diagnose patients faster –reducing diagnosis time from two months to a little over an hour – and quickly place them on the right drugs for curing their TB. Without this test, patients with drug-resistant TB were placed on regimens that were ineffective.

Figure: Trends in TB Cases in Foreign-born Persons, United States, 1992-2012



A paradoxical result of TB progress is the loss of funding and public support for TB programs and an unstable U.S. supply of TB drugs. From December 2012 to December 2013, CDC published nine notices about interruptions in drug and biologics supplies. Anti-TB drugs are old, and the drug supply for TB is dependent upon a handful of U.S. pharmaceutical companies who produce drugs with varying shelf lives and storage requirements. Interruption in the supply of any biologics or drugs used in diagnosing or treating TB impacts nearly every U.S. TB program. CDC and its partners are exploring new mechanisms to assure TB drugs and biologics are continually available; for example, creating buffer supplies of medications to temporarily assuage stockouts. However, options identified to date would require additional funding. Continued drug interruptions put the United States at risk for longer and more costly outbreaks, and ultimately for a TB resurgence, rolling back decades of progress and putting additional Americans at risk of a preventable infection.

CDC will also continue to support improvements in effectiveness and efficiencies that can be gained through program collaboration and service integration (PCSI), by encouraging grantees to address related infections and to develop capacities that can be shared across programs, including HIV, STD and viral hepatitis.

Table: TB Prevention and Control Cooperative Agreement Grant Table^{1,2}

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 President Budget³	2015 +/-2014
Number of Awards	62	62	62	0
- New Awards	0	0	62	+62
- Continuing Awards	62	62	0	-62
Average Award	\$1.304	\$1.304	\$1.304	\$0.000
Range of Awards	\$0.118-\$8.902	\$0.118-\$8.902	TBD	N/A
Total Awards	\$80.860	\$80.860	\$80.860	\$0.000

¹ Awards include funding to address HIV coinfection. Awards do not include funding provided under Direct Assistance.

² Awards do not include funding for Pacific Islands as those jurisdictions are funded another cooperative agreement.

³ A new funding formula is being developed and will be implemented in FY 2015, which would impact any estimates provided.

CDC-Wide HIV/AIDS Funding

Fiscal Year	Domestic HIV/AIDS Prevention and Research (Infectious Disease)	Other Domestic HIV Prevention	Global HIV/AIDS Program ¹	CDC-Wide HIV Total
2004 ^{2,3}	\$667,940,000	\$70,032,000	\$266,864,000	\$1,004,836,000
2005	\$662,267,000	\$69,438,000	\$123,830,000	\$855,535,000
2006 ⁴	\$651,657,000	\$64,008,000	\$122,560,000	\$838,225,000
2007	\$695,454,000	\$62,802,000	\$120,985,000	\$879,241,000
2008 ⁵	\$691,860,000	\$40,000,000	\$118,863,000	\$850,723,000
2009	\$691,860,000	\$40,000,000	\$118,863,000	\$850,723,000
2010 ⁶	\$799,270,000	\$0	\$118,961,000	\$918,231,000
2011	\$800,445,000	\$0	\$118,741,000	\$919,186,000
2012 ⁷	\$822,633,000	\$0	\$131,190,000	\$953,823,000
2013 Final	\$768,635,000	\$0	\$125,254,000	\$893,889,000
2014 Enacted	\$788,809,000	\$0	\$128,735,000	\$917,544,000
2015 Request	\$796,185,000	\$0	\$128,735,000	\$924,920,000

¹ Amounts for the Global HIV/AIDS Program include 2004 amounts for the Prevention of Mother to Child HIV Transmission initiative, which was transferred to the Department of State Office of the Global AIDS Coordinator in FY 2005. Amounts for Global HIV/AIDS do not include President's Emergency Plan for AIDS Relief (PEPFAR) funding.

² From FY 2004 to FY 2005, CDC-wide HIV/AIDS funding was comprised of activities conducted by the Coordinating Center for Infectious Diseases [including the National Center for HIV/AIDS, Viral Hepatitis, STI, and TB Prevention (NCHHSTP)], the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), and the National Center for Birth Defects and Developmental Disabilities (NCBDDD). Funding for NCCDPHP, NCBDDD and the non-NCHHSTP portions of the Coordinating Center for Infectious Diseases are shown in the "Other Domestic HIV Prevention" column.

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

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

⁵ In FY 2010, funds supporting hemophilia/HIV activities in NCBDDD and funds supporting oral health/HIV, BRFS/HIV, and Safe Motherhood/HIV activities in NCCDPHP, previously displayed in the "Other Domestic HIV Prevention" column, were removed from the CDC-Wide HIV/AIDS table. FY 2008 and FY 2009 figures were adjusted to become comparable to FY 2010 figures.

⁶ In FY 2012, HIV prevention activities in the Division of Adolescent and School Health were transferred to NCHHSTP. FY 2010 and FY 2011 funding levels have been made comparable to the budget realignment, reflecting a transfer of \$40,000,000 from Chronic Disease Prevention and Health Promotion to Domestic HIV/AIDS Prevention and Research. Funding levels prior to FY 2010 have not been made comparable to the budget realignment. FY 2010 funding also includes a \$30,400,000 ACA/PPHF allocation.

⁷ FY 2012 and FY 2013 funding levels have been made comparable to FY 2014 Enacted and the FY 2015 request to reflect the permanent realignment of the BSS budget line. Funding levels prior to FY 2012 have not been made comparable to the FY 2015 request.

State Table: HIV Prevention by Health Departments^{1,2,3}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$3,578,735	\$3,806,903	\$3,997,614	\$190,711
Alaska	\$1,071,332	\$1,140,282	\$932,341	-\$207,941
Arizona	\$3,929,216	\$3,929,216	\$4,576,378	\$647,162
Arkansas	\$1,572,818	\$1,689,900	\$1,613,680	-\$76,220
California	\$16,590,442	\$17,282,949	\$17,784,500	\$501,551
Colorado	\$4,334,915	\$4,611,828	\$4,331,146	-\$280,682
Connecticut	\$4,332,016	\$4,337,250	\$4,246,068	-\$91,182
Delaware	\$1,166,692	\$1,121,900	\$1,020,143	-\$101,757
Florida	\$30,638,810	\$33,870,108	\$35,548,124	\$1,678,016
Georgia	\$6,201,421	\$5,770,686	\$5,616,990	-\$153,696
Hawaii	\$1,559,736	\$1,467,317	\$1,300,020	-\$167,297
Idaho	\$823,331	\$988,642	\$766,113	-\$222,529
Illinois	\$3,793,248	\$3,793,003	\$3,487,612	-\$305,391
Indiana	\$2,840,226	\$3,148,285	\$3,039,691	-\$108,594
Iowa	\$973,338	\$1,000,000	\$816,872	-\$183,128
Kansas	\$1,056,311	\$1,004,900	\$907,914	-\$96,986
Kentucky	\$1,590,226	\$1,668,795	\$1,475,335	-\$193,460
Louisiana	\$6,612,692	\$7,213,321	\$6,935,458	-\$277,863
Maine	\$1,061,916	\$1,131,371	\$815,616	-\$315,755
Maryland	\$7,030,860	\$6,987,670	\$5,461,195	-\$1,526,475
Massachusetts	\$6,019,683	\$5,983,274	\$5,522,424	-\$460,850
Michigan	\$6,013,028	\$6,013,027	\$5,923,788	-\$89,239
Minnesota	\$2,563,000	\$2,568,846	\$2,413,535	-\$155,311
Mississippi	\$2,648,029	\$2,816,110	\$3,138,212	\$322,102
Missouri	\$4,042,577	\$4,042,526	\$4,205,657	\$163,131
Montana	\$1,083,895	\$1,058,569	\$937,547	-\$121,022
Nebraska	\$1,198,355	\$1,298,989	\$1,061,690	-\$237,299
Nevada	\$2,277,335	\$2,370,800	\$2,245,880	-\$124,920
New Hampshire	\$926,226	\$787,500	\$813,484	\$25,984
New Jersey	\$15,592,007	\$15,592,007	\$16,095,194	\$503,187
New Mexico	\$1,621,164	\$1,487,541	\$1,323,408	-\$164,133
New York	\$17,698,583	\$18,368,993	\$17,393,614	-\$975,379
North Carolina	\$7,584,255	\$8,883,882	\$8,820,687	-\$63,195
North Dakota	\$667,917	\$711,602	\$752,040	\$40,439
Ohio	\$5,692,974	\$6,259,250	\$6,052,604	-\$206,646
Oklahoma	\$1,714,184	\$1,826,300	\$1,588,825	-\$237,475
Oregon	\$2,359,646	\$2,326,643	\$2,145,092	-\$181,551
Pennsylvania	\$5,383,861	\$6,054,964	\$4,698,243	-\$1,356,721
Rhode Island	\$1,722,804	\$1,794,000	\$1,575,240	-\$218,760
South Carolina	\$5,866,165	\$6,281,003	\$6,123,497	-\$157,506
South Dakota	\$630,995	\$673,536	\$747,204	\$73,668
Tennessee	\$5,140,198	\$5,751,364	\$5,603,710	-\$147,654
Texas	\$15,358,934	\$15,358,934	\$16,349,752	\$990,818
Utah	\$1,261,993	\$1,261,993	\$1,122,250	-\$139,743
Vermont	\$1,376,869	\$1,438,259	\$1,243,348	-\$194,911
Virginia	\$6,944,292	\$7,424,840	\$7,718,380	\$293,540
Washington	\$4,136,489	\$4,404,564	\$4,233,140	-\$171,424
West Virginia	\$986,103	\$913,795	\$820,140	-\$93,655
Wisconsin	\$2,332,144	\$2,327,068	\$2,159,736	-\$167,332
Wyoming	\$720,166	\$787,644	\$759,270	-\$28,374
Cities				

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Baltimore	\$4,271,713	\$5,604,786	\$7,087,483	\$1,482,697
Chicago	\$8,792,225	\$9,991,860	\$9,917,584	-\$74,276
Fulton Co., GA	\$6,870,256	\$8,043,977	\$8,757,224	\$713,247
Houston	\$6,689,649	\$6,689,649	\$8,090,905	\$1,401,256
Los Angeles	\$14,687,503	\$16,285,775	\$16,521,950	\$236,175
New York City	\$32,959,198	\$38,341,343	\$37,365,964	-\$975,379
Philadelphia	\$6,236,632	\$7,273,064	\$8,248,202	\$975,138
San Francisco	\$8,306,109	\$8,398,013	\$7,995,364	-\$402,649
Washington, D.C.	\$5,919,099	\$5,919,099	\$5,963,504	\$44,405
Territories				
Puerto Rico	\$6,400,924	\$6,400,924	\$7,514,250	\$1,113,326
Virgin Islands	\$592,396	\$684,000	\$741,808	\$57,808
Subtotal States	\$232,322,152	\$242,832,149	\$238,260,401	-\$4,571,748
Subtotal Cities	\$94,732,384	\$106,547,566	\$109,948,180	\$3,400,614
Subtotal Territories	\$6,993,320	\$7,084,924	\$8,256,058	\$1,171,134
Total	\$334,047,856	\$356,464,639	\$356,464,639	\$0

CFDA NUMBER: 93-940 [Discretionary]

²Funding amounts include new money only and do not include funding under Direct Assistance.

³FY 2015 amounts were developed using estimated Category A algorithm-based funding and Category B and C funding from FY 2014. Because Category C funding will end for most grantees in FY 2014, total awards by state for FY 2015 may differ somewhat from estimates provided here.

State Table: HIV Surveillance^{1,2}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$929,260	\$1,073,677	\$1,073,677	\$0
Alaska	\$143,126	\$143,126	\$143,126	\$0
Arizona	\$971,435	\$988,110	\$988,110	\$0
Arkansas	\$312,655	\$336,269	\$336,269	\$0
California	\$2,771,711	\$2,689,751	\$2,689,751	\$0
Colorado	\$905,298	\$936,949	\$936,949	\$0
Connecticut	\$897,980	\$929,376	\$929,376	\$0
Delaware	\$258,030	\$286,479	\$286,479	\$0
Florida	\$5,070,928	\$5,058,248	\$5,058,248	\$0
Georgia	\$1,553,541	\$1,691,113	\$1,691,113	\$0
Hawaii	\$236,433	\$255,297	\$255,297	\$0
Idaho	\$175,727	\$184,424	\$184,424	\$0
Illinois	\$702,266	\$865,461	\$865,461	\$0
Indiana	\$787,855	\$778,520	\$778,520	\$0
Iowa	\$219,278	\$261,907	\$261,907	\$0
Kansas	\$239,216	\$353,759	\$353,759	\$0
Kentucky	\$358,499	\$358,499	\$358,499	\$0
Louisiana	\$1,233,391	\$1,349,361	\$1,349,361	\$0
Maine	\$165,307	\$165,307	\$165,307	\$0
Maryland	\$1,636,718	\$2,041,180	\$2,041,180	\$0
Massachusetts	\$917,312	\$1,094,712	\$1,094,712	\$0
Michigan	\$1,167,795	\$1,256,071	\$1,256,071	\$0
Minnesota	\$433,570	\$536,774	\$536,774	\$0
Mississippi	\$753,517	\$826,567	\$826,567	\$0
Missouri	\$639,793	\$765,755	\$765,755	\$0
Montana	\$157,375	\$152,030	\$152,030	\$0
Nebraska	\$207,466	\$246,870	\$246,870	\$0
Nevada	\$438,615	\$471,615	\$471,635	\$0
New Hampshire	\$125,415	\$143,797	\$143,797	\$0
New Jersey	\$2,845,317	\$2,807,225	\$2,807,225	\$0
New Mexico	\$256,159	\$242,676	\$242,676	\$0
New York	\$1,997,625	\$2,066,649	\$2,066,649	\$0
North Carolina	\$1,105,280	\$1,635,204	\$1,635,204	\$0
North Dakota	\$122,098	\$122,097	\$122,097	\$0
Ohio	\$919,116	\$919,116	\$919,116	\$0
Oklahoma	\$370,341	\$405,845	\$405,845	\$0
Oregon	\$399,759	\$426,154	\$426,154	\$0
Pennsylvania	\$813,113	\$953,490	\$953,490	\$0
Rhode Island	\$202,406	\$288,818	\$288,818	\$0
South Carolina	\$1,021,293	\$1,006,998	\$1,006,998	\$0
South Dakota	\$134,032	\$134,032	\$134,032	\$0
Tennessee	\$854,205	\$854,205	\$854,205	\$0
Texas	\$22,596,840	\$2,697,605	\$2,697,605	\$0
Utah	\$273,566	\$330,292	\$330,292	\$0
Vermont	\$125,914	\$132,876	\$132,876	\$0
Virginia	\$1,353,794	\$1,501,785	\$1,501,785	\$0
Washington	\$1,283,509	\$1,308,101	\$1,308,101	\$0
West Virginia	\$208,640	\$224,475	\$224,475	\$0
Wisconsin	\$423,327	\$516,498	\$516,498	\$0
Wyoming	\$111,956	\$123,782	\$123,782	\$0
Cities				

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Chicago	\$1,385,138	\$1,516,906	\$1,516,906	\$0
Houston	\$1,362,647	\$1,508,257	\$1,508,257	\$0
Los Angeles	\$2,429,943	\$2,425,684	\$2,425,684	\$0
New York City	\$5,285,586	\$5,441,619	\$5,441,619	\$0
Philadelphia	\$1,240,718	\$1,389,886	\$1,389,886	\$0
San Francisco	\$1,336,228	\$1,345,902	\$1,345,902	\$0
Washington, D.C.	\$1,458,794	\$1,529,576	\$1,529,576	\$0
Territories				
Puerto Rico	\$1,055,198	\$996,898	\$996,898	\$0
Virgin Islands	\$141,105	\$187,592	\$187,592	\$0
Subtotal States	\$41,827,802	\$44,938,927	\$44,938,927	\$0
Subtotal Cities	\$14,499,054	\$15,157,830	\$15,157,830	\$0
Subtotal Territories	\$1,196,303	\$1,184,490	\$1,184,490	\$0
Total	\$57,523,159	\$61,281,247	\$61,281,247	\$0

²⁶ CFDA NUMBER: 93-944 [Discretionary]

² Funding amounts include new money only and do not include funding under Direct Assistance.

State Table: Sexually Transmitted Disease Prevention^{1,2}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$1,762,308	\$1,786,527	\$1,816,055	\$29,528
Alaska	\$403,039	\$393,416	\$383,830	-\$9,586
Arizona	\$1,305,485	\$1,178,424	\$1,481,153	\$302,729
Arkansas	\$1,183,493	\$1,392,309	\$1,173,465	-\$218,844
California	\$5,413,704	\$5,488,334	\$5,582,341	\$94,007
Colorado	\$1,051,544	\$1,093,498	\$1,143,960	\$50,462
Connecticut	\$718,672	\$753,070	\$787,533	\$34,463
Delaware	\$354,639	\$360,067	\$365,527	\$5,460
Florida	\$4,274,331	\$4,362,042	\$4,456,048	\$94,006
Georgia	\$3,651,750	\$3,636,580	\$3,626,464	-\$10,117
Hawaii	\$363,635	\$367,716	\$377,246	\$9,530
Idaho	\$399,792	\$385,136	\$370,517	-\$14,620
Illinois	\$2,070,464	\$2,148,626	\$2,226,976	\$78,350
Indiana	\$1,672,250	\$1,682,935	\$1,698,501	\$15,567
Iowa	\$727,137	\$722,052	\$717,033	-\$5,020
Kansas	\$793,231	\$779,414	\$765,668	-\$13,745
Kentucky	\$911,915	\$958,999	\$1,006,165	\$47,167
Louisiana	\$2,180,137	\$2,182,093	\$2,189,707	\$7,615
Maine	\$287,424	\$283,494	\$279,592	-\$3,902
Maryland	\$1,232,806	\$1,263,544	\$1,294,395	\$30,851
Massachusetts	\$1,500,700	\$1,516,656	\$1,532,750	\$16,094
Michigan	\$2,591,117	\$2,630,719	\$2,675,073	\$44,353
Minnesota	\$1,018,827	\$1,051,605	\$1,092,975	\$41,369
Mississippi	\$1,354,661	\$1,366,017	\$1,377,498	\$11,481
Missouri	\$1,969,896	\$1,927,731	\$1,888,578	-\$39,153
Montana	\$287,211	\$275,967	\$264,748	-\$11,219
Nebraska	\$430,946	\$438,766	\$446,625	\$7,859
Nevada	\$669,354	\$696,849	\$728,655	\$31,806
New Hampshire	\$269,902	\$271,063	\$272,248	\$1,185
New Jersey	\$3,062,511	\$2,909,120	\$2,756,008	-\$153,112
New Mexico	\$733,234	\$711,166	\$693,697	-\$17,469
New York	\$2,735,229	\$2,670,109	\$2,605,239	-\$64,870
North Carolina	\$2,806,422	\$2,847,631	\$2,893,806	\$46,175
North Dakota	\$248,853	\$236,902	\$224,973	-\$11,929
Ohio	\$3,132,194	\$3,170,300	\$3,214,357	\$44,057
Oklahoma	\$1,109,917	\$1,104,102	\$1,102,904	-\$1,198
Oregon	\$968,331	\$941,784	\$918,034	-\$23,749
Pennsylvania	\$1,955,609	\$2,020,379	\$2,085,328	\$64,949
Rhode Island	\$382,215	\$370,387	\$358,594	-\$11,793
South Carolina	\$1,513,078	\$1,538,550	\$1,564,160	\$25,610
South Dakota	\$275,418	\$269,204	\$263,014	-\$6,190
Tennessee	\$2,199,840	\$2,173,299	\$2,146,957	-\$26,341
Texas	\$6,278,919	\$6,368,740	\$6,462,747	\$94,006
Utah	\$455,262	\$485,445	\$515,670	\$30,225
Vermont	\$173,079	\$176,288	\$179,513	\$3,224
Virginia	\$1,803,108	\$1,880,578	\$1,962,460	\$81,882
Washington	\$2,438,155	\$2,316,036	\$2,194,139	-\$121,897
West Virginia	\$672,513	\$638,830	\$605,207	-\$33,623
Wisconsin	\$913,462	\$1,007,682	\$1,101,985	\$94,303
Wyoming	\$252,480	\$239,835	\$227,212	-\$12,623
Cities				

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Baltimore	\$1,378,397	\$1,323,575	\$1,275,191	-\$48,385
Chicago	\$2,161,829	\$2,138,692	\$2,120,268	-\$18,424
Los Angeles	\$3,552,939	\$3,473,403	\$3,403,632	-\$69,771
New York City	\$6,166,292	\$5,969,935	\$5,780,748	-\$189,187
Philadelphia	\$2,420,697	\$2,295,417	\$2,174,605	-\$120,812
San Francisco	\$1,458,942	\$1,376,899	\$1,304,430	-\$72,469
Washington, D.C.	\$1,172,758	\$1,130,113	\$1,087,574	-\$42,539
Territories				
Puerto Rico	\$1,343,279	\$1,275,999	\$1,208,841	\$67,158
Virgin Islands	\$182,081	\$183,489	\$184,914	-\$1,424
Subtotal States	\$74,960,197	\$75,470,015	\$76,097,328	\$627,313
Subtotal Cities	\$18,311,853	\$17,708,034	\$17,146,448	-\$561,586
Subtotal Territories	\$2,035,000	\$1,969,127	\$1,903,394	-\$65,733
Total	\$95,307,050	\$95,147,176	\$95,147,169	-\$7

¹ CFDA NUMBER: 93-977 [Discretionary]

² Amounts reflect new assistance and include HIV/STD coinfection funds. Amounts do not include funding under Direct Assistance.

³ FY 2014 and 2015 amounts do not include Gonococcal Isolate Surveillance Project awards.

State Table: TB Prevention and Control^{1,2}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget³	Difference +/- 2014
Alabama	\$1,045,496	\$1,045,496	TBD	TBD
Alaska	\$392,758	\$392,758	TBD	TBD
Arizona	\$1,273,872	\$1,273,872	TBD	TBD
Arkansas	\$520,387	\$520,387	TBD	TBD
California	\$8,902,234	\$8,902,234	TBD	TBD
Colorado	\$528,943	\$528,943	TBD	TBD
Connecticut	\$593,957	\$593,957	TBD	TBD
Delaware	\$267,660	\$267,660	TBD	TBD
Florida	\$6,504,276	\$6,504,276	TBD	TBD
Georgia	\$2,530,314	\$2,530,314	TBD	TBD
Hawaii	\$729,596	\$729,596	TBD	TBD
Idaho	\$196,635	\$196,635	TBD	TBD
Illinois	\$1,360,560	\$1,360,560	TBD	TBD
Indiana	\$686,559	\$686,559	TBD	TBD
Iowa	\$413,717	\$413,717	TBD	TBD
Kansas	\$403,739	\$403,739	TBD	TBD
Kentucky	\$608,598	\$608,598	TBD	TBD
Louisiana	\$1,227,208	\$1,227,208	TBD	TBD
Maine	\$181,256	\$181,256	TBD	TBD
Maryland	\$1,299,634	\$1,299,634	TBD	TBD
Massachusetts	\$1,496,082	\$1,496,082	TBD	TBD
Michigan	\$843,612	\$843,612	TBD	TBD
Minnesota	\$2,085,290	\$2,085,290	TBD	TBD
Mississippi	\$831,847	\$831,847	TBD	TBD
Missouri	\$593,743	\$593,743	TBD	TBD
Montana	\$181,984	\$181,984	TBD	TBD
Nebraska	\$284,762	\$284,762	TBD	TBD
Nevada	\$638,482	\$638,482	TBD	TBD
New Hampshire	\$231,564	\$231,564	TBD	TBD
New Jersey	\$3,508,346	\$3,508,346	TBD	TBD
New Mexico	\$356,790	\$356,790	TBD	TBD
New York	\$1,746,556	\$1,746,556	TBD	TBD
North Carolina	\$1,765,588	\$1,765,588	TBD	TBD
North Dakota	\$163,397	\$163,397	TBD	TBD
Ohio	\$1,089,677	\$1,089,677	TBD	TBD
Oklahoma	\$636,376	\$636,376	TBD	TBD
Oregon	\$551,110	\$551,110	TBD	TBD
Pennsylvania	\$884,294	\$884,294	TBD	TBD
Rhode Island	\$329,868	\$329,868	TBD	TBD
South Carolina	\$1,152,291	\$1,152,291	TBD	TBD
South Dakota	\$275,358	\$275,358	TBD	TBD
Tennessee	\$1,381,945	\$1,381,945	TBD	TBD
Texas	\$7,736,436	\$7,736,436	TBD	TBD
Utah	\$330,476	\$330,476	TBD	TBD
Vermont	\$155,826	\$155,826	TBD	TBD
Virginia	\$1,550,712	\$1,550,712	TBD	TBD
Washington	\$1,401,295	\$1,401,295	TBD	TBD
West Virginia	\$297,054	\$297,054	TBD	TBD
Wisconsin	\$460,208	\$460,208	TBD	TBD
Wyoming	\$166,255	\$166,255	TBD	TBD
Cities				

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget³	Difference +/- 2014
Baltimore	\$261,894	\$261,894	TBD	TBD
Chicago	\$1,268,481	\$1,268,481	TBD	TBD
Detroit	\$322,035	\$322,035	TBD	TBD
Houston	\$1,716,298	\$1,716,298	TBD	TBD
Los Angeles	\$4,232,798	\$4,232,798	TBD	TBD
New York City	\$5,929,982	\$5,929,982	TBD	TBD
Philadelphia	\$734,378	\$734,378	TBD	TBD
San Diego	\$1,540,507	\$1,540,507	TBD	TBD
San Francisco	\$846,771	\$846,771	TBD	TBD
Washington, D.C.	\$424,603	\$424,603	TBD	TBD
Territories				
Puerto Rico	\$669,209	\$669,209	TBD	TBD
Virgin Islands	\$118,431	\$118,431	TBD	TBD
Subtotal States	\$62,794,626	\$62,794,626	TBD	TBD
Subtotal Cities	\$17,277,747	\$17,277,747	TBD	TBD
Subtotal Territories	\$2,336,854	\$2,336,854	TBD	TBD
Total	\$82,409,227	\$82,409,227	TBD	TBD

¹ CFDA NUMBER: 93-116 [Discretionary]

² Amounts reflect new assistance and include HIV/TB coinfection funds. Amounts do not include funding under Direct Assistance.

³ FY 2015 estimates are unavailable at this time. A new funding formula is under development and will be implemented in FY 2015.

EMERGING AND ZOOBOTIC INFECTIOUS DISEASES

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President's Budget	2015 +/-2014
	Budget Authority	\$297.222	\$338.447	\$393.549	+\$55.102
	ACA/PPHF	\$44.174	\$52.000	\$51.750	-\$0.250
	Total Request	\$341.396	\$390.447	\$445.299	+\$54.852
	FTEs	1,117	1,117	1,117	0
Emerging and Zoonotic Infectious Diseases					
	- Core Infectious Disease ²	\$216.982	\$218.647	\$249.749	\$31.102
	- National Healthcare Safety Network	\$17.928	\$18.071	\$32.071	\$14.000
	- Food Safety	\$31.009	\$40.089	\$50.089	\$10.000
	- Quarantine	\$31.303	\$31.640	\$31.640	\$0.000
	- Federal Isolation and Quarantine (non-add)	NA	NA	\$1.000	NA
	- Advanced Molecular Detection and Response to Infectious Disease Outbreaks	\$0.000	\$30.000	\$30.000	\$0.000
	- Emerging and Zoonotic Infectious (ACA/PPHF)	\$44.174	\$52.000	\$51.750	-\$0.250

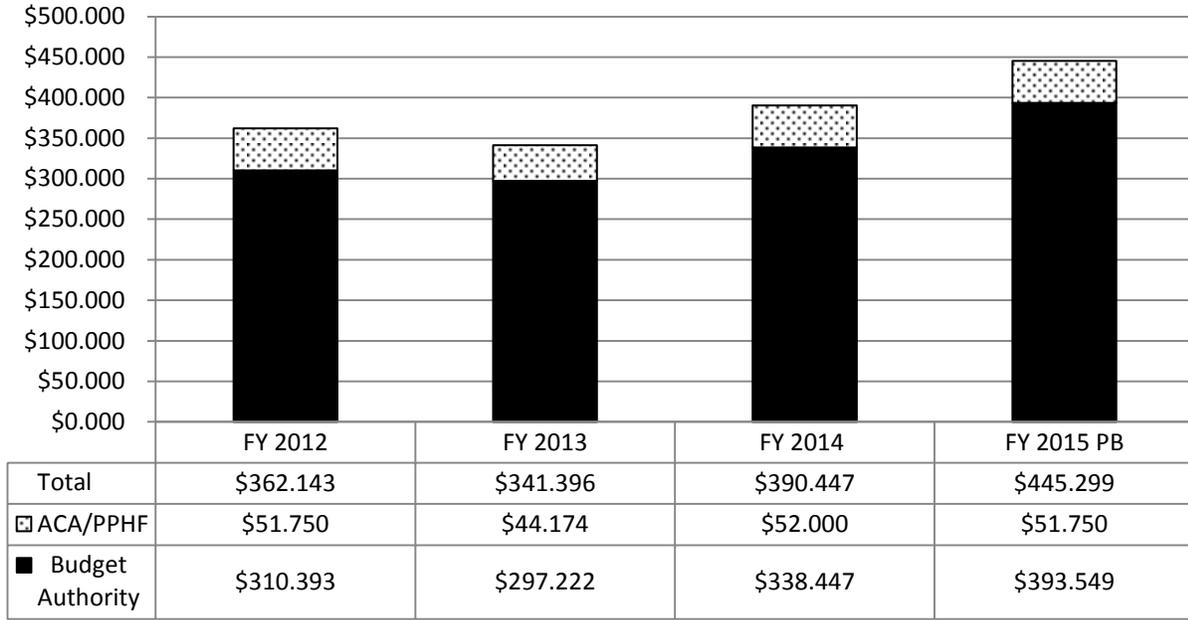
¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and FY 2014 are comparable to FY 2015 to account for the Center for Global Health reorganization.

Summary

CDC's FY 2015 request of **\$445,299,000** for Emerging and Zoonotic Infectious Diseases, including \$51,750,000 from the Affordable Care Act Prevention and Public Health Fund, is an increase of \$54,852,000,000 above the FY 2014 Enacted level. The FY 2015 budget request will allow CDC to further reduce healthcare-associated infections, improve food safety, and invest in antibiotic resistant detection and response activities. CDC's FY 2015 request includes an increase of \$30,000,000 for the Detect and Protect Against Antibiotic Resistance initiative. Through this initiative, CDC will expand the antibiotic resistant (AR) detection and response program to fully integrate enhanced surveillance capacity at local, state, and national levels to characterize and protect patients from imminent domestic AR threats. This request also maintains a \$30,000,000 investment to build capacity through the Advanced Molecular Detection Initiative in bioinformatics and genomics. The \$14,000,000 requested increase for CDC's National Healthcare Safety Network (NHSN) extends the program to more than 3,000 additional sites. Through broadening data collection on healthcare-associated infections (HAIs) and antibiotic use, CDC will accelerate HAI prevention across the spectrum of care. CDC will also continue to implement its provisions of the Food Safety Modernization Act.

Chart: Funding History (dollars in millions)



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

²FY 2013 and FY 2014 are comparable to FY 2015 to account for the Center for Global Health reorganization.

Core Infectious Diseases Budget Request

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015
			President's Budget	+/-2014
Budget Authority²	\$216.982	\$218.647	\$249.749	+\$31.102

¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and FY 2014 are comparable to FY 2015 to account for the Center for Global Health reorganization.

Overview

Protecting Americans and people around the world from constantly-changing infectious diseases involves a cascade of activities that includes laboratory testing, disease tracking, epidemiologic investigations, analysis and reporting, and research and development into solutions. These actions need to occur at many levels (local, state, and national), because pathogens, diseases, and people move across borders. Since we live in an interconnected world, ensuring capacity at each of these levels and working collaboratively across all of these levels is essential in protecting individuals from infectious disease threats. CDC invests in a flexible public health system at national, state, and local levels to:

- Build and maintain a sufficient and competent public health workforce
- Create and support disease tracking systems
- Support modern and efficient laboratories with well-trained laboratory staff
- Prepare and equip outbreak investigation and response teams
- Develop and apply tools for effective epidemiologic, statistical, analytic, and communication approaches

CDC is home to the country's leading experts and laboratories in infectious disease prevention and control. CDC's experts and laboratories detect and track a range of microbes and respond to disease threats from those pathogens. Two recent threats included a large increase of valley fever in the southwest and 2012's nationwide fungal meningitis outbreak. Through specialized surveillance systems that serve as early warning systems, CDC's experts were and remain able to detect and protect the public from a vast number of infectious diseases.

Epidemiology and Laboratory Capacity (ELC) Platform/Emerging Infections Program (EIP)

CDC's multiple approaches to surveillance, control and prevention of infectious diseases are evident in two of CDC's flagship Cooperative Agreements: the [Epidemiology and Laboratory Capacity for Infectious Diseases \(ELC\)](#)²⁷ platform and the [Emerging Infections Program \(EIP\)](#)²⁸. The ELC operates a nationwide cooperative agreement supporting all 50 states, the six largest local health departments, and U.S. territories and affiliates. ELC focuses investments on building essential epidemiology and laboratory capabilities in all grantees while also providing targeted resources for issues of regional concern. The EIP, a network of 10 state public health departments (CA, CO, CT, GA, MD, MN, NM, NY, OR, TN) and their academic partners, conducts gold standard surveillance, epidemiology studies, and prevention research projects. For example, U.S. estimates of foodborne disease illnesses and deaths are generated using data from EIP surveillance. EIP provides similar data for several other infections (e.g. respiratory, healthcare associated, HPV, and tickborne). The EIP also helps answer questions about what public health interventions work best.

²⁷ <http://www.cdc.gov/media/releases/2013/p0820-cdc-awards-funding.html>

²⁸ <http://www.cdc.gov/nceid/dpei/eip/>

Supporting Global Introduction of New Vaccines

CDC provides leadership and scientific expertise for global introduction of new vaccines and vaccine preventable disease (VPD) surveillance to monitor impact, effectiveness and safety for these vaccines. This effort includes the development and introduction of a new meningitis vaccine, and monitoring its impact in African countries that experience meningitis epidemics. The new vaccine has been given to over 100 million persons in 12 countries, with a marked reduction in meningitis and no evidence of vaccine failure to protect against the epidemic strain. It also includes providing assistance with the introduction of rotavirus and pneumococcal vaccines which will reduce global childhood mortality.

Budget Request

CDC's FY 2015 request of **\$249,749,000** for core infectious diseases is an increase of \$31,102,000 above the FY 2014 Enacted level. This increase includes an increase of \$30,000,000 for CDC's "Detect and Protect Against Antibiotic Resistance" initiative.

The initiative will intensify action in detecting the most serious AR threats quickly to stop them before they spread widely and protecting patients and communities by expanding tracking of antibiotic use and developing early warning systems that connect antibiotic use patterns and antibiotic resistance laboratory results. CDC's core infectious diseases budget request includes a number of activities that support surveillance, laboratory and prevention programs in multiple infectious disease areas. These areas include vector-borne diseases (including Lyme disease), high-consequence pathogens (formerly hantavirus/special pathogens), chronic fatigue syndrome, prion, emerging infections, AR, and healthcare-associated infections. The following sections describe select core infectious disease activities.

Vector-Borne Diseases

CDC's [vector-borne diseases program](#)²⁹ is the focal point of the nation's capacity to detect, control, and prevent bacteria and viruses transmitted by mosquitoes, ticks, and fleas. CDC experts combine support to state and local health departments with intramural research, addressing risks to the United States from emerging and invasive pathogens arising anywhere in the world. As the national diagnostic reference center for vector-borne diseases, CDC will continue to monitor the emergence and epidemic potential of exotic and novel vector-borne threats both domestically and abroad.

Current vector-borne disease priorities:

- **Dengue:** In 2013, Puerto Rico faced an epidemic of tens of thousands of cases of dengue, a mosquito-transmitted virus that causes as many as 400 million infections globally each year. Small, locally-transmitted dengue outbreaks were also identified in Florida and Texas.
- **Chikungunya virus:** The [invasion of chikungunya virus](#)³⁰ into the Western hemisphere in 2013 highlights the importance of global health security and effective surveillance for invasive pathogens. Chikungunya is transmitted by the same mosquito as dengue and will spread from the Caribbean to Latin America, and potentially into the U.S.
- **West Nile virus:** The U.S. continues to see outbreaks of West Nile virus each year. A recent CDC publication found healthcare costs and lost productivity from West Nile virus infections have cost \$778 million since 1999.
- **Lyme disease:** Each year, more than 30,000 cases of Lyme disease are reported to CDC, making it the seventh most commonly reported infectious disease in the United States in 2012.

²⁹ <http://www.cdc.gov/ncezid/dvbd/>

³⁰ <http://wwwnc.cdc.gov/travel/notices/watch/chikungunya-saint-martin>

- **Global health security:** The vector-borne diseases program will support the Global Health Security program through projects in Africa and Asia to improve diagnostics, treatment, and prevention of vector-borne diseases.
- **Newly discovered pathogens:** Recently, CDC helped discover four new tick-borne pathogens in the U.S.: *Borrelia miyamotoi*, which causes Lyme-like symptoms; a novel *Borrelia* species; an *Ehrlichia muris*-like bacteria; and Heartland virus. Research continues on how widespread these infections are and who is being infected.

In FY 2015, the United States will confront new threats from domestic and invasive vector-borne pathogens. To address those threats, CDC will:

- Assist public health partners
- Conduct multi-faceted surveillance
- Train and support healthcare providers and laboratories
- Build capacity through partnerships

Assist public health partners

Assist county, state, tribal, and territorial health authorities, as well as [international partners](#)³¹, to detect, prevent, and control diseases spread by mosquitoes, ticks, and fleas. CDC staff will help local authorities conduct fieldwork and research to explain why and how citizens are at risk for vector-borne disease and evaluate the efficacy of prevention efforts.

Conduct multi-faceted surveillance

- **Operate [ArboNET](#)**³² the national surveillance system for arthropod-borne viruses (or *arboviruses*) like West Nile virus and chikungunya. This integrated network funds staff in 49 states, Puerto Rico, and six large municipalities to conduct human case investigations, collect and test mosquitoes, and perform laboratory analyses. CDC evaluates, updates, and shares this information weekly with state and local partners.
- **Support [TickNET](#)**³³ a CDC-funded network of the 16 states with the highest rates of tick-borne diseases, to conduct surveillance and test practical prevention measures for Lyme disease, Rocky Mountain spotted fever, and other tick-borne infections.
- **Evaluate [SaludBoricua](#)**³⁴, an online self-reporting surveillance tool developed with academic partners that has recently opened for public participation. SaludBoricua will be used to track acute febrile illnesses including dengue, influenza, and leptospirosis in Puerto Rico. It is based on the [Flu Near You](#)³⁵ platform used in the U.S. The program can help CDC and the Puerto Rico Department of Health track and mitigate dengue outbreaks before they are identified by traditional surveillance methods.

Train and support healthcare providers and laboratories

Expand training and education for healthcare providers, public health professionals, and the public. CDC is providing training to state and local health departments and PAHO-region laboratories to assure capacity in chikungunya epidemiology, diagnostics, and vector control. CDC is also pioneering the use of continuing medical education curriculum on severe dengue case management. This course is now required for medical licensure by

³¹ <http://blogs.cdc.gov/publichealthmatters/2013/07/dengue-in-angola/>

³² <http://diseasemaps.usgs.gov/>

³³ <http://www.cdc.gov/ticknet/index.html>

³⁴ <https://saludboricua.org/>

³⁵ <https://flunearyou.org/>

the Puerto Rico Department of Health and is being prepared for launch in March 2014 as an [online training](#)³⁶ available to all U.S. physicians.

Continue to support state and global diagnostic laboratories. CDC vector-borne laboratories distribute special supplies to state laboratories, perform confirmatory testing for difficult or complex cases, and develop new diagnostic methods. These new diagnostics are then provided to U.S. and international laboratories, improving testing speed, accuracy, and quality. For example, a CDC-developed dengue testing kit uses the same readily available equipment as tests for influenza, making it possible for more labs to gain diagnostic capacity.

Build capacity through partnerships

Explore public/private partnerships to develop, test, and deploy innovative disease prevention techniques. These include:

- A CDC-developed [dengue vaccine](#)³⁷ that protects against all four dengue virus types.
 - A commercial partner is preparing Phase 2b/Phase 3 trials that are expected to begin in late 2014.
- Host-targeted Lyme disease prevention methods, including commercially-licensed [rodent bait boxes](#)³⁸.
 - In FY 2015, CDC will complete the bait box evaluation and work with partners to develop a unique rodent-targeted vaccine designed to stop Lyme disease transmission in the animal host.
- A [successful pilot project](#)³⁹ in Rocky Mountain spotted fever prevention combining innovative solutions with commercial sponsorship to prevent deaths in Arizona.
 - In FY 2015, CDC will work with tribal partners to expand the project to more at-risk communities.

High-Consequence Pathogens

CDC works to protect Americans from rare, but deadly pathogens like Hantavirus pulmonary syndrome, Ebola and Marburg viral hemorrhagic fevers, rabies, Creutzfeldt-Jakob disease, monkeypox, smallpox, and anthrax. Because the pathogens that cause these diseases are so deadly, with many of them considered bioterrorism threats that are regulated as Tier 1 select agents, CDC maintains biosafety level (BSL)-3 and BSL-4 laboratories. These labs support epidemiologic investigations, research, and prevention efforts to reduce the public health threat of these hazardous and infectious high-consequence pathogens.

CDC provides specialty expertise, training, and laboratory support to state, tribal, local, and territorial health departments as well as to global partners and ministries of health in investigations of:

- Suspected domestic cases of known high-consequence pathogens and of infectious diseases of unknown cause, and
- Outbreaks of high-consequence pathogens that includes response activities to prevent the spread of these deadly diseases.

In 2013, CDC forged partnerships that collectively led to major accomplishments:

- CDC worked with private sector partners including a commercial vaccine manufacturer to develop a vaccine to prevent Rift Valley Fever, a viral disease that affects domestic animals and humans in Africa and the Arabian Peninsula. Preventing it there can help prevent its potential introduction to the U.S.

³⁶ <http://www.cdc.gov/dengue/educationTraining/index.html#index.html>

³⁷ <http://blog.ghettocoalition.org/2013/06/17/working-to-protect-against-the-dangers-of-dengue/>

³⁸ http://www.cdc.gov/ticknet/ltdps/ltdps_bait.html

³⁹ <http://www.youtube.com/watch?v=jdnCdM98oCA>

- CDC collaborated with public health officials in investigating an outbreak of unusual illness among shepherds in the country of Georgia that led to the discovery of a new poxvirus, one that is closely related to smallpox. CDC is now working to develop a test that will help clinicians test sick patients for this poxvirus as well to understand the potential impact this poxvirus can have on the health of both people and animals.
- CDC responded to a multi-state outbreak of human rabies transmitted during organ transplantation. A patient who died of rabies contracted the infection more than a year after having an organ transplant. The patient was one of four people who received an organ from the same donor. CDC laboratories tested tissue samples from the donor and from the deceased organ recipient to confirm transmission of rabies. The other three organ recipients received rabies vaccination and survived.

In FY 2015, CDC will continue to support outbreak investigations and response activities to help states and other countries detect and control the spread of rare, but deadly high-consequence pathogens. A key part of this work will be CDC’s continuing effort to build the [MicrobeNet](#)⁴⁰ platform—a centralized reference laboratory for state health departments and international partners to accelerate the rapid detection and identification of pathogens. CDC will continue to invest in developing global health capacity to handle specimens safely and perform initial screening assays—particularly in parts of Africa and Asia that are recognized as emerging disease “hot spots” for outbreaks of some of the world’s most dangerous pathogens. CDC will continue to promote a “One Health” approach to address the complex interplay between human health, animal health, and the environment by integrating surveillance and response strategies. Additionally, CDC will continue its work on developing:

- New vaccines and improved diagnostic assays,
- Training for healthcare workers in resource poor and strategic areas to better understand the risks for the spread of deadly pathogens to neighboring countries and beyond, and
- Medical and public health interventions for these deadly diseases that often have no specific therapies for treatment.

Emerging Respiratory Pathogens

CDC works to detect and respond to respiratory disease threats domestically and abroad through disease tracking, epidemiologic investigations and response, and laboratory activities. When unexplained respiratory illnesses emerge, one of the first steps is to identify the pathogen that is making people sick. An example of this was in 2012, when what we now call Middle East Respiratory Syndrome (MERS) emerged. As part of the public health response, CDC developed tests to detect the MERS virus in sick patients and trained laboratory professionals in the U.S. and around the world to use the tests to detect MERS. CDC deployed epidemiologists to help in these public health investigations.

Epidemiologic and laboratory findings are also used to identify and evaluate prevention strategies. In 2013, CDC continued to monitor the effectiveness of pneumococcal conjugate vaccines in the EIP, demonstrating the dramatic impact of the recently licensed pneumococcal conjugate vaccine (PCV13) in further reducing the risk of invasive bacterial diseases in both children and adults.

In FY 2015, CDC will support epidemiologic and laboratory surveillance for existing and emerging respiratory diseases. Specific activities will include:

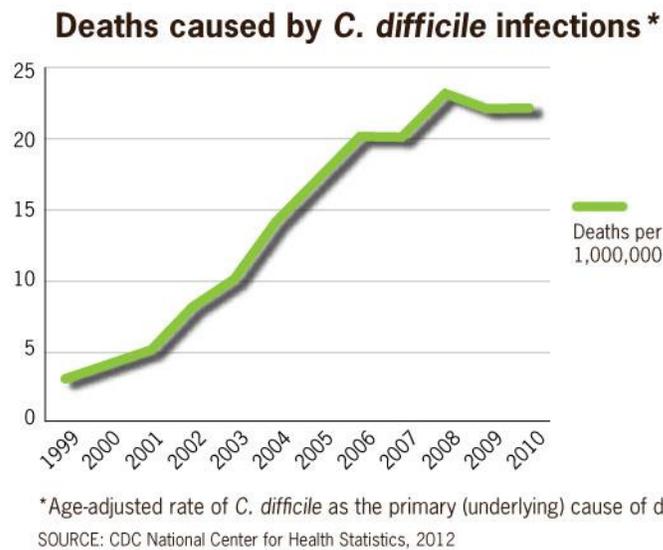
- Continued funding of the EIP sites to monitor respiratory bacterial pathogens, such as Group A and Group B Streptococcus, Legionella pneumophila, and antibiotic resistance;
- Developing diagnostic tests that can test for many pathogens at the same time (multi-array assays);

⁴⁰ <https://microbenet.cdc.gov/>

- Continuing to support planning, surveillance, laboratory testing, and providing technical assistance for MERS;
- Ongoing epidemiologic and laboratory activities for non-influenza respiratory viruses will allow CDC to maintain the expertise to respond to emerging viruses such as MERS.

Antibiotic Resistance Initiative: “Detect and Protect Against Antibiotic Resistance”

The FY 2015 Budget includes an increase of \$30,000,000 to expand the “Detect and Protect Against Antibiotic Resistance” initiative. Some antibiotic resistant (AR) infections are already untreatable. If CDC does not work to stop antibiotic resistance now, minor infections will become life threatening and risk the ability to perform routine surgeries or treat diseases like diabetes and cancer. Each year, CDC estimated that over 2 million illnesses and about 23,000 deaths are caused by antibiotic resistance. In 2013, CDC released [Antibiotic Resistance Threats in the United States](#)⁴¹ outlining solutions needed to address this pressing threat. This initiative will scale up those solutions by building a more robust network to “detect” our most serious AR threats and “protect” patients and communities, saving lives, and reducing costs.



In FY 2015, this initiative will:

- Reduce *Clostridium difficile* (deadly diarrheal illness that kills up to 14,000 Americans per year) by 15%, preventing at least 1,600 deaths, over 13,000 hospitalizations, and over \$170 million in healthcare costs;
- Reduce Carbapenem-resistant Enterobacteriaceae (CRE) infections (the nightmare bacteria with up to a 50% mortality rate) by 10%, drug-resistant pseudomonas by 6% (some strains resistant to nearly all antibiotic therapies), invasive MRSA by 6% (80,000 infections and 11,000 deaths per year), and drug-resistant *Salmonella* infections by 5% (100,000 infections per year);
- Expand drug susceptibility testing for high-priority pathogens by at least five-fold, including a ten-fold increase in the number of resistant *Salmonella* isolates from humans available for comparison with *Salmonella* isolates from animals and foods;
- Begin work on an antibiotic resistant isolate library that will be accessible to pharmaceutical companies testing new antibiotic agents, biotech and diagnostic companies designing the next generation of clinical tests, and researchers evaluating the effectiveness of new interventions;

⁴¹ <http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf>

- Begin implementation of CDC antibiotic protection tools nationwide to improve prescribing in U.S. acute-care hospitals and outpatient settings.

In FY 2015, CDC will leverage existing CDC detection programs and capabilities to:

- Establish a “Detect” network of five regional laboratories that will serve as a national resource to characterize emerging resistance and rapidly identify outbreaks of the most concerning antibiotic resistant threats, including: CRE, extended-spectrum β -lactamases (ESBL), drug-resistant gonorrhea, drug-resistant pseudomonas, drug-resistant staphylococcus aureus, and drug-resistant *Salmonella*. This network will use state-of-the-art methods to characterize known resistance patterns in real time, and to identify clusters of resistant organisms more quickly. It will also track the spread of AR organisms in communities and through food to people. This will dramatically improve our understanding of which AR threats are most common in the United States, and which will be critical for new drug and diagnostic development. As AR threats change, we will tailor the testing protocols of the labs to adapt to new and emerging threats.
- CDC will integrate these five regional laboratories into a domestic and international AR communication network to post “early warning” alerts and report urgent AR results and trends. The regional labs and related communication network will improve the linkage of domestic and international AR lab activities to track urgent and emerging forms of resistance across borders and will also support method development of novel point-of-care diagnostics that could be applied to rapidly detect resistance in patients.

DETECT AND PROTECT PILOT PROGRAMS IN STATES:

- Partnering with hospital associations, HENs, QIOs and others to establish a prevention network of hospitals and long term care facilities to measure AR infections, improve antimicrobial use, and evaluate infection control practices related to AR across healthcare settings
- Using NHSN data to track AR infections and know where resistance is happening to focus prevention and limit the potential for spread of these infections
- Enhancing capacity for CRE identification and outbreak response

Most critically, the initiative will invest in direct action to protect patients and communities by implementing proven interventions that reduce the emergence and spread of AR pathogens and improve appropriate antibiotic use. CDC will leverage existing CDC protection programs and capabilities to:

- Expand existing prevention pilots into comprehensive “Protect” programs in 30 States that will scale up effective evidence-based interventions to stop AR threats in inpatient healthcare settings where the threats are most deadly. Programs will:
 - Actively seek out existing threats like CRE and *C. difficile* and work with healthcare facilities for aggressive case-management implementation of prevention bundles, and standardization of facility-to-facility communications.
 - Scale up antibiotic stewardship programs nationwide, focusing on improving antibiotic prescribing through checklists, provider education, standards setting and benchmarking.
 - Implement healthcare facility reporting of antibiotic use and antibiotic resistance, which will automate and simplify tracking of antibiotic use data; and use electronic health records to provide a more complete picture of resistance patterns within facilities and communities.
 - Engage large health systems to ensure sustainability, improve reach, and provide a bridge to extend interventions to long-term care settings.

- CDC will also implement targeted protection activities to tackle drug resistant issues in the community:
 - **MDR *Salmonella*:** Using data from the regional labs, CDC will attribute resistant *Salmonella* infections to specific foods more rapidly and precisely through targeted research into the spread and prevention of MDR *Salmonella* in food animal reservoirs.
 - **MDR gonorrhea:** Types of gonorrhea strains are showing resistance to antibiotics that are usually used to treat it. Additional testing of drug-resistant cephalosporin-resistant gonorrhea (GC) will allow CDC to better monitor treatment of gonorrhea, rapidly detect treatment failures, evaluate effectiveness of treatments, determine transmission patterns and risk factors for resistant infections and evaluate the value of tests-of-cure for surveillance and clinical treatment, through implementation and evaluation of routine tests-of-cure.
 - **Outpatient Prescribing:** Through a focused assessment of outpatient prescribing, CDC will evaluate state variations in antibiotic use and identify interventions to improve outpatient prescribing nationwide. CDC will expand on its recently published analysis of state-by-state variations in outpatient antibiotic prescribing by supporting targeted education activities in outlier states with the highest rates of prescribing to improve overall outpatient prescribing rates.
 - **Antibiotic Adverse Event Study:** CDC will partner with healthcare providers to develop a new cohort study to evaluate the impact of early pediatric antibiotic use on adverse events later in life. Potential areas of study would retrospectively evaluate the impact of early antibiotic use on obesity, asthma, eczema, allergies, and *C. difficile*.

Over five years, this initiative will:

- Reduce *Clostridium difficile* by 50%, preventing at least 20,000 deaths, 150,000 hospitalizations, and over \$2 billion in healthcare costs;
- Reduce Carbapenem-resistant Enterobacteriaceae (CRE) infections by 50%, drug-resistant pseudomonas by 30%, invasive MRSA by 30%, and drug-resistant *Salmonella* infections by 25%;
- Expand drug susceptibility testing for high-priority pathogens by at least ten-fold, including a twenty-fold increase in the number of resistant *Salmonella* isolates from humans available for comparison with *Salmonella* isolates from animals and foods;
- Establish an antibiotic resistant isolate library that will be accessible to pharmaceutical companies testing new antibiotic agents, biotech and diagnostic companies designing the next generation of clinical tests, and researchers evaluating the effectiveness of new interventions;
- Implement CDC antibiotic protection tools nationwide to improve prescribing in U.S. acute-care hospitals and outpatient settings.

In FY 2015, core AR activities will continue through CDC's Core Infectious Disease funding to support CDC's national and international reference laboratories for antibiotic resistance to collect data and isolates of highly resistant pathogens, to develop new clinical diagnostic tests to detect AR pathogens, and to conduct strain typing and provide international comparisons of strain diversity for important forms of resistance. It will also support CDC's subject matter experts and labs that provide assistance to state health departments, clinical diagnostic laboratories, academic researchers, and hospitals to detect new AR threats, test antibiotic susceptibility, and characterize the epidemiology of multi-drug resistant pathogens.

Healthcare-associated Infections and Adverse Event Outbreak Response

CDC provides national leadership in [healthcare-associated infection \(HAI\)](#)⁴² prevention, identifies emerging threats, and protects patients across healthcare through outbreak detection and control, gold-standard laboratory testing of the healthcare environment and contaminated products, and guideline development for prevention of HAIs and related patient safety threats. These activities complement and are informed by the National Healthcare Safety Network tracking capabilities described later in the request. Outbreaks of healthcare associated infections and healthcare related adverse events are a critical public health problem. CDC estimates that, at any given time, one in 20 hospitalized patients has an HAI, while over one million HAIs occur across the healthcare spectrum each year at a cost of over \$30 billion.

Outbreak investigations provide critical information used to assess populations at risk and to identify prevention strategies.

In 2013, outbreak investigations addressed HAIs from the following:

- emerging pathogens
- contaminated devices and products
- blood transfusion
- organ and tissue transplantation
- major breaches in infection prevention

In FY 2015, to prevent the spread of serious or life threatening infections within and between healthcare settings, CDC will:

- Detect and control outbreaks of HAIs across all healthcare settings
- Serve as a national and international reference laboratory for untreatable pathogens and develop and evaluate new diagnostic tests for HAIs and drug resistant bacteria.
- Develop evidence-based infection prevention guidelines to provide the scientific foundation for HAI prevention interventions and support federal initiatives such as the HHS National Action Plan to Prevent HAIs: Roadmap to Elimination and HHS Agency Priority Goals.
- Work with federal partners, state and local health departments, and private sector partners to prevent HAIs and target healthcare facilities that need additional assistance.

The following graphic highlights CDC's rapid public health response during the 2012 multistate outbreak of fungal meningitis that was linked to tainted steroid injections. This graphic demonstrates the importance of CDC's outbreak capabilities aimed at protecting patients and saving lives. Timely intervention by CDC personnel limited the scope of the outbreak and saved patient lives by early identification of contaminated products as well as prompt identification and treatment of exposed people.

⁴² <http://www.cdc.gov/hai/>

OUTBREAK: FUNGAL MENINGITIS

In September 2012 the first case of fungal meningitis, linked to tainted steroid injections, was reported in Tennessee. Before long, hundreds of other fungal infections began appearing across the country, making this the largest outbreak of healthcare associated infections in the U.S. Thanks to fast actions by local, state, and federal public health agencies nearly 14,000 patients and their physicians were notified of the outbreak and given instructions on how to respond.

EXPOSURE



Patients at Risk

13,534



99% of patients warned of the need to seek immediate care in less than one month

National Healthcare Safety Network Budget Request

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$17.928	\$18.071	\$32.071	\$14.000

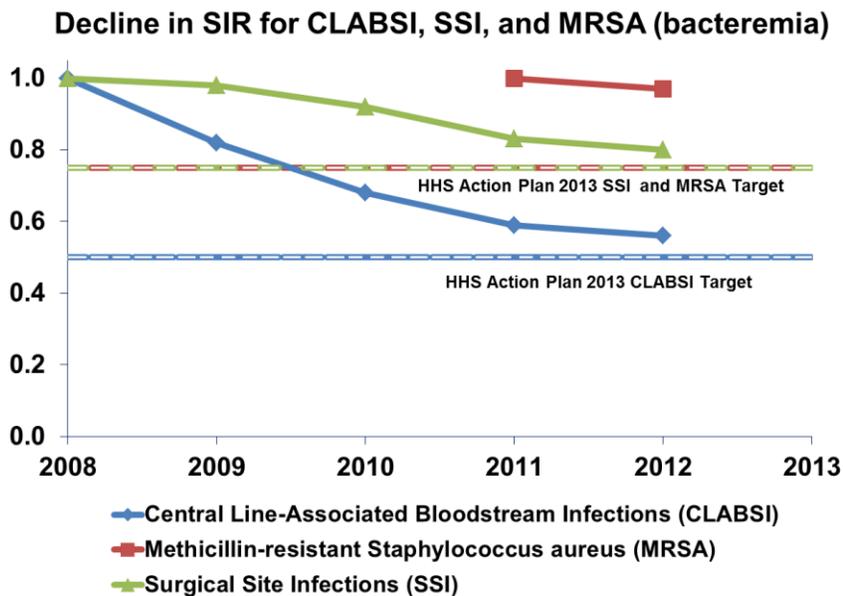
¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC operates the [National Healthcare Safety Network \(NHSN\)](http://www.cdc.gov/nhsn/)⁴³ which is used to protect patients by detecting and preventing healthcare-associated infections (HAI). NHSN is the main HAI reporting system in the U.S., with more than 12,000 healthcare facilities participating in all 50 states. Hospitals and other health care facilities, Center for Medicare and Medicaid (CMS) payment requirements, state oversight of healthcare, and quality improvement programs at local, state and federal levels use NHSN to prevent, detect and respond to HAIs and related patient safety threats. Specifically, NHSN data and the tools provided by the system are used by:

- Healthcare facilities for real-time quality assessment and local practice improvement, such as initiatives for catheter-associated urinary tract infection (CAUTI) prevention.
- State health departments to implement state public reporting mandates and target prevention efforts where most needed.
- CMS to improve the quality of care through payment incentives, and target prevention efforts of CMS-supported Quality Improvement Organizations (QIOs) and Hospital Engagement Networks (HENs) on facilities with the greatest need.
- HHS to track national progress and make decisions on which aspects of healthcare quality should be targeted next (e.g., National Action Plan to Prevent HAIs Agency Priority Goals).

The use of NHSN has allowed facilities to demonstrate significant reductions in central line-associated bloodstream infections (CLABSI), surgical site infections (SSI), and hospital-onset laboratory identified Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia (see graph below).



⁴³ <http://www.cdc.gov/nhsn/>

Budget Request

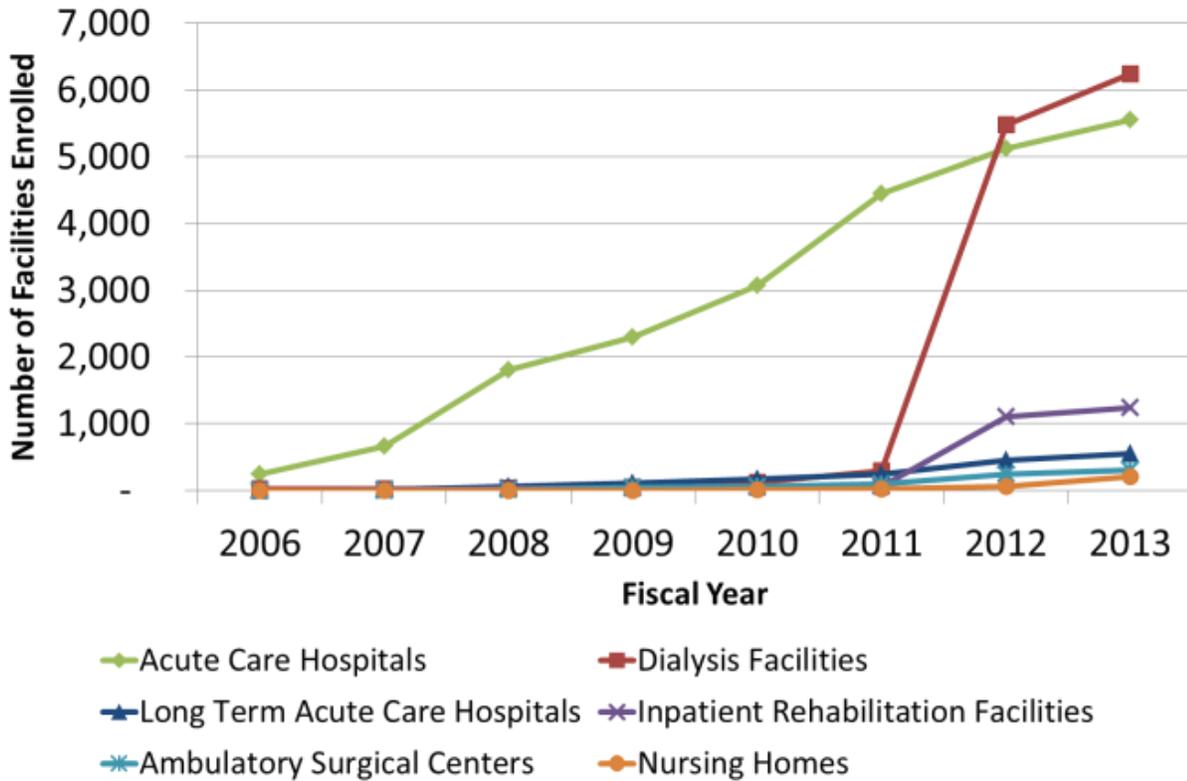
CDC's FY 2015 request of **\$32,071,000** for NHSN is a \$14,000,000 increase over the FY 2014 Enacted level. The FY 2015 budget request extends NHSN reporting to more than 3,000 additional sites. These funds will enable CDC to continue to provide data for national HAI elimination, and targeted HAI prevention intervention. The funds will be used to:

- Support the development of Antibiotic Use and Resistance (AUR) modules in NHSN that will enable rapid detection of highly antibiotic resistant pathogens causing HAIs and allow assessment and tracking of antibiotic use patterns across the nation to better understand and intervene in trends that are promoting the spread of potentially untreatable infections.
- Initiate HAI prevention efforts to ambulatory surgery centers (ASCs), where an increasing proportion of healthcare is being delivered.
- Drive innovation through collaboration with academic research centers in CDC’s Prevention EpiCenters network, which conducts applied research on interventions for infection prevention.

NHSN Participation

HAI Event	Number of Facilities Enrolled in NHSN as of Dec. 2013	Expected Number of Facilities
ACUTE CARE HOSPITALS	5,600	> 5,000
CLABSI - ICU	3,400	> 3,300
CAUTI - ICU	3,375	
SSI	3,800	> 3,800
MRSA Bacteremia	4,150	
<i>C. difficile</i> LabID Event	4,200	
Antimicrobial Use module	50	> 5,000
Antimicrobial Resistance module	0	> 5,000
DIALYSIS FACILITIES	6,300	> 5,600
LONG TERM ACUTE CARE FACILITIES (LTAC)	550	> 400
INPATIENT REHABILITATION FACILITIES (IRF)	1,240	> 1,200
AMBULATORY SURGICAL CENTERS (ASC)	310	> 5,000

Increase in Facility Enrollment in CDC’s National Healthcare Safety Network by Facility Type, 2006-2013



Spurring Prevention by Extending the Reach of NHSN

CDC will use its NHSN infrastructure to track antimicrobial resistant infections to target prevention efforts and assess the quality of antibiotic prescribing to improve how antibiotics are used in US healthcare facilities. Measurement of antimicrobial use in hospitals is an integral part of efforts to reduce inappropriate use and stop unnecessary antibiotic exposure that puts patients at risk of highly resistant infections and secondary complications like *Clostridium difficile* infection. In FY 2015, CDC will continue to refine and extend participation in NHSN’s Antimicrobial Use (AU) module and fully implement the Antimicrobial Resistance (AR) module in more than 500 hospitals to track and analyze those trends and provide national benchmarks to assess the quality of antibiotic use and severity of antibiotic resistance across facilities. CDC will use FY 2015 resources to develop the technical specifications and test the accuracy and usability of these measures for presentation to the National Quality Forum for consideration as national measures. These data are crucial to helping clinicians, facilities, public health officials, industry, and the public understand where AR is a problem and how reverse this dangerous trend.

Non-hospital settings in the United States are lagging behind acute care hospitals in HAI prevention. In 2015, CDC will continue to provide technical assistance and monitoring for HAIs in facilities that provide dialysis, long-term care, rehabilitation, ambulatory surgeries, and other outpatient procedures. CDC will continue to extend prevention beyond acute care hospitals by tracking healthcare personnel influenza immunization coverage in more than 5,000 ambulatory surgery centers (ASC) and outpatient departments nationwide. CDC will continue working with CMS to include healthcare personnel immunization tracking in nursing homes and extend surgical site infection (SSI) reporting to ASCs.

In FY 2015, CDC will continue CLABSI, CAUTI, SSI, MRSA, and *C. difficile* infection reporting in more than 5,000 hospitals, and bloodstream infection reporting in more than 5,000 dialysis facilities and provide these data to the CMS Hospital Compare website, giving the public facility-level data on HAI prevention, enabling healthcare facilities to track and prevent infections locally, and state health departments and others to track HAIs and drive progress in HAI prevention across healthcare.

Promoting Innovation through Research

CDC funds innovative applied research through its Prevention EpiCenters network, which collaborates to identify new and better ways to prevent HAIs and related harms to patients. This network of academic partners will continue to work to fill gaps in the science base for HAI prevention, antibiotic resistance, and other adverse events associated with healthcare. This work is informed by and provides valuable synergy with CDC’s surveillance, outbreak investigations, and HAI expertise. An example of EpiCenters work was published in 2013; the [REDUCE Methicillin-resistant Staphylococcus Aureus \(MRSA\) Trial](#)⁴⁴ demonstrated that a simple intervention of routinely bathing all patients arriving at the intensive care unit with chlorhexidine containing soap reduced MRSA by 37% and the risk of bloodstream infections due to all pathogens by 44%. CDC strives for such actionable innovations using this network to address other critical infection problems like sepsis, *Clostridium difficile* infections, and ventilator-associated pneumonia (VAP).

Table: National Healthcare Safety Network Grant Table¹

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	6	6	20	14
- New Awards	0	0	14	14
- Continuing Awards	6	6	6	0
Average Award	0.111	0.111	0.280	0.169
Range of Awards	0.036-0.217	0.036-0.217	\$0.036-\$1.000	0.783
Total Awards	0.669	0.669	5.600	\$5.600

¹ Reflects awards supported with CDC’s NHSN budget authority.

In FY 2015, CDC will fund additional awardees through existing cooperative agreement programs, including the ELC, the Prevention EpiCenters program, and Public Health Partnerships to produce ward-specific, facility-wide NHSN data on antibiotic resistant HAIs and pathogens, promote data accuracy, and extend HAI prevention efforts to ASCs in collaboration with CMS. The funding will enable state health departments to work through partners including group purchasing organizations, health insurers, healthcare facilities, patient advocacy and healthcare consumer organizations, quality improvement organizations, professional societies, and state hospital associations to increase implementation of HAI prevention programs. CDC bases continuation funding on competitively determined awards. Grantees currently consist of 16 state health departments and Prevention EpiCenters. These grants enhance detection; facilitate faster response to HAI threats; develop innovative strategies to diagnose and prevent infections; and use CDC data to target facilities most in need of improvement to decrease illness and death associated with healthcare delivery.

⁴⁴ http://www.cdc.gov/hai/epiCenters/new_research-reduce-mrsa.html

Food Safety Budget Request

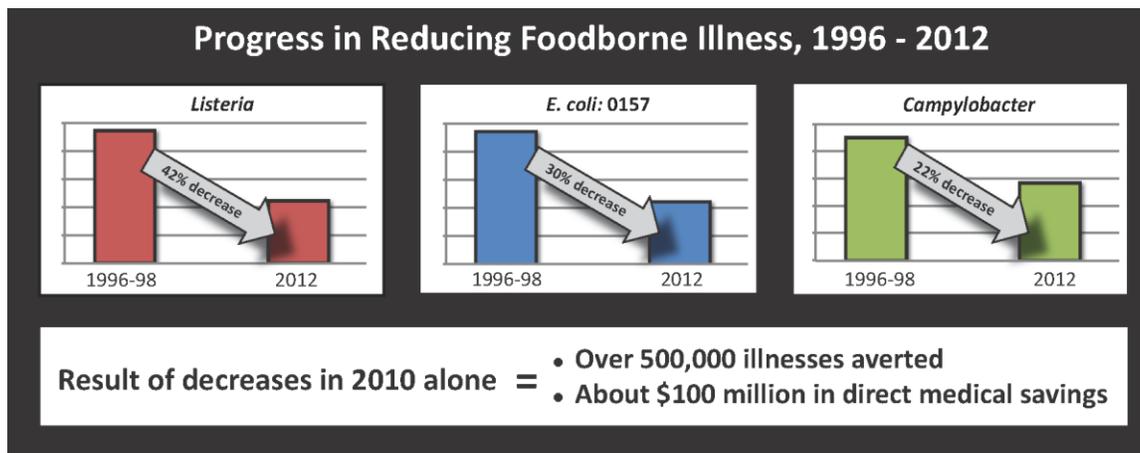
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$31.009	\$40.089	\$50.089	\$10.000

¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's Food Safety Program aims to reduce the estimated 48 million illnesses, 128,000 hospitalizations, and 3,000 deaths of Americans each year caused by pathogens in contaminated food and quantify that impact to inform control measures. Significant progress has been made in reducing human illness caused by three major pathogens (See graphs below). Despite these improvements, changes in our environment, microorganisms, and the food supply are affecting the occurrence and complexity of foodborne diseases. CDC's unique role in food safety is to:

- Detect foodborne illnesses
- Work closely with state health departments and with food regulatory agencies (Food and Drug Administration (FDA) and USDA's Food Safety and Inspection Service (FSIS) to stop outbreaks
- Track emerging and long-term illness trends to determine problems and progress
- Provide data to federal food safety regulators to improve their rules and regulations; and
- Provide technology, expert advice, guidance, training, and education for state and local governments, partners, and consumers.



Budget Request

CDC's FY 2015 request of **\$50,089,000** for food safety activities is an increase of \$10,000,000 over the FY 2014 Enacted level. Approximately one-half of the requested increase in funds will go to state and local health agencies to enhance their vital national surveillance, outbreak detection and response, and food safety prevention efforts, resulting in up to 80 additional full and part-time positions. This funding will address the critical unmet needs in the nation's food safety system, focusing on the following priority areas in food safety at CDC and at state health departments, all of which are required provisions of the Food Safety Modernization Act (FSMA):

- Enhancing and integrating surveillance systems
- Updating PulseNet System

- Improve timeliness of outbreak detection and response in States through the FoodCORE program, which will be expanded from seven to 10 sites
- Attributing illnesses to specific food commodity groups to aid in prevention efforts
- Supporting FSMA's Integrated Food Safety Centers of Excellence

The budget request will be used to:

- Detect, investigate and stop foodborne outbreaks
- Provide information to help guide food safety policy
- Apply advanced DNA technology for faster, better foodborne disease control and prevention

Apply advanced DNA technology for faster, better foodborne disease control and prevention

CDC's [PulseNet](#)⁴⁵ laboratory system is the most effective tool for detecting foodborne disease outbreaks and correcting problems in the food supply. However, PulseNet uses a 20-year old technology that is rapidly becoming obsolete, because it is not compatible with new tests being adopted in to diagnose illness in hospitals and clinics. In 2015, CDC will support and improve PulseNet in all 50 States to improve the completeness and accuracy of detection data. Public health cannot stop or prevent what it cannot detect, and quick detection leads to investigation and control to prevent illnesses, hospitalizations, and deaths.

To modernize PulseNet laboratories, FY 2015 Food Safety funds will be used to:

- Assess the new diagnostic tests being adopted in clinical laboratories (culture-independent diagnostic tests, or CID Tests)
- Establish better techniques at CDC and in states to recover bacteria from CID test specimens, so that current PulseNet surveillance can continue for the short term.
- Evaluate and implement new tools and software that speed primary data collection and sharing with states and other public health partners.

Detecting, investigating and stopping foodborne outbreaks

CDC also depends on the network of state and local public health agencies to report foodborne illnesses as they occur and to respond to outbreaks when they are detected. The FY 2015 Budget will continue to support, coordinate and enhance state epidemiology, laboratory and environmental health capacity needed to track foodborne illnesses and detect and respond to outbreaks. CDC efforts include leading approximately 30 multistate foodborne outbreak investigations each year with local, state and federal agency partners. Together, CDC and states stop outbreaks, prevent illness, and show how improved prevention policies might keep the next outbreak from happening.

The FY 2015 Budget will also strengthen tracking and characterization of outbreaks caused by bacteria (with PulseNet) and new and known strains of norovirus (with [CaliciNet](#)⁴⁶) in all 50 states. CDC will also strengthen the CDC foodborne diseases reference laboratory, which supports state and global efforts in disease tracking by verifying the identification of known pathogens and characterizing new pathogens.

CDC drives improvements in foodborne outbreak detection and response through the [Foodborne Diseases Centers for Outbreak Response Enhancement \(FoodCORE\)](#)⁴⁷ program and the [Integrated Food Safety Centers of Excellence](#)⁴⁸. FoodCORE develops field-tested practices and procedures that speed up tracking and outbreak

⁴⁵ <http://www.cdc.gov/pulsenet/>

⁴⁶ <http://www.cdc.gov/norovirus/php/reporting.html>

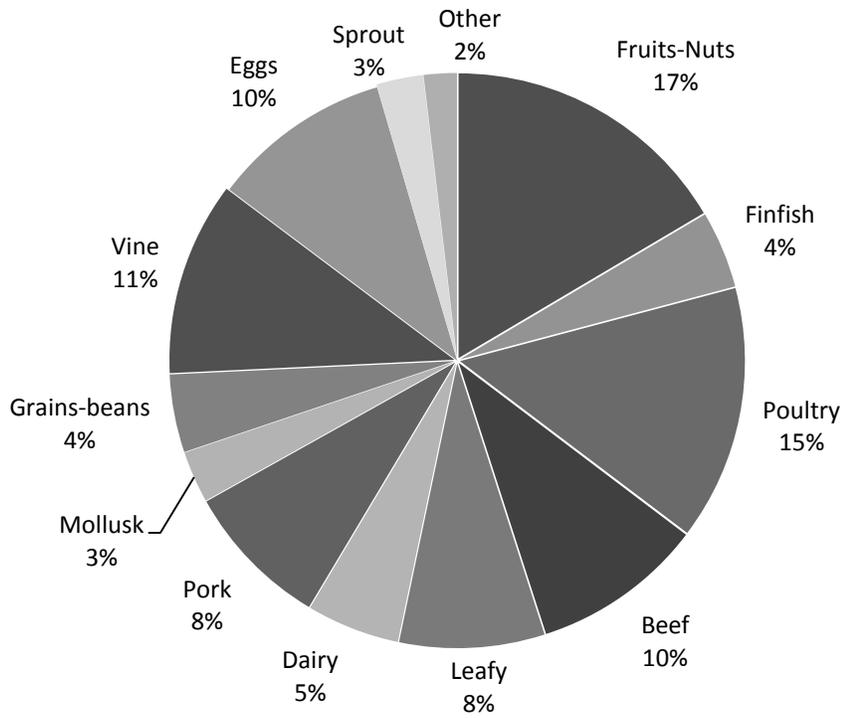
⁴⁷ <http://www.cdc.gov/features/foodcore/>

⁴⁸ <http://www.cdc.gov/foodsafety/centers/>

response. CDC’s five Food Safety Centers of Excellence serve as a resource to other state and local public health programs in improving foodborne disease surveillance and outbreak investigation. In FY 2015 CDC will increase program efforts to:

- Make priority laboratory surveillance activities stronger and faster, including disease tracking in PulseNet, the National Antimicrobial Resistance Monitoring System (NARMS), and CaliciNet laboratory systems.
- Develop and evaluate best practices for more efficient outbreak detection and response at FoodCORE sites for use at the local, state and federal levels
- Train public health personnel in other states in best practices for foodborne disease diagnosis, surveillance, pathogen identification, outbreak investigation, and control.
- Restore and improve state and local capacity to implement a suite of best practices to monitor foodborne illness and respond to outbreaks.

Cause of 24,000 Illnesses of Single Food commodities 2008-2012



Source: CDC National Outbreak Reporting Systems

Providing information to help guide food safety policy

Tracking trends in foodborne infections each year illuminates problems and identifies potential solutions. The funding request for CDC’s Food Safety Program will support and enhance laboratory-confirmed illness surveillance, surveys and studies through [FoodNet](http://www.cdc.gov/foodnet/)⁴⁹, including tracking the impacts that culture-independent diagnostic tests will have on foodborne surveillance. It will also support, through [the National Outbreak Reporting System \(NORS\)](http://www.cdc.gov/nors/)⁵⁰, our ability to [collect and analyze outbreak data](http://www.cdc.gov/foodsafety/fdoss/index.html)⁵¹ from all states and provide the

⁴⁹ <http://www.cdc.gov/foodnet/>

⁵⁰ <http://www.cdc.gov/nors/>

⁵¹ <http://www.cdc.gov/foodsafety/fdoss/index.html>

public with a [searchable database](#)⁵², that offers insights into the foods, germs, and settings linked to foodborne diseases nationally. These networks contribute data used to measure progress in reaching national food safety goals and support prevention efforts to identify high-risk foods for food regulatory agencies and food industries.

To better identify the foods that cause outbreaks, the [Interagency Food Safety Analytics Collaboration](#)⁵³, (a combined effort of CDC, FDA, and FSIS) conducts studies that help regulators and industry target prevention measures to the highest risk foods to prevent foodborne disease and to measure progress. The pie chart shows estimates of the illnesses caused by single food categories over the past five years and shows where prevention is most needed.

In FY 2015 CDC will increase programs efforts to:

- Monitor foodborne pathogens despite changing diagnostic practices, surveys and studies in FoodNet and of foodborne outbreaks in the National Outbreak Reporting System (NORS).
- Rapidly assess trends in foodborne illness, identify high-risk foods, and assess the effectiveness of prevention strategies, in close collaboration with FDA and FSIS via the Interagency Food Safety Analytics Collaboration.
- Improve the integration, analysis, usability, and sharing of data with food safety partners and the public.
- Reduce data gaps and improve linkage across surveillance systems.

Table: Food Safety Grant Table¹

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Number of Awards	57	57	57	0
- New Awards	0	0	0	0
- Continuing Awards	57	57	57	0
Average Award	\$0.19	\$0.27	\$0.36	\$0.11
Range of Awards	\$0.001-\$0.875	\$0.027-\$1.230	\$0.036-\$1.636	\$0.011 - \$.0.394
Total Awards	\$10.980	\$15.520	\$20.520	\$5.000

¹Reflects estimated awards funded by CDC's Food Safety budget authority.

⁵² <http://wwwn.cdc.gov/foodborneoutbreaks/>

⁵³ <http://www.cdc.gov/foodborneburden/attribution/index.html>

Quarantine and Migration Budget Request

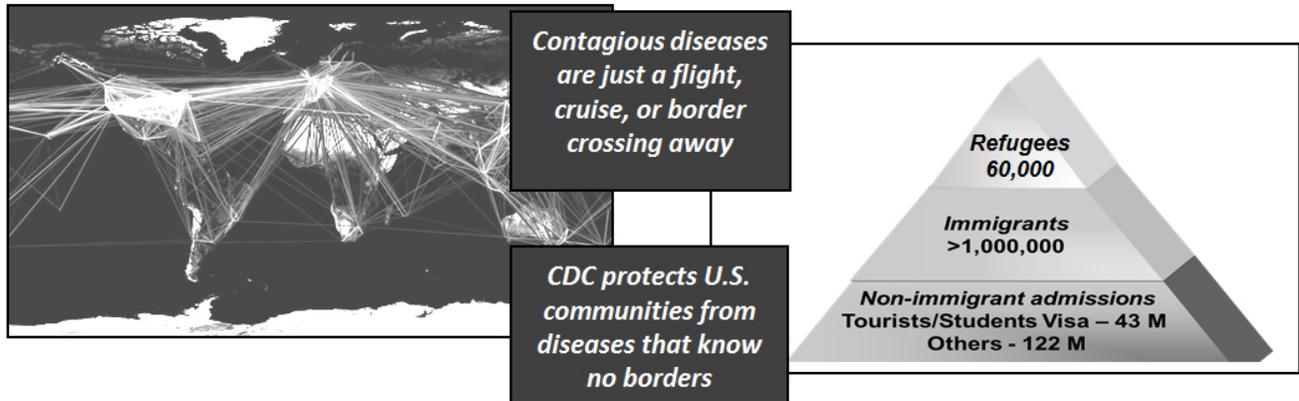
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$31.303	\$31.640	\$31.640	\$0.000
Federal Isolation and Quarantine (non-add)	NA	NA	\$1.000	NA

¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

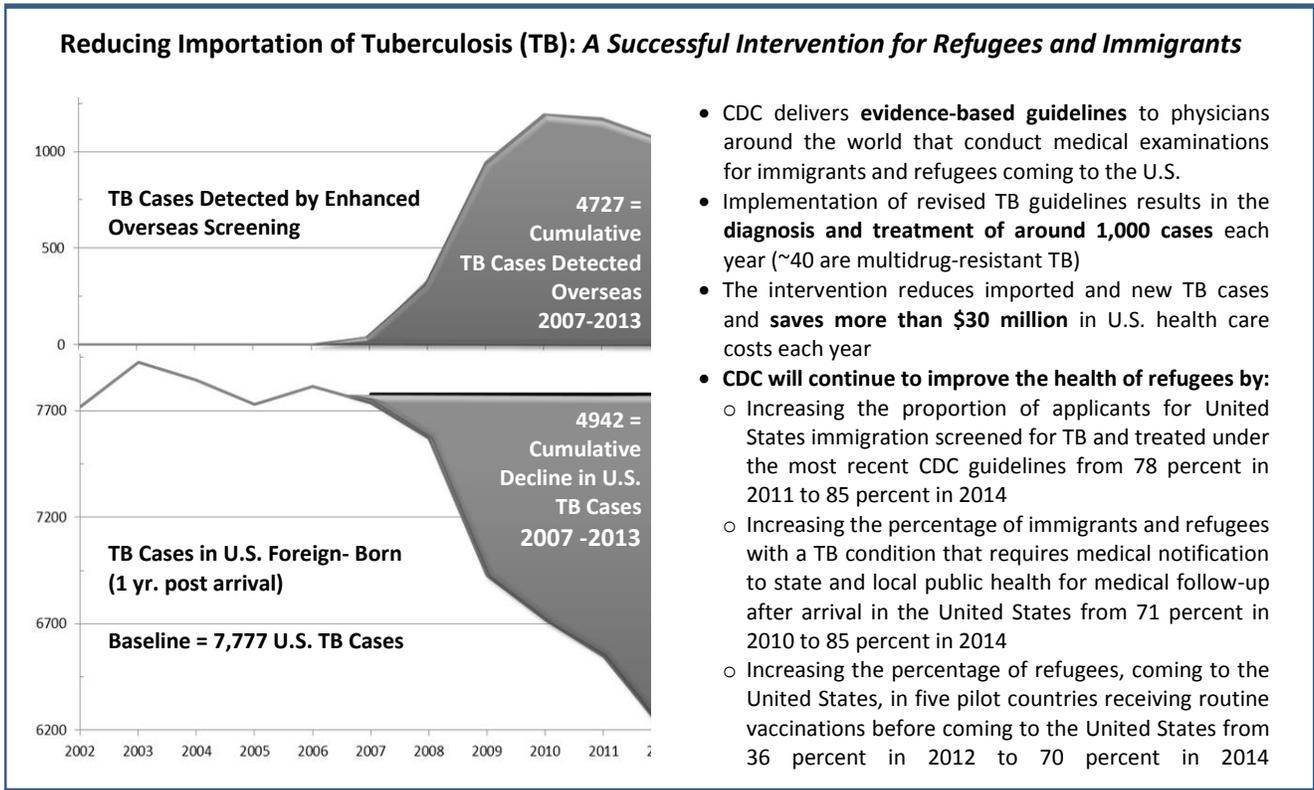
Air travel today allows an infected person to carry a disease from any place in the world to another within 24 hours, often in less time than the incubation periods of many diseases. Infectious diseases among immigrants, refugees, international travelers, and other globally mobile populations pose a significant health risk to these individuals and their families, but also pose a public health risk to the U.S. communities in which they visit and/or reside. [CDC's global migration and quarantine public health and regulatory activities](#)⁵⁴ focus on preventing the spread of infectious disease into the U.S.

Figure: International Flight Patterns and Arrivals in the United States, 2012



CDC uses specialized knowledge of the complex issues surrounding border and migration health to carry out its unique regulatory responsibilities, implement cost-effective public health programs, and leverage non-traditional partnerships for a greater impact through a network of front line responders (e.g., approximately 25,000 Customs and Border Protection agents; 760 physicians; and 3,000 civil surgeons).

⁵⁴ <http://www.cdc.gov/nceid/dgmg/index.html>



Budget Request

CDC's FY 2015 request of **\$31,640,000** for Migration Health and Quarantine is level with the FY 2014 Enacted level. CDC will use these funds in FY 2015 to implement public health programs to protect receiving U.S. communities from infectious diseases, provide cost savings to the U.S. healthcare system, and respond to the needs of people who are traveling around the world or relocating to the U.S. from another part of the world. Within this amount, up to \$1,000,000 is to remain available until expanded for quarantine-related medical and transportation costs. Isolating and quarantining travelers with highly contagious diseases such as multi-drug resistant tuberculosis (MDR-TB) protects the health security of travelers and U.S. communities. Under its regulatory authority, CDC issues federal isolation orders under Title III of the Public Health Service Act. To ensure prompt and effective isolation when necessary, CDC has Memorandums of Agreement with 182 hospitals for transportation, evaluation, diagnosis, care, and treatment of travelers who pose a significant risk to public health.

Table: CDC's FY 2015 Global Migration and Quarantine Public Health Actions

Activities	Examples
Improving the Health of Immigrants, Refugees, and Migrants ⁵⁵	<ul style="list-style-type: none"> • Deliver evidence-based guidelines for medical screening and comprehensive tracking of diseases • Provide information to health departments for medical follow-up • Pilot cost-effective overseas interventions to vaccinate and treat parasitic diseases for refugees (~ 50,000 covered yearly) • Manage field programs in Kenya and Thailand • Monitor occurrence of disease in refugee camps

⁵⁵ <http://www.cdc.gov/ImmigrantRefugeeHealth/>

Activities	Examples
Public Health at U.S. Ports of Entry ⁵⁶	<ul style="list-style-type: none"> • Operate CDC’s 20 Quarantine Stations to ensure that people, animals, and animal products do not spread disease • Distribute life-saving drugs 24/7 (~90 lives saved yearly) • Respond to major health emergencies • Works with partners at ports of entry and along the US-Mexico border to reduce the spread of disease
Keeping Americans Healthy During Travel and While Living Abroad ⁵⁷	<ul style="list-style-type: none"> • Track and analyze occurrences of disease throughout the world to help U.S. travelers and health care providers stay informed • Manage the Travelers’ Health website (~30 million page views yearly) • Publish the CDC Health Information for International Travel: The Yellow Book – the gold standard travel medicine reference
Partnering to Improve US-Mexico Health ⁵⁸	<ul style="list-style-type: none"> • Detect, notify, investigate, and respond to illness reports and infectious disease cases along the U.S.-Mexico border

In FY 2015, CDC will fund 28 domestic and international partners through existing cooperative agreements. The awards help protect the health of U.S. communities, migrants, immigrants, refugees, and international travelers; improve the tracking of disease outbreaks and trends; and build epidemiologic and public health capacity.

Table: Migration Health Grants¹

(dollars in millions)	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President’s Budget	2015 +/-2014
Number of Awards	32	28	28	0
- New Awards	8	4	0	
- Continuing Awards	24	24	28	
Average Award	\$0.147	\$0.167	\$0.167	
Range of Awards	\$0.010-\$1.295	\$0.010-\$1.295	\$0.010-\$1.295	
Total Awards	\$4.719	\$4.683	\$4.683	\$0.000

¹This table includes awards supported with CDC’s Quarantine budget authority.

⁵⁶ <http://www.cdc.gov/Quarantine/>

⁵⁷ <http://wwwnc.cdc.gov/travel/>

⁵⁸ <http://www.cdc.gov/USMexicoHealth/>

Advanced Molecular Detection and Response to Infectious Disease Outbreaks Budget Request

(dollars in millions)	FY 2015			
	FY 2013 Final ¹	FY 2014 Enacted	President's Budget	2015 +/-2014
Budget Authority	N/A	\$30.000	\$30.000	\$0.000

¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

[Advanced molecular detection \(AMD\)](#)⁵⁹ involves the use of the latest pathogen identification technologies along with enhanced capabilities in bioinformatics (an interdisciplinary field involving the use of computer technology, mathematics, and engineering in the analysis of biologic data) to better understand, prevent, and control infectious diseases. Examples of the public health benefits of AMD include faster, more accurate, and cost-effective ways of

- Diagnosing known and emerging infections
- Detecting and responding to outbreaks
- Understanding, characterizing, and controlling antibiotic resistance
- Developing and targeting prevention measures, including vaccines

Earlier molecular detection tools such as polymerase chain reaction (PCR) and pulsed-field gel electrophoresis (PFGE), which examine pieces of DNA from infectious pathogens, have been used for decades to improve our ability to characterize and control infectious threats. Newer, more powerful, pathogen detection technologies, such as whole-genome sequencing (WGS), are designed to identify the complete genetic makeup of organisms and can rapidly deliver massive amounts of data. While these “next-generation” sequencing tools carry the potential to revolutionize our ability to control infectious diseases, sufficient laboratory and bioinformatics capacities along with highly skilled staff are required to extract and interpret relevant information from the large amounts of sequencing data.

As the nation’s and perhaps the world’s premier disease detection agency, CDC is well positioned to adapt these new tools and technologies for public health use but currently lacks the molecular tools, computing infrastructure, and bioinformatics capacity to keep pace with this rapidly changing field. In fact, a 2011 panel of external consultants concluded that CDC runs the risk of being unable to meet its basic mission of protecting public health without strong enhancements to its bioinformatics capacities (see [Bioinformatics Blue Ribbon Panel report](#)⁶⁰).

Genetic sequencing tools are quickly moving from research to clinical laboratories. These tools offer more rapid, less labor-intensive, and less expensive means of diagnosing infections, compared to traditional culture-based methods. While the increasing availability and use of these tools is bringing exciting opportunities for infectious disease control, it is also bringing new expectations for CDC, including provision of bioinformatics expertise and leadership to manage and translate sequence data into meaningful information to guide public health action.

This shift from culture-based to culture-independent diagnostic tests is also necessitating major changes in many of CDC’s national surveillance systems that rely on culture-based specimens to track and prevent infectious diseases. CDC anticipates that within 3 years many traditional methods for detecting and characterizing pathogens will be replaced or supplemented by genome-based methods, requiring adaptation of many programs to the advent of new, data-driven technologies.

⁵⁹ <http://www.cdc.gov/amd/pdf/amd4-2-13.pdf>

⁶⁰ <http://www.cdc.gov/amd/pdf/bioinformatics-panel-report.pdf>

Budget Request

CDC's FY 2015 request of **\$30,000,000** for the crosscutting Advanced Molecular Detection and Response to Infectious Disease Outbreaks initiative is level with the FY 2014 Enacted level. This initiative represents the introduction of cutting edge technologies into CDC's current public health microbiology and informatics that will result in a fundamental change and modernization of CDC's capabilities to protect American's health.

Laboratory techniques for identifying and describing the pathogens/germs that cause infectious diseases have changed dramatically over the past decade which allow us to understand very detailed information about the genetic make-up of the pathogen. The volume of data created by these techniques would completely overwhelm CDC's current information technology infrastructure. More importantly, this detailed information requires experts in microbiology and bioinformatics to examine the information to extract insights and make the information meaningful for public health purposes: detecting cases and outbreaks (outbreak response); tracking diseases (surveillance); developing diagnostic tests for diseases; and developing vaccines. The investment will enable CDC to continue progress on:

Strengthening essential national surveillance systems by re-tooling them to incorporate the most recent technologic advances. The growth in clinical diagnostic tests that do not use culture-based laboratory approaches, but rather faster and cheaper DNA tests, threatens the future of many of CDC's laboratory-based surveillance systems (like PulseNet, the Gonococcal Isolate Surveillance Program, and the National Antimicrobial Resistance Monitoring System), unless we can quickly find ways to transition from the old approaches to the new. Strategic investment in bioinformatics and pathogen genomics is critical to re-tool these laboratory surveillance programs, both at CDC and in state public health laboratories, and incorporate the use of new molecular technologies for more rapid and accurate detection and response to infectious threats.

Enabling CDC and its public health partners to detect and respond quickly and decisively to emerging microbial health threats, such as changes in antimicrobial resistance and pathogen virulence resulting from constantly evolving microbes. The development of bioinformatics tools will allow near real-time analysis and comparison of microbial genomes. The availability of web-accessible, high-quality databases of pathogen information at CDC (e.g., MicrobeNet) will allow states and other domestic and international partners to identify and characterize pathogens quickly with unparalleled accuracy and speed. As this conversion is completed for different programs, states no longer will need to submit certain cultures to CDC for pathogen identification. Instead, they may submit full or partial genome sequences from organisms of concern and obtain immediate information.

Investments in bioinformatics and genomics will result in significant, measurable improvements in the quality, nature, and timeliness of CDC's laboratory-based core surveillance programs, with general improvements to ensure continued effective outbreak response. FY 2015 activities will continue to expand the use of high-throughput sequencing and bioinformatics approaches for major outbreaks, expand the use of molecular sequencing for surveillance and outbreak investigations, and work to establish highly curated reference databases for pathogen sequences. The rich dataset generated from initial efforts on analysis of reference and outbreak samples will speed the development of updated pathogen detection and more precise strain identification techniques. As advanced techniques and approaches are validated against current laboratory standards, they will become incorporated into the routine workflow of CDC laboratories and will replace existing methodologies.

Areas of Focus for CDC's AMD Investments	Background and Specific Activities
<p><i>Improved pathogen identification and detection using genomics and other high-throughput technologies</i></p>	<p>In the second year of the initiative, CDC will</p> <ul style="list-style-type: none"> ▪ Apply DNA sequencing and analysis capabilities to priority projects in CDC infectious disease programs ▪ Support identification of targets for pathogen detection, identification, sub-specific strain typing, and markers for detection of drug resistance, vaccine development, and microbial virulence ▪ Assemble a core team of experts in bioinformatics, pathogen genomics, and other technical specialties to develop, standardize, and refine tools for genome-scale molecular epidemiology and work with program scientists to apply these technologies to CDC's laboratory and surveillance activities ▪ Expand training fellowships with academic institutions to address future bioinformatics workforce needs ▪ Continue to enhance CDC's networking infrastructure, enabling rapid transfer of large genomic datasets for analysis in collaboration with external partners, such as the National Center for Biotechnology Information, Oak Ridge National Laboratory, and other national laboratories ▪ Establish partnerships and cooperative agreements with groups with expertise in high-performance computing, pathogen genomics, and bioinformatics allowing for, in future years, the rapid prototyping and development of next-generation, sequence-based tools for pathogen strain typing and characterization that will benefit a wide range of surveillance and response activities.
<p><i>Adaptation of new diagnostics to meet evolving public health needs</i></p>	<ul style="list-style-type: none"> ▪ Achieve enhanced analysis capabilities and an expanded pathogen dataset enabling CDC to establish leading capability to adapt the next generation of rapid, semi-automated, molecular tests to meet evolving public health needs. These enhancements will significantly improve CDC's ability to pinpoint emerging threats and outbreaks. ▪ Develop new diagnostic tests during outbreaks, and increase the level of detail and quality of information for biosurveillance and disease response activities. ▪ In the second year of the initiative, CDC will initiate research projects needed to identify genomic markers for development of new diagnostic and surveillance assays.
<p><i>Help for states to meet future bioinformatics and genomics needs in a coordinated manner</i></p>	<p>Like at CDC, state public health laboratories will need to adapt to using new genetic technologies</p> <ul style="list-style-type: none"> ▪ CDC will achieve its goal of improved detection of emerging microbial health threats, including those caused by multidrug-resistant organisms, by uploading important stores of genomic information about groups of viral, bacterial, and other pathogens to CDC's internet-based reference databases (e.g., MicrobeNet) and providing access to these databases to state and local public health laboratories, and other partners. ▪ CDC will build capacity for state public health laboratories to adapt to using new AMD technologies but will require the purchase of specialized equipment. ▪ CDC will implement support for state and local public health laboratories through training grants and by providing limited funding support for staff and equipment. Outbreak response activities will become more effective and better integrated as CDC accelerates the rate at which pathogen-specific information is made accessible to partners.

Areas of Focus for CDC's AMD Investments	Background and Specific Activities
	<ul style="list-style-type: none"> ▪ CDC will continue to expand internet reference databases and implement limited pilot projects with states. Most state focused efforts on this goal will occur in FY 2016-2018.
<p><i>Implementation of enhanced, sustainable, and integrated laboratory information systems</i></p>	<p>In the second year of this initiative</p> <ul style="list-style-type: none"> ▪ CDC will adapt its existing Laboratory Information Management System (LIMS) to the new diagnostics and data and knowledge management systems of AMD, ensuring that it remain an integral part of CDC's laboratory services. LIMS currently has limited capability to share information among laboratories within and outside CDC, or with other CDC databases (e.g. MicrobeNet and PulseNet). ▪ CDC will also start implementing cutting-edge technology solutions that support rapid, secure, and accurate information exchange and linking of information among states, tribes, localities, territories, federal agencies, and other partners.
<p><i>Development of tools for the prediction, modeling, and early recognition of emerging infectious diseases</i></p>	<p>In year two of the initiative</p> <ul style="list-style-type: none"> ▪ CDC will initiate small pilot projects to modify and upgrade existing modeling systems to provide comparable improvements to models and their predictions. Over the course of the initiative this component will allow a broad range of capabilities to be fully implemented, including high-throughput screening of clinical and environmental samples for organisms of interest (metagenomics); improved mapping and tracking of vector-borne diseases and re-emerging vaccine-preventable diseases; and prediction and modeling of infectious disease pathways and processes, where pinpointing early threats, outbreaks, and opportunities for disease prevention are most important. Achieving this capacity will greatly improve CDC's ability to derive actionable information from "big data" (e.g., terabyte or larger datasets), and apply this information to better guide public health actions. ▪ CDC will look to build upon its second year AMD activities for the development of tools for the prediction, modeling, and early recognition of emerging infectious diseases ▪ CDC will look at current modeling systems that will need to be adapted to new kinds of laboratory data. This investment will result in diagnostics and surveillance data that are more comprehensive, automated, accurate, and real-time than those available from current systems. ▪ CDC will also look at new types of data and new types of data analyses will need to occur—especially analyses that bridge information from old and new technologies and that can handle the large volume of data that is created from whole genome sequencing.

If CDC is unable to adapt and move toward the long-term public health solution proposed by AMD enhancements, outbreaks will not be detected as quickly and will affect more people, resulting in more medical costs. If CDC does not upgrade its national surveillance systems such as PulseNet that rely solely on culture, the ability of those systems to detect outbreaks will erode and disappear, with the risk of some large and

widespread outbreaks going undetected and unchecked. For example, without PulseNet, large outbreaks such as the outbreak of salmonellosis from tuna in sushi could still be ongoing, with as many as 100 undetected and unlinked cases occurring each month.

Affordable Care Act Prevention and Public Health Fund

(dollars in millions)	FY 2013 Enacted ¹	FY 2014 Request	FY 2015 Request	2015 +/-2014
Budget Authority	\$44.174	\$52.000	\$51.750	\$(0.250)

¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

The Affordable Care Act (ACA) Prevention and Public Health Fund includes the following activities:

- ELC \$40,000,000
- HAI \$11,750,000

Epidemiology and Laboratory ACA/PPHF

Through investments made by ACA/PPHF funds, grantees of the Epidemiology and Laboratory Capacity (ELC) and Emerging Infections Program (EIP) cooperative agreements are strengthening and integrating their capacity to detect and respond to infectious disease and other public health threats including increasing the use of electronic laboratory reporting, improving their information technology infrastructures, improving program coordination, and expanding their training activities. Specific areas that ELC/EIP aims to enhance are:

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

State Healthcare-Associated Infection Prevention

CDC will support the critical public health role of state health departments to implement and ensure adherence to HAI prevention practices. Funding will allow states to build on the success of investments in preventing HAIs and ensure improved leadership and coordination of HAI activities by state health departments. Funding will also help states maintain sustainable HAI programs that work across the healthcare system to maximize HAI prevention efforts through collaboration with and coordination of regional and national public health and healthcare partners, such as local health departments, professional groups, CMS Hospital Engagement Networks, CMS quality improvement organizations (QIOs), state hospital associations, and consumer groups.

The CDC goals for this program are to:

- Continue HAI prevention collaboratives across all healthcare settings (e.g., nursing homes, long-term acute care facilities, dialysis facilities, rehabilitation facilities).
- Increase state and healthcare facilities’ access to and use of data to detect and prevent HAIs, and ability to measure the impact of prevention efforts.
- Enhance state capacity for HAI prevention through partnerships, training, outbreak detection and response, and conducting HAI data validation.

Table: ACA/PPHF Healthcare-Associated Infections Grant Table¹

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President’s Budget	2015 +/-2014
Number of Awards	50	50	50	0
- New Awards	0	0	0	
- Continuing Awards	50	50	50	
Average Award	\$0.195	\$0.195	\$0.190	
Range of Awards	\$0.006-\$0.917	\$0.006-\$0.917	\$0.006-\$0.917	
Total Awards	\$9.738	\$9.738	\$9.490	\$(-0.250)

¹These CDC awards provide essential but previously unavailable resources to implement HAI prevention projects nationwide by identifying facilities with problems improving adherence to HAI prevention practices. The awards support epidemiologists and microbiologists and provide funds to develop capacity in state and local health systems (e.g., hospitals and other healthcare facilities, clinical laboratories) to build sustainable prevention programs through collaboration with public health and healthcare partners. CDC bases continuation funding on competitively determined awards. Grantees include most states, Washington, D.C., and Puerto Rico. The grants build surveillance, strengthen laboratory diagnostics, improve targeting of public health interventions, and decrease illness and death associated with the delivery of healthcare.

State Table¹

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Alabama	\$1,220,227	\$1,282,124	\$1,426,642	\$144,518
Alaska	\$1,581,717	\$1,661,951	\$1,849,282	\$187,331
Arizona	\$2,178,323	\$2,288,821	\$2,546,811	\$257,990
Arkansas	\$1,263,246	\$1,327,325	\$1,476,938	\$149,613
California	\$3,968,225	\$4,169,517	\$4,639,495	\$469,978
Colorado	\$1,692,709	\$1,778,573	\$1,979,050	\$200,476
Connecticut	\$1,645,746	\$1,729,228	\$1,924,143	\$194,914
Delaware	\$906,159	\$952,125	\$1,059,446	\$107,321
Florida	\$1,977,845	\$2,078,173	\$2,312,420	\$234,247
Georgia	\$1,463,840	\$1,538,095	\$1,711,465	\$173,370
Hawaii	\$1,169,150	\$1,228,456	\$1,366,925	\$138,469
Idaho	\$707,306	\$743,185	\$826,955	\$83,770
Illinois	\$2,116,828	\$2,224,206	\$2,474,913	\$250,707
Indiana	\$1,218,631	\$1,280,447	\$1,424,776	\$144,329
Iowa	\$1,928,795	\$2,026,635	\$2,255,072	\$228,437
Kansas	\$1,442,420	\$1,515,588	\$1,686,422	\$170,833
Kentucky	\$581,314	\$610,802	\$679,650	\$68,848
Louisiana	\$1,268,295	\$1,332,631	\$1,482,841	\$150,211
Maine	\$886,307	\$931,266	\$1,036,236	\$104,970
Maryland	\$2,239,055	\$2,352,633	\$2,617,816	\$265,183
Massachusetts	\$3,206,671	\$3,369,333	\$3,749,116	\$379,783
Michigan	\$2,605,921	\$2,738,109	\$3,046,742	\$308,633
Minnesota	\$2,544,704	\$2,673,787	\$2,975,169	\$301,383
Mississippi	\$655,469	\$688,718	\$766,349	\$77,631
Missouri	\$923,702	\$970,558	\$1,079,957	\$109,399
Montana	\$971,744	\$1,021,037	\$1,136,125	\$115,089
Nebraska	\$1,384,875	\$1,455,124	\$1,619,142	\$164,018
Nevada	\$1,180,757	\$1,240,652	\$1,380,495	\$139,843
New Hampshire	\$1,305,116	\$1,371,319	\$1,525,891	\$154,572
New Jersey	\$2,122,567	\$2,230,236	\$2,481,623	\$251,387
New Mexico	\$1,421,547	\$1,493,656	\$1,662,018	\$168,361
New York	\$2,897,470	\$3,044,447	\$3,387,610	\$343,163
North Carolina	\$1,247,793	\$1,311,089	\$1,458,871	\$147,783
North Dakota	\$761,660	\$800,296	\$890,503	\$90,207
Ohio	\$2,096,548	\$2,202,898	\$2,451,203	\$248,305
Oklahoma	\$878,196	\$922,743	\$1,026,753	\$104,009
Oregon	\$2,363,877	\$2,483,787	\$2,763,753	\$279,966
Pennsylvania	\$1,862,955	\$1,957,455	\$2,178,095	\$220,640
Rhode Island	\$1,291,875	\$1,357,407	\$1,510,410	\$153,004
South Carolina	\$1,681,065	\$1,766,339	\$1,965,436	\$199,097
South Dakota	\$747,611	\$785,534	\$874,078	\$88,543
Tennessee	\$1,157,228	\$1,215,930	\$1,352,986	\$137,057
Texas	\$1,239,968	\$1,302,867	\$1,449,723	\$146,856
Utah	\$2,526,060	\$2,654,197	\$2,953,372	\$299,175
Vermont	\$1,659,723	\$1,743,914	\$1,940,484	\$196,570
Virginia	\$1,909,971	\$2,006,856	\$2,233,064	\$226,208
Washington	\$2,237,943	\$2,351,465	\$2,616,516	\$265,051
West Virginia	\$1,316,293	\$1,383,063	\$1,538,959	\$155,895
Wisconsin	\$2,708,797	\$2,846,204	\$3,167,021	\$320,817
Wyoming	\$966,809	\$1,015,851	\$1,130,356	\$114,504

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference +/- 2014
Cities				
Chicago	\$681,294	\$715,853	\$796,543	\$80,689
Houston	\$977,741	\$1,027,338	\$1,143,137	\$115,799
LA County	\$1,365,778	\$1,435,059	\$1,596,815	\$161,756
New York City	\$3,331,450	\$3,500,441	\$3,895,002	\$394,561
Philadelphia	\$821,583	\$863,259	\$960,563	\$97,304
Washington, D.C.	\$198,531	\$208,602	\$232,115	\$23,513
Territories				
American Samoa	\$94,201	\$98,979	\$110,136	\$11,157
Federated States of Micronesia	\$27,548	\$28,945	\$32,208	\$3,263
Guam	\$25,000	\$26,268	\$29,229	\$2,961
Marshall Islands	\$30,103	\$31,630	\$35,195	\$3,565
Republic of Palau	\$155,995	\$163,908	\$182,383	\$18,475
U.S. Virgin Islands	\$146,735	\$154,178	\$171,557	\$17,379
Puerto Rico	\$313,368	\$329,264	\$366,378	\$37,114
Subtotal States	\$81,331,053	\$85,456,655	\$95,089,119	\$9,632,464
Subtotal Cities	\$7,376,377	\$7,750,551	\$8,624,174	\$873,623
Subtotal Territories	\$792,950	\$833,173	\$927,086	\$93,913
Total Estimated for AMD	NA	NA	\$1,996,500	\$1,996,500
Total Estimated for AR			\$10,000,000	\$10,000,000
Grand Total	\$89,500,380	\$94,040,380	\$104,640,380	\$ 22,596,500

¹The table includes ELC awards that fund all 50 states as well as select local and territorial/U.S. affiliated grantees. Awards include Prevention and Public Health funding as well as funding from National Centers other than NCEZID.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$769.517	\$741.962	\$608.253	-\$133.709
ACA/PPHF	\$233.033	\$446.000	\$469.704	+\$23.704
Total Request	\$1,002.550	\$1,187.962	\$1,077.957	-\$110.005
FTEs	921	921	921	
Tobacco Prevention and Control	\$191.086	\$210.767	\$210.767	\$0.000
ACA/PPHF (non-add)	\$60.302	\$105.000	\$105.000	\$0.000
Nutrition, Physical Activity and Obesity	\$43.604	\$40.092	\$40.092	\$0.000
ACA/PPHF (non-add)	\$0.000	\$35.000	\$4.000	-\$31.000
School Health	\$13.335	\$15.424	\$15.424	\$0.000
Health Promotion	\$17.707	\$19.483	\$19.483	\$0.000
Prevention Research Centers	\$23.946	\$25.530	\$25.000	-\$0.530
ACA/PPHF (non-add)	\$15.279	\$0.000	\$25.000	+\$25.000
Heart Disease and Stroke	\$54.417	\$130.188	\$130.188	\$0.000
ACA/PPHF	\$0.000	\$73.000	\$73.000	\$0.000
Diabetes	\$64.041	\$140.306	\$140.306	\$0.000
ACA/PPHF (non-add)	\$0.000	\$73.000	\$73.000	\$0.000
National Diabetes Prevention Program	\$0.000	\$10.000	\$10.000	\$0.000
Cancer Prevention and Control	\$337.919	\$350.982	\$308.012	-\$42.970
ACA/PPHF (non-add)	\$0.000	\$104.000	\$179.204	+\$75.204
Breast and Cervical Cancer (non-add)	\$197.342	\$207.269	\$169.204	-\$38.065
ACA/PPHF (non-add)	\$0.000	\$104.000	\$169.204	\$65.204
WISEWOMAN (non-add)	\$20.216	\$21.170	\$21.170	\$0.000
Colorectal Cancer (non-add)	\$41.989	\$43.410	\$39.515	-\$3.895
All Other Cancer	\$0.000	\$0.000	-\$10.900	-\$10.900
New Cancer Demonstration Project (ACA/PPHF)	\$0.000	\$0.000	\$10.000	+\$10.000
Oral Health	\$14.906	\$15.790	\$15.790	\$0.000
Safe Motherhood and Infant Health	\$45.057	\$45.589	\$45.589	\$0.000
Arthritis and Other Chronic Diseases	\$24.876	\$26.806	\$26.806	\$0.000
Community Grants	\$160.544	\$131.005	\$80.000	-\$51.005
Racial and Ethnic Approaches to Community Health (REACH)	\$14.204	\$51.005	\$0.000	-\$51.005
ACA/PPHF (non-add)	\$0.000	\$30.000	\$0.000	-\$30.000
Community Transformation Grants (ACA/PPHF)	\$146.340	\$0.000	\$0.000	\$0.000
Partnerships to Improve Community Health	\$0.000	\$80.000	\$80.000	\$0.000
Million Hearts® (ACA/PPHF)	\$4.612	\$4.000	\$4.000	\$0.000
Workplace Health (ACA/PPHF)	\$0.000	\$10.000	\$0.000	-\$10.000
Healthy Weight Task Force Obesity Activities (ACA/PPHF)	\$4.000	\$4.000	\$4.000	\$0.000
Hospitals Promoting Breastfeeding (ACA/PPHF)	\$2.500	\$8.000	\$2.500	-\$5.500

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

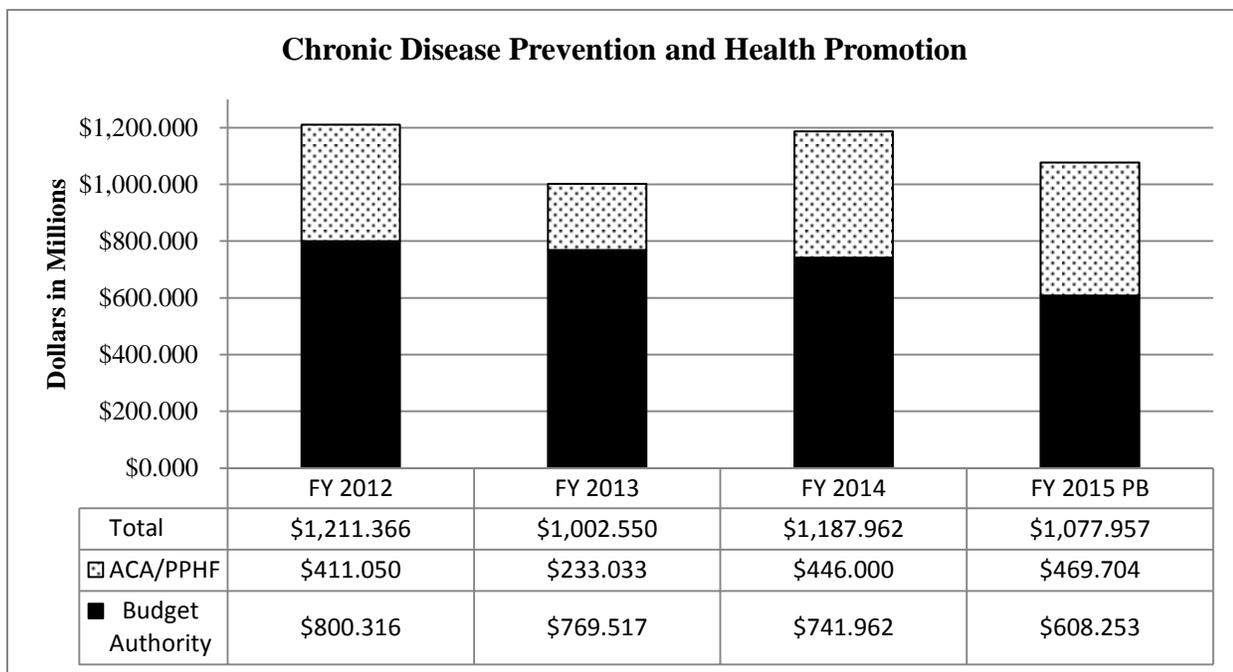
CDC's FY 2015 request of **\$1,077,957,000** for Chronic Disease Prevention and Health Promotion is \$110,005,000 below the FY 2014 Enacted level. The FY 2015 request for Breast and Cervical and Colorectal Cancer is a decrease of \$41,960,000 below the FY 2014 level reflecting increased coverage for these services through health reform.

Chronic diseases are among the most prevalent, costly, and deadly of all health problems—and the most preventable. CDC leads U.S. efforts to prevent and control chronic diseases and associated risk factors by funding programs in states, tribes, territories, and local communities. CDC’s chronic disease prevention and health promotion efforts contribute to CDC’s overarching goal of preventing the leading causes of disease, disability, and death.

Core activities include:

- Preventing and controlling the leading causes of disease, death and disability, including tobacco use, obesity, heart disease and stroke, diabetes, and cancer
- Promoting community health, oral health, safe motherhood, infant health, and healthy behaviors, such as physical activity and nutrition
- Maintaining surveillance systems to track and monitor behavioral risk factors

Figure: Chronic Disease Prevention and Health Promotion Funding History¹



¹FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Chronic Disease Prevention Grants to States and D.C

In 2013, CDC funded the [State Public Health Actions](http://www.cdc.gov/chronicdisease/about/state-public-health-actions.htm)⁶¹ to Prevent Chronic Disease. This program supports states to implement cross-cutting strategies to promote health and prevent and control chronic diseases and their risk factors. The coordinated approach integrates the Diabetes; Heart Disease and Stroke Prevention; School Health; and Nutrition, Physical Activity, and Obesity state programs. Collectively, these programs support a set of complementary activities and intervention strategies in four domains: epidemiology and surveillance, environmental strategies, health systems improvements, and community-clinical linkages. In FY 2014, additional funding was made available through the Omnibus Appropriations Bill to support expansions of state chronic disease prevention efforts. CDC will support currently funded State Public Health Actions grantees for expanded

⁶¹ <http://www.cdc.gov/chronicdisease/about/state-public-health-actions.htm>

action at the state and local level to address diabetes, heart disease and stroke as well as their associated risk factors. The expanded cooperative agreement will increase access to diabetes self-management education; increasing control of A1c, blood pressure and cholesterol; improving medication adherence for adults with high blood pressure and expand State capacity in epidemiology and surveillance, environmental strategies, and health systems improvements. Coordinating these efforts into a single program encourages states to implement a cohesive set of evidence and practice-based interventions that address four inter-related chronic diseases and risk factors. These interventions are implemented in multiple settings, such as schools, communities, health care, and work sites. Under the new program, states will implement interventions that are more purposefully aligned and coordinated. They will be more likely to efficiently achieve measurable health impacts related to each of the categorical programs. This combined approach reduces duplication, allowing states to target more funds for program activities. This new program also provides all states with core funding to build expertise and capacity in core areas that are fundamental to the success of all categorical chronic disease and risk factor prevention programs.

The program contains two components:

Basic, Non-Competitive

Supports basic strategies resulting in measurable impacts to address school health, nutrition and physical activity risk factors, obesity, diabetes, heart disease, and stroke in all 50 states and the District of Columbia. CDC continues to hold states accountable for achieving specific outcomes in the core public health functions related to cross-cutting expertise, such as surveillance, policy, communications, evaluation, and health systems. Funding for this component is determined by a formula based on factors, such as population size and poverty. Some cross-cutting activities conducted under the basic component include: 1) partnership engagement; 2) workforce development; 3) guidance and support for programmatic efforts; 4) strategic communications efforts to translate data for stakeholders, decision-makers, partners, and the public; and 5) ongoing collection, analysis and release of data and information about chronic disease burden, solutions, and programmatic impact. The average funding award for this component was approximately \$550,000 in 2013.

Competitive, Enhanced

Builds on and extends activities supported with basic funding to achieve even greater reach and impact. In FY 2013, CDC funded 32 states to implement evidence and practice-based interventions that improve physical activity and nutrition and reduce obesity, diabetes, heart disease, and stroke. Enhanced strategies include the following: 1) implementing environmental approaches to promote health and support healthful behaviors (e.g. access to healthy food, beverages, and physical activity); 2) expanding health system interventions to improve delivery and use of clinical and other preventive services; and 3) enhancing community clinical linkages to support cardiovascular disease and diabetes prevention and control efforts. For states that successfully compete, award amounts were determined by a funding formula based on population size. The range of awards for the enhanced component was \$1.0–1.7 million in 2013.

At the end of five years, grantees will demonstrate measurable improvements in the following:

- Increased state, community, worksite, school, and early child care and education environments that promote and reinforce healthful behaviors and practices across the life span related to diabetes, cardiovascular health, physical activity and healthful foods and beverages, obesity and breastfeeding.
- Improved quality, effective delivery and use of clinical and other preventive services to support prevention and management of hypertension and diabetes.
- Increased community clinical linkages to support prevention, self-management and control of diabetes, hypertension and obesity.
- Improved prevention and control of hypertension, diabetes, and overweight and obesity.

Contextual Indicator	Most Recent Result	FY 2015 Target
Coronary Heart Disease: Reduce the annual age-adjusted rate of coronary heart disease deaths (per 100,000 population).	FY 2010: 113.6	108.6
Stroke: Reduce the annual age-adjusted rate of stroke deaths (per 100,000 population).	FY 2010: 39.1	36.4
Diabetes: Reduce the annual age-adjusted rate of diabetes-related deaths (per 100,000 population).	FY 2010: 70.7	68.5

Table: The State Public Health Actions to Chronic Disease Prevention Program^{1,2}

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	51	51	51	0
- New Awards (core)	51	TBD	TBD	N/A
- Continuing Awards (core)	0	TBD	TBD	N/A
- New Awards (enhanced)	32	TBD	TBD	N/A
- Continuing Awards (enhanced)	0	TBD	TBD	N/A
Average Award (core)				
Average Award (enhanced)				
Range of Awards (core)	\$0.502 to \$0.745	TBD	TBD	N/A
Range of Awards (enhanced)	\$1.000 to \$1.700	TBD	TBD	N/A
Total Awards	\$67.572	\$197.444	\$197.444	\$0.000

¹In FY 2013, CDC issued a new five-year combined cooperative agreement as described in the summary section of this request; the cooperative agreement contains four programs, including Nutrition, Physical Activity and Obesity, School Health, Heart Disease and Stroke and Diabetes. It consists of two components: Basic (Core) component that will fund all 50 states and Washington, D.C.; and a Competitive (Enhanced) component that will fund up to 32 states with an average award size of \$1.7 million.

²FY 2014 and FY 2015 total grand awards reflect an addition of \$5.872 million from a prior diabetes state cooperate agreement that was closed out in FY 2013.

Tobacco Prevention and Control Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$130.784	\$105.767	\$105.767	\$0.000
ACA/PPHF	\$60.302	\$105.000	\$105.000	\$0.000
Total	\$191.086	\$210.767	\$210.767	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Tobacco use is the leading preventable cause of disease, disability, and death in the United States. One of five U.S. adults and one of four U.S. high school students are current smokers. Smoking and smokeless tobacco use are initiated primarily during adolescence. CDC is the lead federal agency for comprehensive tobacco control and prevention efforts. The [National Tobacco Control Program](#)⁶² provides funding and technical support to health departments and national networks. The program's primary goals are to eliminate secondhand smoke exposure, promote quitting, prevent initiation, and identify and eliminate disparities. States with strong tobacco control programs have [demonstrated achievement of a \\$55:\\$1 return](#)⁶³ on their investment. CDC also conducts research and surveillance on tobacco use and translates science into best practices that help states plan, implement, evaluate, and sustain their own programs. In FY 2014, CDC provided guidance to states through the release of [Best Practices for Comprehensive Tobacco Control Program](#)⁶⁴, an evidence-based guide to help states plan and establish comprehensive tobacco control programs.

As the lead for the Surgeon General Reports on tobacco, CDC examines evidence of the impact of tobacco use on health, both to users and nonusers. In FY 2014, CDC released the landmark [50th Anniversary Surgeon General's Report](#)⁶⁵ on tobacco and health. By monitoring various indicators regarding smoking and tobacco use, as well as secondhand smoke, CDC adds to our understanding of the tobacco use epidemic and the impact of interventions to address it.

The Institute of Medicine, National Cancer Institute, and Surgeon General all recommended a national media campaign as part of a comprehensive approach for ending the tobacco use epidemic. CDC warns the public about the consequences of tobacco use through the national tobacco education campaign, [Tips From Former Smokers](#)⁶⁶. Recent analyses show that the *Tips* 2012 campaign generated an estimated 1.6 million new quit attempts among U.S. adult smokers and approximately 100,000 sustained quits of six months or more. In 2013, CDC conducted the second wave of the campaign, which generated more than 150,000 additional calls to the 1-800-QUIT-NOW quitlines and almost 2.8 million additional visitors to the *Tips* website.

Number of weekly telephone calls made to national portal to state tobacco quitlines before, during, and after CDC's *Tips from Former Smokers* Campaign (TIPS), compared with 2011 calls — United States, March 5–June 24, 2012. The 2012 *Tips from Former Smokers* campaign was conducted during March 19–June 10, 2012.

⁶² http://www.cdc.gov/tobacco/tobacco_control_programs/ntcp/index.htm

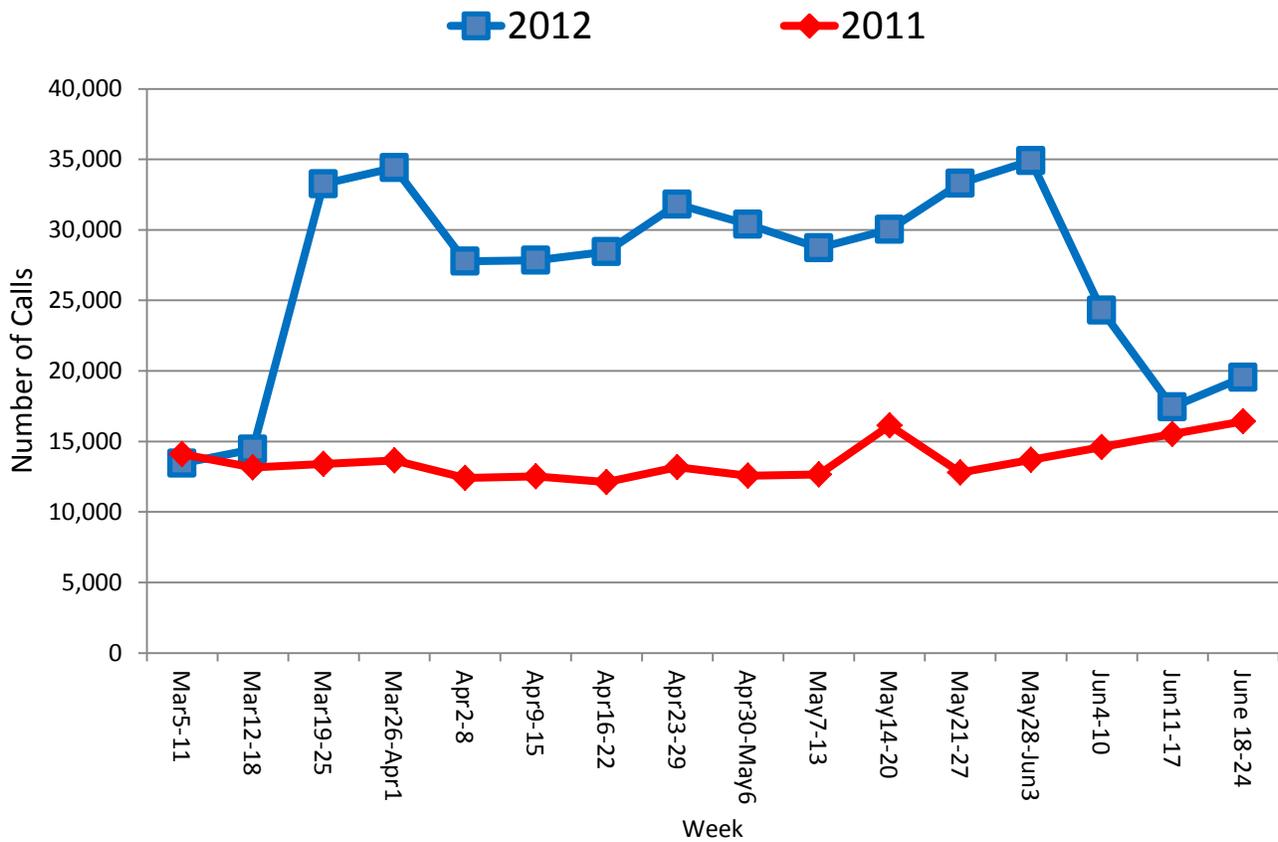
⁶³ <http://www.ncbi.nlm.nih.gov/pubmed/23418411>

⁶⁴ http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm

⁶⁵ http://www.cdc.gov/TOBACCO/data_statistics/sgr/index.htm

⁶⁶ <http://www.cdc.gov/tobacco/campaign/tips/>

1-800-QUITNOW Weekly Call Volume, U.S., 2011-2012



The figure shows the number of weekly telephone calls made to a national portal to state tobacco quitlines before, during, and after CDC's 2012 Tips from Former Smokers Campaign (TIPS), compared with 2011 calls. Total call volume during the TIPS campaign was 365,194 calls, compared with 157,675 calls during the corresponding 12 weeks in 2011, for a total of 207,519 additional calls or a 132% increase.

Budget Request

CDC's FY 2015 request of **\$210,767,000** for Tobacco Prevention and Control, including \$105,000,000 from the Affordable Care Act Prevention and Public Health Fund, is level with the FY 2014 Enacted level. At this funding level, CDC will implement comprehensive tobacco control and prevention activities and enhance educational efforts. CDC will continue the national tobacco education campaign to raise awareness of the health effects of tobacco use and prompt smokers to quit, as well as increase tobacco cessation quitline capacity to respond to smokers seeking help to quit.

In FY 2015, CDC will provide expertise and guidance on tobacco control efforts at the state and local level through the [National Tobacco Control Program](http://www.cdc.gov/tobacco/tobacco_control_programs/ntcp/index.htm)⁶⁷, which funds all 50 states, Washington, D.C., eight U.S. territories/jurisdictions, and eight tribal-serving organizations. In addition, CDC will fund national networks to provide guidance to states on reducing tobacco use among certain population groups and address tobacco-related cancer health issues. CDC efforts to support smoking cessation services in 50 states, two territories, and Washington, D.C., will maintain and augment the national network of tobacco cessation quitlines as a result of

⁶⁷ http://www.cdc.gov/tobacco/tobacco_control_programs/ntcp/index.htm

increases in quit attempts due to national education campaign efforts. Stakeholders will use data from the National Quitline Data Warehouse to evaluate state quitline progress.

CDC will continue conducting and disseminating tobacco prevention research through its Tobacco Laboratory. [The Tobacco Laboratory](#)⁶⁸ examines toxic and addictive substances in tobacco products, tobacco smoke, tobacco users, and people exposed to secondhand smoke. Priority areas for CDC include sustaining state tobacco prevention, control, and surveillance programs, as well as addressing emerging public health concerns about non-combustible (e.g., electronic cigarettes, snuff, dissolvables, moist and dry snuff, chewing tobacco) and other nontraditional tobacco products (e.g. little cigars, hookah).

Tobacco Prevention and Control Grants to States

CDC’s tobacco prevention and control grants help states prevent tobacco use initiation among youth and young adults, promote cessation, eliminate secondhand smoke exposure, and identify and eliminate tobacco-related disparities. CDC will issue a new, competitive, five-year funding announcement for the planned continuation of activities in 2014. Eligible grantees include all 50 states and Washington, D.C. CDC determines funding levels by the state or jurisdiction’s population, spending history, and quality of their application.

Table: Tobacco Prevention and Control

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	51	51	51	0
- New Awards	0	0	51	51
- Continuing Awards	51	51	0	0
Average Award	\$1.181	\$1.181	\$1.181	\$0.000
Range of Awards	\$0.532–\$1.872	\$0.532–\$1.872	\$0.532–\$1.872	N/A
Total Awards	\$60.321	\$60.321	\$60.321	\$0.000

⁶⁸ <http://www.cdc.gov/biomonitoring/tobacco.html>

Nutrition, Physical Activity, and Obesity Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$43.604	\$5.092	\$36.092	+\$31.000
ACA/PPHF	\$0.00	\$35.000	\$4.000	-\$31.000
Total	\$43.604	\$40.092	\$40.092	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's [Nutrition, Physical Activity, and Obesity \(NPAO\) Program](#)⁶⁹ is responding to the urgent threat of [obesity](#)⁷⁰ among Americans of all ages. One out of every six children (17%) and over one-third of adults (36%) are obese and are at increased risk for hypertension, high cholesterol, type 2 diabetes, heart disease, and certain cancers. Furthermore, the U.S. economy suffers the negative consequences of obesity due to reduced workforce productivity and rising health care costs. Across all payers, obese people have annual per capita medical spending that was \$1,429 greater than spending for non-obese people. CDC is responding to this threat by increasing access to safe places and opportunities to be physically active, improving access to fruits and vegetables and healthy beverages, and creating environments that support breastfeeding. As a result of this work, child and adult obesity rates have leveled after decades of increases, and small declines have occurred in obesity among low-income preschool age children. More adults are engaging in leisure time physical activity and consumption of sugar sweetened beverages is declining among children and adults.

CDC received \$5,000,000 in FY 2014 to address obesity in counties where the rate of adult obesity is over 40%, with an emphasis on rural areas. CDC will conduct a pilot with up to five land grant universities with cooperative extension units, to achieve the following:

- Increase the number of early care and education (ECE) and community environments (e.g., out of school time venues) that promote improved behaviors and practices related to physical activity, healthful foods and beverages
- Improve awareness, knowledge, and practices of ECE providers, family members and children that support healthy lifestyles (healthy eating and physical activity)
- Increase evidence-based extension and outreach services for youth and families that support healthy lifestyles including healthy eating and physical activity

Budget Request

CDC's FY 2015 request of **\$40,092,000** for Nutrition, Physical Activity, and Obesity, including \$4,000,000 from the Affordable Care Act Prevention and Public Health Fund, is level with the FY 2014 Enacted level. By 2015, CDC aims to increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity from 43.5 percent to 45.7 percent, increase the daily intake of vegetables from 0.8 to 0.95 cups per 1,000 calories, and to increase the percentage of infants who are breastfed at age six months from 43 percent to 51 percent. CDC will continue to provide national leadership to reduce obesity, increase physical activity, and improve dietary quality. Requested funds will support for the 50 states and the District of Columbia to implement evidence-based obesity and chronic disease prevention programs through the State Public Health Actions to Prevent Chronic Disease cooperative agreement. Nutrition, Physical Activity, and Obesity initiatives in FY 2015 include:

⁶⁹ <http://www.cdc.gov/nccdphp/dnpao/index.html>

⁷⁰ <http://www.cdc.gov/obesity/index.html>

Table: Public Health Activities to Support Nutrition, Physical Activity, and Obesity

Initiatives	Examples of Activities
NPAO State Program Support	<ul style="list-style-type: none"> Funded 50 states and D.C. in FY 2013, to implement improved nutrition, physical activity, and obesity prevention efforts; and 32 states to implement enhanced prevention strategies with expanded reach and impact
Early Care and Education	<ul style="list-style-type: none"> Improve the nutrition and physical activity environments in child care centers nationwide
Childhood Nutrition	<ul style="list-style-type: none"> Provide training and assistance to support 89 hospitals to adopt baby friendly best practices
Strengthen the NPAO science base	<ul style="list-style-type: none"> Conduct surveillance, research, and evaluation to identify national and state trends in nutrition, physical activity, and obesity-related behaviors and health outcomes, and determine which interventions are most effective

Improving Physical Activity – Walking to Better Health

CDC leads the national agenda on [physical activity](#)⁷¹ promotion. Walking is the most popular form of physical activity with six in ten adults reporting walking, yet many people engage in no leisure time activity. To increase physical activity, CDC experts are assisting state and community leaders in designing communities where children can walk to school; adults can use public transit to get to work; and where there is access to recreational venues for adults and children. In FY 2015, CDC will support activities to help Americans increase physical activity:

- [Pedestrian-friendly street design](#)
- [Physical education requirements in schools and child care centers](#)
- [Community agreements permitting after-hours use of school and mall facilities](#)
- [Infrastructure support for persons on bicycles and in wheel chairs](#)

CDC is also working closely with the Surgeon General’s Office to release a Call to Action on Walking, which will provide critical guidance on factors that support and facilitate physical activity and improve health across the lifespan.

Breastfeeding

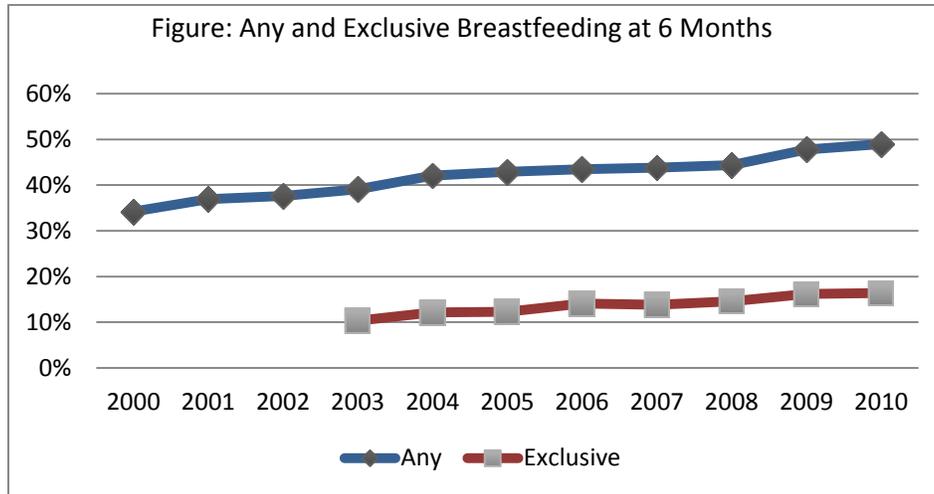
CDC supports the use of [breastfeeding](#)⁷² best practices among states, communities, and hospitals. Breastfeeding reduces the risk of infections and Sudden Infant Death Syndrome (SIDS) in infancy, obesity in childhood, and type 2 diabetes, later in life. Additionally, the benefits of breastfeeding include reduced risk of breast and ovarian cancer for the mother, cost savings for employers and health care providers, and

⁷¹ http://www.cdc.gov/healthyweight/physical_activity/index.html

⁷² <http://www.cdc.gov/breastfeeding/>

environmental and economic benefits for the broader community. The work of CDC and its partners resulted in significant increases in any breastfeeding at 6 months from 34% in 2000 to 49% in 2010 and exclusive breastfeeding at 6 months from 10% in 2003 to 16% in 2010. By FY 2015, CDC plans to increase breastfeeding at six months to over 58% by increasing access to breastfeeding friendly environments in hospitals, communities, and worksites. Through the Chronic Disease State Public Health Actions Program, work is focused on increasing:

- Breastfeeding supportive practices in hospitals
- The number of “baby friendly hospitals”
- Access to and the number of peer and professional lactation consultants
- The percentage of employers who provide space and time for nursing mothers to express breast milk



Early Care and Education

In FY 2015, CDC will continue partnering with the Administration for Children and Families, the United States Department of Agriculture, and the First Lady’s ["Let’s Move!"](#)⁷³ campaign to improve physical activity and nutrition environments in early care and education centers (ECE), including limiting screen time and supporting breastfeeding. CDC provides consultation and in-person training on best practices to ECE directors, providers, and resource and referral service groups in states and at national and regional meetings, and distributes resource kits, activity guides and tip sheets on best practices.

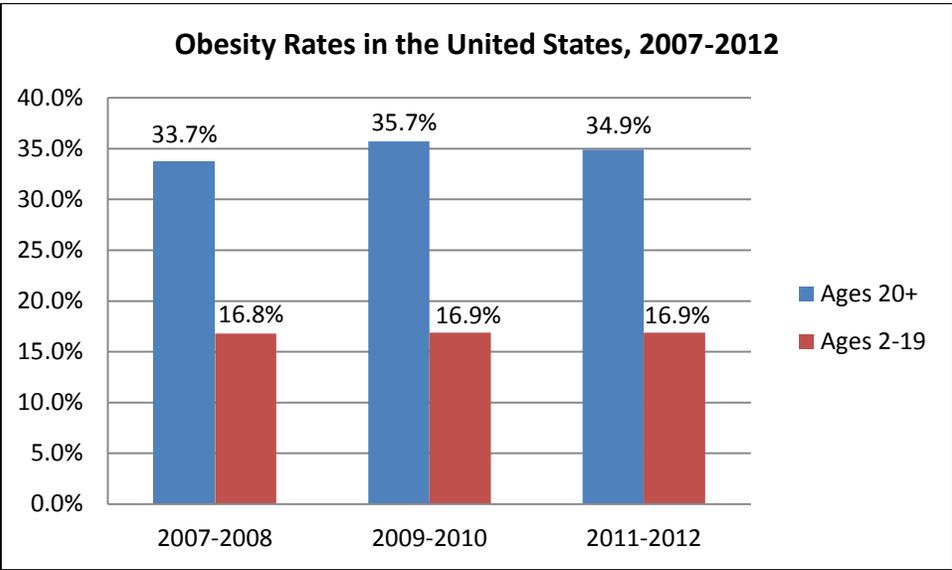
Surveillance, Research and Evaluation

CDC conducts surveillance on nutrition, breastfeeding, physical activity, and obesity prevalence to identify trends and monitor progress on important public health outcomes. In FY 2015, CDC will to:

- Administer [surveys](#)⁷⁴ of practices, environmental supports, and policies that improve nutrition, increase physical activity, and prevent obesity and other chronic diseases including maternity care practices and policies related to breastfeeding
- Conduct research to identify evidence-based obesity and chronic disease prevention strategies as well as report on state performance on key behavioral and policy indicators that promote healthy eating and physical activity
- Provide evaluation expertise to examine the impact and effectiveness of state and local prevention programs

⁷³ <http://www.letsmove.gov/>

⁷⁴ <http://www.cdc.gov/breastfeeding/data/mpinc/survey.htm>



School Health Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$13.335	\$15.424	\$15.424	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Schools play a critical role in helping children develop lifelong, healthy habits. Early intervention is more effective than attempting to reverse unhealthy behaviors during adulthood. Each day, 132,000 schools provide a setting to 55 million students to learn about health and healthy behaviors. Increasing the quantity and quality of physical education and [physical activity](#)⁷⁵ in schools is critical for health and has a positive impact on academic performance. A growing body of research demonstrates the [school food environment](#)⁷⁶ is associated with youth dietary behaviors and [obesity](#)⁷⁷. CDC funds all 50 states and Washington, D.C. to promote and implement sustainable strategies in schools and school districts and provide training in effective interventions to improve health outcomes for K-12 students, with 32 states receiving additional funds to implement enhanced prevention strategies with expanded reach and impact. For example, in August 2012, Massachusetts established one of the strongest [competitive foods and beverages](#)⁷⁸ (foods sold outside of the school meal program) standards in the country. The CDC-funded Massachusetts School Health Program provided analysis, guidance documents, and extensive training to support ongoing implementation of the new standards. As a result, more than 950,000 students in more than 1,800 schools now have access to healthier foods and beverages. In addition, CDC funds seven non-governmental organizations to increase the capacity of education and health agencies, community-based organizations, and institutions of higher learning to improve health and educational outcomes among children and adolescents.

Budget Request

CDC's FY 2015 request of **\$15,424,000** for School Health is level with the FY 2014 Enacted level. CDC's School Health program will continue supporting state health departments to increase local capacity to implement [high quality, cost-effective, school-based health programs](#)⁷⁹ through the State Public Health Actions to Prevent Chronic Disease cooperative agreement and disseminate best practices from the program. School Health initiatives in FY15 include:

Table: Public Health Activities to Support School Health

Initiatives	Examples of Activities
School Health State Program Support	Funded 50 states and D.C. in FY 2013, to implement improved nutrition, physical activity, and obesity prevention efforts; and 32 states to implement enhanced prevention strategies with expanded reach and impact
Physical Activity	Expand multi-component quality physical education programs and opportunities for students before, during, and after school through state cooperative agreement guidelines and technical assistance.

⁷⁵ <http://www.cdc.gov/healthyyouth/physicalactivity/facts.htm>

⁷⁶ <http://www.cdc.gov/healthyyouth/nutrition/facts.htm>

⁷⁷ <http://www.cdc.gov/healthyyouth/obesity/facts.htm>

⁷⁸ <http://www.cdc.gov/healthyyouth/nutrition/standards.htm>

⁷⁹ <http://www.cdc.gov/healthyyouth/npao/strategies.htm>

Initiatives	Examples of Activities
School Nutrition	Improve school nutrition environments on K-12 campuses through adoption and implementation of School Meal Nutrition standards, competitive food and beverage standards, and marketing only nutritious foods through guidelines, technical assistance and professional development for school and health department staff
Manage Chronic Conditions in schools	Enhance school capacity to meet daily management and emergency care needs of students with chronic conditions (e.g., asthma, food allergies, epilepsy), and prevent tobacco use through guidelines, technical assistance and professional development for school and health department staff

School Health Grants

CDC will continue funding national non-governmental organizations to focus on physical activity and physical education, nutrition, and management of chronic conditions, including food allergies and school health services. These organizations are funded through a competitive five-year cooperative agreement first awarded in FY 2011. At the end of FY 2016, CDC expects grantees to demonstrate evidence of strengthened capacity in states and school districts to implement school health programs that support quality physical education and physical activity, promote healthy foods, and manage chronic conditions.

Table: School Health—Non-Governmental Organizations

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final¹	Enacted	President Budget	2015 +/-2014
Number of Awards	7	7	7	0
- New Awards	0	0	0	0
- Continuing Awards	7	7	7	0
Average Award	\$0.248	\$0.248	\$0.248	0
Range of Awards	\$0.150–\$0.300	\$0.150–\$0.300	\$0.150–\$0.300	N/A
Total Awards	\$1.736	\$1.736	\$1.736	\$0.000

Health Promotion Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$17.707	\$19.483	\$19.483	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC conducts and funds epidemiological research to define the public health burden and impact of emerging chronic diseases and identifies how public health can most effectively reduce the disease burden. CDC develops and promotes cutting-edge approaches that will shape how public health responds to chronic disease problems in the future.

Diseases currently being addressed include:

- Healthy Aging and Alzheimer's Disease
- Chronic Kidney Disease
- Excessive Alcohol Use Prevention
- Glaucoma
- Inflammatory Bowel Disease
- Interstitial Cystitis
- Visual Screening Education

Budget Request

CDC's FY 2015 request of **\$19,483,000** for Health Promotion activities is level with the FY 2014 Enacted level. CDC will use FY 2015 funding to continue an overarching approach to the Health Promotion activities that uses modest investments to strengthen the science base for the prevention of leading and emerging causes of disease, disability, and death. At this funding level CDC will:

- Advance science and effective public health response across chronic disease prevention and health promotion
- Improve surveillance and define the burden of emerging conditions
- Identify high-impact opportunities for public health intervention
- Develop and disseminate effective interventions and public health responses
- Develop tools and resources to support implementation of prevention strategies for emerging diseases and risk factors
- Provide leadership through partnership and collaboration

CDC will also assess disease and risk factor trends, correlating risk factors (such as the aging of the U.S. population), and future chronic disease threats so that the public health community can prepare for the chronic disease issues of the future.

Healthy Aging and Alzheimer's Disease

Given the rapid growth in numbers and the increasing proportion of the population aged 65 or older in the United States, the importance of promoting cognitive health and addressing cognitive impairments is critical to public health efforts. Alzheimer's disease is the sixth leading cause of death among US adults and the fifth leading cause of death among adults aged 65 and older. Through the [Healthy Brain Initiative](#)⁸⁰ within its Healthy

⁸⁰ <http://www.cdc.gov/aging/healthybrain/>

Aging Program, CDC funds surveillance efforts and works to translate scientific knowledge and research into effective public health action in states and communities. Building on the Congressionally mandated “[National Plan to Address Alzheimer’s Disease](#)”⁸¹ (*National Plan*), in 2013, CDC and partners released “[The Public Health Road Map for State and National Partnerships, 2013-2018](#)”⁸² (*Road Map*) detailing key roles that state and local public health agencies can play in addressing cognitive impairment and caregiving, and increasing cognitive health awareness among the public and health professionals.

In FY 2015, CDC will fund one or more national organizations to help implement the *Road Map*. CDC will continue to serve on the National Advisory Council on Alzheimer’s Research, Care, and Services, and develop and implement key milestones in the *National Plan*. CDC will also continue co-leading the *Healthy People 2020* topic areas for “Dementia” and “Older Adults” and continue to fund related surveillance efforts.

Chronic Kidney Disease

Chronic kidney disease (CKD) is our nation’s ninth leading cause of death and a serious and growing problem. More than 20 million U.S. adults 20 years of age and older have CKD and most are unaware of their condition. According to a recent CDC study, the annual Medicare expenses attributable to CKD (per person) were \$1,700 for stage 2, \$3,500 for stage 3, and \$12,700 for stage 4, adjusted to 2010 dollars. The findings suggest the medical costs attributable to CKD are substantial among Medicare beneficiaries, even during the early stages; moreover, costs increase as disease severity worsens. CDC works with partners to develop kidney disease surveillance capacity, assess CKD’s economic burden, advance public health research, and develop a state-based screening and demonstration project for detecting high-risk people. In addition, CDC supports the [National CKD Surveillance System](#)⁸³ to document the burden of CKD and its risk factors in the United States, and tracks progress in CKD prevention, detection, and management.

CDC awarded competitive cooperative agreements to the University of California at San Francisco and the University of Michigan for the period of FY 2011–15 to further the National CKD Surveillance System on monitoring the disease burden, awareness, risk factors, and quality of care. In FY 2015, the grantees will continue to develop, implement, maintain, and evaluate the National CKD Surveillance System with a focus on updating CKD surveillance data, identifying new data sources for CKD surveillance at the state and local levels, and disseminating CKD surveillance data through an interactive website. CDC will also continue to study the science of CKD to better understand who is at risk of progression to kidney failure or premature death.

Excessive Alcohol Use Prevention

[Excessive alcohol use](#)⁸⁴ is responsible for 88,000 deaths annually and shortens lives by a potential 30 years, costing about \$223.5 billion, or \$1.90 per drink consumed. Binge drinking (5 or more drinks for a man or 4 or more drinks for a woman, in about two hours) is responsible for more than half of these deaths and 3 of every 4 dollars in economic costs. CDC strengthens the science for preventing excessive alcohol use by:

- Improving public health surveillance, particularly on binge drinking,
- Building state public health capacity in alcohol epidemiology,
- Supporting adoption of evidence-based recommendations on the prevention of excessive drinking

In FY 2014, CDC competitively funded a new five-year cooperative agreement (FY 2014–18) to support monitoring and reduction of youth exposure to alcohol marketing. Findings will be used by public health professionals to inform the public about the dangers of excessive alcohol use.

⁸¹ <http://aspe.hhs.gov/daltcp/napa/NatlPlan2013.pdf>

⁸² <http://www.cdc.gov/aging/pdf/2013-healthy-brain-initiative.pdf>

⁸³ <http://nccd.cdc.gov/CKD/>

⁸⁴ <http://www.cdc.gov/alcohol/>

Funding in FY 2015 will support:

- Continued public health surveillance on excessive drinking and related harms
- Alcohol marketing activities, a major risk factor for underage and binge drinking
- Full-time alcohol epidemiologists in New Mexico and Michigan
- Provide scientific support for Community Guide-recommended strategies for preventing excessive drinking
- Development of tools and resources to support implementation of Community Guide recommended strategies for excessive drinking

Glaucoma

Nearly 2.7 million Americans aged 40 years and older have glaucoma. This debilitating eye disease has no symptoms in its early stages, but once visual field damage occurs, vision cannot be restored. CDC estimates that only half the people with glaucoma know they have the disease. In FY 2013, CDC funded the University of Alabama–Birmingham and Wills Eye Institute to conduct demonstration projects to improve glaucoma screening, referral, and treatment for high risk populations. CDC also funded an evaluation project to identify accomplishments, needs, and best practices for improving glaucoma screening, referrals, and treatment for populations at greatest risk for the disease.

In FY 2015, CDC will use information from the demonstration projects to identify best practices for improving glaucoma screening, referrals, and treatment for populations at the greatest risk of disease.

Vision Screening Education

More than 3.4 million Americans aged 40 years and older are either blind or visually impaired, and millions more are at risk for developing vision impairment and blindness. CDC's [Vision Health Initiative](#)⁸⁵ promotes vision health, enhances surveillance and epidemiology, and studies vision-related health economics and health outcomes. CDC supports the Innovative Network for Sight Research (INSIGHT) study, a collaborative vision research network of investigators at Johns Hopkins University, University of Miami, University of Alabama at Birmingham, and Wills Eye Institute. The INSIGHT researchers will assess and evaluate system-level and individual-level factors that affect eye care access and quality.

CDC will continue collaborating with these partners to assess and evaluate system and individual-level factors that impact eye care access and quality, as well as identify barriers to effective eye care delivery. These programs will document methods for improving access to and quality of eye care among people with diabetes, provide data on eye diseases, and determine follow-up adherence to eye screening recommendations. Findings from the program will guide decision-making, further assessments, and capacity building at the national, state, and local levels.

Inflammatory Bowel Disease

Up to two million people in the United States live with inflammatory bowel disease (IBD). CDC builds the science base to better understand IBD and the factors that predict the disease course, and supports an epidemiologic research study to understand the causes of IBD, learn why the course of illness varies among individuals, and determine what factors may improve outcomes.

In FY 2015, CDC will continue to fund national surveillance systems and fund the Crohn's & Colitis Foundation of America (CCFA) through a competitively awarded, five-year cooperative agreement (FY 2013–17). Funding

⁸⁵ <http://www.cdc.gov/visionhealth/>

supports an epidemiological research study to estimate IBD prevalence and incidence, define the demographic and clinical characteristics of IBD, assess the impact of various clinical practices in the management of IBD, and understand the impact of the disease on the health of affected persons.

Interstitial Cystitis

[Interstitial Cystitis \(IC\)](#)⁸⁶, or bladder pain syndrome, is more common in women than men; the most recent epidemiologic research suggests that up to 12% of women may have early symptoms of IC. CDC's IC efforts promote public awareness and partnerships, provide IC education for the public and health care providers, and improve interaction and information sharing among those with IC, their family members, and health care providers.

CDC supports the Interstitial Cystitis Association (ICA) through a five-year, competitive cooperative agreement (FY 2010–14). ICA, a national organization serving IC patients and health care providers, is educating providers on IC identification, diagnosis, and referral through a health care provider module. ICA is also educating specific populations affected with IC through webcasts and a self-management module. These efforts support people afflicted with IC by providing them valuable information about the disease and improved care opportunities. CDC will issue a new, competitive award in FY 2015 to develop, implement, and evaluate a national campaign to increase public awareness and educate providers through media and health provider toolkits.

⁸⁶ <http://www.cdc.gov/ic/>

Prevention Research Centers Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$8.667	\$25.530	\$0.000	-\$25.530
ACA/PPHF (non-add)	\$15.279	\$0.000	\$25.000	+\$25.000
Total	\$23.946	\$25.530	\$25.000	-\$0.530

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

[Prevention Research Centers](#)⁸⁷ (PRCs) are a network of academic research institutions throughout the United States that conduct applied public health prevention research on new and innovative ways to promote health and prevent disease, especially in areas with high chronic disease disparities. PRCs design, test, and share effective public health programs to improve public health practice and policy. PRCs also develop collaborations with health departments, educational boards, and the private sector to lead rigorous scientific public health research. PRCs work closely with community partners so the research is relevant and beneficial to those communities. The PRC network allows the flexibility for special interest projects, which provide CDC and other federal agencies an opportunity to competitively fund specific, short-term research projects and to collaborate on priority health issues key to prevention efforts, such as healthy aging, nutrition, obesity, physical activity, cancer, and epilepsy.

The PRC program uses a research model for cost-effective, sustainable interventions. For example, an economic analysis of Group Health Cooperative Medicare enrollees participating in the PRC-developed [EnhanceFitness](#)⁸⁸ program had significantly fewer hospitalizations and lower average health care costs. This program is now recommended by the CDC Arthritis program and the Administration for Community Living.

Budget Request

CDC's FY 2015 request of **\$25,000,000** for Prevention Research Centers, all from the Affordable Care Act Prevention and Public Health Fund, is \$530,000 below the FY 2014 Enacted level. In FY 2015, CDC will continue to fund 26 PRCs with the goal of more quickly leveraging research findings to build a collection of tested community prevention interventions for use across the United States.

CDC supported PRC research will focus on ways to maximize public health resources and reduce health care costs, with an emphasis on the leading causes of disease and disability. For every \$1 invested in PRCs in FY 2012, the PRCs generated an average of \$6.93 in additional research funds. Through their projects, PRCs expect to include nearly 30 million people in their research, including those in underserved communities. PRCs build partnerships with public health departments and communities to ensure their research has direct application in real-world settings. CDC will provide guidance by working with PRCs to develop research ideas then move successful intervention strategies from PRC communities to communities nationwide by sharing case studies of effective interventions.

In FY 2015, PRCs will conduct professional trainings on health topics, such as program evaluation, health literacy, and social marketing for an anticipated 8,000 people, including community agency representatives and public health employees of state, county, and local governments.

CDC will award a new, five-year cooperative agreement in FY 2014. Schools of public health and schools of medicine or osteopathy with an accredited preventive medicine residency were eligible to apply. At the end of

⁸⁷ <http://www.cdc.gov/prc/>

⁸⁸ <http://www.projectenhance.org/enhancefitness.aspx>

this five-year cooperative agreement, CDC expects PRCs to produce and share research findings that demonstrate intervention effectiveness in key areas of chronic disease prevention and other leading causes of death and disability.

Table: Prevention Research Centers Grant

(dollars in millions)	FY 2013	FY 2014	FY 2015	2015
	Final¹	Enacted	President Budget	+/-2014
Number of Awards	37	26	26	0
- New Awards	0	26	0	-26
- Continuing Awards	37	0	26	+26
Average Award	\$0.490	\$0.650-\$0.720	\$0.630-\$0.700	N/A
Range of Awards	\$0.272-\$0.536	\$0.650-\$0.720	\$0.630-\$0.700	N/A
Total Awards	\$18.138	\$19.148	\$18.628	-\$0.520

Heart Disease and Stroke Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$54.417	\$57.188	\$57.188	\$0.000
ACA/PPHF (non-add)	\$0.000	\$73.000	\$73.000	\$0.000
Total	\$54.417	\$130.188	\$130.188	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Total costs associated with heart disease in the United States exceed \$312.6 billion, annually. CDC’s [Vital Signs](#) data revealed that 67 million American adults have high blood pressure, a leading risk factor for heart disease and stroke, and more than half of them don’t have it under control. Reducing per capita sodium intake to 2,300 mg/day could prevent 11 million cases of hypertension annually. CDC works with public and private partners to prevent, detect, and treat risk factors for heart disease and stroke, the first and fourth leading killers in the nation. Through these partnerships, CDC ensures that state and local health departments—as well as local clinicians—are familiar with public health practices related to heart disease and stroke prevention, leading to reduced health disparities. CDC supports [state-based heart disease and stroke prevention](#) activities, the [Paul Coverdell Acute Stroke Registry](#)⁸⁹, [Sodium Reduction in Communities Program](#)⁹⁰, and [WISEWOMAN programs](#)⁹¹ (funding is reflected in the Cancer Prevention and Control budget line). For example, to help prevent and control hypertension, CDC promotes reduction of sodium intake through grantee activities which reduced sodium in two elementary schools in New York by 20%, and decreased sodium by almost 10% in one year in approximately 109,000 senior home-delivered and group meals.

Budget Request

CDC’s FY 2015 request of **\$130,188,000** for Heart Disease and Stroke, including \$73,000,000 from the Affordable Care Act Prevention and Public Health Fund, is level with the FY 2014 Enacted level. At this funding level, CDC will continue to coordinate national heart disease and stroke prevention efforts. Requested funds will continue CDC’s support for the 50 states and the District of Columbia to implement evidence-based heart disease and stroke prevention programs. In FY 2014, with funding from the Prevention and Public Health Fund, CDC expanded its heart disease and stroke prevention efforts focused on state and local investments on the ABCs of clinical prevention, reducing health disparities, and primary prevention to improve cardiovascular health, largely through the State Public Health Actions for Chronic Disease Prevention cooperative agreement.

Heart Disease and Stroke Prevention. Initiatives in FY 2015 include:

Table: Public Health Activities to Support Heart Disease and Stroke Prevention

Initiatives	Examples of Activities
Heart Disease and Stroke State Program Support	<ul style="list-style-type: none"> Funded 50 states and D.C. in FY 2013, to implement improved heart disease and stroke prevention efforts and 32 states to implement enhanced strategies with expanded reach and impact

⁸⁹ http://www.cdc.gov/dhdsp/programs/stroke_registry.htm

⁹⁰ http://www.cdc.gov/dhdsp/programs/sodium_reduction.htm

⁹¹ <http://www.cdc.gov/wisewoman/>

Initiatives	Examples of Activities
Improve Clinical Performance	<ul style="list-style-type: none"> • Increase use of team-based care in health systems; use of non-physician team members (nurses, pharmacists, etc.) in hypertension management;; and use of self-measured blood pressure monitoring tied with clinical support
Blood Pressure Control and Cholesterol Management	<ul style="list-style-type: none"> • Improve blood pressure control by increasing medication adherence for more than half of the population with high blood pressure • Improve the prevention and control of hypertension at the national level • Increase support of community health care extenders in support of high blood pressure self-management
Sodium Management	<ul style="list-style-type: none"> • Support state and local efforts to reduce sodium consumption and educate the public • Build the evidence base to guide sodium reduction strategies through evaluation of ongoing initiatives, enhance monitoring of sodium intake, and expand the scientific literature related to sodium reduction
Stroke Quality of Care	<ul style="list-style-type: none"> • Support the Paul Coverdell National Acute Stroke Registry Program by funding 11 states with a total of 468 participating hospitals to ensure that all Americans receive high quality acute stroke care, reduce deaths, prevent disability, and avoid recurrent strokes

CDC will expand on past successes achieved as a result of state-based heart disease and stroke prevention efforts which include the following: a) An increase in the percent of adults who are aware they have high blood pressure from 29% to 34.2% in Michigan; and b) Improved clinical outcomes for patients with CVD and hypertension in Rhode Island, by increasing the number of providers trained to provide self-management education from 39 to 74 through the Certified Cardiovascular Outpatient Educators program (i.e., nurses, dietitians and pharmacists). Additionally, between, 2005 through mid-2012, more than 350,000 patients have benefited from hospital participation in the Paul Coverdell National Acute Registry Program.

In FY 2015, CDC will:

- Ensure that evidence based strategies are effectively translated to practice at the state, local, territorial and tribal level
- Conduct research and surveillance on heart disease and stroke prevention
- Monitor performance and evaluation activities
- Work with partners to expand the scientific literature around dietary sodium to better understand its relationship to high blood pressure and its impact on the public’s health

In FY 2013 alone, 122 products translating research to practice were disseminated to stakeholders in the field of heart disease and stroke prevention; 54 peer-reviewed publications were disseminated; and 88 additional publications are in progress.

Paul Coverdell National Acute Registry Program

The Paul Coverdell National Acute Stroke Registry Program is a three-year cooperative agreement competitively awarded to 11 states to improve quality of care and transition of care from first contact with EMS through in-hospital care and transition to next care provider. In FY 2015, CDC will continue to support year three of the cooperative agreement, funding state-based registries to conduct activities which allow development of statewide systems of care for stroke patients through coordination with emergency medical services and collaboration among statewide partners.

Table: Paul Coverdell National Acute Stroke Registry Program Grant

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	11	11	11	0
- New Awards	0	0	0	0
- Continuing Awards	11	11	11	0
Average Award	\$0.346	0.356	\$0.356	\$0.000
Range of Awards	\$0.266–\$0.485	\$0.275–\$0.500	\$0.275–\$0.500	N/A
Total Awards	\$3.807	\$3.925	\$3.925	\$0.000

WISEWOMAN

The [Well-Integrated Screening and Evaluation for Women Across the Nation \(WISEWOMAN\) program](#)⁹² focuses on reducing cardiovascular disease (CVD) risk factors among at-risk women. CVD, which includes heart disease, myocardial infarction, and stroke, is the leading cause of death for women in the United States. WISEWOMAN provides preventive services to 40-64 year old underserved women, including blood pressure, cholesterol, and diabetes testing, as well as lifestyle programs targeting poor nutrition, physical inactivity, and smoking during their National Breast and Cervical Cancer Early Detection Program (NBCCEDP) office visit. Between 2008 and 2013, the WISEWOMAN program served nearly 150,000 women and provided over 217,000 cardiovascular disease screenings. From July 2012 to June 2013, the WISEWOMAN program reported 9,920 cases of high blood pressure, 6,538 cases of high cholesterol, 4,009 cases of diabetes, and 6,898 smokers among participants.

Budget Request (funded through the National Breast and Cervical Cancer Early Detection Program)

CDC’s FY 2015 request of **\$21,413,000** for WISEWOMAN, all from the Affordable Care Act Prevention and Public Health Fund is level with the FY 2014 President’s Budget. CDC competitively awarded a four-year cooperative agreement for the WISEWOMAN program to 19 state health departments and 2 Alaska Native organizations in FY 2013. At the end of this four-year period, CDC expects these programs will have completed up to 150,000 screenings to assess women's cardiovascular risk, and provide intervention services to those in need. In FY 2015, WISEWOMAN programs will concentrate efforts on blood pressure control through lifestyle programs, including healthy lifestyle counseling and referrals for clinical intervention.

⁹² <http://www.cdc.gov/wisewoman/>

Table: WISEWOMAN Grant

(dollars in millions)	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	21	21	21	0
- New Awards	21	0	0	0
- Continuing Awards	0	21	21	0
Average Award	\$0.760	\$0.760	\$0.760	\$0.000
Range of Awards	\$0.500–\$1.472	\$0.500–\$1.472	\$0.500–\$1.472	N/A
Total Awards	\$15.983	\$16.900	\$16.900	\$0.000

Diabetes Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$64.041	\$67.306	\$67.306	\$0.000
ACA/PPHF	\$0.000	\$73.000	\$73.000	\$0.000
National Diabetes Prevention Program	\$0.000	\$10.000	\$10.000	\$0.000
Total	\$64.041	\$150.306	\$150.306	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Nearly 26 million Americans have [diabetes](#) and over 200,000 people die each year of related complications. Approximately 7 million Americans have diabetes and do not know it. If the current trends continue, one in every three U.S. adults will have diabetes by 2050. Similarly, in 2010, CDC estimated that 1 of every 3 US adults (79 million, or 35% of Americans aged 20 years or older) [had pre-diabetes](#), a serious health condition that increases the risk of developing type 2 diabetes, heart disease and stroke. To reduce the burden of diabetes and its complications, CDC and its partners implemented lifestyle change programs in 45 states to prevent type 2 diabetes as a part of the National Diabetes Prevention Program (National DPP). Additionally, CDC is also funding all 50 states and the District of Columbia to increase access to diabetes self-management education (DSME) through State Public Health Approaches to Prevent Chronic Disease. The evidence supports the effectiveness of DSME in improving diabetes outcomes by increasing control of A1c, blood pressure and cholesterol, and promoting access to tobacco cessation, among people with diabetes. Controlling A1c is an important measure of how a person is controlling diabetes and it is the best indicator and determinant of risk for developing complications of diabetes like chronic kidney disease, blindness and amputations. For example, the North Carolina Diabetes Education Recognition Program has helped 58 DSME programs across the state achieve American Diabetes Association Recognition and provided services to over 7,000 patients with diabetes.

Budget Request

CDC's FY 2015 request of **\$150,306,000** for Diabetes, including \$73,000,000 from the Affordable Care Act Prevention and Public Health Fund, is level with the FY 2014 Enacted level. CDC will continue to provide national leadership to impact the overwhelming burden of diabetes and its associated risk factors like obesity, physical inactivity and unhealthy eating choices. Requested funds will continue CDC's support for the 50 states and the District of Columbia to implement evidence-based diabetes and chronic disease prevention and control programs. In FY 2014, with funding from the Prevention and Public Health Fund, CDC expanded its diabetes prevention efforts focused on state and local investments to address primary prevention for individuals with pre-diabetes including nutrition and physical inactivity, through the State Public Health Actions to Prevent Chronic Disease cooperative agreement. CDC's national diabetes prevention and control efforts in FY 2015 include:

Table: Public Health Activities to Support Diabetes Prevention and Control

Initiatives	Examples of Activities in FY 2013
Diabetes State Program Support	Funded 32 states to implement improved and enhanced diabetes prevention and control strategies with expanded reach and impact that address primary prevention and support the National Diabetes Prevention Program lifestyle change intervention
Surveillance	Track and monitor trends and document the public health burden of diabetes and its complications

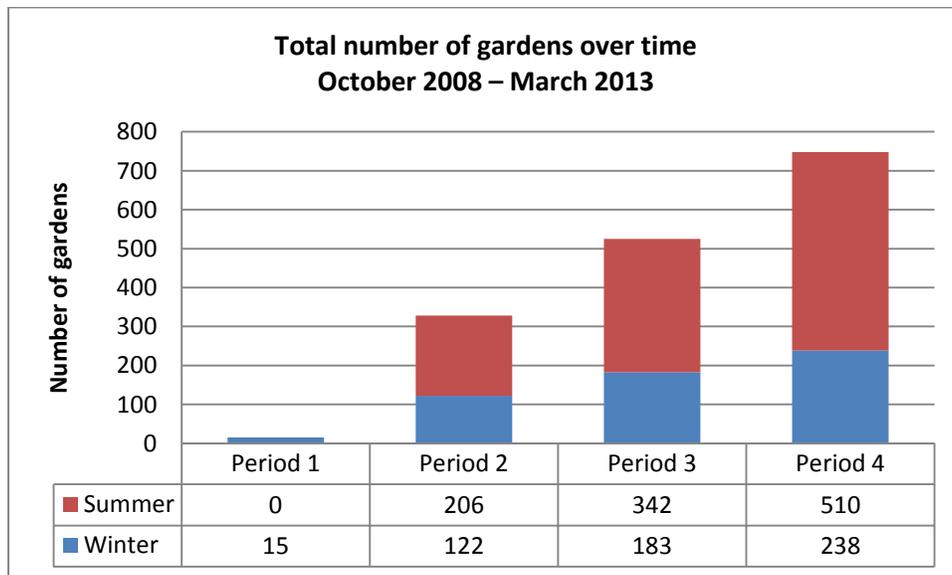
Initiatives	Examples of Activities in FY 2013
Diabetes Prevention	Enhance diabetes prevention efforts by expanding access to lifestyle change programs in community settings to prevent type 2 diabetes as a part of the National DPP
Strengthen the science of effective strategies	Conduct research and evaluation to support evidence-based practice and implement public health strategies to prevent and control diabetes (e.g., early detection of undiagnosed diabetes)

Diabetes and Health Disparities

CDC strives to reduce illness, premature death, and eliminate health disparities associated with type 2 diabetes. In FY 2015, CDC will continue several programs to address the elimination of diabetes related health disparities through:

- [Native Diabetes Wellness Program](#)
- [National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations](#)
- [Funding to U.S. Territories](#)

For example, the Native Diabetes Wellness Program (NDWP) Traditional Foods Project supports the prevention of diabetes and other chronic diseases in American Indian/Alaska Native (AI/AN) communities through reintroduction of traditional foods, increasing opportunities for physical activity, using social support, and promoting systems change. Collectively, the Traditional Foods projects have demonstrated a steady growth in numbers of gardens; partners report an increase from 219 gardens in 2010 to 748 gardens in 2013. Physical activity and healthy diets rich in fruits and vegetables have been shown to reduce the risk of diabetes and other chronic diseases.



In FY 2015, CDC’s NDWP will issue a new five-year competitive funding opportunity announcement (FY 2015-FY2020), for up to seventeen tribes/tribal organizations to address priority areas in diabetes prevention and control, allowing CDC to reach populations who are disproportionately impacted by diabetes and its devastating complications in Indian country.

Table: Diabetes American Indian/Alaska Native Grants

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted ²	President's Budget	2015 +/-2014
Number of Awards	16	16	Up to 17	+1
- New Awards	0	0	0	0
- Continuing Awards	16	16	Up to 17	+1
Average Award	\$0.100	\$0.100	\$0.100	\$0.000
Range of Awards	\$0.094-\$0.100	\$0.094-\$0.100	\$0.094-\$0.100	N/A
Total Awards	\$1.600	\$1.700	\$1.700	\$0.000

* From 2009 – 2013, \$1M of \$1.6 M Total Awards was allocated to CDC through a Special Diabetes Program for Indians appropriation through the Indian Health Service should these funds continue, CDC will fund Tribes/Tribal Organizations at the highest level...

¹ – FY 13 Post Sequester funding request for the NDWP was \$1.6 million.

CDC competitively awards funding through a five-year cooperative agreement (FY2014-FY2019) to six Pacific Island Jurisdictions, the U.S. Virgin Islands and Puerto Rico to implement public health actions to prevent and control diabetes. These grants allow CDC to work with the grantees and their partners to reach populations who are disproportionately impacted by diabetes and its devastating complications in the U.S. Associated Pacific Islands.

Table: Diabetes Territories Grant

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	6	8	8	0
- New Awards	0	0	0	0
- Continuing Awards	6	8	8	0
Average Award	\$0.106	\$0.106	\$0.106	\$0.000
Range of Awards	\$0.058-\$0.200	\$0.058-\$0.200	\$0.058-\$0.200	N/A
Total Awards	\$0.635	\$1.075	\$1.075	\$0.000

In FY2015, CDC will maintain funding for the [National Program to Eliminate Diabetes Related Disparities in Vulnerable Populations](http://www.cdc.gov/diabetes/projects/foa.htm)⁹³, a five-year cooperative agreement (FY2014-FY2019). Grantees will focus on activities for people with diabetes to increase physical activity, eat healthier, and gain a greater understanding how diabetes and its complications can affect their lives. Diabetes related coalitions have been established to address diabetes issues in 18 communities and each of them is implementing evidence-based interventions to address diabetes.

Table: Diabetes and Vulnerable Populations

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	6	6	6	0
- New Awards	0	0	0	0
- Continuing Awards	6	6	6	0
Average Award	\$0.466	\$0.466	\$0.466	\$0.000
Range of Awards	\$0.466	\$0.466	\$0.466	N/A
Total Awards	\$2.800	\$2.800	\$2.800	\$0.000

⁹³ <http://www.cdc.gov/diabetes/projects/foa.htm>

National Diabetes Prevention Program (National DPP)

In FY 2015, CDC’s request of \$10,000,000 for the National DPP is level with the FY 2014 Enacted level. CDC’s [National DPP⁹⁴](#) puts into practice the groundbreaking clinical trial finding that type 2 diabetes can be prevented or delayed through lifestyle changes in high-risk adults. The National DPP is an evidence-based intervention program being used in communities to help prevent or delay type 2 diabetes. CDC estimates the National DPP could save the U.S. healthcare system approximately \$5.7 billion. The program has four components:

National DPP Components	Examples of Activities
Training	Build training infrastructure and support the diabetes prevention workforce by training lifestyle coaches to deliver the program. Since FY 2010, our partners have trained over 2,300 lifestyle coaches.
Recognition	Maintain quality assurance and provide recognition for organizations that deliver the lifestyle change intervention. Over 400 organizations are undergoing review for CDC recognition.
Intervention	Fund six national organizations to sustain the lifestyle change program. Through these organizations the program has expanded, reaching 45 states, to prevent type 2 diabetes.
Promotion	Increase participation and better educate the public about type 2 diabetes. CDC is developing a suite of materials for the public, providers, employers, and insurers.

In FY 2015, CDC will continue funding the National DPP’s existing grantees to increase availability of the program in more cities throughout the country. Additionally, CDC will award a new contract to explore reimbursement options for organizations that deliver the lifestyle change program and to work with employers to design benefit packages that offer the lifestyle change program as a covered health benefit.

During this funding cycle, CDC expects grantees and contractors to increase the number of:

- Participants in the National DPP lifestyle change intervention
- Employers who offer the lifestyle intervention program as a covered health benefit for employees
- Private and public payers reimbursing organizations that deliver the lifestyle intervention

For example, the Diabetes Prevention and Control Alliance, a CDC grantee, is working with stakeholders in Colorado—such as the Colorado Prevention Alliance, the Colorado Business Group on Health, the State Department of Personnel Administration, and major health plans—to get the National DPP lifestyle change intervention approved as a covered benefit for state employees. As a result of their efforts, 44,011 Colorado state employees are now eligible to participate in the program based on their risk for prediabetes and insurance provider. Additionally, the State Health Department is now educating state employees about their risk for prediabetes, providing information and or referring staff to organizations delivering the National DPP lifestyle intervention.

⁹⁴ <http://www.cdc.gov/diabetes/prevention/about.htm>

Table: National Diabetes Prevention Program Grant

(dollars in millions)	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	0	6	6	0
- New Awards	0	0	0	0
- Continuing Awards	6	6	6	0
Average Award	\$0.000	\$0.875	\$0.875	\$0.000
Range of Awards	\$0.000	\$0.750–\$1.003	\$0.750–\$1.003	N/A
Total Awards	\$0.000	\$6.750	\$6.750	\$0.000

¹As a result of no funding for the National DPP in FY 2013, compared to \$10 million in FY 2012, CDC was not able to fully fund the program in FY13 ; however, programs maintained minimal activities in the areas above using limited carryover funds

Surveillance

In FY 2015, CDC will continue to fund the [National Diabetes Surveillance System \(NDSS\)](#)⁹⁵ to identify key disparities and document the public health burden of diabetes and its complications in the United States. This surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize resources for diabetes control and prevention. States, Tribes, and communities use the information from the NDSS to identify areas of need, guide decision-making, set priorities, plan strategies for interventions, and evaluate the impact of the intervention to assist in make progress toward public health targets and performance goals. In FY 2015, CDC will:

- Conduct innovative research to monitor and track the burden of diabetes, its risk factors and complications
- Conduct studies to examine the impact of diabetes interventions and assess the cost and impact of diabetes care
- Prioritize interventions and policies
- Develop and share informational briefs and tools to raise awareness about the disease

⁹⁵ <http://www.cdc.gov/diabetes/surveillance/index.htm>

Cancer Prevention and Control Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$337.919	\$246.982	\$128.808	-\$118.174
ACA/PPHF	\$0.000	\$104.000	\$179.204	+\$75.204
Total	\$337.919	\$350.982	\$308.012	-\$42.970
Cancer Prevention and Control	\$337.919	\$350.982	\$308.012	-\$42.970
ACA/PPHF (non-add)	\$0.000	\$104.000	\$179.204	+\$75.204
Breast and Cervical Cancer (non-add)	\$197.342	\$207.269	\$169.204	-\$38.065
ACA/PPHF (non-add)	\$0.000	\$104.000	\$169.204	+\$65.204
WISEWOMAN (non-add)	\$20.216	\$21.170	\$21.170	\$0.000
Colorectal Cancer (non-add)	\$41.989	\$43.410	\$39.515	-\$3.895
All Other Cancer	\$0.000	\$0.000	-\$10.900	-\$10.900
New Cancer Demonstration Project (ACA/PPHF) (non-add)	\$0.000	\$0.000	\$10.000	+\$10.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

As a leader in nationwide efforts to reduce illness and death from cancer, CDC works with national cancer organizations, state and local public health agencies, and other key groups to develop, implement, and promote strategies to prevent and control cancer, the second leading cause of death in the United States. CDC's Cancer Prevention and Control programs provide state and local public health agencies and other health care provider organizations with data, technical guidance and applied research needed to improve the prevention, detection, and control of cancer.

CDC funds cooperative agreements with states, territories, and tribes or tribal organizations to implement four major cancer control programs: the [National Breast and Cervical Cancer Early Detection Program \(NCCEDP\)](#)⁹⁶, the [National Program of Cancer Registries \(NPCR\)](#)⁹⁷, the [National Comprehensive Cancer Control Program \(NCCCP\)](#)⁹⁸, and the [Colorectal Cancer Control Program \(CRCCP\)](#)⁹⁹.

Additionally, CDC conducts education, awareness, and applied research activities related to breast cancer in young women, and prostate, ovarian, skin, and gynecologic cancers. These activities extend CDC's reach beyond national programs to inform surveillance, enhance health communication and education for providers and the public, and help cancer prevention and control efforts to meet community needs. CDC enhances support for these activities with funding awarded to the Cancer Prevention and Control Research Network, other academic institutions, and non-governmental organizations.

Budget Request

CDC's FY 2015 request of **\$308,012,000** for Cancer Prevention and Control, including \$179,204,000 from the Affordable Care Act Prevention and Public Health Fund, is \$42,970,000 below the FY 2014 Enacted level.

In 2015, funding for the NCCEDP and the CRCCP is reduced by \$42 million for direct cancer screenings for breast, cervical, and colorectal cancer that are now covered through health reform. In 2014, the Affordable Care Act (ACA) is increasing the availability of health insurance coverage to millions of people through new state health insurance exchanges and Medicaid expansion. Through ACA, most health plans are required to cover

⁹⁶ <http://www.cdc.gov/cancer/nbccedp/index.htm>

⁹⁷ <http://www.cdc.gov/cancer/npcr/>

⁹⁸ <http://www.cdc.gov/cancer/ncccp/>

⁹⁹ <http://www.cdc.gov/cancer/crccp/>

breast, cervical, and colorectal cancer screenings without co-pays or deductibles. The law also requires new health plans to cover prevention counseling for women who are at a greater risk for breast cancer and, starting in 2014, it ensures that no one can be denied health insurance because of a pre-existing condition. The Budget directs limited resources to services that are not financed through health reform such as healthcare associated infections and food safety and reduces funding for direct screenings such as breast and cervical and colorectal screening that are already covered by insurance. This shift aligns with recent reports that have stated CDC should only pay for services not covered by insurance.

The NBCCEDP provides clinical screening and diagnostic services to low-income, uninsured, and underinsured women as mandated by Congress. The program also supports public health activities such as education and outreach, quality assurance, surveillance, and patient navigation/case management to help ensure women receive quality screening. Because the ACA affords greater access to coverage for these screening services, the size of the populations eligible for the NBCCEDP and CRCCP are expected to shrink. Estimates show that in 2014, up to 6.8 million NBCCEDP-eligible women could gain insurance coverage for breast or cervical cancer screening; however, at least 4.5 million women may remain uninsured and eligible for breast or cervical cancer screening through the program. Therefore in 2015, CDC anticipates it will meet the needs of a larger proportion of underserved women than currently served through the NBCCEDP.

Access to health insurance coverage is not the only factor that limits participation in cancer screening. Numerous barriers to screening will continue to exist, including:

- Patient factors, such as:
 - Education
 - Limited English proficiency
 - Lack of awareness or health literacy
- Provider or clinical system factors, such as:
 - Lack of physician availability or physician recommendation,
 - Absence of reminder systems
 - Not using provider assessment and feedback

The new cancer demonstration proposed in 2015 will work to enhance population-based activities that address known barriers to screening, recruit people in need of screening, help navigate people through the health care system and assure delivery of quality screening. CDC surveillance and research documented that current screening rates are low for certain disparate populations that may have access to coverage but encounter these barriers.

In FY 2015 and beyond, CDC's cancer screening programs will continue to complement the benefits provided through ACA by leveraging their extensive capacity and linkages with the clinical care system to increase cancer screening on a population level, while still providing direct services to people who are not covered by insurance. CDC screening programs will continue to provide targeted screening services as appropriate. Funding will also be used to emphasize organized approaches to increase population-level screening rates, support enhanced education and outreach including social media, and promote patient navigation to ensure appropriate screening and follow-up. Grantees will work with health care systems, FQHCs, state Medicaid offices, employers, and private insurers to implement systematic approaches to improve cancer screening participation, such as direct invitation and use of client/provider reminders. Grantees will also assure quality screening using the model systems CDC has developed to ensure timely diagnosis and treatment of positive screening tests.

To further these population-based efforts and the transition away from providing services covered by health insurance, the FY 2015 budget request includes \$10,000,000 in PPHF investments to support a new cancer

demonstration project that will enable funded grantees to develop and implement innovative strategies to increase population-level screening rates for recommended breast, cervical and colorectal cancer screenings. Programs would use funding to leverage their connections to the clinical care system and enhance efforts to expand population-based, public health activities, facilitate more organized cancer screening efforts that link people to care, and improve screening rates for all recommended populations. Activities may incorporate systems or policy level approaches that have the potential to be generalizable, replicable and scalable. For example, funding could support efforts to collaborate with large health systems (e.g., federally qualified health centers), insurers (e.g., Medicaid, Medicare, and large private insurers), large workplaces/employers, or others (e.g., State healthcare quality organizations) to:

- Implement evidence-based policy or systems approaches that increase screening rates and the delivery of high quality cancer screening.
- Design population-level cancer screening registries or surveillance systems
- Develop and implement innovative strategies that target higher risk populations in need of screening.
- Develop organized, population-based strategies that may extend screening efforts beyond traditional medical settings.
- Promote patient navigation to help link people to care and ensure appropriate screening and follow-up occurs when needed.

National Breast and Cervical Cancer Early Detection Program

The NBCCDEP is a five-year cooperative agreement (FY2012-FY2017) competitively awarded to 50 states, Washington, D.C., five territories, and 11 tribal organizations. In FY 2015, CDC will continue to enable grantees to provide breast and cervical cancer screenings and diagnostic follow up services for low-income, uninsured, and underserved women. CDC will also assist grantees to expand the use of evidence-based interventions and screening promotion practices that can increase population-level screening rates.

Tables: National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grant¹
(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	67	67	67	0
- New Awards	67	0	0	0
- Continuing Awards	0	67	67	0
Average Award	\$2.260	\$0.238–\$8.172	TBD	N/A
Range of Awards	\$0.238–\$8.172	\$0.189–\$7.488	TBD	N/A
Total Awards	\$151.441	\$151.441	TBD	N/A

National Program of Cancer Registries

The [National Program of Cancer Registries \(NPCR\)](#) funds central cancer registries to collect, manage, and analyze data about cancer cases for 96% of the U.S. population, effectively providing a census of all cancer cases in the nation. This data enables health agencies to report on cancer trends, assess the impact of cancer prevention and control efforts, and participate in research. In 2013, NPCR was successful in getting cancer reporting from providers to state cancer registries included as an objective in the Centers for Medicaid and Medicare Services and Office of the National Coordinator for Health IT final rule for Stage 2 Meaningful Use for electronic health records (EHRs). Enhanced use of EHRs will improve the timeliness, completeness and quality of cancer data reported from non-hospital facilities and increase public health programs' ability to plan and target health care interventions designed to reduce cancer incidence or improve early detection.

The NPCR is a five-year cooperative agreement (FY2012 – FY2017) competitively awarded to 45 states, Washington, D.C., Puerto Rico, and the U.S. Pacific Island jurisdictions. In FY 2015, CDC will continue to collect vital data about cancer cases and deaths to provide essential information for health agencies to report on cancer trends, assess the impact of cancer prevention efforts, participate in research, and respond to reports of suspected increases in cancer. The current funding cycle for this FOA runs through 2017. CDC expects to continue maintaining the existing 48 cancer registries that provide high-quality data while expanding electronic reporting to cancer registries and enhancing use of registry data.

Table: National Program of Cancer Registries (NPCR) Grant¹

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	48	48	48	0
- New Awards	48	0	0	0
- Continuing Awards	0	48	48	0
Average Award	\$0.769	\$0.769	\$0.769	\$0.000
Range of Awards	\$0.275–\$3.045	\$0.275–\$3.045	\$0.275–\$3.045	N/A
Total Awards	\$36.900	\$36.900	\$36.900	\$0.000

National Comprehensive Cancer Control Program

The [National Comprehensive Cancer Control Program \(NCCCP\)](http://www.cdc.gov/cancer/ncccp/)¹⁰⁰ brings together coalitions of key public and private partners to develop and implement cancer plans and prioritize efforts to reduce the highest burden cancers within their state, territory or tribal organization. The NCCCP provides the evidence base to develop and implement approaches aimed at primary prevention (e.g., reducing exposure to tobacco), detecting cancers earlier when they are more treatable (e.g., colorectal cancer screening), increasing access to treatment, and improving the quality of life of cancer survivors. For example, the Maryland Cancer Collaborative has prioritized worksite wellness initiatives from the Maryland Comprehensive Cancer Control Plan as a means to prevent cancer. Get Healthy Kent is a worksite wellness initiative partnership between the Kent County Health Department, Chester River Hospital Center, local healthcare providers, participating worksites, and the Maryland Department of Health and Mental Hygiene’s Healthiest Maryland Businesses initiative. As of January 2013, 16 businesses had joined the Get Healthy Kent program, which represents more than 3,000 employees and 46% of the total county workforce.

The NCCCP is a five-year cooperative agreement (FY2012 – FY2017) competitively awarded to 50 states, Washington, D.C., seven tribal organizations, and seven U.S. territories. CDC will continue to support NCCCP grantees to maintain and strengthen cancer coalitions of key public and private partners to develop and implement state cancer plans and prioritize efforts to reduce the highest burden cancers within their jurisdiction. In FY 2015, CDC will also use lessons learned from a 5-year demonstration project (FY2010 – FY2014) to support the use of systems and environmental change strategies for cancer control among all grantees. This demonstration project provided supplemental funding for 13 grantees to develop and implement interventions to improve social and physical environments that make adopting healthy behaviors easier, make accessing quality clinical care more convenient, and make successfully managing post-treatment follow-up more probable.

¹⁰⁰ <http://www.cdc.gov/cancer/ncccp/>

Table: National Comprehensive Cancer Control Program (NCCCP) Grant¹

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	65	65	65	0
- New Awards	65	0	0	0
- Continuing Awards	0	65	65	0
Average Award	\$0.340	\$0.340	\$0.340	\$0.000
Range of Awards	\$0.195–\$0.722	\$0.195–\$0.722	\$0.195–\$0.722	N/A
Total Awards	\$22.058	\$22.058	\$22.058	\$0.000

Colorectal Cancer Control Program

The [Colorectal Cancer Control Program \(CRCCP\)](#)¹⁰¹ aims to increase population-level colorectal cancer (CRC) screening rates. The primary emphasis of the program is to promote population-level screening through practices such as small/mass media, client/provider reminders, and patient navigation while still providing limited CRC screening and diagnostic follow-up services to low-income, uninsured, or underinsured men and women age 50 to 64.

The CRCCP is a five-year cooperative agreement (FY2009 – FY2014) competitively awarded to 25 states and four tribes/ tribal organizations. In FY 2015, a reduction of \$3.9 million may result in the elimination of up to 5 grantees. CDC will continue funding grantees to emphasize evidence-based interventions to increase population-level screening rates, and facilitate the provision of direct screening services to underserved people. CDC remains committed to improving and increasing the delivery of quality colorectal cancer screening for insured and uninsured people age 50 to 75.

Table: Colorectal Cancer Control Program (CRCCP) Grant¹

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	29	29	24	-5
- New Awards	0	0	24	+24
- Continuing Awards	29	29	0	-29
Average Award	\$0.810	\$0.810	\$0.885	+\$0.075
Range of Awards	\$0.327–\$1.303	\$0.327–\$1.303	\$0.362–\$1.497	N/A
Total Awards	\$23.496	\$23.496	\$21.676	-\$1.820

¹⁰¹ <http://www.cdc.gov/cancer/crccp/>

Oral Health Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$14.906	\$15.790	\$15.790	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Tooth decay is one of the most common chronic diseases of children aged 6 to 11 years (53% in primary and permanent teeth) and adolescents aged 12 to 19 years (59 % in permanent teeth). CDC's [Division of Oral Health](#)¹⁰² leads federal, national, and state initiatives to prevent oral diseases by monitoring health trends, translating research to practice, and advancing safe and effective strategies that can improve oral health and reduce dental care expenditures. Two key strategies are community water fluoridation and dental sealants. Every \$1 invested in community water fluoridation saves \$38 in dental treatment costs. From 2008 to 2010, nine million additional people had access to fluoridated water, saving an estimated \$250 million. In addition, from 2003 to 2008, there was a 60% increase in the delivery of school-based sealants in states with CDC funding, which saved an estimated \$1 million in Medicaid dental expenditures. In addition, CDC develops [infection control guidelines](#)¹⁰³ for dental settings to ensure the safe delivery of dental care for patients and dental health care personnel.

Budget Request

CDC's FY 2015 request of **\$15,790,000** for Oral Health is level with the FY 2014 Enacted level. Bolstered by a strong evidence base, CDC funds 21 programs in [state health departments](#)¹⁰⁴ to:

- Strengthen the nation's oral health infrastructure
- Extend the use of proven strategies to prevent oral diseases
- Reduce inequalities in oral health

In FY 2015, CDC-funded states will increase the number of high-risk children receiving dental sealants by selecting schools with a high percentage of students on free and reduced-cost meal programs. CDC awards competitive funding for the five-year Oral Health cooperative agreement to states according to the strength of their developed Oral Health work plan. At the end of this funding cycle (July 30, 2018), CDC expects grantees to:

- Increase the number of funded states that have an oral health surveillance system to 100%
- Increase the number of children aged six to nine years who have received dental sealants on one or more permanent teeth through a school-based sealant program in CDC funded states. Increase by 2% (from 74.6% to 76.5%) the proportion of the population served by community water systems with optimally fluoridated water

In FY 2015, CDC will continue to provide consultation and expertise to all states, collect and share best practices, and support oral health leadership in state health departments nationwide through a five-year cooperative agreement with the [Association of State and Territorial Dental Directors](#). Furthermore, CDC will work with states and partners to expand access to optimally fluoridated water systems nationwide, monitor and assess health trends, translate intervention cost-effectiveness results, facilitate efficient program delivery, and evaluate program impact. CDC will collaborate with other HHS agencies to increase access to preventive oral health services, including dental sealants among Medicaid and SCHIP beneficiaries.

¹⁰² <http://www.cdc.gov/oralhealth/>

¹⁰³ <http://www.cdc.gov/OralHealth/infectioncontrol/index.htm>

¹⁰⁴ http://www.cdc.gov/OralHealth/state_programs/index.htm

CDC will promote the Healthy People 2020 definition of a state oral and craniofacial surveillance system and provide targeted technical guidance to states to build their capacity to monitor and assess oral health based on the results of a capacity assessment implemented by the Council of State and Territorial Epidemiologists. CDC conducts research, analysis and translation of national and standardized state-level data on oral disease burden, dental care service use, preventive services and cost-effectiveness data. CDC, in collaboration with the National Institute of Dental and Craniofacial Research (NICDR), has enhanced surveillance of dental caries (tooth decay) and dental fluorosis in the National Health and Nutrition Examination Survey (NHANES) to monitor the impact of these changes to fluoride level recommendations.

Table: Oral Health State Grant

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	21	21	21	0
- New Awards	21	0	0	0
- Continuing Awards	0	21	21	0
Average Award	\$0.298	\$0.298	\$0.298	\$0.000
Range of Awards	\$0.150–\$0.370	\$0.200–\$0.350	\$0.200–\$0.350	N/A
Total Awards	\$5.965	\$5.965	\$5.965	\$0.000

Safe Motherhood and Infant Health Budget Request

(dollars in millions)

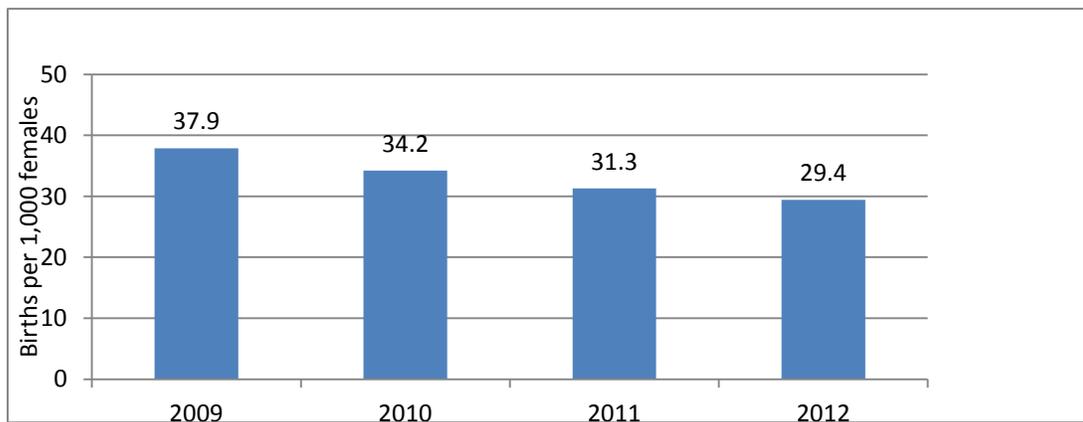
	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$45.057	\$45.589	\$45.589	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC analyzes nationwide pregnancy data to identify changes and trends in maternal and infant health and mortality by conducting research and surveillance national, state and local levels. CDC collects population-based data on maternal attitudes, experiences, and health before, during, and shortly after delivery and on infant health through its [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#)¹⁰⁵. Through the [National Assisted Reproductive Technology \(ART\) Surveillance System \(NASS\)](#)¹⁰⁶, CDC collects data from all clinics in the U.S. that use ART to treat infertility. Preliminary results for 2011 (the most recent data available) indicate 163,044 ART cycles were performed at 451 reporting clinics in the United States, resulting in the delivery of 61,310 infants. Understanding these figures and trends allows CDC to improve the quality of services provided to mothers and newborns increasing positive health outcomes. CDC also studies new and safe methods of contraceptives for women and teens deemed at high risk for unintended pregnancy and sexual risk behaviors and other risk factors impacting reproductive, maternal, and infant health. The U.S. birth rate for teenagers aged 15-19 dropped 8% from 2010 to 2011; the preterm birth rate (less than 37 weeks) declined for the fifth straight year to 11.73% of all births (down 2% from 2010); and the U.S. infant mortality rate declined 12% from 2005 through 2011. These figures demonstrate the effectiveness of CDC's efforts toward maternal and child health surveillance and research; programs to improve women's reproductive health, pregnancy health and care; and fetal, newborn, and infant health

Figure, Birth rate among adolescent females, ages 15-19, 2009-2012¹⁰⁷



Budget Request

CDC's FY 2015 request of **\$45,589,000** for Safe Motherhood and Infant Health is level with 2014 Enacted level. Within this level, \$17,215,000 is included for Teen Pregnancy prevention. In FY 2015, the program will support national and state-based surveillance systems to monitor trends and investigate health issues; conduct

¹⁰⁵ <http://www.cdc.gov/prams/>

¹⁰⁶ <http://www.cdc.gov/art/>

¹⁰⁷ Martin JA, Hamilton BE, Osterman, JK, et al. Births: Final data for 2012- National vital statistics reports; vol 62 no 9. Hyattsville, MD: National Center for Health Statistics. 2013.

epidemiologic, behavioral, demographic, and health services research; and integrate research findings into health care practice health promotion strategies. Additionally, CDC will continue to provide direct assistance to 16 state, local, and tribal public health agencies by providing maternal and child health epidemiologists and graduate-level fellows.

Table: Public Health Activities to Support Maternal and Infant Health

Maternal and Infant Health Initiatives	Activities
<p>Monitor behaviors, health, and health care outcomes through surveillance and research</p>	<ul style="list-style-type: none"> • Fund nine states for the Sudden Unexpected Infant Death (SUID) Case Registry¹⁰⁸ to improve data collected on infant deaths and promote consistent classification and reporting of cause of death for SUID cases • Continue the National Assisted Reproductive Technology (ART) Surveillance System (NASS), collecting data from all clinics in the U.S. that use ART to treat infertility.
<p>Strengthen the science of effective reproductive health strategies</p>	<ul style="list-style-type: none"> • Fund four states for the States Monitoring ART (SMART)¹⁰⁹ collaborative that link NASS data and state vital records data to provide a more comprehensive picture of maternal and infant health outcomes post-ART treatment. • Conduct surveillance and research on deaths related to pregnancy as well as severe non-fatal pregnancy complications to identify initiatives to improve maternal health and health care. Provide epidemiologic expertise and support to state health departments, other federal agencies, and foreign Ministries of Health
<p>Improve clinical performance</p>	<ul style="list-style-type: none"> • Provide support for state-based Perinatal Quality Collaboratives to identify interventions to improve quality of maternity care and health outcomes for women and newborns. • Assess the usage and implementation of CDC’s <i>U.S. Medical Eligibility Criteria for Contraceptive Use, 2010</i>, and <i>U.S. Selected Practice Recommendations for Contraceptive Use, 2013</i> by providers of family planning services; update the guidance as needed based on new evidence • Track the utilization of services recommended in <i>Quality Family Planning Services</i> guidance (to be released 2014) and develop performance measures. • Assess and improve quality of maternity care in low-resource settings.

¹⁰⁸ <http://www.cdc.gov/sids/CaseRegistry.htm>

¹⁰⁹ <http://www.cdc.gov/art/SMART.htm>

Maternal and Infant Health Initiatives	Activities
Teen Pregnancy Prevention	<ul style="list-style-type: none"> • Conduct intervention research and surveillance to identify teens at increased risk for pregnancy and new ways to prevent teen pregnancies • Conduct evaluation in two teen pregnancy prevention communities to determine changes in youth access to preventive services and in youth abstinence and contraceptive use. • Provide scientific and programmatic guidance to ten communities to evaluate the impact of a multi-component, community level effort to reduce teen birth rates. • Provide training and education to youth service providers to implement accessible, affordable, and evidence-based reproductive health services for adolescents.

Pregnancy Risk Assessment Monitoring System (PRAMS) Grants

CDC will continue to fund 40 states and New York City, representing approximately 78% of all U.S. live births, to collect and analyze population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS helps to identify women and infants at risk for health problems, monitor access to care and services, identify changes in behavior and health status, and measure progress in improving the health of mothers and infants.

Table: Pregnancy Risk Assessment Monitoring System (PRAMS) Grant

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	41	41	41	0
- New Awards	0	0	0	0
- Continuing Awards	41	41	41	0
Average Award	\$0.143	\$0.143	\$0.143	\$0.000
Range of Awards	\$0.121-\$0.190	\$0.121-\$0.190	\$0.121-\$0.190	N/A
Total Awards	\$5.863	\$5.863	\$5.863	\$0.000

Arthritis and Other Chronic Diseases Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$24.876	\$26.806	\$26.806	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

[Arthritis](#)¹¹⁰ is the most common cause of disability in the United States, with approximately [52.5 million adults reporting diagnosed arthritis](#)¹¹¹ and 22.7 million reporting arthritis-attributable activity limitations. Arthritis is widespread among adults with heart disease (49%), diabetes (47%), and obesity (36%), and complicates managing these co-occurring diseases because of associated activity limitations. CDC's long-term program goal is to reduce pain and disability, and improve quality of life among people affected by arthritis. CDC-recommended interventions improve the quality of life of people with arthritis by increasing their ability to manage their condition, reduce pain, and increase function. To expand the reach of effective interventions, CDC works with 12 state health departments, national organizations (e.g., Arthritis Foundation, the National Association of Chronic Disease Directors, and Y-USA), and other partners (e.g., cooperative extension service programs and state/local recreation and parks associations) to embed self-management and physical activity interventions within existing systems of service and care.

[Epilepsy](#)¹¹², a chronic neurological condition, affects about 2.3 million adults and over 465,000 children 0-17 years of age resulting in an estimated \$15.5 billion in medical costs and lost productivity. CDC's Epilepsy Program works with the National Epilepsy Foundation (EF) to strengthen professional and public education about seizures and epilepsies to increase awareness, reduce stigma, and enhance care and safety for people with epilepsy. For example, in 2012 the EF reached 16,751 middle and high school students and teachers through the Seizures and Youth: Take Charge programs; trained 1,212 staff in Adult Day Programs to enhance staff's recognition of seizures in older adults; and trained almost 2,000 childcare personnel who work in child day care centers. CDC supports the [Managing Epilepsy Well Network](#)¹¹³, through the CDC-funded Prevention Research Centers, to conduct innovative research for epilepsy self-management. For example, the first evidence-based online epilepsy self-management program ([WebEASE](#))¹¹⁴ is now available at no cost on the EF website. CDC also conducts studies to better understand who epilepsy impacts. In 2013, CDC published a [study](#)¹¹⁵ which found that adults with epilepsy reported co-occurring cardiovascular, respiratory, some inflammatory, and other disorders more frequently than respondents without epilepsy.

[Lupus](#) is a rheumatic autoimmune disease that can cause inflammation and tissue damage to virtually any organ system in the body and result in serious disability, pain, and premature death. Lupus affects women far more than men and, unlike other autoimmune diseases, affects African Americans far more than whites. Because lupus is difficult to diagnose, its severity and corresponding burden on society has been extremely difficult to estimate. CDC-funded population-based lupus registries in Georgia and Michigan published results in 2013 that describe for the first time lupus cases from two comparable urban populations.

¹¹⁰ <http://www.cdc.gov/arthritis/>

¹¹¹ http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6244a1.htm?s_cid=mm6244a1_w

¹¹² <http://www.cdc.gov/epilepsy/index.htm>

¹¹³ <http://web1.sph.emory.edu/ManagingEpilepsyWell/>

¹¹⁴ <http://www.epilepsyfoundation.org/livingwithepilepsy/Webease/index.cfm>

¹¹⁵ http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6243a2.htm?s_cid=mm6243a2_w

Budget Request

CDC’s FY 2015 request of **\$26,806,000** for Arthritis and Other Chronic Diseases is level with the FY 2014 Enacted level.

In 2015, CDC’s will address the burden of Arthritis and Other Conditions by doing the following:

- Increasing access and availability of evidence-based interventions
- Conducting surveillance to measure burden
- Strengthening the science base of effective strategies
- Increasing awareness and promoting health equity

Table: Public Health activities to support Arthritis and Other Chronic Conditions.

Activities	Examples
Access and availability of effective interventions	<p><u>Arthritis</u>: Fund 12 states and work with national organizations and other partners to expand access to proven arthritis physical activity and self-management interventions.</p> <p><u>Epilepsy</u>: Fund Epilepsy Foundation to expand access to effective interventions.</p>
Surveillance and epidemiological studies	<p><u>Arthritis</u>: Support surveillance and analysis of arthritis and arthritis-attributable activity limitations and its impacts.</p> <p><u>Lupus</u>: Fund the completion of population-based registries in CA, NY, and the Indian Health Service to estimate lupus among Hispanics, Asians, and American Indians/Alaska Natives. Fund follow-up studies on treatment, healthcare access, and factors associated with outcomes.</p> <p><u>Epilepsy</u>: Support studies to define epilepsy incidence and prevalence in various populations.</p>
Strengthen the science of effective strategies	<p><u>Arthritis</u>: Support research for new and adapted effective arthritis self-management and physical activity interventions.</p> <p><u>Epilepsy</u>: Fund the Managing Epilepsy Well Network to conduct research that promotes self-management and improved quality of life using innovative methods to overcome transportation and stigma barriers.</p>
Awareness and health equity	<p><u>Epilepsy</u>: Fund Epilepsy Foundation to develop and implement programs to enhance public awareness and promote partnerships, education, and communication at local and national levels, including a focus on underserved populations.</p>

CDC will work closely with grantees to improve and increase self-management attitudes and behaviors among persons with arthritis. CDC’s Arthritis Program awards funds to 12 state health departments to expand access to proven arthritis interventions. Specifically, the competitive five-year cooperative agreements (FY 2012–FY 2016) require grantees to embed arthritis interventions that also benefit other chronic conditions, such as the [Chronic Disease Self-Management Program](#)¹¹⁶ and [EnhanceFitness](#)¹¹⁷, in health care and community delivery systems. At the end of this project period, CDC expects grantees to reach over 450,000 individuals with arthritis-appropriate, evidenced-based programs and strategies, conduct surveillance and use data to inform priority setting and

¹¹⁶ <http://patienteducation.stanford.edu/programs/cdsmp.html>

¹¹⁷ <http://www.projectenhance.org/enhancefitness.aspx>

decision making, and implement health communications campaigns. CDC will continue to work with national arthritis grantees, such as the Arthritis Foundation and the National Association of Chronic Disease Directors to make physical activity and self-management education interventions more accessible.

Tables: Arthritis State Grant

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	12	12	12	0
- New Awards	0	0	0	0
- Continuing Awards	12	12	12	0
Average Award	\$0.405	\$0.425	\$0.425	\$0.000
Range of Awards	\$0.200–\$0.500	\$0.200–\$0.500	\$0.200–\$0.500	N/A
Total Awards	\$4.869	\$5.100	\$5.100	\$0.000

In FY 2013, CDC funded California, Michigan, and New York City for lupus surveillance activities through competitive cooperative agreements. CDC plans to fund lupus surveillance in three sites in FY 2014 and 2015 to focus on identifying disparities in lupus among specific populations, including Hispanics, Asians, American Indians/Alaska Natives, and African Americans. Follow-up cohort studies are expected to add to the understanding of the natural history of lupus, risk factors, and treatment.

Table: Lupus Grant

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	3	3	3	0
- New Awards	0	2	0	-2
- Continuing Awards	3	1	3	+2
Average Award	\$1.075	\$0.800	\$0.800	\$0.000
Range of Awards	\$0.750–\$1.238	\$0.400–\$1.800	\$0.400–\$1.800	N/A
Total Awards	\$3.227	\$2.400	\$2.400	\$0.000

Community Grants

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$14.204	\$101.005	\$80.000	-\$21.005
ACA/PPHF	\$146.340	\$30.000	\$0.000	-\$30.000
Total	\$160.544	\$131.005	\$80.000	-\$51.005
Partnerships to Improve Community Health	\$0.000	\$80.000	\$80.000	\$0.000
Racial and Ethnic Approaches to Community Health ACA/PPHF (non-add)	\$14.204	\$51.005	\$0.000	-\$51.005
Community Transformation Grants (ACA/PPHF)	\$0.000	\$30.000	\$0.000	-\$30.000
	\$146.340	\$0.000	\$0.000	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Community-approaches play an important role in improving health and wellness as they are designed to reach the greatest number of people outside of traditional health care venues. Settings, such as schools, worksites, and communities, provide opportunities to reach people through existing structures and maximize impact as people often have high levels of contact across these settings. A community approach to healthy living can have far-reaching effects above and beyond the efforts of individuals working on their own to make healthy changes and improve health outcomes. CDC’s Partnerships to Improve Community Health is a new community-based chronic disease prevention initiative designed to strengthen community-level health efforts throughout the nation and to help communities prevent death and disability and promote healthy living. The Partnerships to Improve Community Health program supports local communities in implementing evidence-based interventions and innovative promising practices to achieve the critical local changes necessary to prevent chronic diseases and their risk factors. The program mobilizes community leadership and resources to bring change to the places and organizations that touch people’s lives every day – at work sites, schools, community centers, and health care settings – to reduce the burden of chronic disease. Special emphasis is directed toward populations that bear a disproportionate burden of disease and lack of access to preventive services.

Budget Request

CDC's FY 2015 request of **\$80,000,000** for Community Grants is \$51,005,000 below the FY 2014 Enacted level. In FY 2015, CDC will continue to support the Partnerships to Improve Community Health program, initiated in FY 2014. The FY 2015 budget request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program. The Partnerships to Improve Community Health Program will build on past program successes and lessons learned from CDC’s community-based programs. This effort will also adopt best practices and lessons learned from the REACH program into its strategy in program planning and implementation.

Through the new Partnerships to Improve Community Health program CDC will fund a mix of urban, rural, and tribal communities to: 1) develop and implement effective models for local action in communities, worksites, schools, and health care; 2) work collaboratively with partners to improve and increase access to quality preventive health services; 3) mentor other communities that want to take action and replicate successful strategies; and 4) support the elimination of racial and ethnic health disparities. In addition, CDC will fund selected national organizations, which will provide support to communities in the form of technical assistance, provision of linkages to resources such as national experts and nontraditional partners, leadership in community evaluation methods, and sustainability planning.

Table: Partnerships to Improve Community Health Program

(dollars in millions)	FY 2013 Enacted¹	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	0	TBD	TBD	N/A
- New Awards	0	0	0	0
- Continuing Awards	0	0	0	0
Average Award	\$0.000	TBD	TBD	N/A
Range of Awards	\$0.000	TBD	TBD	N/A
Total Awards	\$0.000	\$68.000	\$68.000	\$0.000

Affordable Care Act Prevention and Public Health Fund

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
ACA/PPHF	\$233.033	\$446.000	\$469.704	+\$23.704

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

The following activities are included:

- Tobacco Campaign and Quitlines, \$105,000,000 (included in the Tobacco Prevention and Control narrative)
- Nutrition, Physical Activity and Obesity, \$4,000,000 (included in the Nutrition, Physical Activity and Obesity narrative)
- Cancer Prevention and Control, \$169,204,000 (included in the Cancer Prevention and Control narrative)
- Cancer Screening Demonstration, \$10,000,000 (Included in the Cancer Prevention and Control narrative)
- Million Hearts™®, \$4,000,000
- Prevention Resource Centers, \$25,000,000 (included in the Prevention Resource Centers narrative)
- Heart Disease and Stroke Prevention, \$73,000,000 (included in the Heart Disease and Stroke narrative)
- Diabetes Prevention, \$73,000,000 (included in the Diabetes narrative)
- Healthy Weight Task Force/Early Child Care Collaboratives, \$4,000,000
- Hospitals Promoting Breastfeeding, \$2,500,000

Million Hearts®

Million Hearts® is a national, public-private initiative to prevent one million heart attacks and strokes by 2017. Co-led by CDC and the Centers for Medicare & Medicaid Services, the initiative brings together communities, health care professionals, health systems, nonprofit organizations, federal agencies, and other public and private-sector partners to improve care and empower Americans to make heart-healthy choices. The initiative will result in:

- [Improved performance on the “ABCS” of clinical prevention](#) – Aspirin when appropriate, blood pressure control, cholesterol management and smoking cessation – to prevent heart attacks and strokes. Reduced number of people needing medical treatment.
- [Preventing heart attacks and strokes by making healthy living easier](#) — Preventing or quitting tobacco use and reducing salt (sodium) and trans fat consumption.
- Reduced health disparities in the rates of those who experience cardiovascular disease.

In FY 2013, Million Hearts® developed [sample evidence-based treatment protocols for improving blood pressure control, including customizable protocols](#)¹¹⁸, for practices and health care systems to select from when caring for patients. In FY 2014, Million Hearts® focused on deploying the full potential of Electronic Health Records for improved identification of hypertension. CDC’s FY 2015 request includes \$4,000,000 in Prevention and Public Health Fund investments to support Million Hearts®. These investments will support selected heart disease and stroke prevention activities within the Million Hearts® initiative that directly complement state and local heart disease and stroke prevention activities.

¹¹⁸ <http://millionhearts.hhs.gov/resources/protocols.html>

Healthy Weight Task Force Activities/Early Child Care Collaboratives

Childhood obesity has more than tripled in the past 30 years, putting our nation's youth at immediate and long-term risk for developing costly, preventable chronic diseases, and early morbidity. Many of the nation's children are already obese by the time they enter kindergarten. Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure, and to experience more severe forms of obesity as adults.

The FY 2015 budget request includes \$4,000,000 from PPHF to continue CDC support for the Let's Move Child Care Initiative. CDC will continue to fund Early Child Care Collaboratives, with a special focus on six states (Arizona, Florida, Indiana, Kansas, Missouri, and New Jersey) to bring together teams of child care providers and support them with technical assistance, tools, materials, and resources for obesity prevention. Through these efforts more than 10,000 child care professionals and organizations have registered to implement new criteria for nutrition, physical activity and limited screen time.

Hospitals Promoting Breastfeeding

Breastfeeding significantly reduces health risks for infants, which in turn improves child health and reduces medical care needs and health care costs. The medical care needs for non-breastfed infants are greater than those of their breastfed counterparts. Suboptimal breastfeeding rates cost the country at least \$13 billion annually, including at least \$2.2 billion in avoidable direct medical costs and \$1.2 billion in indirect medical costs.

Supporting breastfeeding is a key CDC strategy for improving the health of mothers and infants. CDC is committed to supporting women who choose to breastfeed by supporting recommended breastfeeding practices within hospitals, early care and education, and other community settings.

In FY 2015, Hospitals Promoting Breastfeeding program plans to support a new funding opportunity to provide decentralized technical assistance through multiple organizations to assist hospitals in improving maternity care practices in their locales. This decentralized model will focus on overcoming local, state, and regional barriers to breastfeeding and will capitalize on local knowledge, experiences, and challenges in a way that cannot be accomplished by a single national entity. CDC also continues to support breastfeeding as a strategy to reduce obesity and funds activities proven to increase breastfeeding through the State Public Health Actions to Prevent Chronic Disease and The Partnerships to Improve Community Health grant programs.

State Table: National Breast and Cervical Cancer Early Detection Program¹¹⁹

	FY 2013 Final¹	FY 2014 Enacted	FY 2015¹²⁰ President Budget	Difference +/-2014
Alabama	\$2,945,926	\$2,945,926	TBD	TBD
Alaska	\$2,076,013	\$2,076,013	TBD	TBD
Arizona	\$2,269,965	\$2,269,965	TBD	TBD
Arkansas	\$2,444,457	\$2,444,457	TBD	TBD
California	\$6,818,539	\$6,818,539	TBD	TBD
Colorado	\$3,571,086	\$3,571,086	TBD	TBD
Connecticut	\$1,120,601	\$1,120,601	TBD	TBD
Delaware	\$1,007,872	\$1,007,872	TBD	TBD
Florida	\$4,732,416	\$4,732,416	TBD	TBD
Georgia	\$4,071,850	\$4,071,850	TBD	TBD
Hawaii	\$1,118,641	\$1,118,641	TBD	TBD
Idaho	\$1,724,478	\$1,724,478	TBD	TBD
Illinois	\$5,972,943	\$5,972,943	TBD	TBD
Indiana	\$1,919,000	\$1,919,000	TBD	TBD
Iowa	\$2,474,019	\$2,474,019	TBD	TBD
Kansas	\$2,201,895	\$2,201,895	TBD	TBD
Kentucky	\$2,598,592	\$2,598,592	TBD	TBD
Louisiana	\$1,678,892	\$1,678,892	TBD	TBD
Maine	\$1,591,330	\$1,591,330	TBD	TBD
Maryland	\$4,266,212	\$4,266,212	TBD	TBD
Massachusetts	\$2,040,026	\$2,040,026	TBD	TBD
Michigan	\$8,171,969	\$8,171,969	TBD	TBD
Minnesota	\$4,233,087	\$4,233,087	TBD	TBD
Mississippi	\$2,082,015	\$2,082,015	TBD	TBD
Missouri	\$2,730,904	\$2,730,904	TBD	TBD
Montana	\$2,102,711	\$2,102,711	TBD	TBD
Nebraska	\$2,681,281	\$2,681,281	TBD	TBD
Nevada	\$2,216,255	\$2,216,255	TBD	TBD
New Hampshire	\$1,424,957	\$1,424,957	TBD	TBD
New Jersey	\$2,748,306	\$2,748,306	TBD	TBD
New Mexico	\$3,075,255	\$3,075,255	TBD	TBD
New York	\$7,773,586	\$7,773,586	TBD	TBD
North Carolina	\$3,173,127	\$3,173,127	TBD	TBD
North Dakota	\$1,280,300	\$1,280,300	TBD	TBD
Ohio	\$4,138,701	\$4,138,701	TBD	TBD
Oklahoma	\$1,190,779	\$1,190,779	TBD	TBD
Oregon	\$2,138,227	\$2,138,227	TBD	TBD
Pennsylvania	\$2,548,819	\$2,548,819	TBD	TBD
Rhode Island	\$1,451,878	\$1,451,878	TBD	TBD
South Carolina	\$2,952,918	\$2,952,918	TBD	TBD
South Dakota	\$811,626	\$811,626	TBD	TBD
Tennessee	\$1,187,135	\$1,187,135	TBD	TBD
Texas	\$6,205,712	\$6,205,712	TBD	TBD
Utah	\$2,110,225	\$2,110,225	TBD	TBD
Vermont	\$817,292	\$817,292	TBD	TBD
Virginia	\$2,474,054	\$2,474,054	TBD	TBD
Washington	\$4,121,807	\$4,121,807	TBD	TBD
West Virginia	\$3,929,089	\$3,929,089	TBD	TBD

¹¹⁹ CFDA NUMBER: 93.919, DISCRETIONARY

¹²⁰ Specific FY 2015 state grant award amounts are unavailable at this time.

	FY 2013 Final¹	FY 2014 Enacted	FY 2015¹²⁰ President Budget	Difference +/-2014
Wisconsin	\$3,000,110	\$3,000,110	TBD	TBD
Wyoming	\$683,086	\$683,086	TBD	TBD
Territories				
American Samoa	\$238,338	\$238,338	TBD	TBD
Guam	\$392,683	\$392,683	TBD	TBD
Northern Mariana Islands	\$242,699	\$242,699	TBD	TBD
Palau	\$561,500	\$561,500	TBD	TBD
Other Grantees				
Indian Tribes	\$7,066,152	\$7,066,152	TBD	TBD
University of Puerto Rico	\$329,868	\$329,868	TBD	TBD
Washington, D.C.	\$509,816	\$509,816	TBD	TBD
Subtotal, States	\$142,099,964	\$142,099,964	TBD	TBD
Subtotal, Territories	\$1,435,220	\$1,435,220	TBD	TBD
Subtotal, Other Grantees	\$7,905,836	\$7,905,836	TBD	TBD
Total	\$151,441,020	\$151,441,020	TBD	TBD

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

State Table: National Comprehensive Cancer Control Program¹²¹

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$297,420	\$297,420	\$297,420	\$0
Alaska	\$332,865	\$332,865	\$332,865	\$0
Arizona	\$268,941	\$268,941	\$268,941	\$0
Arkansas	\$294,093	\$294,093	\$294,093	\$0
California	\$0	\$0	\$0	\$0
Colorado	\$438,765	\$438,765	\$438,765	\$0
Connecticut	\$212,355	\$212,355	\$212,355	\$0
Delaware	\$266,622	\$266,622	\$266,622	\$0
Florida	\$367,457	\$367,457	\$367,457	\$0
Georgia	\$244,348	\$244,348	\$244,348	\$0
Hawaii	\$245,611	\$245,611	\$245,611	\$0
Idaho	\$294,116	\$294,116	\$294,116	\$0
Illinois	\$222,057	\$222,057	\$222,057	\$0
Indiana	\$252,450	\$252,450	\$252,450	\$0
Iowa	\$501,647	\$501,647	\$501,647	\$0
Kansas	\$341,701	\$341,701	\$341,701	\$0
Kentucky	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0
Maine	\$391,899	\$391,899	\$391,899	\$0
Maryland	\$249,854	\$249,854	\$249,854	\$0
Massachusetts	\$721,953	\$721,953	\$721,953	\$0
Michigan	\$714,480	\$714,480	\$714,480	\$0
Minnesota	\$468,878	\$468,878	\$468,878	\$0
Mississippi	\$234,300	\$234,300	\$234,300	\$0
Missouri	\$251,107	\$251,107	\$251,107	\$0
Montana	\$306,344	\$306,344	\$306,344	\$0
Nebraska	\$338,877	\$338,877	\$338,877	\$0
Nevada	\$252,450	\$252,450	\$252,450	\$0
New Hampshire	\$258,919	\$258,919	\$258,919	\$0
New Jersey	\$445,677	\$445,677	\$445,677	\$0
New Mexico	\$327,964	\$327,964	\$327,964	\$0
New York	\$613,011	\$613,011	\$613,011	\$0
North Carolina	\$719,497	\$719,497	\$719,497	\$0
North Dakota	\$335,100	\$335,100	\$335,100	\$0
Ohio	\$425,168	\$425,168	\$425,168	\$0
Oklahoma	\$198,000	\$198,000	\$198,000	\$0
Oregon	\$499,807	\$499,807	\$499,807	\$0
Pennsylvania	\$530,605	\$530,605	\$530,605	\$0
Rhode Island	\$311,098	\$311,098	\$311,098	\$0
South Carolina	\$292,380	\$292,380	\$292,380	\$0
South Dakota	\$234,001	\$234,001	\$234,001	\$0
Tennessee	\$303,272	\$303,272	\$303,272	\$0
Texas	\$422,463	\$422,463	\$422,463	\$0
Utah	\$551,752	\$551,752	\$551,752	\$0
Vermont	\$255,033	\$255,033	\$255,033	\$0
Virginia	\$229,383	\$229,383	\$229,383	\$0
Washington	\$568,659	\$568,659	\$568,659	\$0
West Virginia	\$294,254	\$294,254	\$294,254	\$0

¹²¹ CFDA NUMBER: 93.283, Discretionary

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Wisconsin	\$267,247	\$267,247	\$267,247	\$0
Wyoming	\$252,608	\$252,608	\$252,608	\$0
Washington, D.C.	\$198,000	\$198,000	\$198,000	\$0
University of Kentucky	\$426,615	\$426,615	\$426,615	\$0
Louisiana State University	\$415,525	\$415,525	\$415,525	\$0
CA Public Health Institute	\$533,189	\$533,189	\$533,189	\$0
Indian Tribes	\$1,896,458	\$1,896,458	\$1,896,458	\$0
American Samoa	\$198,000	\$198,000	\$198,000	\$0
Guam	\$247,500	\$247,500	\$247,500	\$0
Marshall Islands	\$198,000	\$198,000	\$198,000	\$0
Micronesia	\$497,781	\$497,781	\$497,781	\$0
Northern Mariana Islands	\$195,000	\$195,000	\$195,000	\$0
Palau	\$197,913	\$197,913	\$197,913	\$0
Puerto Rico	\$0	\$0	\$0	\$0
University of Puerto Rico	\$207,900	\$207,900	\$207,900	\$0
Virgin Islands	\$0	\$0	\$0	\$0
Total	\$22,058,387	\$22,058,387	\$22,058,387	\$0

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

State Table: State Public Health Approaches to Chronic Disease Prevention Program

	FY 2013 Enacted Diabetes Prevention and Control Program¹	FY 2013 Enacted Nutrition, Physical Activity, Obesity Program²	FY 2013 Enacted Heart Disease and Stroke Prevention Program³	FY 2013 Enacted School Health Program⁴
Alabama	\$182,399	\$147,450	\$205,860	\$60,508
Alaska	\$153,909	\$124,419	\$173,706	\$51,057
Arizona	\$544,977	\$471,939	\$685,588	\$213,368
Arkansas	\$566,884	\$423,934	\$512,904	\$205,775
California	\$816,952	\$607,602	\$726,810	\$298,274
Colorado	\$516,924	\$425,211	\$631,449	\$144,757
Connecticut	\$440,874	\$381,505	\$553,992	\$172,317
Delaware	\$154,166	\$124,627	\$173,996	\$51,142
Florida	\$650,762	\$535,592	\$796,828	\$181,186
Georgia	\$194,514	\$157,244	\$219,534	\$64,526
Hawaii	\$154,786	\$125,128	\$174,695	\$51,347
Idaho	\$547,166	\$376,450	\$453,521	\$129,730
Illinois	\$170,021	\$137,444	\$191,891	\$56,401
Indiana	\$509,656	\$442,863	\$644,549	\$201,108
Iowa	\$510,446	\$380,950	\$458,967	\$185,689
Kansas	\$524,915	\$391,328	\$470,419	\$191,172
Kentucky	\$485,689	\$419,303	\$608,097	\$188,813
Louisiana	\$188,186	\$152,128	\$212,391	\$62,427
Maine	\$452,462	\$372,101	\$552,439	\$127,264
Maryland	\$491,047	\$426,250	\$620,020	\$193,305
Massachusetts	\$519,376	\$427,063	\$633,372	\$146,039
Michigan	\$555,405	\$483,507	\$704,407	\$220,085
Minnesota	\$490,406	\$425,732	\$619,296	\$193,093
Mississippi	\$496,070	\$428,218	\$620,989	\$192,800
Missouri	\$503,088	\$437,029	\$635,959	\$198,386
Montana	\$449,250	\$389,322	\$565,794	\$176,182
Nebraska	\$461,989	\$379,644	\$561,863	\$130,753
Nevada	\$156,573	\$126,573	\$176,713	\$51,940
New Hampshire	\$154,711	\$125,067	\$174,611	\$51,322
New Jersey	\$693,533	\$471,792	\$561,498	\$160,221
New Mexico	\$186,424	\$150,704	\$210,404	\$61,843
New York	\$657,801	\$541,408	\$805,614	\$183,052
North Carolina	\$586,621	\$509,266	\$740,816	\$230,984
North Dakota	\$153,870	\$124,387	\$173,662	\$51,044
Ohio	\$168,266	\$136,025	\$189,909	\$55,819
Oklahoma	\$157,989	\$127,717	\$178,311	\$52,410
Oregon	\$563,017	\$387,110	\$466,048	\$133,295
Pennsylvania	\$636,115	\$523,622	\$779,454	\$176,796
Rhode Island	\$467,328	\$384,087	\$568,731	\$132,055
South Carolina	\$672,334	\$461,598	\$554,856	\$158,646
South Dakota	\$154,056	\$124,538	\$173,872	\$51,105
Tennessee	\$674,395	\$463,275	\$557,211	\$159,339
Texas	\$214,301	\$173,239	\$241,866	\$71,090
Utah	\$439,861	\$380,687	\$552,849	\$171,981
Vermont	\$153,794	\$124,326	\$173,576	\$51,018
Virginia	\$541,247	\$471,016	\$686,079	\$214,303
Washington	\$545,467	\$474,951	\$692,017	\$216,246
West Virginia	\$181,187	\$146,470	\$204,493	\$60,105

	FY 2013 Enacted Diabetes Prevention and Control Program¹	FY 2013 Enacted Nutrition, Physical Activity, Obesity Program²	FY 2013 Enacted Heart Disease and Stroke Prevention Program³	FY 2013 Enacted School Health Program⁴
Wisconsin	\$496,791	\$431,417	\$627,678	\$195,754
Wyoming	\$139,011	\$112,375	\$156,891	\$46,114
Washington, D.C.	\$183,232	\$148,123	\$206,800	\$60,784
Indian Tribes	\$0	\$0	\$0	\$245,620
Total	\$20,710,241	\$16,713,756	\$ 23,263,294	\$6,884,772

¹ CFDA# 93.988

² CFDA # 93.945

³ CFDA# 93.283

⁴ CFDA# 93.938

At the time of publication, individual state award amounts were being finalized. As a result, there may be some variability. However, the aggregate categorical allocation for state awards will match the totals reflected above.

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

State Table: Tobacco Prevention and Control Program¹²²

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$1,325,680	\$1,325,680	\$1,325,680	\$0
Alaska	\$1,155,593	\$1,155,593	\$1,155,593	\$0
Arizona	\$1,260,271	\$1,260,271	\$1,260,271	\$0
Arkansas	\$1,104,566	\$1,104,566	\$1,104,566	\$0
California	\$1,515,182	\$1,515,182	\$1,515,182	\$0
Colorado	\$1,096,773	\$1,096,773	\$1,096,773	\$0
Connecticut	\$1,015,072	\$1,015,072	\$1,015,072	\$0
Delaware	\$645,173	\$645,173	\$645,173	\$0
Florida	\$1,634,732	\$1,634,732	\$1,634,732	\$0
Georgia	\$1,093,243	\$1,093,243	\$1,093,243	\$0
Hawaii	\$824,956	\$824,956	\$824,956	\$0
Idaho	\$1,141,438	\$1,141,438	\$1,141,438	\$0
Illinois	\$1,180,546	\$1,180,546	\$1,180,546	\$0
Indiana	\$748,800	\$748,800	\$748,800	\$0
Iowa	\$931,380	\$931,380	\$931,380	\$0
Kansas	\$1,245,400	\$1,245,400	\$1,245,400	\$0
Kentucky	\$1,082,573	\$1,082,573	\$1,082,573	\$0
Louisiana	\$932,083	\$932,083	\$932,083	\$0
Maine	\$761,510	\$761,510	\$761,510	\$0
Maryland	\$1,202,815	\$1,202,815	\$1,202,815	\$0
Massachusetts	\$1,558,516	\$1,558,516	\$1,558,516	\$0
Michigan	\$1,665,557	\$1,665,557	\$1,665,557	\$0
Minnesota	\$609,262	\$609,262	\$609,262	\$0
Mississippi	\$1,020,824	\$1,020,824	\$1,020,824	\$0
Missouri	\$1,130,441	\$1,130,441	\$1,130,441	\$0
Montana	\$963,235	\$963,235	\$963,235	\$0
Nebraska	\$1,236,506	\$1,236,506	\$1,236,506	\$0
Nevada	\$857,913	\$857,913	\$857,913	\$0
New Hampshire	\$943,733	\$943,733	\$943,733	\$0
New Jersey	\$1,257,333	\$1,257,333	\$1,257,333	\$0
New Mexico	\$1,081,221	\$1,081,221	\$1,081,221	\$0
New York	\$1,315,958	\$1,315,958	\$1,315,958	\$0
North Carolina	\$1,669,808	\$1,669,808	\$1,669,808	\$0
North Dakota	\$1,155,818	\$1,155,818	\$1,155,818	\$0
Ohio	\$1,166,009	\$1,166,009	\$1,166,009	\$0
Oklahoma	\$1,315,958	\$1,315,958	\$1,315,958	\$0
Oregon	\$1,094,341	\$1,094,341	\$1,094,341	\$0
Pennsylvania	\$1,288,278	\$1,288,278	\$1,288,278	\$0
Rhode Island	\$992,666	\$992,666	\$992,666	\$0
South Carolina	\$1,192,781	\$1,192,781	\$1,192,781	\$0
South Dakota	\$963,055	\$963,055	\$963,055	\$0
Tennessee	\$1,240,862	\$1,240,862	\$1,240,862	\$0
Texas	\$1,846,957	\$1,846,957	\$1,846,957	\$0
Utah	\$1,215,563	\$1,215,563	\$1,215,563	\$0
Vermont	\$1,063,990	\$1,063,990	\$1,063,990	\$0
Virginia	\$870,707	\$870,707	\$870,707	\$0
Washington	\$1,381,885	\$1,381,885	\$1,381,885	\$0
West Virginia	\$1,165,999	\$1,165,999	\$1,165,999	\$0

¹²² CFDA NUMBER: 93.919, Discretionary

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Wisconsin	\$1,141,878	\$1,141,878	\$1,141,878	\$0
Wyoming	\$962,213	\$962,213	\$962,213	\$0
Indian Tribes	\$1,865,338	\$1,865,338	\$1,865,338	\$0
American Samoa	\$139,305	\$139,305	\$139,305	\$0
Guam	\$206,570	\$206,570	\$206,570	\$0
Marshall Islands	\$100,000	\$100,000	\$100,000	\$0
Micronesia	\$211,403	\$211,403	\$211,403	\$0
Northern Mariana Islands	\$148,650	\$148,650	\$148,650	\$0
Palau	\$131,470	\$131,470	\$131,470	\$0
Puerto Rico	\$404,331	\$404,331	\$404,331	\$0
Virgin Islands	\$201,990	\$201,990	\$201,990	\$0
Washington, D.C.	\$530,517	\$530,517	\$530,517	\$0
Total	\$61,217,509	\$61,217,509	\$61,217,509	\$0

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

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITIES AND HEALTH

(dollars in millions)

	FY 2013 Final ^{1,2}	FY 2014 Enacted ²	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$133.539	\$132.337	\$61.541	-\$70.796
ACA/PPHF	\$0.000	\$0.000	\$70.796	+\$70.796
Total Request	\$133.539	\$132.337	\$132.337	\$0.000
FTEs	231	231	211	0
Child Health and Development	\$63.580	\$64.366	\$64.366	\$0.000
- Budget Authority	\$63.580	\$64.366	\$46.932	-\$17.434
- ACA/PPHF	\$0.000	\$0.000	\$17.434	+\$17.434
Health and Development for People with Disabilities	\$50.603	\$53.362	\$53.362	\$0.000
- Budget Authority	\$50.603	\$53.362	\$0.000	-\$53.362
- ACA/PPHF	\$0.000	\$0.000	\$53.362	+\$53.362
Public Health Approach to Blood Disorders (BA)³	<i>\$19.356</i>	<i>\$14.609</i>	<i>\$14.609</i>	<i>\$0.000</i>
Public Health Approach to Blood Disorders (BA)	\$0.000	\$4.000	\$4.000	\$0.000
Hemophilia (BA)	\$17.249	\$3.504	\$3.504	\$0.000
Hemophilia Treatment Centers (BA)	\$0.000	\$5.000	\$5.000	\$0.000
Thalassemia (BA)	\$1.863	\$2.105	\$2.105	\$0.000
All Other Blood Disorders⁴	<i>\$0.244</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and 2014 PB Disabilities and Health line has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

³ In FY 2013, Public Health Approach to Blood Disorders included Hemophilia and Thalassemia.

⁴ In FY 2013 All Other Blood Disorders line has been added to accurately display the sum of the funding history

Summary

CDC's FY 2015 request of **\$132,337,000** for [Birth Defects, Developmental Disabilities, Disabilities and Health](#)¹²³ is level with the FY 2014 Enacted level and reflects the transfer of the Paralysis Resource Center to the Administration for Community Living (ACL) in FY 2014.

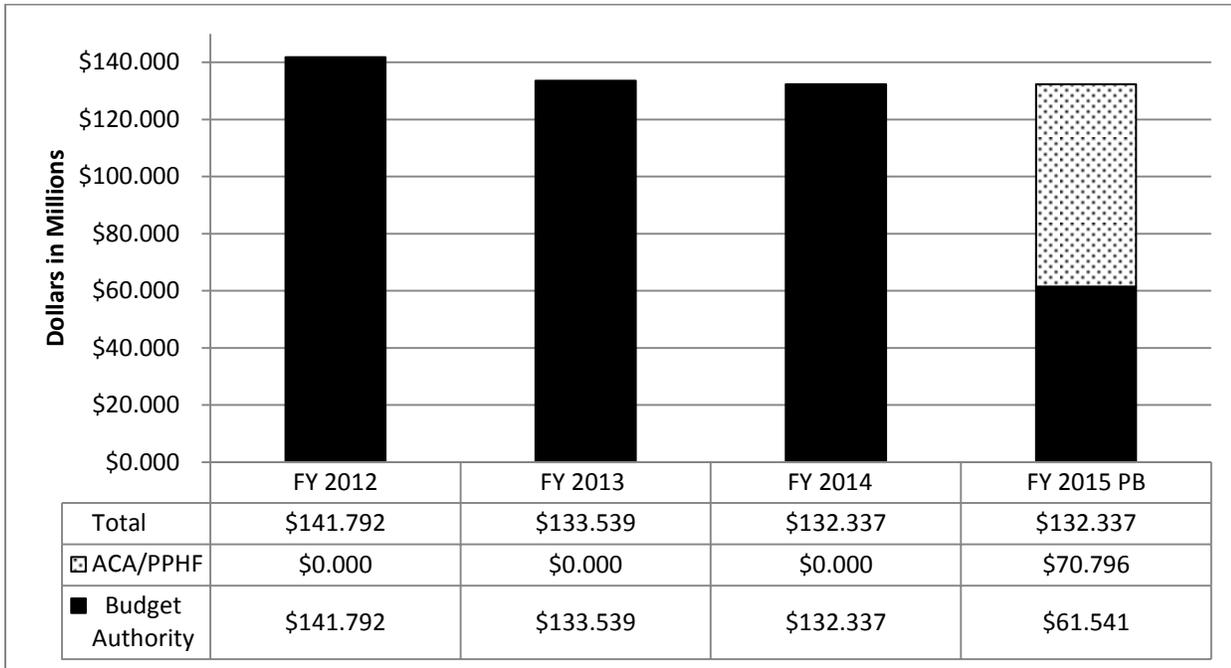
CDC programs enhance the potential for full, productive living for a large and diverse segment of the American public:

- 1 in 33 babies born with a major birth defect
- 56 million Americans with disabilities
- 1 in 6 children with developmental disabilities
- Thousands of people affected by blood disorders like sickle cell disease and hemophilia

These activities further CDC's mission of preventing the leading causes of disease, disability, and death, and promoting the health of people of all ages. CDC is measuring the impact of birth defects, disabilities, and blood disorders using cutting-edge surveillance, research, and science. Then, CDC puts these research findings and recommendations into public health action to foster a safer, healthier population. Through this essential work, CDC is preventing these conditions where possible and enhancing the health and quality of life for individuals who live with them.

¹²³ <http://www.cdc.gov/ncbddd/index.html>

Figure: Birth Defects and Developmental Disabilities Funding History^{1,2}



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 Disabilities and Health line has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

Child Health and Development Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$63.580	\$64.366	\$46.932	-\$17.434
Autism (non-add)	\$21.665	\$23.031	\$23.031	\$0.000
ACA/PPHF	\$0.000	\$0.000	\$17.434	+\$17.434
Total	\$63.580	\$64.366	\$64.366	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Birth defects are common, costly, and critical. They include conditions like fetal alcohol spectrum disorders, spina bifida and other neural tube defects, congenital heart defects, and craniofacial defects. Developmental disabilities (including autism, cerebral palsy, and other conditions) involve an impairment in physical, learning, language, or behavioral areas. CDC's core activities in child health and development employ surveillance and science to understand the characteristics of birth defects and developmental disabilities and then use these findings to inform actions to prevent them and enhance the health of people affected by them:

- [State-based birth defects surveillance](#)¹²⁴, intervention, and prevention programs are working to understand more about the characteristics and prevalence of birth defects and fetal deaths
- [National Birth Defects Prevention Network](#)¹²⁵, a national network of state and population-based birth defects programs, focuses on understanding factors that may lead to birth defects, identifying strategies for reducing birth defects, and working to prevent potential secondary disabilities
- [Centers for Birth Defects Research and Prevention](#)¹²⁶, which collaborated on the National Birth Defects Prevention Study and began collaborating on the Birth Defects Study to Evaluate Pregnancy exposures (BD-STEPS) in late 2013, are investigating risk factors for birth defects as the first step toward preventing them and reducing their effects
- [Autism and Developmental Disabilities Monitoring \(ADDM\) Network](#)¹²⁷ is studying the number and characteristics of children with autism at different points in time and among different groups to guide research into potential risk factors and to help communities strategically direct outreach
- [Study to Explore Early Development \(SEED\)](#)¹²⁸, the largest study of its kind in the United States, is identifying factors that may put children at risk for autism and other developmental disabilities

Budget Request

CDC's FY 2015 request of **\$64,366,000** for Child Health and Development is level with the FY 2014 Enacted level. These funds will enable CDC to continue monitoring birth defects and developmental disabilities, uncovering their causes and modifiable risk factors, and turning these findings into real-world practice and prevention strategies.

CDC's continuing work will focus on eight main areas: birth defects, congenital heart defects, fetal death, fetal alcohol spectrum disorders, folic acid, spina bifida, infant health, and autism.

¹²⁴ <http://www.cdc.gov/ncbddd/birthdefects/research.html>

¹²⁵ <http://www.cdc.gov/ncbddd/birthdefects/research.html>

¹²⁶ <http://www.cdc.gov/ncbddd/birthdefects/research.html>

¹²⁷ <http://www.cdc.gov/ncbddd/autism/addm.html>

¹²⁸ <http://www.cdc.gov/ncbddd/autism/seed.html>

Birth Defects

Every 4.5 minutes, a baby is born with a [birth defect](#)¹²⁹ in the United States. Major birth defects are responsible for an estimated \$2.6 billion in hospitalization costs each year. In FY 2015, CDC will invest in state and local programs that gather data needed to understand how birth defects can be prevented and to improve the lives of people who have them. This includes funding 22 competitive awards to track birth defects, collect and analyze data on risk factors, refer individuals born with birth defects to appropriate medical and social services, and implement prevention strategies to reduce the number of babies affected by major birth defects.

Toward the goal of understanding how birth defects can be prevented, CDC will continue the *Birth Defects Study To Evaluate Pregnancy exposures (BD-STEPS)*. BD-STEPS builds upon experience from previous collaborative case-control studies of birth defects, such as the [National Birth Defects Prevention Study \(NBDPS\)](#)¹³⁰. BD-STEPS identifies modifiable maternal exposures in early pregnancy that may increase the risk for having a pregnancy affected by certain major structural birth defects, with a focus on four main areas:

- Maternal diabetes, obesity, and physical activity
- Chronic maternal medical conditions
- Infertility
- Medication use during pregnancy

CDC’s research efforts will support the interagency initiative launched in FY 2013, [TR_eating for Two](#)¹³¹, which aims to increase the evidence base for the risk of birth defects associated with maternal health conditions and their treatments during pregnancy and disseminate this information to assist pregnant women and their healthcare providers in making informed treatment decisions.

To improve the lives of people who have birth defects, CDC will continue working with state-based programs and academic partners to assess health services use, longer-term health outcomes, and the healthcare costs for individuals with birth defects. The aim is to identify potential interventions to reduce disparities in care and outcomes to improve the length and quality of life. CDC will also continue conducting surveillance of both fetal deaths and birth defects.

In FY 2015, CDC will fund 14 new awardees for state-based birth defects surveillance, intervention, and prevention activities and determined through a competitive application process. Funding will primarily support birth defects surveillance, research, intervention, and prevention activities to advance the aforementioned goals. The majority of the FY 2015 grantees will consist of state/territory health departments, academic research centers, and a non-governmental organization.

Table: Birth Defects and Surveillance of Fetal Deaths Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	2015
	Final	Enacted	Request	+/-2014
Number of Awards	31	23	23	0
- New Awards	7	0	14	+14
- Continuing Awards	24	23	9	-14
Average Award	\$0.281	\$0.347	\$0.347	\$0.000
Range of Awards	\$0.005–\$0.571	\$0.005–\$0.800	\$0.005–\$0.800	N/A
Total Awards	\$8.712	\$7.985	\$7.985	\$0.000

¹²⁹ <http://www.cdc.gov/ncbddd/birthdefects/index.html>

¹³⁰ <http://www.nbdps.org/>

¹³¹ http://www.cdc.gov/ncbddd/birthdefects/documents/ncbddd_birth-defects_medicationuseonepager_cdcrole.pdf

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) costs the United States over a \$4 billion annually; this does not include costs for less severe types of [fetal alcohol spectrum disorders \(FASDs\)](#)¹³². CDC will reduce risky alcohol use among women who may become pregnant to prevent exposure to alcohol during pregnancy, which can result in FAS and other FASDs. These conditions can result in physical, behavioral, and learning problems of varying severity.

FASDs are 100% preventable if a woman does not drink alcohol during pregnancy, but about 1 in 13 pregnant women report recent alcohol use, and the Indian Health Service estimates that rates are 1 in 2 for American Indian women. In partnership with organizations serving American Indian communities, CDC will provide training on alcohol screening and brief intervention approaches, including [CHOICES](#)¹³³ – an intervention for preventing alcohol-exposed pregnancy in high risk women before they become pregnant.

Through the [FASD Training Centers](#)¹³⁴ and enhanced collaboration with medical societies and national partners, CDC will improve the knowledge and skills of healthcare professionals on the prevention, identification, and management of FASDs. In FY 2014, CDC will transition these training efforts from a regional to a national approach—strengthening FASD expertise and capacity across the nation and improving provider practice.

In FY 2015, CDC will fund 12 competitively-selected FAS grants to train medical and allied health students and practitioners and to implement and evaluate prevention strategies to reduce alcohol-exposed pregnancies. The awards include a continuation of the FY 2013 grantees, the Denver Health and Hospital Authority and Board of Regents, and University of Wisconsin System. In FY 2014, two FOAs will be released and expected to support five academic research centers, four medical societies/professional organizations, and one national partner group.

Table: Fetal Alcohol Syndrome Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	25 ¹	15 ²	12 ²	-3
- New Awards	2	10	0	-10
- Continuing Awards	23	5	12	+7
Average Award	\$0.152	\$0.226	\$0.264	+\$0.038
Range of Awards	\$0.013–\$0.500	\$0.075–\$0.275	\$0.250–\$0.275	N/A
Total Awards	\$3.809	\$3.400	\$3.175	-\$0.225

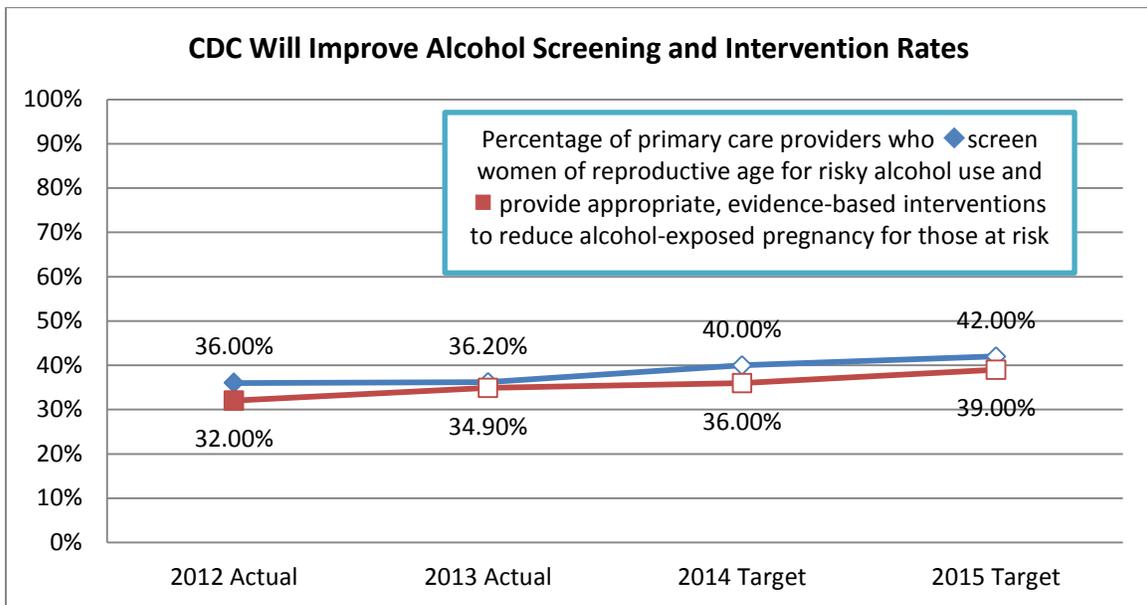
1 This number includes 14 BRFSS grantees funded in FY2013 via a National Center for Chronic Disease Prevention and Control FOA with funding ranging from \$13K to \$30. They are also included within the 23 continuing awards for FY13.

2 The number of awards decreases from 2014 to 2015 because three of the five continuation awards projected in FY14 are extensions that will not exceed 12-months of funding.

¹³² <http://www.cdc.gov/ncbddd/fasd/index.html>

¹³³ <http://www.cdc.gov/ncbddd/fasd/research-preventing.html>

¹³⁴ <http://www.cdc.gov/ncbddd/fasd/training.html#RTCS>



Folic Acid

CDC will continue efforts to eliminate [folic acid-preventable neural tube defects \(NTDs\)](#)¹³⁵ like spina bifida and anencephaly, which are severe birth defects of the brain and spine. Almost all babies born with anencephaly will die shortly after birth and children with spina bifida often face life-long disabilities. CDC’s accomplishments and expertise in NTDs have been instrumental in demonstrating that a daily intake of four-hundred micrograms of folic acid, before and during pregnancy, can greatly reduce the risk of NTDs. In addition, over the past ten years, efforts to fortify cereal grain products labeled as enriched in the United States has achieved cost-savings of approximately \$4.5 billion (\$100 saved for each \$1 invested). By working with internal and external partners in surveillance, training, awareness, and prevention, CDC will continue to provide information on the benefits of folic acid fortification, determine optimal blood folate levels, and monitor health disparities.

In FY 2015, CDC will fund one to two competitively-selected grantees to increase folic acid intake among women of reproductive age; support NTD prevention efforts; and enhance training, surveillance, and monitoring of NTDs and blood folate levels. In 2013, this grant award was not impacted by sequestration; reductions were taken to other activities. Grantees will consist of multilateral organizations and non-governmental organizations.

Table: Folic Acid Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	2	1-2	1-2	0
- New Awards	0	0	0	0
- Continuing Awards	2	1-2	1-2	0
Average Award	\$0.325	\$0.239	\$0.239	\$0.000
Range of Awards	\$0.040–\$0.609	\$0.050–\$0.427	\$0.050–\$0.427	N/A
Total Awards	\$0.649	\$0.477	\$0.477	\$0.000

¹³⁵ <http://www.cdc.gov/ncbddd/folicacid/index.html>

Spina Bifida Surveillance and Research

Despite the successes of folic acid fortification, there are still many people living with [spina bifida](#)¹³⁶ in the United States today, and each year, about 1,500 more babies are born with this debilitating condition. While most cases of spina bifida are preventable with folic acid, some are not; there are still questions to be answered about risk factors for those neural tube defects that are not preventable with folic acid.

In FY 2015, CDC will fund 17-18 competitive spina bifida awards to improve surveillance capacity, better understand the epidemiology, and identify other modifiable causes of spina bifida. These grants will identify and implement strategies to prevent spina bifida—the annual medical care and surgical costs for which exceed \$200 million. Grantees will consist of state health departments as well as academic, multilateral, and non-profit organizations.

Table: Spina Bifida Surveillance and Research Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	24	17-18	17-18	0
- New Awards	7	1-2	13-14	+12
- Continuing Awards	17	16	4	-12
Average Award	\$0.045	\$0.036	\$0.036	\$0.000
Range of Awards	\$0.005–\$0.196	\$0.005–\$0.227	\$0.005–\$0.227	N/A
Total Awards	\$0.682	\$0.629	\$0.629	\$0.000

Infant Health

Early life experiences can significantly affect a person’s health and wellbeing for decades to come. To promote healthy starts to life, CDC will support [infant health](#)¹³⁷ activities, on several fronts: strengthening global birth defects surveillance; supporting global efforts to increase folic acid intake among women of reproductive age; improving early identification of autism and other developmental disabilities; supporting birth defects surveillance, research, intervention, and prevention activities; and developing, implementing, and evaluating prevention strategies around cytomegalovirus (a virus that can cause serious disease in babies who are infected before birth).

In FY 2015, CDC will fund three to six competitive infant health awards to conduct the aforementioned infant health activities. Grantees will consist of governmental and non-government organizations.

Table: Infant Health Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	6	3-6	3-6	0
- New Awards	2	1	0	-1
- Continuing Awards	4	3-5	3-6	+1
Average Award	\$0.150	\$0.175	\$0.175	\$0.000
Range of Awards	\$0.025–\$0.250	\$0.050–\$0.250	\$0.050–\$0.250	N/A
Total Awards	\$0.900	\$0.875	\$0.875	\$0.000

¹³⁶ <http://www.cdc.gov/ncbddd/spinabifida/index.html>

¹³⁷ <http://www.cdc.gov/ncbddd/jump/child.html>

Hearing loss is another infant health issue with significant life-long impact early identification of infants with hearing loss and receipt of intervention improves outcomes and prevents an estimated \$200 million in additional education costs each year. In FY 2015, CDC will provide support through a cooperative agreement to develop guidelines for medical home providers to help ensure children identified with hearing loss receive the interventions they need and avoid extended delay in follow-up.

In addition, CDC supports activities to simplify reporting and standardization of hearing screening, diagnostic, and intervention data by expanding the capacity of public health programs to electronically receive and exchange this data. By making it easier for healthcare providers to report and receive data about infants needing services, CDC helps ensure all infants with hearing loss are identified early and reach their full potential. Also, CDC supports research to identify ways to ensure infants receive recommended services and assess the outcomes of children identified with hearing loss. CDC previously funded research to develop and evaluate a clinic-based screening and brief intervention related to cytomegalovirus infection, since about 1 in 5 children born with congenital cytomegalovirus infection will develop permanent issues, such as hearing loss.

Table: Infant Health (Hearing Loss) Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	2015
	Final	Enacted	Request	+/-2014
Number of Awards	3	2	2	0
- New Awards	1	0	0	0
- Continuing Awards	2	2	2	0
Average Award	\$0.188	\$0.150	\$0.150	\$0.000
Range of Awards	\$0.136–\$0.225	\$0.100–\$0.250	\$0.100–\$0.250	N/A
Total Awards	\$0.654	\$0.300	\$0.300	\$0.000

Autism

CDC’s FY 2015 request includes **\$23,031,000** for autism activities in budget authority. CDC will support work in autism and developmental disabilities through the multi-site [Autism and Developmental Disabilities Monitoring \(ADDM\) Network¹³⁸](#), which uses the gold standard method for estimating prevalence and describing the characteristics of children with autism and other developmental disabilities. Data from the ADDM Network show about 1 in 88 children have been identified as having autism in the United States. CDC will also continue investigating the risk factors for autism through the [Centers for Autism and Developmental Disabilities Research and Epidemiology \(CADDRE\)¹³⁹](#). The CADDRE Network conducts the [Study to Explore Early Development \(SEED\)¹⁴⁰](#), which is the largest study in the United States working to identify factors that may put children at risk for autism and other developmental disabilities.

CDC will continue to support efforts to improve early identification by working closely with partners and [other federal agencies¹⁴¹](#). [CDC works through its existing systems and networks](#) to disseminate materials on early identification and developmental monitoring to healthcare professionals, early childhood educators, and parents of young children. Addressing autism costs an estimated \$3.2 million in lifetime costs per child. Early identification and intervention can improve functioning and outcomes for children, and saves an estimated \$650,000 per child over their lifetime. Despite this, most children are not diagnosed until after age 4, even though developmental concerns before age 3 are noted for almost 90% of children with autism.

In FY 2015, CDC anticipates funding 20 competitive autism awards to enhance surveillance and research for autism and other developmental disabilities, monitor prevalence and contributing risk factors, and better inform

¹³⁸ <http://www.cdc.gov/ncbddd/autism/addm.html>

¹³⁹ <http://www.cdc.gov/ncbddd/autism/caddre.html>

¹⁴⁰ <http://www.cdc.gov/ncbddd/autism/seed.html>

¹⁴¹ <http://iacc.hhs.gov/index.shtml>

policies and programs for prevention and services. These grants will also help evaluate strategies to reduce racial and ethnic disparities in the identification of autism and other developmental disabilities.

Table: Autism Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	20	20	20	0
- New Awards	2	12	0	-12
- Continuing Awards	18	8	20	+12
Average Award	\$0.591	\$0.605	\$0.605	\$0.000
Range of Awards	\$0.025–\$1.050	\$0.025–\$1.050	\$0.025–\$1.050	N/A
Total Awards	\$11.821	\$12.544	\$12.544	\$0.000

Congenital Heart Defects

CDC continues to expand work on [congenital heart defects](#)¹⁴² through cooperative agreements designed to better understand the survival, healthcare utilization, and longer term outcomes of adolescents and adults affected by congenital heart defects.

In FY 2015, CDC will competitively fund at least three new awards to state health departments, academic sites, or other institutions to improve the epidemiology of congenital heart defects across the life span, with emphasis on adolescents and adults, preventing congenital heart defect occurrence, and improving the lives of those born with a congenital heart defect. Funding will primarily support activities to collect, link, and analyze data related to congenital heart defects.

Table: Congenital Heart Defects (CHD) Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	4	4	4	0
- New Awards	0	1	3	+2
- Continuing Awards	4	3	1	-2
Average Award	\$0.296	\$0.350	\$0.500	+\$0.150
Range of Awards	\$0.035–\$0.396	\$0.050–\$0.450	\$0.050 - \$0.650	N/A
Total Grant Awards	\$1.184	\$1.400	\$2.000	+\$0.600

¹⁴² <http://www.cdc.gov/ncbddd/heartdefects/index.html>

Health and Development for People with Disabilities Budget Request

(dollars in millions)

	FY 2013 Final ^{1,2}	FY 2014 Enacted ²	FY 2015 President's Budget	2015 +/- 2014
Budget Authority	\$50.603	\$53.362	\$0.000	-\$53.362
ACA/PPHF	\$0.000	\$0.000	\$53.362	+\$53.362
Total	\$50.603	\$53.362	\$53.362	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

Overview

CDC's Human Development and Disability program prevents disease and promotes equity in health and development for adults and children with [disabilities](#)¹⁴³. There are many types of disabilities, such as those that affect a person's hearing, vision, movement, thinking, remembering, learning, communicating, mental health, and social relationships. Disability is often equated with poor health; however, people with disabilities can, and should, have the same opportunity for good health as people without disabilities. But currently, compared to people without disabilities, people with disabilities are more likely to be obese, smoke, and have more difficulty accessing preventive health services. Disabilities are associated with approximately \$400 billion in healthcare costs each year.

CDC collaborates with a variety of partners and through cooperative agreements with grantees to address public health challenges facing the 1 in 5 Americans who have a disability. These activities represent our nation's primary public health commitment to support populations with disabilities. CDC's commitment to serving individuals with disabilities builds a strong public health framework, allowing CDC to implement crosscutting public health strategies (e.g., surveillance, communication/education, healthcare access) in support of a community faced with a variety of health challenges.

Budget Request

CDC's FY 2015 request of **\$53,362,000** for Health and Development for People with Disabilities is level with the FY 2014 Enacted level. CDC will use FY 2015 funds to invest in public health surveillance activities to identify and highlight public health issues associated with human development; and reduce disability-associated health disparities, and promote the health and wellbeing of people with disabilities. This effort includes enhancement of the [Disability and Health Data System \(DHDS\)](#)¹⁴⁴ as CDC seeks to expand the utility of this innovative information resource.

Disability and Health

Recognizing that lifelong challenges are associated with many types of disabilities, CDC works to integrate science and public health practice through a variety of both state and nationally-based programs and initiatives. In FY 2015, CDC will continue to support the [Disability and Health Data System \(DHDS\)](#)¹⁴⁵ to document and disseminate disability and health data. The DHDS enables the development of data-driven, fiscally-responsible programs, services, and policies that include people with disabilities, assists CDC and states with identifying key health disparities as well as generate research questions to investigate factors that contribute to differences in health experienced by adults with disabilities.

¹⁴³ <http://www.cdc.gov/ncbddd/jump/disabilities.html>

¹⁴⁴ <http://dhds.cdc.gov/>

¹⁴⁵ <http://dhds.cdc.gov/>

In FY 2015, CDC funding for the University of Alabama Birmingham’s National Center on Health, Physical Activity, and Disability (NCHPAD) will be maintained this funding line ensuring a continuation of the broader health promotion activities designed to serve people with disabilities.

In FY 2015, CDC will also fund 18 [state disability and health programs](#)¹⁴⁶. These competitive grants support health disparities surveillance and health promotion activities including:

- Identifying and reducing disparities in key health indicators among people with disabilities by including people with disabilities in ongoing state disease prevention, health promotion, and emergency response activities
- Increasing healthcare access for people with disabilities
- Addressing environmental barriers, such as inaccessible healthcare facilities and examination equipment
- Providing training and communication to public health and healthcare providers about disability

All of the states have the same overarching goals, but each customizes its activities based on the infrastructure and priorities of the state.

Table: Disability and Health Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	18	18	18	0
- New Awards	0	0	18	+18
- Continuing Awards	18	18	0	-18
Average Award	\$0.300	\$0.300	\$0.300	\$0.000
Range of Awards	\$0.290–\$0.300	\$0.290–\$0.300	\$0.290–\$0.300	N/A
Total Grant Awards	\$5.400	\$5.400	\$5.400	\$0.000

In FY 2015, CDC will continue to collaborate with partners to support a variety of [public health practice and resource centers](#)¹⁴⁷ focused on improving the health and quality of life for people with [limb loss](#)¹⁴⁸, [intellectual disability](#)¹⁴⁹, paralysis, [physical activities for people with disabilities](#)¹⁵⁰, [attention deficit/hyperactivity disorder \(ADHD\)](#)¹⁵¹, and [Tourette syndrome](#)¹⁵². These resource centers help individuals living with disabilities by providing health information and education and consultation to healthcare professionals, people with disabilities, caregivers, media, researchers, policymakers, and the public.

CDC will improve developmental outcomes for children and adolescents by collaborating with the Administration on Children and Families (ACF) and the Health Resources and Services Administration (HRSA) to incorporate CDC's [Legacy for Children program](#)¹⁵³ into [Early Head Start](#)¹⁵⁴ and [Healthy Start](#)¹⁵⁵. Incorporation of this evidence-based public health intervention will enable pilot Early Head Start and Healthy Start pilot programs to improve child health and development at the earliest developmental stages.

¹⁴⁶ <http://www.cdc.gov/ncbddd/disabilityandhealth/programs.html>

¹⁴⁷ <http://www.cdc.gov/ncbddd/disabilityandhealth/national-programs.html>

¹⁴⁸ <http://www.amputee-coalition.org/limb-loss-resource-center/>

¹⁴⁹ http://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/IntellectualDisability.pdf

¹⁵⁰ <http://www.ncpad.org/>

¹⁵¹ <http://www.cdc.gov/ncbddd/adhd/>

¹⁵² <http://www.cdc.gov/ncbddd/tourette/index.html>

¹⁵³ <http://www.cdc.gov/ncbddd/childdevelopment/legacy.html>

¹⁵⁴ <https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc>

¹⁵⁵ <http://mchb.hrsa.gov/programs/healthystart/>

CDC also works to improve outcomes for people with intellectual disability, the average lifetime costs of which are about \$1,014,000 per person. To understand the factors associated with intellectual disability, CDC supported four grants in FY 2013 to address the research efforts focused on reducing health disparities among people with intellectual disabilities. CDC also supported a grant to conduct health assessments of people with disabilities during athletic events and provide educational information to people with intellectual disabilities and their caregivers.

Early Hearing Detection and Intervention

CDC’s FY 2015 funding request continues support for the [Early Hearing Detection and Intervention \(EHDI\)](#)¹⁵⁶ program. Working in collaboration with the Health Resources and Services Administration (HRSA), CDC funds jurisdictional health departments for the development, maintenance, and enhancement of EHDI Information Systems (EHDI-IS). These EHDI-IS are electronic tracking and surveillance systems that capture information about what hearing related services infants have received and alert health departments about what recommended services infants still need. EHDI-IS programs capture and use information to help ensure all newborns with hearing loss are identified early and reach their full potential. Over 95% of infants in the United States are screened for hearing loss and EHDI programs have helped to identify over 28,000 infants with hearing loss since 2005. CDC works to ensure all infants receive recommended follow-up. This is an essential activity because approximately 35% of infants do not receive the recommended services. CDC funded EHDI-IS directly support necessary follow up and intervention services for individuals with hearing loss.

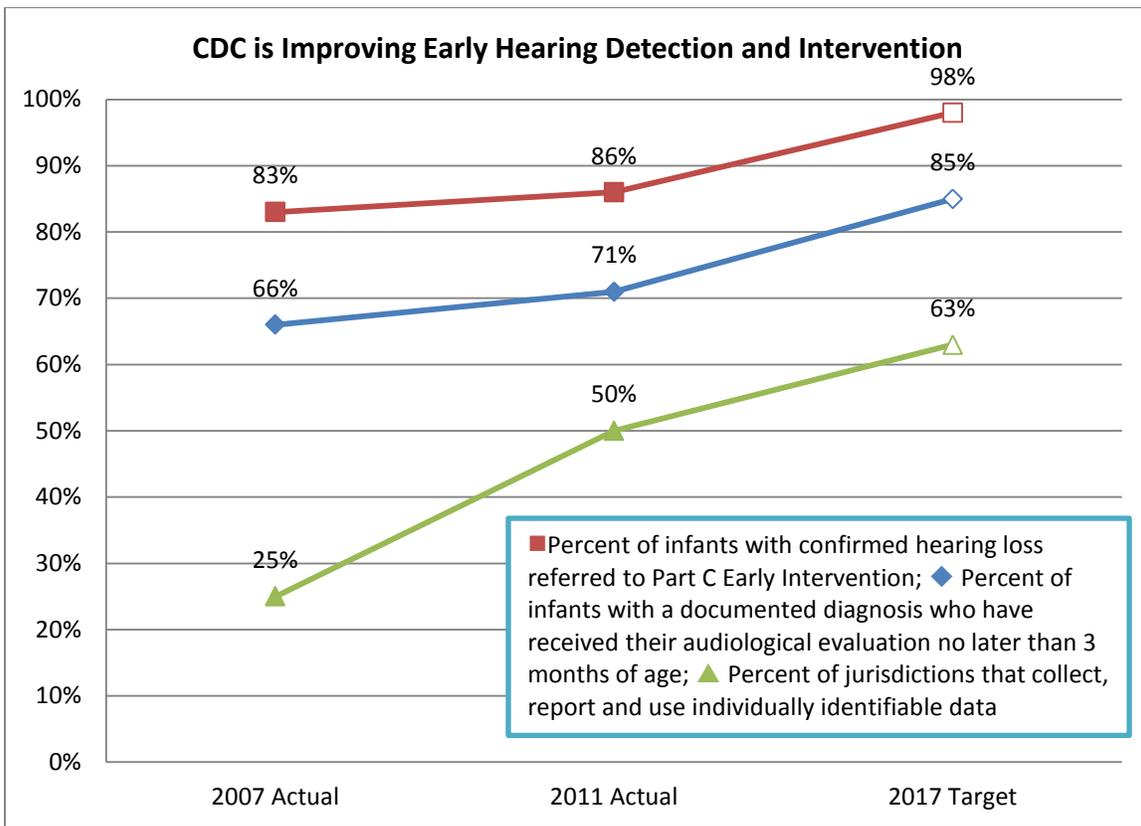
In addition, CDC plans to expand its support of activities to help simplify the reporting and standardization of hearing screening, diagnostic, and intervention data by strengthening the ability of public health programs to electronically receive and exchange this data. Specifically, this will help increase the capacity of awardees to collect and exchange data accurately, effectively, and securely between an EHDI-IS and the electronic health record systems that are used by the healthcare providers that care for these infants. This in turn will help ensure all infants with hearing loss are identified early and receive appropriate intervention services.

In FY 2015, CDC will fund 53 EHDI awards to provide support and scientific and programmatic expertise to state/territory public health departments (or their designated entity) to implement and enhance state/territory EHDI Information Systems. These grants improve rates and documentation of newborn hearing screening and follow-up services for all infants born in the United States. CDC also funds research through one cooperative agreement to improve loss-to-follow-up/documentation through screening at Women, Infants, and Children visits and to collect and analyze developmental outcomes for infants and children who are deaf or hard of hearing.

Table: Early Hearing Detection and Intervention (EHDI) Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	53	53	53	0
- New Awards	0	0	0	0
- Continuing Awards	53	53	53	0
Average Award	\$0.134	\$0.150	\$0.150	\$0.000
Range of Awards	\$0.071–\$0.400	\$0.095–\$0.400	\$0.095–\$0.400	N/A
Total Grant Awards	\$7.219	\$7.800	\$7.800	\$0.000

¹⁵⁶ <http://www.cdc.gov/ncbddd/hearingloss/index.html>



Limb Loss

CDC funds programs and activities to improve the health of people with limb loss (PWLL) and promote their well-being, quality of life, prevent disease, and provide support to their families and caregivers.

In FY 2014, CDC limb loss funding supports the Amputee Coalition and Limb Loss Resource Center. The Amputee Coalition will significantly increase program operations and public health activities related to PWLL or limb difference. In FY 2015, CDC will publish a new Funding Opportunity Announcement to support limb loss activities.

Table: Limb Loss Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	2	1	1	0
- New Awards	0	0	1	+1
- Continuing Awards	2	1	0	-1
Average Award	\$0.965	\$2.100	\$2.100	\$0.000
Range of Awards	\$0.000	\$0.000	\$0.000	N/A
Total Grant Awards	\$0.965	\$2.100	\$2.100	\$0.000

Tourette Syndrome

CDC conducts Tourette Syndrome (TS) research to improve the understanding of TS prevalence, risk and protective factors, health risk behaviors, and quality of life among people affected by TS.

In FY 2015, CDC will continue to support the National Public Health Practice and Resource Center on Tourette Syndrome to improve the health and quality of life for people with Tourette Syndrome. The Resource Center

helps individuals living with Tourette Syndrome by providing health information, education and consultation to health care professionals, people with disabilities, caregivers, media, researchers, policymakers, and the public. As part of a partnership with the Tourette Syndrome Association, CDC supports the education of parents, health care providers and teachers in the awareness of a new, evidence-based behavioral treatment for tics, the Comprehensive Behavioral Intervention for Tics (CBIT).

Table: Tourette Syndrome Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	1	1	1	0
- New Awards	1	0	1	+1
- Continuing Awards	0	1	0	-1
Average Award	\$0.800	\$0.800	\$0.800	\$0.000
Range of Awards	\$0.800	\$0.800	\$0.800	N/A
Total Grant Awards	\$0.800	\$0.800	\$0.800	\$0.000

Muscular Dystrophy

CDC developed a multi-state system of record-review to determine prevalence of [Duchenne and Becker Muscular dystrophies](#)¹⁵⁷, age at diagnosis, and quality of life of persons with these dystrophies. In FY 2015, CDC will continue surveillance of nine dystrophies, and will examine administrative records to determine whether they are an efficient resource for answering questions relating to muscular dystrophies.

In FY 2015, CDC will provide support and scientific and programmatic expertise to five awardees. The current four cooperative agreements supporting two public health departments (Colorado and New York) and two universities (Arizona and Iowa) expire in 2014. A new FOA will be for awardees to conduct population-based surveillance of nine muscular dystrophies. The goal is to determine prevalence, survival, healthcare service utilization and costs, disparities in access to care, and impact of specific clinical treatments on outcomes and to share this information with muscular dystrophy stakeholders. Grantees will evaluate the logistics of conducting surveillance and the quality and utility of the data throughout the funding period. The grantees will also analyze and disseminate data generated from this and previously collected surveillance data, and may propose additional pilot research studies to learn more about important issues that affect people with muscular dystrophy. These studies are optional and would be supported if funds were available and projects deemed to provide important information.

Table: Muscular Dystrophy Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	4	5	5	0
- New Awards	0	5	0	-5
- Continuing Awards	4	0	5	+5
Average Award	\$0.525	\$0.570	\$0.570	\$0.000
Range of Awards	\$0.450–\$0.749	\$0.500–\$0.750	\$0.500–\$0.750	N/A
Total Grant Awards	\$2.275	\$3.100	\$3.100	\$0.000

¹⁵⁷ <http://www.cdc.gov/ncbddd/muscular dystrophy/index.html>

Attention Deficit Hyperactivity Disorder

CDC conducts research to improve the understanding of Attention-Deficit/Hyperactivity Disorder (ADHD) to help determine risk factors, identify best treatments, and inform resources to help people living with ADHD.

In FY 2015, CDC will continue to support the [National Public Health Practice and Resource Center on ADHD](#)¹⁵⁸ which focuses on improving the health and quality of life for people with ADHD by developing and providing evidenced-based and scientifically valid health promotion programs, and health communication and education resources for both professionals and the public regarding ADHD. The center operates a web-site and a call center with trained staff to answer questions about ADHD.

Table: Attention Deficit Hyperactivity Disorder Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	1	1	1	0
- New Awards	1	0	1	+1
- Continuing Awards	0	1	0	-1
Average Award	\$0.800	\$0.800	\$0.800	\$0.000
Range of Awards	\$0.800	\$0.800	\$0.800	N/A
Total Grant Awards	\$0.800	\$0.800	\$0.800	\$0.000

In FY 2015 CDC will continue to conduct a set of population-based research projects of pediatric neurobehavioral disorders (including ADHD and Tourette Syndrome) that describe prevalence, treated prevalence, and co-occurrence of internalizing, externalizing, and tic disorders of childhood; and to describe current and previous receipt of mental health treatment in children with previously diagnosed mental disorders. An additional goal of these projects is to assess diversion and misuse of psychoactive medications prescribed for the purpose of treating a mental disorder.

Table: [Project to Learn About Youth \(PLAY\)](#)¹⁵⁹ – Mental Health Grant Table¹

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	2	4	4	0
- New Awards	2	2	2	0
- Continuing Awards	0	2	2	0
Average Award	\$0.200	\$0.275	\$0.250	-\$0.025
Range of Awards	\$0.200	\$0.250-\$0.300	\$0.250	N/A
Total Grant Awards	\$0.400	\$1.100	\$1.000	-\$0.100

¹ Funding for these awards is supported by multiple funding lines including ADHD, TS, and Child Development

Fragile X

Fragile X Syndrome (FXS) is a known cause of intellectual disabilities. CDC partners with clinicians, university researchers and non-profit research foundations conducting research to better understand FXS and co-occurring conditions, life course development, and interventions to improve participation of individuals with FXS and quality of life for them and their families. CDC will continue to work with these partners to describe the current state of the science and identify gaps in knowledge in order to better inform the public health research agenda for Fragile X.

¹⁵⁸ <http://www.help4adhd.org/>

¹⁵⁹ <http://www.cdc.gov/ncbddd/adhd/play.html>

CDC funds the Fragile X Clinical Research Consortium (FXCRC), a multisite research consortia involving 26 Fragile X clinical sites across the United States, to build a Fragile x registry and longitudinal database. Findings from the longitudinal data will lead to a greater understanding of Fragile X syndrome and be used to improve the lives, care, and health care of persons with fragile X syndrome, increase understanding of contributors to adverse or positive outcomes, and may provide information that could benefit other groups affected by intellectual disabilities.

CDC researchers are pilot testing a method using a state-based linked administrative data system studying 15-24 year-olds with FXS to learn what health care services are being used, other medical conditions that a person with FXS has, their progress in high school, vocational school or college, and whether they are participating in state employment programs. Linking administrative data in this way may prove to be an effective approach for public health research of complicated medical conditions like FXS.

In 2015, CDC will publish a new Funding Opportunity Announcement to support Fragile X activities.

Table: Fragile X Syndrome Grant Table

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	2	2	1-4	-1-2
- New Awards	0	0	1-4	+1-4
- Continuing Awards	2	2	0	-2
Average Award	\$0.375	\$0.332	\$0.350	+\$0.018
Range of Awards	\$0.201-\$0.550	\$0.114-\$0.550	\$0.200-\$0.700	N/A
Total Grant Awards	\$0.751	\$0.664	\$1.050	+\$0.386

Spina Bifida

Each year, about 1,500 babies are born with [spina bifida](#)¹⁶⁰, a condition they will have for the duration of their lives. Spina bifida is a complex, disabling condition that has a tremendous impact on individuals and families, from difficulty accessing care, to incurring high healthcare costs associated with frequent surgeries and hospitalizations. CDC research and programs improve the quality of life and encourage full participation at every age for those with spina bifida.

In FY 2015, CDC will continue to support the national effort toward electronic medical records (EMR). CDC's partner, the [Spina Bifida Association](#)¹⁶¹, conducted a pilot of the spina bifida EMR in three sites (Children's Hospital of Alabama, Children's Hospital Los Angeles, and Children's Hospital Colorado). The experiences and observations reported by the three sites suggest that the spina bifida EMR represents a feasible and useful solution for managing information in spina bifida clinical operations, with potential application to and integration with spina bifida research.

This project was implemented in support of the [National Spina Bifida Patient Registry \(NSBPR\)](#)¹⁶² which now has data on more than 3,500 children and adults who are living with the condition from 19 U.S. clinics. Data from the NSBPR are used to describe the registry population; examine association between outcomes, interventions, demographic variables, and other factors; identify best practices; establish measures of quality care; and compare outcomes among participating clinics. These awards enhance research used to identify measures to develop national standards of care for patients with spina bifida and to assess progress toward those standards.

¹⁶⁰ <http://www.cdc.gov/ncbddd/spinabifida/index.html>

¹⁶¹ <http://www.spinabifidaassociation.org/site/c.evKRI7OXIoJ8H/b.8028963/k.BE67/Home.htm>

¹⁶² <http://www.cdc.gov/ncbddd/spinabifida/nsbprregistry.html>

In FY 2015, CDC will fund 15 new awardees to support spina bifida clinics that collect and maintain longitudinal data in the NSBPR. The current 17 awards support 19 spina bifida clinics and are funded under two Funding Opportunity Announcements (FOAs) that expire in 2014. Clinic sites will also participate in research projects aimed at improving patient care and outcomes utilizing the NSBPR data.

Table: Spina Bifida Grant Table¹

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	17	15	15	0
- New Awards	0	15	0	-15
- Continuing Awards	17	0	15	+15
Average Award	\$0.070	\$0.070	\$0.070	\$0.000
Range of Awards	\$0.050–\$0.070	\$0.070	\$0.070	N/A
Total Grant Awards	\$1.190	\$1.050	\$1.050	\$0.000

¹A new, 3-component FOA will be competed in FY 2014 to fund a total of 26 awards– including approximately 15 that will support spina bifida clinics, 10 sites that will implement a urologic management protocol for newborns and 1 clinical care network. The 15 awards in FY 2014 and 2015 reflect one component of the FOA, most comparable to the 2013 awards. The 10 urologic and 1 clinical care network awards are not reflected in this table.

Public Health Approach to Blood Disorders Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$0.000	\$4.000	\$4.000	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

[Blood disorders](#)¹⁶³—including bleeding, clotting, and red blood cell disorders, affect millions of Americans each year. These conditions have serious health consequences and are costly, absorbing billions of dollars in healthcare expenditures annually. Working with academia, national professional organizations, state and local health departments, and other federal agencies, CDC identifies how often and in which settings blood disorders occur to better understand who is at risk, identify effective prevention strategies, and reduce complications. CDC develops and promotes system-level applications and education and awareness activities that increase the public and healthcare provider’s knowledge of the signs and symptoms, diagnosis, and use of proven treatments to reduce the burden of and improve the quality of life for people with a blood disorder.

Budget Request

CDC’s FY 2015 request of **\$4,000,000** for Public Health Approach to Blood Disorders is level with the FY 2014 Enacted level. This funding will allow CDC to continue to improve health outcomes and limit complications for those who are at risk for or currently have blood disorders. Activities funded under this budget line will assist with continued public health advancements in data collection and health system development, as well as promotion of proven interventions addressing the following blood disorders:

[Venous thromboembolism](#)¹⁶⁴ (VTE) is a serious but preventable condition which includes blood clots in the legs and life-threatening clots in the lungs affecting an estimated one million Americans each year with annual healthcare costs of up to \$10 billion. At least one in 10 of those affected dies, oftentimes before being diagnosed. Almost half occur during or soon after discharge from a hospital stay or surgery. In FY 2014, CDC analyzed information on VTEs occurring in populations that have age and race diversity using two small and unique pilot projects at Duke University Medical Center and the University of Oklahoma Health Sciences Center. In FY 2015, CDC will use lessons learned from these projects to develop the tools and systems needed to identify and monitor efforts to prevent and lower the risk of VTE and associated death. CDC will collaborate with academia and the Veterans Administration to develop an adaptive self-learning tool and Natural Language Processing software that can extract information from electronic health records (EHR) and other data sources to fully identify VTEs that are missed using insurance claims. These innovative methods will allow CDC to provide more accurate estimates of incidence and risk factors for VTE. CDC will also work with the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, and hospital networks to begin monitoring the effectiveness of healthcare systems-level approaches such as risk assessment tools and EHR clinical decision prompts for preventing VTEs while hospitalized and after discharge.

[Sickle cell disease](#)¹⁶⁵ (SCD) is one of the most common inherited red blood cell disorders. SCD affects 90,000 to 100,000 people in the United States, causing episodes of severe pain, organ damage, serious infections, stroke, and repeated hospitalizations. People with the most severe form of SCD have a 20-30 year lower life expectancy than people without SCD. It is estimated that up to 80% of hospitalizations for SCD are paid for by public insurance programs like Medicaid or Medicare. To address this issue of critical public health importance, in

¹⁶³ <http://www.cdc.gov/ncbddd/blooddisorders/index.html>

¹⁶⁴ <http://www.cdc.gov/ncbddd/dvt/features/keyfinding-hospitalizations-vte.html>

¹⁶⁵ http://www.cdc.gov/ncbddd/sicklecell/documents/scd-factsheet_what-is-scd.pdf

FY2015 CDC will continue its efforts to prevent and control complications of SCD by analyzing information on healthcare use and the impact of proven interventions like hydroxyurea which reduces the frequency of severe pain and other complications associated with SCD such as acute chest syndrome, and Transcranial Doppler screening, a test critical for identifying children with SCD who need chronic transfusions to prevent stroke. CDC will also evaluate the use of systems-level protocols and instruments such as electronic health records with embedded clinical decision prompts as potential tools for increasing awareness, education and use of proven therapies and advances in SCD management.

An estimated 3 million additional Americans have [sickle cell trait](#)¹⁶⁶ (SCT) which can be passed onto their offspring, putting them at risk for having SCD. In FY 2014, CDC provided technical assistance to national professional organizations, other federal agencies, and subject matter experts to complete an educational and information resource toolkit for (SCT) through funding from the American Society of Hematology. The toolkit focuses on prevention of complications and management of SCT and is tailored to meet the needs of people who are affected by SCT, their families, as well as healthcare providers, athletes and coaches, teachers and health educators, and state health departments.

In FY 2015, CDC will continue to fund blood disorder activities addressing [Healthy People 2020’s Blood Disorders and Blood Safety focus area](#)¹⁶⁷, which includes reducing the development of joint mobility issues in persons with hemophilia, reducing the number of adults who develop a VTE in hospitals, and increasing the proportion of persons with SCD who receive evidence-based recommended treatments to prevent complications.

In FY 2015, CDC will fund 2 continuing and 3 new competitively selected awards addressing blood disorders to primarily professional organizations, state health departments, healthcare institutions, and academic centers for data collection and monitoring, developing and disseminating health promotion and education materials, and community outreach. These activities contribute to improving the lives of people with blood disorders by providing essential information identifying what CDC knows and can do to prevent and control complications from blood disorders.

Table: Public Health Approach to Blood Disorders Grant Table

(dollars in millions)	FY 2013 ¹ Final	FY 2014 ² Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	19	5	5	0
- New Awards	0	3	2	-1
- Continuing Awards	19	2	3	+1
Average Award	\$0.425	\$0.260	\$0.260	\$0.000
Range of Awards	\$0.200–\$3.992	\$0.150–\$0.550	\$0.150–\$0.550	N/A
Total Grant Awards	\$8.112	\$1.300	\$1.300	\$0.000

¹ FY2013 Includes funded awards for– Hemophilia and Thalassemia supported under the FY2013 Public Health Approach to Blood Disorders budget line

² FY2014 and FY2015 include funded awards for Public Health Approach to Blood Disorders supported under the now separated FY2014 and FY2015 Public Health Approach to Blood Disorders budget line

¹⁶⁶ http://www.cdc.gov/ncbddd/sicklecell/documents/sicklecelltraitfactsheet_english.pdf

¹⁶⁷ http://www.cdc.gov/nchs/healthy_people/hp2020/hp2020_topic_areas.htm

Hemophilia Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$17.249	\$3.504	\$3.504	\$0.000

¹FY 2013 levels have been made comparable to FY 2014 PB to reflect the permanent realignment of the BSS budget line.

Overview

[Hemophilia](#)¹⁶⁸, is an inherited life-long bleeding disorder that can cause damage to internal organs and chronic joint disease and pain. In FY 2013, CDC replaced the [Universal Data Collection](#)¹⁶⁹ (UDC) system with the [Public Health Surveillance Project on Bleeding Disorders](#)¹⁷⁰ (PHSPBD), the Registry for Bleeding Disorders Surveillance component of the American Thrombosis and Hemostasis Network's "Community Counts!" The PHSPBD increases the scope of the data previously collected in the UDC, providing information on emergent issues related to bleeding disorders and chronic diseases that have become more prevalent as people with hemophilia live longer lives. In FY 2014 CDC began collecting information on and testing blood samples collected from people with hemophilia treated at hemophilia treatment centers participating in PHSPBD. Special emphasis is on routine screening of blood samples for detection of [inhibitors](#)¹⁷¹, antibodies which decrease the effectiveness of the treatment product used to stop bleeding that can cause treatment costs that exceed \$1,000,000 a year. About 15-20% of people with hemophilia will develop this complication. CDC maintains a repository of the blood samples for future investigations of blood-borne infectious transmissions and other product safety issues. In FY 2015, CDC will continue testing and storing blood samples which help inform research and the development of effective prevention practices and treatment protocols.

Budget Request

CDC's FY 2015 request of **\$3,504,000** for CDC's hemophilia activities is level with the FY 2014 Enacted level. This funding will support CDC's hemophilia laboratory staff, instrumentation and information technology needed for processing, testing and storage of blood samples.

¹⁶⁸ <http://www.cdc.gov/ncbddd/hemophilia/data.html>

¹⁶⁹ <http://www.cdc.gov/ncbddd/blooddisorders/udc/>

¹⁷⁰ <http://www.athn.org/content/public-health-surveillance>

¹⁷¹ <http://www.cdc.gov/ncbddd/hemophilia/inhibitors.html>

Hemophilia Treatment Centers Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$0.000	\$5.000	\$5.000	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

[Hemophilia Treatment Centers](#)¹⁷² (HTCs) are specialized health care centers that bring together a team of doctors, nurses, and other health professionals experienced in treating people with hemophilia. HTCs participating in CDC's [Public Health Surveillance Project on Bleeding Disorders](#)¹⁷³ (PHSPBD) collect and submit blood samples and information from people with hemophilia treated in the HTCs to CDC's Blood Disorders Laboratory for testing and analysis of the data and information which informs research and the development of prevention practices and effective treatments for people with hemophilia.

Budget Request

CDC's FY 2015 request of **\$5,000,000** for Hemophilia Treatment Centers is level with the FY 2014 Enacted level. In FY 2015 this funding will continue the collection and submission of blood samples and patient information to CDC's Blood Disorders laboratory for testing and analysis of the samples, as well as the collection and analysis of information from people with hemophilia.

Table: Hemophilia Treatment Centers

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	0	3	3	0
- New Awards	0	0	3	+3
- Continuing Awards	0	3	0	-3
Average Award	\$0.000	\$1.460	\$1.460	\$0.000
Range of Awards	\$0.000	\$0.190-4.000	\$0.200-\$4.000	N/A
Total Grant Awards	\$0.000	\$4.380	\$4.380	\$0.000

¹FY 2013 appropriated funding did not include a separate funding line for Hemophilia Treatment Centers.

¹⁷² <http://www.cdc.gov/ncbddd/hemophilia/htc.html>

¹⁷³ <http://www.athn.org/content/public-health-surveillance>

Thalassemia Budget Request

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
Budget Authority	\$1.863	\$2.105	\$2.105	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

[Thalassemia](#)¹⁷⁴ is a group of genetic blood disorders that cause an anemia that begins at birth and lasts throughout life. The most severe of these disorders is Cooley's Anemia which causes a life-threatening anemia requiring regular blood transfusions and extensive ongoing medical care. These lifelong blood transfusions put people with thalassemia at higher risk for transfusion-related infections and complications from therapy such as iron overload and acute lung injury that can result in organ failure and early death.

Budget Request

CDC's FY 2015 request of **\$2,105,000** for Thalassemia is level with the FY 2014 Enacted level. In FY 2015, this funding will support continued collection of clinical information and blood samples through the Blood Safety Surveillance among People with Blood Disorders project initiated in FY 2014, to help identify non-infectious complications and infectious transmissions in heavily-transfused populations. In FY 2015, the Blood Safety Surveillance among People with Blood Disorders will continue to monitor complications of heavily transfused patients. FY 2015 funding will also support CDC's Public Health Research, Epidemiology and Surveillance for Hemoglobinopathies (PHRESH) project to gain a greater understanding of thalassemia in the general population, identify gaps in knowledge and needs of healthcare providers regarding thalassemia-associated topics and strategies for the development and dissemination of materials to fill these needs.

In FY 2015 CDC will fund 3 grantees to develop and disseminate health promotion and education materials, community outreach, and monitoring blood safety for thalassemia.

Table: Thalassemia

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	8	3	3	0
- New Awards	0	2	1	-1
- Continuing Awards	8	1	2	+1
Average Award	\$0.149	\$0.350	\$0.350	\$0.000
Range of Awards	\$0.050-0.300	\$0.200-.0570	\$0.200-.0570	N/A
Total Grant Awards	\$1.900	\$1.050	\$1.050	\$0.000

¹⁷⁴ <http://www.cdc.gov/ncbddd/thalassemia/index.html>

State Table: Early Hearing Detection and Intervention¹

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$134,600	\$147,030	\$147,030	\$0
Alaska	\$126,435	\$156,933	\$156,933	\$0
Arizona	\$173,014	\$163,933	\$163,933	\$0
Arkansas	\$94,940	\$154,440	\$154,440	\$0
California	\$146,360	\$148,800	\$148,800	\$0
Colorado	\$157,296	\$157,297	\$157,297	\$0
Connecticut	\$122,837	\$170,000	\$170,000	\$0
Delaware	\$94,246	\$137,047	\$137,047	\$0
District of Columbia	-	-	-	-
Florida	\$96,751	\$145,561	\$145,561	\$0
Georgia	\$159,909	\$159,909	\$159,909	\$0
Hawaii	-	-	-	-
Idaho	\$57,573	\$137,801	\$137,801	\$0
Illinois	\$151,940	\$169,060	\$169,060	\$0
Indiana	\$147,820	\$170,000	\$170,000	\$0
Iowa	\$175,000	\$190,000	\$190,000	\$0
Kansas	-	-	-	-
Kentucky	\$153,939	\$166,920	\$166,920	\$0
Louisiana	\$166,461	\$166,072	\$166,072	\$0
Maine	\$126,276	\$157,334	\$157,334	\$0
Maryland	\$146,651	\$146,651	\$146,651	\$0
Massachusetts	\$154,163	\$156,470	\$156,470	\$0
Michigan	\$175,000	\$175,000	\$175,000	\$0
Minnesota	\$108,661	\$130,144	\$130,144	\$0
Mississippi	\$99,827	\$153,265	\$153,265	\$0
Missouri	\$113,572	\$140,255	\$140,255	\$0
Montana	\$154,998	\$154,998	\$154,998	\$0
Nebraska	\$112,854	\$142,682	\$142,682	\$0
Nevada	\$129,699	\$132,985	\$132,985	\$0
New Hampshire	\$112,701	\$164,000	\$164,000	\$0
New Jersey	\$172,000	\$172,000	\$172,000	\$0
New Mexico	\$129,670	\$134,144	\$134,144	\$0
New York	\$156,115	\$156,338	\$156,338	\$0
North Carolina	\$163,962	\$163,392	\$163,392	\$0
North Dakota	\$155,703	\$155,703	\$155,703	\$0
Ohio	\$100,622	\$130,782	\$130,782	\$0
Oklahoma	\$125,750	\$142,750	\$142,750	\$0
Oregon	\$162,365	\$162,365	\$162,365	\$0
Pennsylvania	-	-	-	-
Rhode Island	\$146,000	\$146,000	\$146,000	\$0
South Carolina	\$135,197	\$138,804	\$138,804	\$0
South Dakota	\$96,305	\$138,972	\$138,972	\$0
Tennessee	\$156,873	\$156,873	\$156,873	\$0
Texas	\$78,500	\$170,257	\$170,257	\$0
Utah	\$141,809	\$154,950	\$154,950	\$0
Vermont	\$150,000	\$150,000	\$150,000	\$0
Virginia	\$122,583	\$156,274	\$156,274	\$0
Washington	\$146,940	\$173,602	\$173,602	\$0
West Virginia	-	-	-	-
Wisconsin	\$154,627	\$170,791	\$170,791	\$0
Wyoming	\$141,924	\$141,924	\$141,924	\$0

CDC FY 2015 Congressional Justification

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Territories				
America Samoa	\$139,333	\$144,414	\$0	\$0
Guam	\$141,000	\$141,000	\$0	\$0
Marshall Islands	\$71,267	\$89,333	\$0	\$0
Micronesia	\$72,868	\$83,056	\$0	\$0
Northern Marianas	\$90,219	\$122,350	\$122,350	\$0
Puerto Rico	-	-	-	-
Palau	\$73,774	\$91,229	\$91,229	\$0
Virgin Islands	-	-	-	-
Total	\$6,818,929	\$7,781,890	\$7,781,890	\$0

State Table: [Disability and Health Grants](#)^{1,3}

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget²	Difference +/-2014
Alabama	\$300,000	\$300,000	TBD	TBD
Alaska	\$300,000	\$300,000	TBD	TBD
Arizona	-	-	TBD	TBD
Arkansas	\$299,774	\$299,943	TBD	TBD
California	-	-	-	-
Colorado	-	-	TBD	TBD
Connecticut	-	-	TBD	TBD
Delaware	\$299,992	\$299,992	TBD	TBD
Florida	\$300,000	\$300,000	TBD	TBD
Georgia			TBD	TBD
Hawaii	-	-	TBD	TBD
Idaho	-	-	TBD	TBD
Illinois	\$300,000	\$300,000	TBD	TBD
Indiana			TBD	TBD
Iowa	\$300,000	\$300,000	TBD	TBD
Kansas			TBD	TBD
Kentucky	-	-	TBD	TBD
Louisiana	-	-	TBD	TBD
Maine	-	-	TBD	TBD
Maryland	-	-	TBD	TBD
Massachusetts	\$300,000	\$300,000	TBD	TBD
Michigan	\$300,000	\$300,000	TBD	TBD
Minnesota			TBD	TBD
Mississippi	-	-	TBD	TBD
Missouri	-	-	TBD	TBD
Montana	\$300,000	\$300,000	TBD	TBD
Nebraska			TBD	TBD
Nevada	-	-	TBD	TBD
New Hampshire	\$300,000	\$300,000	TBD	TBD
New Jersey			TBD	TBD
New Mexico	-	-	TBD	TBD
New York	\$300,000	\$300,000	TBD	TBD
North Carolina	\$300,000	\$300,000	TBD	TBD
North Dakota	\$300,000	\$300,000	TBD	TBD
Ohio	\$300,000	\$300,000	TBD	TBD
Oklahoma			TBD	TBD
Oregon	\$300,000	\$300,000	TBD	TBD
Pennsylvania			TBD	TBD
Rhode Island	\$300,000	\$300,000	TBD	TBD
South Carolina	\$299,976	\$299,930	TBD	TBD
South Dakota			TBD	TBD
Tennessee	-	-	TBD	TBD
Texas	-	-	TBD	TBD
Utah	-	-	TBD	TBD
Vermont	-	-	TBD	TBD
Virginia	-	-	TBD	TBD
Washington	-	-	TBD	TBD
West Virginia	-	-	TBD	TBD
Wisconsin	-	-	TBD	TBD
Wyoming	-	-	TBD	TBD

CDC FY 2015 Congressional Justification

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget²	Difference +/-2014
Territories				
America Samoa	-	-	-	-
Guam	-	-	-	-
Marshall Islands	-	-	-	-
Micronesia	-	-	-	-
Northern Marianas	-	-	-	-
Puerto Rico	-	-	-	-
Palau	-	-	-	-
Virgin Islands	-	-	-	-
Total	\$5,399,742	\$5,399,865	\$5,399,865	\$0.000

¹This state table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees).

²FY 2015 state award levels to be determined when awards are re-competed.

³<http://www.cdc.gov/ncbddd/disabilityandhealth/programs.html>

PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget	2015 +/-2014
	Budget Authority	\$193.238	\$397.266	\$377.723	-\$19.543
	PHS Evaluation Transfer	\$247.769	\$85.691	\$95.086	+\$9.395
	ACA/PPHF	\$51.501	\$0.000	\$53.000	+\$53.000
	Total Request	\$492.508	\$482.957	\$525.809	+\$42.852
	FTEs	1,098	1,098	1,098	0
Health Statistics		\$153.843	\$155.397	\$155.397	\$0.000
Surveillance, Epidemiology, and Public Health Informatics ²		\$275.122	\$275.156	\$303.008	+\$27.852
Public Health Workforce and Career Development		\$63.543	\$52.404	\$67.404	+\$15.000

¹FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2015 amount includes \$5 million for Vital Statistics at the National Center for Health Statistics.

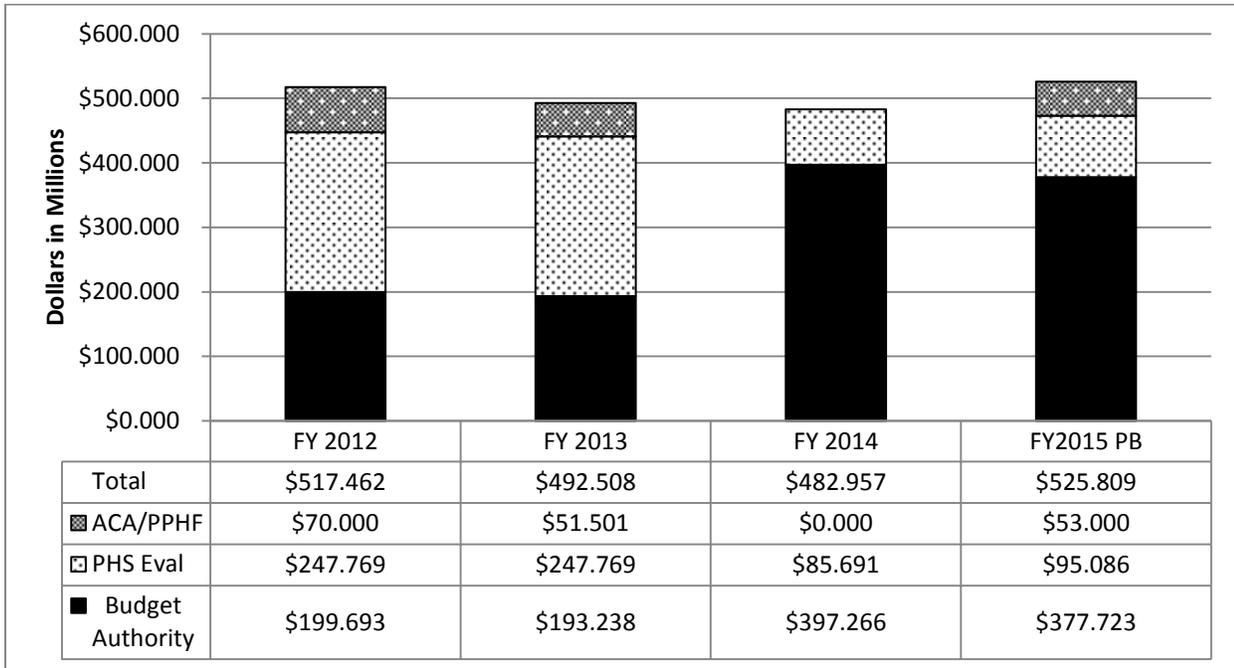
Summary

Public Health Scientific Services (PHSS) leads, promotes, and facilitates, science standards and policies to reduce the burden of diseases in the United States and globally. Public health scientific services support efforts across the agency through four main strategic initiatives:

- Increase use of electronic health records as part of an integrated strategy for public health surveillance
- Provide public health data access, analysis, interpretation, and communication
- Lead development of an efficient, sustainable and integrated network of public health laboratories
- Prepare the public health workforce to meet the 21st century challenges

CDC's FY 2015 request of **\$525,809,000** for Public Health Scientific Services, including \$95,086,000 in Public Health Service (PHS) Evaluation Transfer funds and \$53,000,000 from the Affordable Care Act Prevention and Public Health Fund, is \$42,852,000 above the FY 2014 Enacted level. This increase will maintain activities, which support public health scientific services across CDC. These activities include: providing ongoing administrative, research, and technical support for the operations of the Community Guide; tracking effects of the Affordable Care Act on the healthcare system and on health outcomes; and maintaining the number of entry-level trainees through the Public Health Associate Program (PHAP). The increase also will allow CDC to provide more support to other major fellowship programs affected by funding cuts in FY 2014. The FY 2015 Budget maintains CDC's capacity to monitor key health indicators, purchase 12 months birth and death records from the vital registration jurisdictions, and phase in use of electronic death registration systems in up to eight jurisdictions. Within the total, \$5 million is also included for public health systems research as authorized under section 4301 of ACA.

Figure: Public Health Scientific Services Funding History¹



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Health Statistics Budget Request

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget	2015 +/-2014
	Budget Authority	\$15.160	\$69.706	\$155.397	+\$85.691
	PHS Evaluation Transfer	\$138.683	\$85.691	\$0.000	-\$85.691
	Total	\$153.843	\$155.397	\$155.397	+\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's [National Center for Health Statistics](#)¹⁷⁵ (NCHS) is the nation's principal health statistics agency, producing data used to identify emerging health issues and help guide actions and policies to improve the health of Americans. In FY2013, the NCHS website received twelve million visits, connecting researchers, policy makers, and other data users to high quality data on a variety of health and health-related topics. **CDC collects data on births, deaths, health status, and health care through four main mechanisms:**

- National Vital Statistics System (NVSS)
- National Health Interview Survey (NHIS)
- National Health and Nutrition Examination Survey (NHANES)
- National Health Care Surveys

Combined, these surveys allow CDC to create a comprehensive picture of health across the nation.

Budget Request

CDC's FY 2015 request of **\$155,397,000** for health statistics is level with the FY 2014 Enacted Level. At this level CDC will continue supporting:

- National Health Care Surveys
- National Health Interview Survey
- National Health and Nutrition Examination Survey
- National Vital Statistics System
- Survey Design, Data Analysis and Dissemination

National Health Care Surveys

The [National Health Care Surveys](#)¹⁷⁶ collect information about organizations and providers that supply health care, the services rendered, and the patients served. These data help answer questions about the factors that influence the use of health care resources, the quality of health care, and disparities in health care services provided to population subgroups. In FY 2015, CDC will collect data for the [National Hospital Care Survey](#)¹⁷⁷ (NHCS) on inpatient discharges, relying on administrative data for information on inpatient stays. In addition, sampled hospitals will provide data on visits to emergency rooms, outpatient departments, and ambulatory surgery locations. The emergency department component of the NHCS will obtain data on drug-related emergency department visits using data elements from the Drug Abuse Warning Network (previously conducted by the Substance Abuse and Mental Health Services Administration).

¹⁷⁵ <http://www.cdc.gov/nchs>

¹⁷⁶ <http://www.cdc.gov/nchs/dhcs.htm>

¹⁷⁷ <http://www.cdc.gov/nchs/nhcs.htm>

In FY 2015, CDC's [National Ambulatory Medical Care Survey](#)¹⁷⁸ (NAMCS) will continue to collect data on care provided in physician offices and community health centers. CDC, in collaboration with the Assistant Secretary for Planning and Evaluation, will test the expansion of NAMCS data collection to include patient visits to nurse practitioners and physician assistants. To improve data quality and timeliness, CDC will continue to explore the collection of healthcare data from electronic health records (EHRs) by allowing participating physicians and hospitals to transmit electronic data from EHRs.

In FY 2015, CDC will release the second wave of data from the [National Study of Long-Term Care Providers](#)¹⁷⁹, which will provide nationally representative statistical information about the supply and use of paid, regulated, long-term care providers. The first wave of data released in 2013 showed that in 2012, about 58,000 paid, regulated long-term care services providers served about eight million people in the United States.

National Health Interview Survey

In FY 2015, CDC conduct household interviews through the [National Health Interview Survey](#)¹⁸⁰ (NHIS), obtaining data on health status, use of health services, health behaviors, injuries, health conditions, and health insurance and access to care. CDC will continue to release preliminary NHIS data on a quarterly basis to meet user needs for timely data. CDC will develop and evaluate methods to better connect NHIS users to data, such as the NHIS Online Analytic Real-time System, a tool in development that will address the need for more state-level data by allowing users to analyze both public-use data and unreleased data due to confidentiality constraints (notably state identifiers).

In FY 2014, CDC will release data from the National Health Care Interview Survey, a telephone and web-based follow-back survey with previous NHIS participants designed to monitor changes over time in health status, health care access, and health behaviors. In 2014, CDC launched the first ever Native Hawaiian and Pacific Islander (NHPI) NHIS. The 2012 American Community Survey identified a sample of households for administration of this questionnaire. Data from the NHPI NHIS will be available in 2015.

To improve precision of national estimates and increase the number of states for which CDC has key data, CDC was able to expand the NHIS sample size from 35,000 to approximately 42,000 households in 2012 (supported by Prevention and Public Health Funds). As a result, the 2012 NHIS produced health insurance coverage estimates for 43 states, compared to 20 before the sample increase. These data allow better monitoring of health care access and use in order to evaluate, target, and improve health and health-related policies and programs. Because no funding was received from the Prevention and Public Health Fund in FY 2014, the 2015 NHIS sample will return to 35,000 with a limited number of state estimates.

National Health and Nutrition Examination Survey

CDC will conduct the [National Health and Nutrition Examination Survey](#)¹⁸¹ (NHANES) in FY 2015. This unique national survey is designed to assess the health and nutritional status of adults and children. The survey visits 15 randomly selected counties each year, selecting a nationally representative sample of approximately 5,000 people for interviews as well as physical examinations. Physical examinations are done in mobile examination centers. A particular strength of this comprehensive approach is the ability to provide data on diagnosed and undiagnosed conditions. For example, data from NHANES 2011-2012 showed that among adults with hypertension: 82.7% were aware of their hypertension; 75.6% reported currently taking prescribed medication to lower their blood pressure; and 51.8% had their blood pressure controlled.

¹⁷⁸ <http://www.cdc.gov/nchs/ahcd.htm>

¹⁷⁹ <http://www.cdc.gov/nchs/nsltcp.htm>

¹⁸⁰ <http://www.cdc.gov/nchs/nhis.htm>

¹⁸¹ <http://www.cdc.gov/nchs/nhanes.htm>

In FY 2015, these data will be available from the 2013-2014 NHANES. Routinely collected data will be available, as well as an assessment of dental fluorosis and exposure to fluoride in children. The data will be collected using specially enhanced digital photography and measures of fluoride in the blood and from the participant's water supply.

In FY 2015, NHANES will provide the first measurement of current human papillomavirus (HPV) infection in males on a national survey.

National Vital Statistics System

The [National Vital Statistics System](#)¹⁸² (NVSS) is a network of 57 vital registration jurisdictions. CDC collaborates with these jurisdictions to collect and analyze data on births, deaths, and fetal deaths. The collection and analyses of these data in 2015 will provide key information to measure the health of the U.S. population, including the infant mortality rate, life expectancy at birth, and the leading causes of death. CDC continually works to improve timeliness of vital statistics to allow prompt monitoring of public health programs and policies. For example, CDC published preliminary data for 2012 births eight months after the end of the year, a one-month improvement over 2011, allowing faster access to these data for planning and evaluating efforts to improve maternal and infant health.

Survey Design, Data Analysis and Dissemination

CDC conducts statistical research to improve methods of data collection and analysis. In FY 2015, CDC will evaluate and improve its data collection processes through its [Questionnaire Design Research Laboratory](#)¹⁸³, a laboratory that develops and tests survey instruments, thereby improving the reliability and validity of CDC surveys. CDC surveys provide data at the national, regional, or state level, contingent on the sample size. To address the gap in availability of estimates for smaller geographic areas, CDC will continue to develop and evaluate [small-area estimation techniques](#)¹⁸⁴, such as incorporating auxiliary data to enhance small-area estimation for CDC survey outcomes.

CDC will continue to promote access and dissemination by making public-use data files and statistical reports easily accessible in a timely manner to health professionals, researchers, and policy makers. In 2013, CDC published over 100 reports and journal articles, including reports on:

- Declines in infant mortality
- Trends in hospital inpatient deaths
- Caloric intake from fast food
- Strategies taken by individuals to reduce prescription drug costs

Each year, CDC produces [Health, United States](#)¹⁸⁵, the Secretary's yearly report to Congress on the health of the nation, providing a timely overview of trends related to health status and its determinants, health care, and health insurance.

CDC will provide analysis and statistical expertise for [Healthy People 2020](#)¹⁸⁶, coordinating the effort to measure progress over the decade by tracking data for more than 1,200 health objectives from about 200 data sources.

CDC will optimize the value and usability of its data through online [tutorials](#)¹⁸⁷ which provide analytic guidance, [linkage with other data sets](#),¹⁸⁸ and the development and improvement of on-line access systems such as the

¹⁸² <http://www.cdc.gov/nchs/nvss.htm>

¹⁸³ <http://www.cdc.gov/qdrl/>

¹⁸⁴ <http://www.copafs.org/UserFiles/file/seminars/2012FCSM/Session06PavlinaRumchevaFCSMpresentation.pdf>

¹⁸⁵ <http://www.cdc.gov/nchs/hus.htm>

¹⁸⁶ http://www.cdc.gov/nchs/healthy_people/hp2020.htm

[Health Data Interactive](#)¹⁸⁹ and [Health Indicators Warehouse](#)¹⁹⁰. The [Research Data Center](#)¹⁹¹ will provide access to confidential CDC data, allowing researchers to conduct analyses that build on information presented in standard health statistics reports.

Table: Selected 2013 NCHS Data Products

For data users seeking to...	Product (release date)
Determine how many births there were in a particular state in 2012 by race and Hispanic origin of mother.	<ul style="list-style-type: none"> • Births: Preliminary Data for 2012¹⁹²
Learn how Americans are dealing with the out-of-pocket cost of their health care.	<ul style="list-style-type: none"> • Problems Paying Medical Bills: Early Release of Estimates from the National Health Interview Survey, January 2011-June 2012¹⁹³ • Strategies Used By Adults to Reduce Their Prescription Drug Costs¹⁹⁴
Conduct their own analyses of 2012 NHIS data.	<ul style="list-style-type: none"> • 2012 NHIS Public-use data files¹⁹⁵
Discover how many physicians are using electronic health record systems that meet meaningful use criteria.	<ul style="list-style-type: none"> • Physician Experience With Electronic Health Record Systems That Meet Meaningful Use Criteria: NAMCS Physician Workflow Survey, 2011¹⁹⁶
Find national estimates of obesity among U.S. adults, based on measured weight and height.	<ul style="list-style-type: none"> • Prevalence of Obesity Among Adults: United States, 2011–2012¹⁹⁷

¹⁸⁷ <http://www.cdc.gov/nchs/tutorials/NHANES/index.htm>

¹⁸⁸ http://www.cdc.gov/nchs/data_access/data_linkage_activities.htm

¹⁸⁹ <http://www.cdc.gov/nchs/hdi.htm>

¹⁹⁰ <http://healthindicators.gov/>

¹⁹¹ <http://www.cdc.gov/rdc/>

¹⁹² http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_03.pdf

¹⁹³ http://www.cdc.gov/nchs/data/nhis/earlyrelease/problems_paying_medical_bills_january_2011-june_2012.pdf

¹⁹⁴ <http://www.cdc.gov/nchs/data/databriefs/db119.pdf>

¹⁹⁵ http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm

¹⁹⁶ <http://www.cdc.gov/nchs/data/databriefs/db129.htm>

¹⁹⁷ <http://www.cdc.gov/nchs/data/databriefs/db131.pdf>

Surveillance, Epidemiology, Informatics, and Laboratory Science Budget Request

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget	2015 +/-2014
	Budget Authority	\$130.144	\$275.156	\$169.922	-\$105.234
	PHS Evaluation Transfer	\$109.086	\$0.000	\$95.086	+\$95.086
	ACA/PPHF²	\$35.892	\$0.000	\$38.000	+\$38.000
	Total	\$275.122	\$275.156	\$303.008	+\$27.852

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2015 amount includes \$5 million for Vital Statistics at the National Center for Health Statistics.

Overview

CDC’s public health scientific support services provide expertise in public health surveillance systems and informatics, epidemiologic analysis, and laboratory policy and practice. CDC supports public health science through various surveillance systems, utilizing external sources of information, and sharing best practices in collecting, managing, and using information among CDC programs and the public health community. As of September 30, 2013, 45 out of 50 state health departments are capable of receiving meaningful use immunization data through required message standards. In addition, 43 (41 states and 2 large local) jurisdictions accept required message standards into the immunization registry production database.

In 2013, CDC released the [CDC Health Disparities and Inequalities Report — United States, 2013](#)¹⁹⁸, which examines some of the key factors that affect health and lead to health disparities in the United States. CDC also added functionality to Epi Info, CDC’s outbreak investigation software, which allows distribution of customized data collection surveys by web to many locations and then into a single database.

Budget Request

CDC’s FY 2015 request of **\$303,008,000** for surveillance, epidemiology, informatics, and laboratory science, including \$95,086,000 in Public Health Service (PHS) Evaluation Transfer funds and \$38,000,000 from the Affordable Care Act Prevention and Public Health Fund, is \$27,852,000 above the FY 2014 Enacted level. This increase provides ongoing administrative, research, and technical support for the operations of the Community Guide and for tracking effects of the Affordable Care Act on the healthcare system and on health outcomes. Included in the Affordable Care Act Prevention and Public Health Fund request is \$5,000,000 to support HHS and CDC’s capability to monitor key health indicators through the National Center for Health Statistics and to purchase 12 months of birth and death records from the vital registration jurisdictions. The investment will also phase in use of electronic death registration systems in up to eight jurisdictions.

The FY 2015 Budget Request maintains CDC’s capacity to support:

- Ongoing quality, timeliness, and accessibility of public health data for decision-making
- Development of methods to improve quality
- Access to information from electronic health records

Surveillance

CDC’s public health surveillance and informatics program strengthens the quality and utility of public health surveillance and the ability of public health departments to benefit from and manage advances in electronic health information. CDC advances surveillance science and practice by managing various surveillance systems

¹⁹⁸ <http://www.cdc.gov/DisparitiesAnalytics>

used across CDC, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Notifiable Diseases Surveillance System (NNDSS).

- Expand current efforts to produce cost-efficient, state and local-level estimates, and
- Fund states to continue increasing the percentage of interviews completed by cellular telephone respondents to 27%, which will ensure adequate population coverage for states and selected metropolitan statistical areas.

CDC works in partnership with state and territorial health departments through competitive cooperative agreements to administer the BRFSS. In FY 2015, CDC will fund an estimated 56 grantees to complete approximately 450,000 BRFSS surveys. There is no prescribed funding formula. Awards are based primarily on the required sample size needed in the state to produce reliable estimates, the type of data collector used by the state (i.e., in-house, university, or private company) and special projects (e.g., mail and web pilots, call-back surveys, etc.).

Table: Behavioral Risk Factor Surveillance System (BRFSS) Grant Table

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	56	TBD	56	0
- New Awards	0	0	0	0
- Continuing Awards	56	TBD	56	N/A
Average Award	\$0.236	TBD	\$0.236	N/A
Range of Awards	\$0.065–\$0.393	TBD	\$0.065–\$0.393	N/A
Total Awards	\$13.200	TBD	\$13.200	N/A

¹ The BRFSS was funded through budget authority, Public Health Service evaluation funds, funding from other CDC programs, and Prevention and Public Health Fund (PPHF) dollars in FY 2013. Non-core funding from other CDC programs and PPHF dollars are not reflected in this table.

In FY 2015, CDC’s [National Notifiable Diseases Surveillance System \(NNDSS\)](#)¹⁹⁹ will complete these activities.

Table: NNDS activities and goals for FY 2015

Activities	Goals
Funding for state and local health departments	Funding health departments in 64 jurisdictions to improve their ability to identify and monitor disease outbreaks, develop policies and public health programs to prevent and control the spread of disease, and evaluate the effectiveness of those interventions within their jurisdictions.
Improving the timeliness and quality of reporting	Leading the development of national standards for disease reporting and case definitions, and by collaborating with jurisdictions to increase Electronic Laboratory Reporting (ELR). For example, Arizona’s ELR initiative demonstrated an increase from 9% of labs reporting in 2009 to over 40% in 2012. This advancement reduced the overall median reporting time for reportable conditions from five days to two.
Summarizing data collection	Continue to summarize the data collected from funded state and local jurisdictions in the weekly MMWR notifiable diseases tables ²⁰⁰ , which enables regional and national awareness of disease trends and informs disease prevention strategies.
Data sharing	Initiate sharing weekly NNDSS data on Data.CDC.gov ²⁰¹ to enhance its use in public health research and evaluation.

¹⁹⁹ <http://wwwn.cdc.gov/nndss/default.aspx>

²⁰⁰ http://www.cdc.gov/mmwr/mmwr_wk/wk_cvol.html

²⁰¹ <https://data.cdc.gov/>

In January 2013, CDC completed an evaluation to identify the needs and perspectives of state and local health departments regarding NNDSS. The evaluation revealed a need to address gaps in public health informatics capabilities; challenges in implementing standards for health information exchanges; increase reporting for ELR and electronic health record; and increase coordination across CDC programs for use of common surveillance standards. In response, CDC will focus on making recommended improvements to data quality and completeness; improve implementation of reporting standards and efficiencies; and provide users with better tools in FY 2015.

In FY 2013, the second year of a five-year cooperative agreement period, CDC added the U.S. Virgin Islands as a grantee, totaling 64 funded jurisdictions. These cooperative agreement awards are competitive, based on grantee request, and subject to the availability of funds. CDC's NNDSS funding provides local and state public health agencies with the means to track, report, and respond to notifiable diseases. CDC collaborates with the Council of State and Territorial Epidemiologists (CSTE) to identify which Public Health Emergencies of International Concern-eligible conditions are reportable in states and territories in support of the revised International Health Regulations.

Table: National Notifiable Diseases Surveillance System (NNDSS) Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	64	64	64	0
- New Awards	1	0	0	0
- Continuing Awards	63	64	64	0
Average Award	\$0.157	\$0.165	\$0.165	\$0.000
Range of Awards	\$0.009–\$0.362	\$0.010–\$0.373	\$0.010–\$0.373	N/A
Total Awards	\$10.049	\$10.359	\$10.359	\$0.000

Epidemiology

CDC supports evidenced based decision making by providing CDC scientists with access to epidemiological resources, scientific literature, and databases covering multidisciplinary topics related to disease prevention and control. In FY 2013, the CDC Public Health Library and Information Center provided electronic access to nearly 70,000 journals, books and databases and anticipates growing demand in FY 2015 and beyond as library products and services become increasingly electronic.

CDC supports health departments, non-profit hospitals and others engaged in assessing the health of their communities with epidemiologic tools and resources such as suggested health metrics, survey instruments, and a web application. The Community Health Status Indicators project allows counties to track indicators for the leading causes of mortality and morbidity and benchmark their progress against demographically similar peer counties.

The nonfederal, independent Community Preventive Services Task Force (Task Force) makes recommendations about evidence-based options for promoting healthful lifestyles, encouraging a healthy environment, and helping to ensure that all Americans have access to affordable and appropriate clinical preventive services and treatment. CDC is responsible for conducting the systematic reviews that provide the basis for these recommendations.

In FY 2013, CDC conducted 14 systematic reviews on high-priority public health problems such as reducing tobacco use and secondhand smoke exposure, cardiovascular disease prevention, preventing skin cancer, and increasing physical activity. CDC provided professional advice to 26 states, which helped them locate, select, and use Community Guide interventions that best meet their needs and resources.

Table: Epidemiology activities and goals for FY 2015

Activities	Goals
Provide ongoing administrative, technical and research support to the Community Preventive Services Task Force	Conduct systematic reviews of the evidence on community preventive programs, services and policies used by the Community Preventive Services Task Force (Task Force) as the basis for their recommendations. Enhance dissemination of Task Force recommendations and provide technical assistance to those requesting help in implementing recommendations.
Provide access to public health information for public health partners	Collaborate with CMS and other Federal agencies to increase scientists' access to clinical data (e.g. hospitalization and CMS data), which can be used for surveillance, research, and evaluation. These efforts will increase the utility of existing health care data for identifying what works to improve population health.
Disseminate timely, useful health information	Expand the readership of <i>MMWR</i> and <i>CDC Vital Signs</i> by collaborating with constituents in state and local health departments; international colleagues; clinical medicine counterparts; and print, broadcast, and online media. In FY2013, CDC delivered critical epidemiological data and recommendations to over 190,000 clinicians, epidemiologists, laboratorians, and other public health professionals through the MMWR.
Provide trainings and e-learning materials to public health professionals	Expand the utility of Epi Info ²⁰² software through increased trainings and e-learning materials such as videos and tutorials. To date, CDC has conducted 54 instructor-led training courses of the newest version of the software.

²⁰²<http://www.cdc.gov/epiinfo/>

Public Health Informatics

CDC's informatics program supports public health surveillance by bridging the gap between the public health community and clinical care using advances in information technology and electronic health information. CDC supports interoperability between public health agencies and healthcare in support of CMS' Meaningful Use of Electronic Health Records incentive program by:

- Implementing as part of an integrated surveillance strategy
- Hosting an innovative applied public health informatics laboratory and research cloud
- Providing data management and information exchange services to CDC programs and the public health community

In FY 2015, CDC will work to increase the utility and further explore new public health uses of EHR-MU, automated laboratory information systems, and health information exchanges by supporting standard informatics guidelines and tools in collaboration with other CDC programs. CDC will use these standards to support critical public health functions such as, health information exchange, emergency outbreak alerting, and laboratory science practices.

CDC will continue to pursue informatics innovations resulting in improved quality and quantity of data to public health officials' decision-making and program management. CDC will also identify and assist with public health needs in the field by providing the policies, analytic tools, data management tools, and other useful services to state and local partners, other federal agencies and organizations within CDC. CDC will continue to develop a public health information system to enhance the mechanisms to collecting, processing, analyzing, and disseminating collected electronic health data. CDC will aim to serve current and future public health needs, designed with the potential to accommodate ever-changing technology.

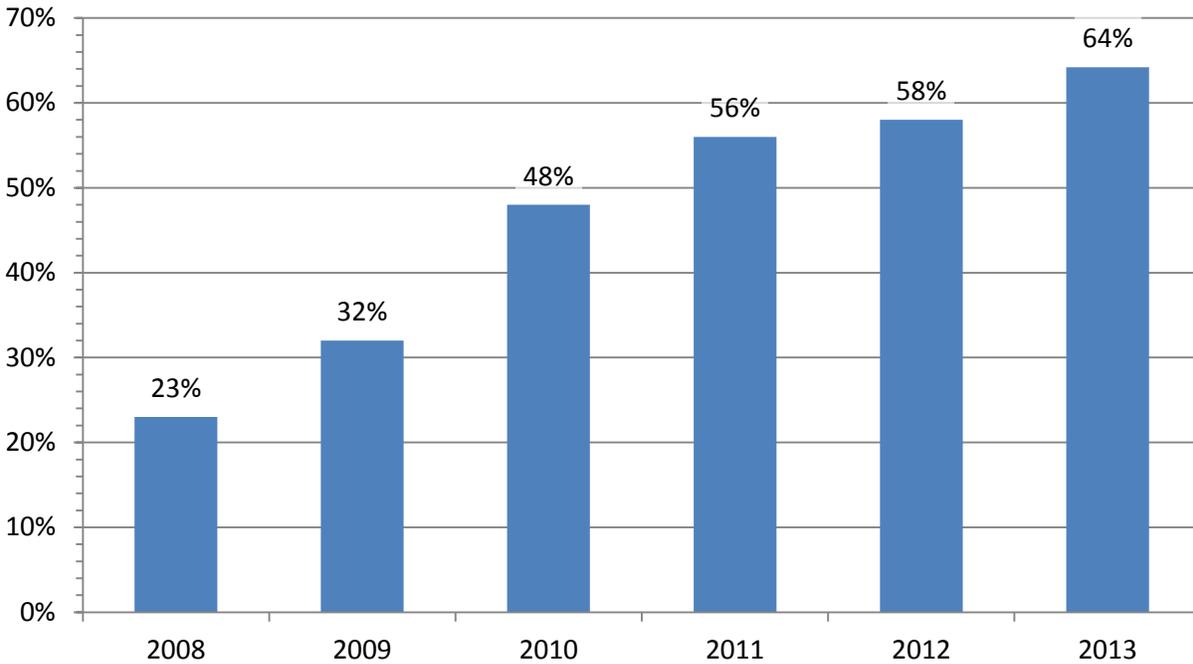
Laboratory Standards and Services

CDC's laboratory standards and services provide leadership to strengthen the quality of public health and clinical laboratory practice and the reliability of laboratory testing in the United States and globally. CDC supports these efforts by:

- Developing evidence-based guidelines
- Supporting standardized test ordering and reporting linked to electronic health records
- Delivering training and other services to public health and clinical laboratories

In FY 2013, CDC supported regional capacity building for emergency preparedness through awards for the formation of a North-East regional network of eight state (and one metropolitan) public health laboratories to share testing services. CDC supported state public health labs with an informatics self-assessment tool to assist with gap analysis and decision-making. CDC laboratory standards and services achieved its FY 2013 target for improvements in practices and policies resulting from hands-on trainings. CDC enhanced the safety and security of laboratories; accuracy and timeliness of test results; and responses to outbreaks. These achievements enabled CDC to improve the cost efficiency of clinical testing procedures.

Percentage of Public Health and Clinical Laboratory Professionals who Improve Laboratory Policies and Practices as a Result of Participating in CDC Laboratory Training Workshops (Outcome)



In FY 2015, CDC will:

- Lead the implementation of new agency-wide policies for specimen management
- Support scientific research and discovery through improved access to CDC's scientific specimen collections managed by the CDC and ATSDR Specimen Packaging, Inventory, and Repository (CASPIR)
- Ensure compliance with select agents and toxins and dual-research of concern federal policies and regulatory requirements
- Create resources and provide scientific and programmatic expertise to improve public health laboratories' efficiency, effectiveness, and sustainability
- Develop and deliver a minimum of 60 training courses in advanced public health laboratory practice to state and local public health professionals

Public Health Workforce and Career Development Budget Request

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget	2015 +/-2014
	Budget Authority	\$47.934	\$52.404	\$52.404	\$0.000
	ACA/PPHF	\$15.609	\$0.000	\$15.000	+\$15.000
	Total	\$63.543	\$52.404	\$67.404	+\$15.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

A well-trained public health workforce is critical to ensuring the highest level of efficiency and effectiveness in protecting population health—a responsibility that only public health systems ensure. CDC supports a prepared, diverse, and sustainable public health workforce through programs that recruit new talent through on-the-job fellowships, increase access to high-quality workplace training (including e-learning), and work with academia to improve education about population health. As of September 30, 2013, CDC supported 614 fellows, 401 (65%) of whom were in state, tribal, local, and territorial field assignments in 46 states, American Samoa, the District of Columbia, Guam, Puerto Rico, and six tribal locations; the remainder were assigned to CDC.

Budget Request

CDC’s FY 2015 request of **\$67,404,000** for Public Health Workforce and Career Development, including \$15,000,000 from the Affordable Care Act Prevention and Public Health Fund, is \$15,000,000 above the FY 2014 Enacted level. This increase will support a prepared, diverse, and sustainable public health workforce through programs that recruit new talent through experiential fellowships and increase access to high-quality workplace training, including e-learning. With this increase, CDC will support over 600 fellows with an enhanced focus on expanding the reach of our training to state and local health departments.

CDC cannot clearly estimate the effects of the FY 2014 budget reductions. However, the fellowships that may be affected include:

- Epidemic Intelligence Service
- Public Health Associate Program
- Prevention Effectiveness Fellowship
- Public Health Informatics Fellowship
- Informatics Training-in-Place Program
- Applied Public Health Informatics Fellowship (cooperative agreement with CSTE, ASTHO, NACCHO, PHII)
- Health Systems Integration Program (cooperative agreement with CSTE, ASTHO, NACCHO, PHII)
- CDC/CSTE Applied Epidemiology Fellowship (cooperative agreement with CSTE)
- Emerging Infectious Diseases Laboratory Fellowship (cooperative agreement with APHL)
- Academic Partnerships to Improve Health cooperative agreements (cooperative agreements with ASPPH, AAMC, APTR, AACN)

Also, the FY 2014 funding level would reduce the number of fellows that are assigned to state and local health departments. Currently, 65% of the fellows that CDC supports are assigned to state, territorial, local and tribal, partners.

Table: Fellows Supported by Public Health Workforce and Career Development Funding

	FY 2013 Final	FY 2014 Enacted²	FY 2015 President Budget	2015 +/-2014
Number of Fellows	614	507	651	+144
- Fellows assigned to STLT agencies	401	331	425	+94
- Fellows assigned to CDC	213	176	226	+50

²The number of fellows supported in FY14 are estimated, since the programs have not yet received their FY14 funding allocations.

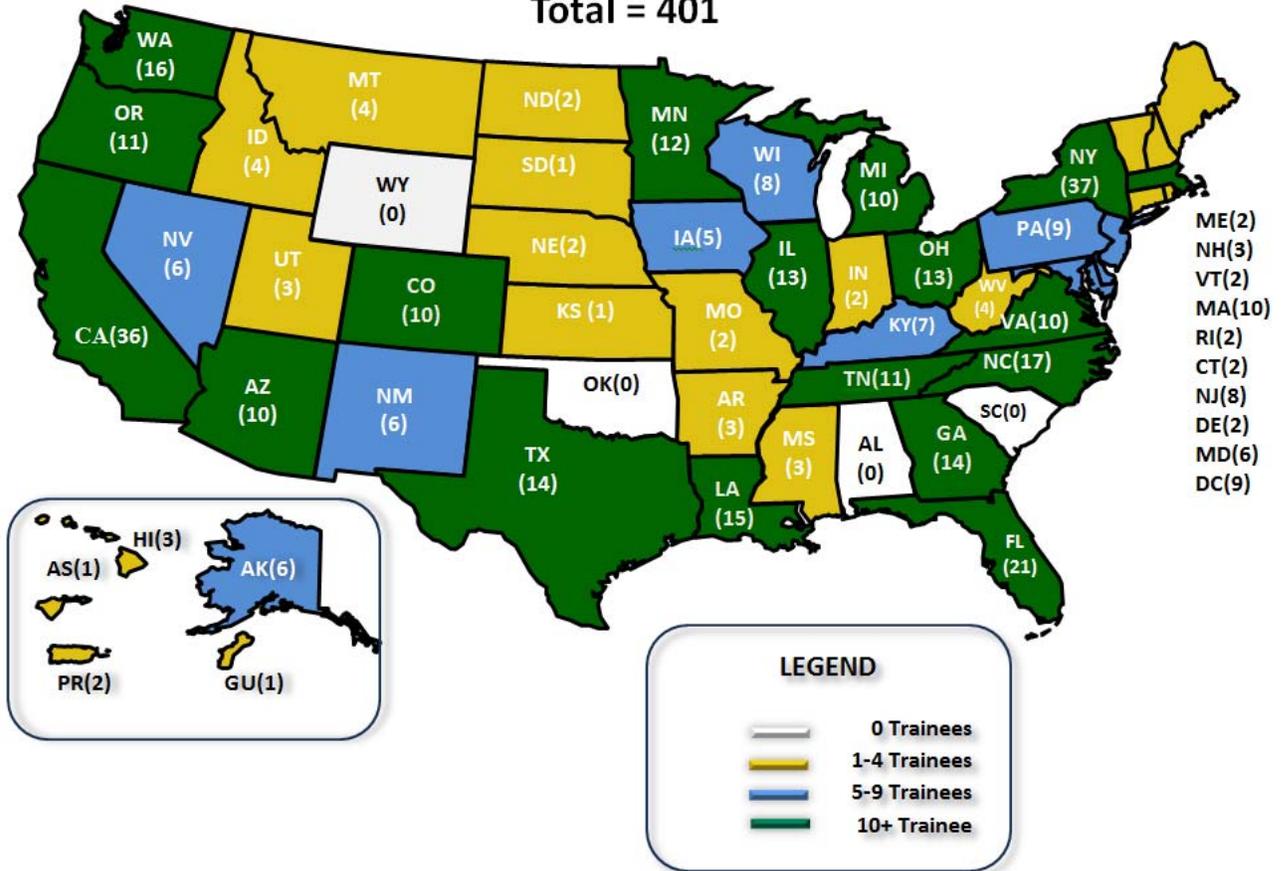
In FY 2015, CDC will focus on the following public health workforce goals and activities.

Table: Public Health Workforce Goals and Activities for FY 2015

Goals	Activities
Enhance public health workforce training	Support fellowship programs that provide robust on-the-job learning while filling critical gaps in the public health workforce. Expand continuing education and training for the existing health professional workforce.
Assist state, tribal, local, and territorial (STLT) public health agencies fill critical workforce gaps	Place more trainees in STLT public health agencies (for example, through PHAP) to meet STLT needs while training the next generation of the public health workforce.
Equip EIS officers with the skills to meet 21 st century public health challenges	Modernize EIS training to enhance officers' ability to support integrated surveillance approaches and systems that leverage existing data sources. Focus on innovative epidemiology methods, informatics training, and communication skills including social media.
Ensure that the public health workforce has a common foundation in core public health sciences	Offer a public health core curriculum to staff across all levels of public health, enhancing skills in epidemiology, surveillance, informatics, prevention effectiveness, and laboratory practice. Make an e-learning version of the core curriculum available for free to the public via CDC TRAIN.
Expand informatics training for the public health workforce	Use innovative methods to enhance the informatics training provided to the public health workforce (including CDC's fellows). For example, CDC will support an informatics training-in-place program for staff at state and local public health agencies by providing training and guidance to complete high-priority informatics projects in their agencies (such as using electronic health record data to address Meaningful Use and other public health challenges).
Educate more health professionals on population health and make public health education more practical	Work with academic partners to integrate population health concepts into the curricula at medical and nursing schools. Connect public health schools with local, on-the-ground public health needs, so that students can gain a practice-based education while addressing current needs in their communities.

CDC State, Tribal, Local, and Territorial Field Trainees – 9/30/2013

Total = 401



CDC’s fellowships and student programs train new public health professionals in critical disciplines. These on-the-job training programs offer on-the-job training:

- Develop skilled public health workers
- Serve state and local health departments
- Fill gaps in key public health areas

CDC supports the current workforce by offering public health training and continuing education. Many health professionals need continuing education to maintain their professional licensure and enhance necessary job skills to further their careers. CDC is the only HHS agency accredited to award six types of continuing education for health professionals; in FY 2013, over 173,000 free continuing education units were awarded through CDC. CDC provides a central location for quality public health e-learning, training information, and learning resources through the [CDC Learning Connection](http://www.cdc.gov/learning/)²⁰³. This website provides access to CDC TRAIN, a free resource where individuals across public health and health care can identify educational activities to support their professional development. As of December 31, 2013, over 5,800 courses were available to over 78,000 registered learners. CDC TRAIN creates efficiencies across CDC by increasing access to training resources for all health professionals and reducing travel costs and fees associated with training for state and local health departments.

²⁰³ <http://www.cdc.gov/learning/>

These collective efforts help ensure that the nation has a public health workforce that is ready to meet 21st century challenges. FY 2015 funding will be used to address state and local workforce needs, enhance public health informatics training, and disseminate a public health core curriculum while continuing important fellowship, e-learning, and academic partnership activities.

CDC also works with academic partners to promote the integration of population health concepts into the curricula of medical and nursing schools and to ensure that public health education is focused on ground-level public health priorities. Through cooperative agreements, CDC funds four national academic associations that represent the education of public health professionals, physicians, and nurses. The four awardees are the Association of American Medical Colleges, Association for Prevention Teaching and Research, Association of Schools and Programs of Public Health, and American Association of Colleges of Nursing. Activities focus on improving population health through curricular enhancements, inter-professional exchange, partnerships, and fellowships. At the end of five years, CDC expects awardees to expand by 25 % the number of medical and nursing schools that integrate population health concepts into their curricula. This grant award was not impacted by sequestration; reductions were taken in other activities.

Table: Academic Partners Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	4	4	4	0
- New Awards	0	0	0	0
- Continuing Awards	4	4	4	0
Average Award	\$0.265	\$0.265	\$0.265	\$0.000
Range of Awards	\$0.203–\$0.295	\$0.203–\$0.295	\$0.203–\$0.295	N/A
Total Awards	\$1.062	\$1.062	\$1.062	\$0.000

¹Total grant award represents the core award; other CDC offices can choose to fund supplemental awards using this cooperative agreement.

Affordable Care Act Prevention and Public Health Fund

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	
			President Budget	2015 +/-2014
ACA/PPHF	\$51.501	\$0.000	\$53.000	+\$53.000

The following activities are included:

- Community Guide, \$8,000,000
- Public Health Research, \$5,000,000
- Vital Statistics, \$5,000,000
- Healthcare Surveillance/Health Statistics, \$20,000,000
- Public Health Workforce Capacity, \$15,000,000 (included in the Public Health Workforce narrative)

Community Guide

CDC’s FY 2015 request of \$8,000,000 for the Community Guide in the Prevention Fund will provide ongoing administrative, research, and technical support for the operations of the Community Guide. The Community Preventive Services Task Force —an independent, nonfederal panel—is congressionally mandated to develop findings and recommendations identifying programs, services, and policies proven effective in reducing disease, death, disability, and injury in a variety of real-world settings, such as communities, worksites, schools, and health plans. Task Force recommendations empower decision makers to 1) Use resources efficiently; 2) protect and improve health; 3) reduce demand for future health care spending driven by preventable disease and disability; and 4) increase the U.S. workforce’s productivity and economic competitiveness.

Task Force recommendations are not mandates for compliance or spending. Instead, they provide information about evidence-based options that decision makers and stakeholders may wish to consider when determining what best meets the needs, preferences, available resources, and constraints of their jurisdictions and constituents. Task Force recommendations and findings are used by:

- Employers and worksites to increase productivity and save money;
- Health systems, health plans, and clinics to enhance the delivery of clinical preventive services, improve quality of care delivery, and save money;
- State and local health departments and other governmental agencies to achieve public health goals and support accreditation of public health departments;
- Schools, community health centers, community centers, faith-based organizations, and others to address the unique needs of their local constituents;
- Funding agencies and foundations to establish priorities for funding opportunities to fill evidence gaps;
- Researchers and program evaluators to develop studies aimed at filling evidence gaps; and
- Educators to develop training curricula for public health and clinical training programs for university students and continuing education.

Examples of The Community Guide in use include:

- Duval County Health Department in Jacksonville, Florida implemented Task Force recommendations to improve appropriate vaccination and within one year saw the percentage of 2-year-olds with complete immunization records rise from 75% to the national target of 90%.

- Through a grant from National Center for Injury Prevention and Control, Arizona's San Carlos Apache Tribal Police Department implemented Task Force-recommended interventions aimed at reducing alcohol-impaired driving. Motor vehicle crashes decreased 29% from 2004 to 2009.
- Implementing the Task Force recommendation to combine (1) employee assessment of health risk with (2) feedback to employees and (3) follow-up health improvement programming—as was done by Johnson & Johnson and BAE Systems' worksite wellness programs—returned to these employers approximately \$3.00 for every \$1.00 invested within a 3-year period.

Vital Statistics

In FY 2015, CDC requests \$5,000,000 in Prevention and Public Health Funds to improve the quality and timeliness of vital statistics data by phasing in and expanding electronic death registration systems in up to eight jurisdictions and developing systems that support vital records collection, analysis, and dissemination. These funds will support CDC's National Center for Health Statistics. Electronic birth and death registration systems play an important role in speeding up the transfer of data from the jurisdictions to NCHS for analysis and reporting. In 2013, NCHS completed the funding of remaining states seeking assistance for development and/or implementation of an electronic birth registration system. Similar progress has not been made with electronic death registration systems. Widespread use of electronic death registration systems allows for faster reporting of final annual mortality data and real time surveillance of deaths of public health importance. Widespread use also allows for quick matching with birth certificates, assuring that birth certificates of people who have recently died are not issued to others for fraudulent purposes. As of October 2013, 38 jurisdictions have an operational electronic death registration system and five have a system in development. Of those 38 with a system, many still have low numbers of records filed electronically and capture incomplete information on the cause of death.

Healthcare Surveillance/Health Statistics

CDC's FY 2015 request for health care surveillance/health statistics is \$20,000,000 above the FY 2014 Enacted level. In FY 2015, CDC will target the \$20,000,000 request in Prevention and Public Health Fund investments toward tracking effects of the Affordable Care Act on the healthcare system and on health outcomes. The National Health Interview Survey (NHIS) and the National Ambulatory Medical Care Survey (NAMCS) are the core data systems used to monitor the effects of the Affordable Care Act. Existing and new content on the NHIS tracks the Affordable Care Act impact on health care access and utilization. The reduction in funding in FY 2014 eliminated the new content added to the 2011-2014 NHIS, but the content will be reinstated in 2016. After returning to typical sample sizes in 2015, the NHIS sample will increase in 2016 to provide stable estimates for targeted populations, including a greater number of estimates at the state level. The 2016 NAMCS sample of physicians will expand to permit greater precision for more precise national estimates. The expansion of the NAMCS sample allows for some state-level estimates related to care that different population groups and groups with different conditions receive. States will use the Behavioral Risk Factor Surveillance System (BRFSS) to continue collecting detailed data for state- and sub-state adult populations on health insurance coverage, access to healthcare, and use of clinical preventive services. This funding will provide an additional year of data that state and local health departments can use to monitor the impacts of the Affordable Care Act on state healthcare access and utilization. Data will also evaluate the impacts of the Affordable Care Act on state prevalence estimates for diseases, health conditions, and risk behaviors associated with the leading causes of death and disability.

Public Health Systems Research

The FY 2015 request includes \$5,000,000 for public health systems research as authorized under section 4301 of ACA. CDC will undertake research that seeks to identify the economic and budgetary impacts of public health interventions; expand data on health care utilization and effectiveness; and inform how public health should evolve and public health and health care should collaborate as the health care delivery system transforms.

State Table: Behavioral Risk Factor Surveillance System

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$155,012	TBD	\$155,012	\$0
Alaska	\$302,351	TBD	\$302,351	\$0
Arizona	\$302,351	TBD	\$302,351	\$0
Arkansas	\$209,172	TBD	\$209,172	\$0
California	\$317,831	TBD	\$317,831	\$0
Colorado	\$294,616	TBD	\$294,616	\$0
Connecticut	\$224,663	TBD	\$224,663	\$0
Delaware	\$171,491	TBD	\$171,491	\$0
District of Columbia	\$248,821	TBD	\$248,821	\$0
Florida	\$176,572	TBD	\$176,572	\$0
Georgia	\$130,700	TBD	\$130,700	\$0
Hawaii	\$238,101	TBD	\$238,101	\$0
Idaho	\$253,227	TBD	\$253,227	\$0
Illinois	\$224,935	TBD	\$224,935	\$0
Indiana	\$297,593	TBD	\$297,593	\$0
Iowa	\$234,482	TBD	\$234,482	\$0
Kansas	\$355,793	TBD	\$355,793	\$0
Kentucky	\$152,093	TBD	\$152,093	\$0
Louisiana	\$228,573	TBD	\$228,573	\$0
Maine	\$358,140	TBD	\$358,140	\$0
Maryland	\$254,728	TBD	\$254,728	\$0
Massachusetts	\$317,186	TBD	\$317,186	\$0
Michigan	\$292,743	TBD	\$292,743	\$0
Minnesota	\$392,833	TBD	\$392,833	\$0
Mississippi	\$187,000	TBD	\$187,000	\$0
Missouri	\$194,935	TBD	\$194,935	\$0
Montana	\$312,051	TBD	\$312,051	\$0
Nebraska	\$316,993	TBD	\$316,993	\$0
Nevada	\$223,289	TBD	\$223,289	\$0
New Hampshire	\$301,964	TBD	\$301,964	\$0
New Jersey	\$313,564	TBD	\$313,564	\$0
New Mexico	\$340,430	TBD	\$340,430	\$0
New York	\$250,421	TBD	\$250,421	\$0
North Carolina	\$343,543	TBD	\$343,543	\$0
North Dakota	\$184,693	TBD	\$184,693	\$0
Ohio	\$148,470	TBD	\$148,470	\$0
Oklahoma	\$225,459	TBD	\$225,459	\$0
Oregon	\$276,601	TBD	\$276,601	\$0
Pennsylvania	\$152,903	TBD	\$152,903	\$0
Rhode Island	\$105,000	TBD	\$105,000	\$0
South Carolina	\$224,339	TBD	\$224,339	\$0
South Dakota	\$179,676	TBD	\$179,676	\$0
Tennessee	\$177,119	TBD	\$177,119	\$0
Texas	\$236,626	TBD	\$236,626	\$0
Utah	\$287,534	TBD	\$287,534	\$0
Vermont	\$201,726	TBD	\$201,726	\$0
Virginia	\$177,720	TBD	\$177,720	\$0
Washington	\$252,351	TBD	\$252,351	\$0
West Virginia	\$297,957	TBD	\$297,957	\$0
Wisconsin	\$279,648	TBD	\$279,648	\$0
Wyoming	\$229,691	TBD	\$229,691	\$0

CDC FY 2015 Congressional Justification

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Territories		TBD		
America Samoa	\$65,006	TBD	\$65,006	\$0
Guam	\$145,004	TBD	\$145,004	\$0
Micronesia	\$87,300	TBD	\$87,300	\$0
		TBD		
Palau	\$97,004	TBD	\$97,004	\$0
Puerto Rico	\$243,610	TBD	\$243,610	\$0
Virgin Islands	\$0	TBD	\$0	\$0
			TBD	
Subtotal States	\$12,555,710	TBD	\$12,555,710	\$0
Subtotal Territories	\$637,924	TBD	\$637,924	\$0
Total	\$13,193,634	TBD	\$13,193,634	\$0

¹ Table does not include non-core BRFSS funding from other CDC programs and the Affordable Care Act/Prevention and Public Health Fund.

² This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

State Table: National Notifiable Diseases Surveillance System (NNDSS) ^{204,205}

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$232,905	\$240,108	\$240,108	\$0
Alaska	\$217,957	\$224,698	\$224,698	\$0
Arizona	\$96,974	\$99,973	\$99,973	\$0
Arkansas	\$106,408	\$109,699	\$109,699	\$0
California	\$291,185	\$300,191	\$300,191	\$0
Colorado	\$225,890	\$232,876	\$232,876	\$0
Connecticut	\$175,076	\$180,491	\$180,491	\$0
Delaware	\$75,171	\$77,496	\$77,496	\$0
Florida	\$124,276	\$128,120	\$128,120	\$0
Georgia	\$120,358	\$124,080	\$124,080	\$0
Hawaii	\$176,048	\$181,493	\$181,493	\$0
Idaho	\$104,874	\$108,118	\$108,118	\$0
Illinois	\$136,952	\$141,188	\$141,188	\$0
Indiana	\$94,445	\$97,366	\$97,366	\$0
Iowa	\$196,494	\$202,571	\$202,571	\$0
Kansas	\$154,429	\$159,205	\$159,205	\$0
Kentucky	\$69,375	\$71,521	\$71,521	\$0
Louisiana	\$249,726	\$257,449	\$257,449	\$0
Maine	\$121,444	\$125,200	\$125,200	\$0
Maryland	\$314,057	\$323,770	\$323,770	\$0
Massachusetts	\$144,864	\$149,344	\$149,344	\$0
Michigan	\$91,743	\$94,580	\$94,580	\$0
Minnesota	\$256,266	\$264,192	\$264,192	\$0
Mississippi	\$84,345	\$86,954	\$86,954	\$0
Missouri	\$176,857	\$182,327	\$182,327	\$0
Montana	\$132,366	\$136,460	\$136,460	\$0
Nebraska	\$228,370	\$235,433	\$235,433	\$0
Nevada	\$192,936	\$198,903	\$198,903	\$0
New Hampshire	\$138,375	\$142,655	\$142,655	\$0
New Jersey	\$193,661	\$199,650	\$199,650	\$0
New Mexico	\$108,586	\$111,944	\$111,944	\$0
New York	\$362,279	\$373,484	\$373,484	\$0
North Carolina	\$95,455	\$98,407	\$98,407	\$0
North Dakota	\$105,317	\$108,574	\$108,574	\$0
Ohio	\$322,584	\$332,561	\$332,561	\$0
Oklahoma	\$131,863	\$135,941	\$135,941	\$0
Oregon	\$245,061	\$252,640	\$252,640	\$0
Pennsylvania	\$256,044	\$263,963	\$263,963	\$0
Rhode Island	\$210,132	\$216,631	\$216,631	\$0
South Carolina	\$154,545	\$159,325	\$159,325	\$0
South Dakota	\$57,062	\$58,827	\$58,827	\$0
Tennessee	\$159,635	\$164,572	\$164,572	\$0
Texas	\$72,028	\$74,256	\$74,256	\$0
Utah	\$121,220	\$124,969	\$124,969	\$0
Vermont	\$198,889	\$205,040	\$205,040	\$0
Virginia	\$340,205	\$350,727	\$350,727	\$0
Washington	\$256,822	\$264,765	\$264,765	\$0

²⁰⁴ <http://www.cdc.gov/exposurereport/>

²⁰⁵ CFDA NUMBER: 93-521 [Discretionary]

	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
West Virginia	\$177,359	\$182,844	\$182,844	\$0
Wisconsin	\$178,684	\$184,210	\$184,210	\$0
Wyoming	\$165,904	\$171,035	\$171,035	\$0
Territories	--	--	--	--
American Samoa	\$56,067	\$57,801	\$57,801	\$0
Guam	\$105,233	\$108,488	\$108,488	\$0
Marshall Islands	\$23,872	\$24,610	\$24,610	\$0
Micronesia	\$9,293	\$9,580	\$9,580	\$0
Northern Mariana Islands	\$23,484	\$24,210	\$24,210	\$0
Puerto Rico	\$77,808	\$80,214	\$80,214	\$0
Palau	\$44,143	\$45,508	\$45,508	\$0
Virgin Islands	\$77,484	\$79,880	\$79,880	\$0
Cities	--	--	--	--
Chicago	\$132,685	\$136,789	\$136,789	\$0
District of Columbia	\$147,095	\$151,644	\$151,644	\$0
Houston	\$142,137	\$146,533	\$146,533	\$0
Los Angeles	\$272,230	\$280,649	\$280,649	\$0
New York City	\$204,257	\$210,574	\$210,574	\$0
Philadelphia	\$89,276	\$92,037	\$92,037	\$0
Subtotal, States	\$8,643,501	\$8,910,826	\$8,910,826	\$0
Subtotal, Territories	\$417,384	\$430,291	\$430,291	\$0
Subtotal, Cities	\$987,680	\$1,018,226	\$1,018,226	\$0
Total	\$10,048,565	\$10,359,343	\$10,359,343	\$0

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

ENVIRONMENTAL HEALTH

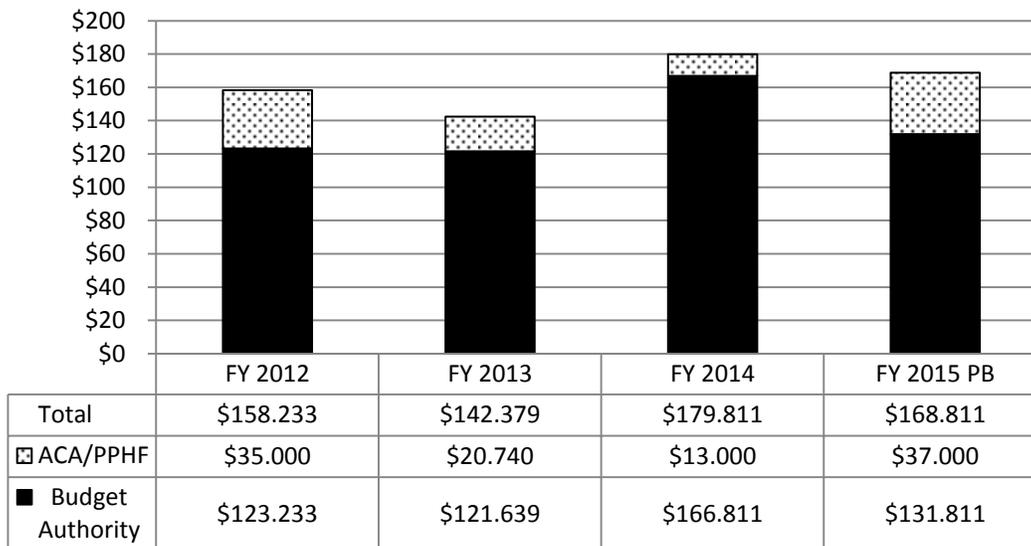
(dollars in millions)		FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President's Budget	2015 +/-2014
	Budget Authority	\$121.639	\$166.811	\$131.811	-\$35.000
	ACA/PPHF	\$20.740	\$13.000	\$37.000	+\$24.000
	Total Request	\$142.379	\$179.811	\$168.811	-\$11.000
	FTEs	456	456	456	0
Environmental Health					
	- Environmental Health Laboratory	\$49.826	\$56.003	\$56.003	\$0.000
	- Environmental Health Activities	\$40.227	\$45.684	\$45.684	\$0.000
	- Asthma	\$26.100	\$27.596	\$27.596	\$0.000
	- Childhood Lead Poisoning	\$2.341	\$15.528	\$15.528	\$0.000
	ACA/PPHF (non-add)	\$0.000	\$13.000	\$13.000	\$0.000
	- Environmental and Health Outcome Tracking Network	\$23.885	\$35.000	\$24.000	-\$11.000
	ACA/PPHF (non-add)	\$20.740	\$0.000	\$24.000	+\$24.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

CDC serves the public through responsive public health actions to promote healthy and safe environments and prevent harmful exposures. CDC's FY 2015 request of **\$168,811,000** for Environmental Health, including \$37,000,000 from the Affordable Care Act Prevention and Public Health Fund, is \$11,000,000 below the FY 2014 Enacted level. Funding for the Environmental and Health Outcome Tracking Network accounts for all of the proposed decrease.

Funding History (dollars in millions)



Environmental Health Laboratory

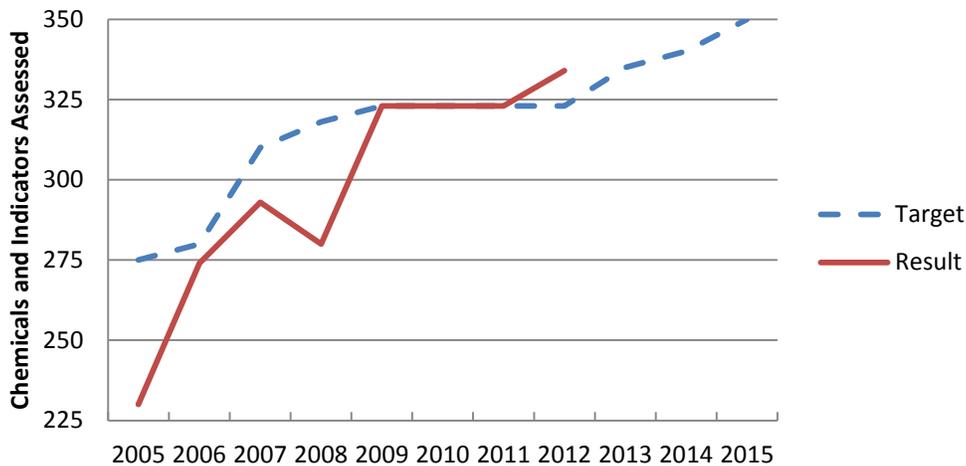
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015 +/-2014
			President's Budget	
Budget Authority	\$49.826	\$56.003	\$56.003	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [Environmental Health Laboratory](http://www.cdc.gov/nceh/information/health_laboratory.htm)²⁰⁶ improves the detection, diagnosis, treatment, and prevention of diseases resulting from exposure to harmful environmental chemicals and diseases that need advanced laboratory measurement for accurate diagnosis. The lab develops and applies innovative measurement techniques to assess disease risk, determine Americans' exposure levels, and respond to public health emergencies. It also assures the quality of newborn screening tests for early detection of deadly, but treatable diseases. Additionally, the lab standardizes cholesterol tests and diagnostic tests for chronic diseases to ensure results are sufficiently accurate for clinical and research use.

Number of Environmental Chemicals and Nutritional Indicators that CDC Assessed for Exposure of the U.S. population, 2005–2012



Budget Request

CDC's FY 2015 request of **\$56,003,000** for the Environmental Health Laboratory is the same as the FY 2014 Enacted level. Requested funds are needed to maintain the world's most advanced, state-of-the-art environmental public health laboratory.

Environmental Health Laboratory's projected contributions in FY 2015:

- Measure more than 300 priority chemicals and nutritional indicators in Americans
- Conduct more than 50 studies of harmful chemical exposures
- Ensure accurate testing in over 1,000 laboratories
- Standardize cholesterol tests and develop new reference tests for chronic disease biomarkers
- Fund eight states to investigate harmful exposures and expand newborn screening

²⁰⁶ http://www.cdc.gov/nceh/information/health_laboratory.htm

Biomonitoring to Assess Americans' Nutritional Status and Exposure to Harmful Chemicals

CDC uses biomonitoring—measurements in human blood and urine—to identify harmful exposures or nutritional deficiencies in the U.S. population. The lab, the sole source for numerous high-quality laboratory tests, measures more than 300 chemicals and nutritional indicators in Americans. CDC publishes findings in the most comprehensive, ongoing assessments of the nation's exposure to environmental chemicals and nutritional status: the [National Report on Human Exposure to Environmental Chemicals](#)²⁰⁷ and the [National Report on Biochemical Indicators of Diet and Nutrition in the U.S. Population](#).²⁰⁸

In FY 2015, CDC expects to release new biomonitoring results, adding to previously published data for 269 chemicals and 58 nutritional indicators, and to collaborate on more than 50 studies to assess environmental exposures in vulnerable population groups or investigate the relationship between environmental exposures and adverse health effects. These studies help determine safe and harmful levels of exposure; identify true hazards; avoid unnecessary regulation; and assess the effectiveness of exposure reduction interventions.

Improving Testing Quality and Standardizing Laboratories

CDC uses expert measurement science to continuously improve the accuracy, precision, and cost effectiveness of laboratory tests for environmental chemicals, nutritional indicators, heart disease and stroke, and newborn screening. CDC's efforts reach more than 1,000 domestic and international laboratories, including newborn screening laboratories in all 50 states. In FY 2015, CDC will provide quality assurance materials, conduct training, and transfer laboratory testing methods to state, local, research, and clinical laboratories. CDC will help state newborn screening programs use new molecular testing techniques to improve detection of diseases like cystic fibrosis and congenital adrenal hyperplasia. In addition, the lab will continue implementing advanced technologies, such as robotics, to increase testing speed, reduce cost, and enable measurement of multiple substances in a single laboratory test.

Standardizing Chronic Disease Biomarkers

CDC standardizes biomarker measurements for important cardiovascular and breast cancer disease biomarker measurements that need improvement in accuracy and precision. The lab develops reference methods and materials to assure the quality of tests for cholesterol, small low-density lipoprotein (small LDL), apolipoprotein B, high-sensitivity C-reactive protein, troponin and estrogen (estradiol) in academic research and clinical laboratories. Accurate and precise laboratory measurements help clinicians better diagnose and determine risk for heart disease; reduce costs associated with repeated laboratory testing; and improve the diagnosis and treatment of breast cancer.

In FY 2014, CDC will ensure the accuracy of more than 300 million cholesterol tests in the United States. CDC will maintain highly accurate reference methods for measuring total cholesterol, high-density lipoprotein (HDL), LDL, and triglycerides; monitor and train laboratories and manufacturers; and provide reference materials to more than 80 labs. CDC will also complete 50% of the development of new, reference-quality tests for measuring size fractions of LDL and HDL cholesterol (including small LDL), which are promising, better diagnostic markers for cardiovascular disease. In addition, CDC will standardize estradiol measurements in six major research and clinical laboratories, improving the diagnosis and treatment of breast cancer.

In FY 2015, CDC will continue to maintain methods and provide services to ensure the quality of clinical tests for total cholesterol, HDL, LDL, and triglycerides. CDC will complete 80% of the development of new, reference-quality tests for LDL and HDL size fractions. CDC will also provide estradiol quality assurance materials to a total of eight major research and clinical laboratories and measure estradiol in a nationally representative sample of Americans. These measurements will help identify population groups at risk for disease.

²⁰⁷ <http://www.cdc.gov/exposurereport/>

²⁰⁸ <http://www.cdc.gov/nutritionreport/>

Supporting State-based Laboratory Biomonitoring Programs

Biomonitoring grants help states assess environmental factors that can make people sick. Grantees are chosen competitively based on laboratory expertise, facilities, and local biomonitoring support. State-based laboratories use CDC funding to purchase laboratory equipment and supplies; hire and train specialized staff; and conduct fieldwork and data analysis, in order to assess exposures of concern in their communities. CDC is starting a new, five-year cooperative agreement cycle in FY 2014 for up to five states. In FY 2015, CDC plans to award the second year of funding.

Grants to State-based Laboratory Biomonitoring Programs

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	3	5	5	0
- New Awards	0	5	0	-5
- Continuing Awards	3	0	5	+5
Average Award	\$1.667	\$1.00	\$1.00	\$0.000
Range of Awards	\$1.000-\$2.652	\$0.500-\$2.500	\$0.500-\$2.500	N/A
Total Awards	\$5.000	\$5.000	\$5.000	\$0.000

Expanding State Newborn Screening for Severe Combined Immunodeficiency

State and territorial newborn screening laboratories receive CDC funding to implement testing for severe combined immunodeficiency (SCID), a deadly disease that is curable if treated soon after birth. CDC began a two-year cooperative agreement cycle with Virginia, Georgia, and Oklahoma in FY 2013. Eligible state or territorial newborn screening programs were those that had not previously conducted state-wide SCID newborn screenings and that demonstrated sufficient laboratory expertise, facilities, and legal authority to conduct screenings. In FY 2015, CDC plans to start a new, two-year cooperative agreement cycle for up to three states.

Grants to Implement SCID Testing

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	3	3	3	0
- New Awards	3	0	3	+3
- Continuing Awards	0	3	0	-3
Average Award	\$0.281	\$0.281	\$0.333	+\$0.052
Range of Awards	\$0.269-\$0.299	\$0.269-\$0.299	\$0.200-\$0.600	N/A
Total Awards	\$0.845	\$0.845	\$1.00	+\$0.155

Environmental Health Activities

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015
			President Budget	+/-2014
Budget Authority	\$40.227	\$45.684	\$45.684	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Each day, people everywhere experience environmental exposures that can make them sick, cause death, and be very costly. CDC’s environmental health programs identify these harmful exposures, investigate environmental pathways, and find ways to eliminate the threat to people’s health, thereby saving money and lives.

Budget Request

CDC’s FY 2015 request of **\$45,684,000** for Environmental Health Activities is the same as the FY 2014 Enacted level. CDC programs funded under Environmental Health Activities monitor environmentally related disease, respond to urgent public health threats, apply environmental health research, provide training and guidance for the nation’s environmental health workforce, assist in emergency preparedness and response efforts, and support grants that improve state and local capacity.

Environmental Health Activities’ projected contributions in FY 2015:

- Train 1,250 state and local officials in environmental emergency response
- Investigate 25 public health threats from non-infectious agents
- Train 500 planners and health professionals on healthy community design
- Assist 16 states and two cities in addressing the health implications of climate change
- Fund 50 cooperative agreements with states and cities

Amyotrophic Lateral Sclerosis Registry

The [National Amyotrophic Lateral Sclerosis Registry](http://wwwn.cdc.gov/als/)²⁰⁹—a joint effort between CDC and the ATSDR—is an important resource for scientists to understand, cure, and prevent the disease. Also known as Lou Gehrig’s disease, Amyotrophic Lateral Sclerosis (ALS) is a progressive, fatal, neurodegenerative disorder that has no cure and the cause of which is poorly understood. An estimated 30,000 individuals in the United State live with ALS, while approximately 5,000 new cases are diagnosed each year. The ALS registry uses data from the Centers for Medicare and Medicaid Services and the U.S. Department of Veterans Affairs, as well as information provided by persons with ALS through a [secure, online portal](https://wwwn.cdc.gov/als/ALSCreateAccount.aspx).²¹⁰ To date, patients from all 50 states have enrolled in the registry and the number of enrollees increases each day. The online surveys that registrants may take help researchers learn more about potential risk factors for the disease.

In addition to enrolling persons, CDC and ATSDR are enhancing the capabilities of the National ALS Registry. In FY 2013, CDC and ATSDR launched a notification mechanism that puts researchers directly in contact with registry enrollees interested in taking part in new clinical trials and epidemiologic studies. To date, this notification mechanism has linked approximately 5,000 patients from the registry to new clinical trials and epidemiologic studies being conducted by external researchers.

In FY 2015, CDC will test the completeness of the registry using active surveillance data collected from three states and eight metropolitan areas, leading to the release of a national prevalence estimate of ALS in the

²⁰⁹ <http://wwwn.cdc.gov/als/>

²¹⁰ <https://wwwn.cdc.gov/als/ALSCreateAccount.aspx>

United States. CDC may also implement a bioregistry component in FY 2015 that links specimen data (e.g., blood, saliva, and tissue) to existing registry surveys, offering researchers new insights into the disease.

Built Environment and Health Initiative

The [Built Environment and Health Initiative](#)²¹¹ helps states and communities integrate health considerations into transportation and community planning decisions. CDC applies research, helps states undertake health impact assessments, tracks environmental public health indicators, and trains health and planning professionals. The Built Environment and Health Initiative supports the National Prevention Strategy and Healthy People 2020.

Since 2005, CDC funding and technical support in 20 states led to the completion of 50 health impact assessments—a process that evaluates the potential health effects of a plan, project, or policy before it is built or implemented. In FY 2015, CDC will support the completion of 20 health impact assessments. In addition, CDC will train 500 planners and health professionals on healthy community design through an [online course](#)²¹², launch a transportation and health toolkit with the U.S. Department of Transportation, and work with partners to link community design and health metrics.

CDC funds state and local agencies to carry out at least three health impact assessments a year. Grantees are selected competitively based on the scope of their plans, involvement of multiple community stakeholders, and their ability to sustain efforts after direct CDC funding ends. CDC is starting a new, three-year cooperative agreement cycle in FY 2014 for up to six states. In FY 2015, CDC plans to award the second year of funding.

Built Environment and Health Grants

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	6	6	6	0
- New Awards	0	6	0	-6
- Continuing Awards	6	0	6	+6
Average Award	\$0.154	\$0.145	\$0.145	\$0.000
Range of Awards	\$0.115-\$0.180	\$0.100-\$0.175	\$0.100-\$0.175	N/A
Total Awards	\$0.924	\$0.870	\$0.870	\$0.000

Climate and Health

The [Climate and Health](#)²¹³ program leads public health efforts to address health issues associated with climate change. CDC works with cities and states to reduce impacts on our health and our healthcare system. Centralizing CDC’s climate change expertise in the National Center for Environmental Health ensures a coordinated approach to incorporating climate change across any disease-specific programs or functions within the agency.

In FY 2015, CDC will provide continued funding, guidance, and technical support to 16 states and two cities to forecast climate change health impacts in local communities, identify vulnerabilities, and develop and implement a Climate and Health Adaptation plan. These efforts strengthen planning, surveillance, and response activities. Grantees were chosen competitively based on their ability to demonstrate a need for a program within their jurisdiction, ability to develop and implement action plans to reduce health effects of climate change, and ability to build partnerships across public health programs and non-health sectors.

²¹¹ http://www.cdc.gov/nceh/information/built_environment.htm

²¹² <http://advance.captus.com/Planning/hia2/home.aspx>

²¹³ <http://www.cdc.gov/climateandhealth/>

Climate Preparedness Grants

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	18	18	18	0
- New Awards	10	0	0	0
- Continuing Awards	8	18	18	0
Average Award	\$0.208	\$0.249	\$0.249	\$0.000
Range of Awards	\$0.173-\$0.250	\$0.173-\$0.250	\$0.173-\$0.250	N/A
Total Awards	\$3.618	\$4.500	\$4.500	\$0.000

Safe Water

The [Safe Water](#)²¹⁴ program focuses on water sources that are not regulated by the Safe Drinking Water Act—such as private wells, cisterns, and springs. In order to reduce exposures and disease from these water sources, CDC provides scientific expertise, conducts trainings, investigates the root causes of waterborne illness outbreaks, and conducts water research to identify those at risk. For example, CDC is conducting an investigation with three states to identify health impacts of drought on well owners and barriers to maintaining safe and adequate water supply during drought. In addition, CDC is leading a team of public health and industry experts to produce the first-ever national [Model Aquatic Health Code](#)²¹⁵ to provide voluntary guidance for local and state agencies on the design, construction, operation, and maintenance of swimming pools, spas, and hot tubs. The Model Aquatic Health Code will prevent drowning, injuries, and water illnesses.

In 2015, CDC will continue the Safe Water cooperative agreements to support state and local health departments in investigating water-related exposure risks for the 45 million Americans who use non-federally regulated drinking water systems. CDC awards funding competitively based on the capacity to implement prevention activities and address risks for exposure to unsafe levels of contaminants. CDC funded 11 health departments under a two-year cooperative agreement in FY 2013 and FY 2014. CDC will fund up to 11 health departments under a new, five-year cooperative agreement in FY 2015.

Safe Water Grants

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	11	11	11	0
- New Awards	11	0	11	+11
- Continuing Awards	0	11	0	-11
Average Award	\$0.145	\$0.145	\$0.145	\$0.000
Range of Awards	\$0.050-\$0.171	\$0.050-\$0.171	\$0.075-\$0.175	N/A
Total Awards	\$1.589	\$1.589	\$1.589	\$0.000

All Other Environmental Health Activities

CDC provides national leadership to protect Americans from unhealthy environmental exposures. CDC scientists identify contaminants and toxins that make people sick, investigate environmental sources, and eliminate threats to people. CDC scientific and programmatic activities inform policies and practices that prevent health threats.

²¹⁴ <http://www.cdc.gov/nceh/hsb/cwh/>

²¹⁵ <http://www.cdc.gov/healthywater/swimming/pools/mahc/>

Responding to environmental health emergencies

CDC's environmental health experts assist in federal and state responses to disease outbreaks and emergencies. CDC's data analysis identifies at-risk people, leading to action by federal, state, and local officials. Public health and emergency management officials rely on CDC's experts and its rapid needs assessment toolkit—[Community Assessment for Public Health Emergency Response](#)²¹⁶—to quickly prioritize resources in response to a disaster. CDC's [Environmental Health Training in Emergency Response courses](#)²¹⁷ teach state and local officials how to restore clean drinking water, dispose of sewage properly, ensure food safety, and prevent the spread of diseases after disasters. CDC anticipates that at least 1,250 state and local officials will take courses in FY 2015.

Responding to toxic health threats

Environmental health programs at CDC respond to public health threats from non-infectious agents, such as acute toxic poisonings, that can result in severe or fatal illnesses. CDC's epidemiologists and toxicologists review data in the National Poison Data System and when a potential public health threat is identified, the agency immediately alerts state public health authorities. If needed, CDC may investigate further or initiate a rapid response. CDC expects to respond to 25 or more such health threats in FY 2015.

Providing expertise on radiation and health

CDC is the nation's radiation and health expert. [CDC's radiation guidelines](#)²¹⁸ help public officials and clinicians prepare and respond to radiation emergencies and treat exposures. In FY 2015, CDC will launch an online training program for personal protective equipment; investigate the best ways for public health officials to monitor exposure to radiation; and identify trends in patient radiation doses from medical diagnostics across the United States.

Mentoring state and local health professionals

CDC provides [training](#)²¹⁹ and guidance to teach state and local environmental health professionals to be more effective at their jobs. Four of the top 10 services provided by state and local health departments are environmental health activities, such as food service establishment inspection, food safety education, school and daycare center inspection, and environmental health surveillance. State and local health departments participating in CDC's [Environmental Health Specialists Network](#)²²⁰ are better equipped to identify the root causes of foodborne illness, such as food handling practices, worker health policies, and food source attribution. In 2014, CDC released a [voluntary surveillance system](#)²²¹ to capture environmental assessment data collected during foodborne illness outbreak investigations and launched a [web-based course](#)²²² to help investigators. In 2015, CDC will work with state and local public health food safety programs to use environmental data from outbreak investigations in restaurants and other food service establishments.

Funding state and local health departments

Environmental Health Services Network [cooperative agreements](#)²²³ support state and local health departments in investigating the root environmental causes of food and waterborne disease outbreaks. CDC made 15 awards to states and communities under a five-year cooperative agreement FY 2010 through FY 2014. In FY 2015, CDC

²¹⁶ <http://www.cdc.gov/nceh/hsb/disaster/casper.htm>

²¹⁷ <http://www.cdc.gov/nceh/ehs/eLearn/EHTER.htm>

²¹⁸ <http://emergency.cdc.gov/radiation/>

²¹⁹ <http://www.cdc.gov/nceh/ehs/eLearn/index.htm>

²²⁰ <http://www.cdc.gov/nceh/ehs/EHSNet/>

²²¹ <http://www.cdc.gov/nceh/ehs/NVEAIS/index.htm>

²²² http://www.cdc.gov/nceh/ehs/eLearn/EA_FIO/index.htm

²²³ <http://www.cdc.gov/nceh/ehs/EHSNet/partners/index.htm>

will fund up to 15 states and communities under a new, five-year cooperative agreement cycle. CDC will select grantees competitively based on their capacity to implement prevention activities and address risks for exposure to unsafe levels of contaminants.

Environmental Health Specialists Network Grants

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	15	15	15	0
- New Awards	0	0	15	+15
- Continuing Awards	15	15	0	-15
Average Award	\$0.155	\$0.155	\$0.155	\$0.000
Range of Awards	\$0.750-\$1.750	\$0.750-\$1.750	\$0.75-\$1.750	N/A
Total Awards	\$2.325	\$2.325	\$2.325	\$0.000

Asthma

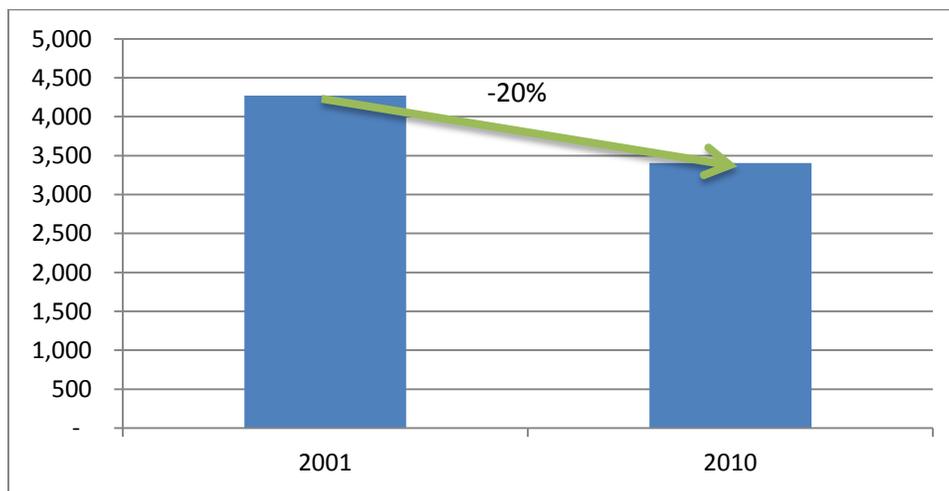
(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015
			President's Budget	+/-2014
Budget Authority	\$26.100	\$27.596	\$27.596	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [National Asthma Control Program](#)²²⁴ helps millions of Americans with asthma control their disease. In the United States today, nearly 26 million people have asthma, including 7 million children. The disease disproportionately affects African American children, who are twice as likely to be hospitalized and over four times more likely to die from asthma than white children. While the overall prevalence of asthma has increased over the last 10 years, trends show that more people with asthma are living with their disease under control, meaning lower medical costs and saved lives. In our latest [National Surveillance of Asthma](#)²²⁵ report, CDC measured almost a 20% reduction in U.S. asthma deaths—from 4,269 deaths per year in 2001 to 3,404 deaths per year in 2010—demonstrating the effectiveness of asthma control programs at improving health outcomes.

Number of U.S. asthma-related deaths in 2001 compared to 2010.



Budget Request

CDC’s FY 2015 request of **\$27,596,000** for the National Asthma Control Program is the same as the FY 2014 Enacted level. Expansion of health insurance coverage under the Affordable Care Act allows more people with asthma access to health care providers and medication, and CDC supports critical components of comprehensive asthma control. In FY 2015, CDC will monitor disease trends to identify high risk populations; guide interventions and train health care providers on effective treatment; educate patients and parents to manage asthma outside the doctor’s office; and reduce exposure environmental factors that make asthma worse.

CDC plans to fund 20 state health departments and four national non-governmental organizations in FY 2015 through asthma cooperative agreements. State health departments will use CDC funding to conduct home, school, and health system-based intervention strategies that better link primary care and public health control efforts in vulnerable communities. For its new, five-year cooperative agreement cycle in FY 2014, CDC is reducing the number of state grantees from 36 to 20 to support full implementation of comprehensive asthma

²²⁴ <http://www.cdc.gov/asthma/nacp.htm>

²²⁵ http://www.cdc.gov/nchs/data/series/sr_03/sr03_035.pdf

control programs. In FY 2015, CDC will award the second year of funding to 20 states and issue new awards for four non-governmental organizations to develop education and training programs on asthma and air quality.

Asthma Grants to Health Departments and Non-governmental Organizations

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	40	24	24	0
- New Awards	0	20	4	-16
- Continuing Awards	40	4	20	+16
Average Award	\$0.331	\$0.598	\$0.598	\$0.000
Range of Awards	\$0.257-\$0.528	\$0.300-\$0.800	\$0.300-\$0.800	N/A
Total Awards	\$13.240	\$14.360	\$14.360	\$0.000

Childhood Lead Poisoning Prevention

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President's Budget	+/-2014
	Budget Authority	\$2.341	\$2.528	\$2.528	\$0.000
	ACA/PPHF	\$0.000	\$13.000	\$13.000	\$0.000
	Total	\$2.341	\$15.528	\$15.528	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [Childhood Lead Poisoning Prevention](#)²²⁶ program provides national expertise, guidance, and analyses of childhood lead poisoning in the United States. From 1991–2012, CDC funded 35 programs in 42 states and 7 cities that were essential to reducing the number of children exposed to lead. Today, an estimated 535,000 children in the United States, or 2.6% of those aged 1–5 years, still have blood lead levels greater than or equal to the reference value of 5 micrograms per deciliter. Communities where children are most at risk need lead poisoning prevention resources.

Budget Request

CDC's FY 2015 request of **\$15,528,000** for Childhood Lead Poisoning Prevention, including \$13,000,000 from the Affordable Care Act Prevention and Public Health Fund, is level with the FY 2014 Enacted Level. Funding for the program builds on CDC's past success in reducing children's blood lead levels in the United States. In FY 2015, CDC will fund state lead poisoning prevention programs, advise state and local agencies and stakeholders in lead poisoning prevention, provide epidemiological and laboratory expertise, and [monitor trends in childhood blood lead levels](#)²²⁷ for states that provide data.

Surveillance is critical to preventing, and ultimately eliminating, childhood lead poisoning. Beginning in FY 2014, CDC plans to fund approximately 41 state and local health departments through 3-year, competitive cooperative agreements. States and cities will use CDC funding to enhance local surveillance capacity. Data on the nature and extent of high blood lead levels will help guide appropriate management of children identified with high blood lead levels. States and cities will also identify remaining at-risk geographic areas and implement population-based, primary prevention interventions (e.g., housing rehabilitation, enforcement of housing and health codes, and early childhood and other educational activities). CDC plans to award the second year of funding to state and local health departments in FY 2015.

Childhood Lead Poisoning Grants

(dollars in millions)	FY 2013	FY 2014	FY 2015	2015
	Final	Enacted	Request	+/-2014
Number of Awards	0	41	41	0
- New Awards	0	41	0	-41
- Continuing Awards	0	0	41	+41
Average Award	\$0.00	\$0.268	\$0.268	\$0.000
Range of Awards	\$0.000-\$0.000	\$0.091-\$0.445	\$0.091-\$0.445	N/A
Total Awards	\$0.000	\$11.000	\$11.000	\$0.000

²²⁶ http://www.cdc.gov/nceh/information/healthy_homes_lead.htm

²²⁷ <http://www.cdc.gov/nceh/lead/data/index.htm>

Environmental and Health Outcome Tracking Network

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President's Budget	+/-2014
	Budget Authority	\$3.145	\$35.000	\$0.000	-\$35.000
	ACA/PPHF	\$20.740	\$0.000	\$24.000	+\$24.000
	Total	\$23.885	\$35.000	\$24.000	-\$11.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [Environmental and Health Outcome Tracking Network](#)²²⁸ is a dynamic, [web-based system](#)²²⁹ that tracks and reports environmental hazards and related health problems. Public health and safety officials use the tracking network to make decisions about where to focus resources and interventions. To date, the tracking network includes 17 datasets, 34 indicators, and over 300 health measures. Before the tracking program existed, even simple questions about health and the environment could take months to answer. With the tracking program public health officials can apply the same disease detective skills used in infectious disease surveillance to locate hazard sources or answer residents' concerns quickly, often within hours. In the past seven years, state and local health officials reported using the tracking network more than 170 times to prevent sickness and the loss of life.

Recent Public Health Actions Using the Tracking Network

Activities	Examples
Inform policy, legislation, and regulation	Maine passed a law to require CO detectors in all new homes, rental property and existing homes at the time of transfer.
Respond to community, agency, or legislator concerns	Massachusetts responded to community concerns about cancer incidence in towns near the Vermont Yankee Nuclear Power plant.
Identify populations at risk or risk factors to better target intervention	Utah quantified the health effects to residents of Millard County from drinking arsenic contaminated water from private wells. The state recommended that wells not be used for potable water and issued a remediation method to reduce exposure.
Address environmental health impact and city planning	In Massachusetts, Holyoke City Council requested tracking data on asthma to determine potential impact of proposed development of United Waste Management station.
Issue health alerts and advisories	Missouri linked demolitions with childhood blood lead levels. The state now issues neighborhood alerts if demolitions are scheduled.

Budget Request

CDC's FY 2015 request of **\$24,000,000** for the Environmental and Health Outcome Tracking Network, which is all from the Affordable Care Act Prevention and Public Health Fund, is \$11,000,000 below the FY 2014 Enacted level. Funding for the tracking network is used at CDC to update and add data to the tracking network, acquire information technology, create animated maps that show 10-year disease trends, manage projects that link

²²⁸ <http://ephtracking.cdc.gov/>

²²⁹ <http://ephtracking.cdc.gov/QueryPanel/EPHTNQuery/EPHTQuery.html>

environmental and health data, establish data sharing agreements, and host data for other public health programs. The FY 2015 budget request maintains core tracking network activities and functions.

Impact of the \$11,000,000 reduction in the FY 2015 budget request:

- Reduces funding for cooperative agreements.
- Eliminates the provision of technical assistance to non-funded states.
- Eliminates supplemental state funding for emerging topics and innovative methods.
- Reduces support for national data organizations and other national partners.

Tracking network grants support the information technology that brings together health and environmental data, as well as the people who use the data to identify, prioritize, and evaluate environmental health interventions. With CDC funding, state and local health departments develop their own tracking networks and contribute data to the national system. CDC awards competitive funding to 24 state and local health departments. The most successful applicants are able to demonstrate accomplishments in using tracking data to improve public health and make progress in identifying and sharing new data. In FY 2015, CDC will reduce funding for cooperative agreements.

Tracking Network Grants

(dollars in millions)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	24	24	24	0
- New Awards	0	24	0	0
- Continuing Awards	24	0	24	0
Average Award	\$0.596	\$0.860	\$0.583	-\$0.277
Range of Awards	\$0.020-\$0.850	\$0.125-\$1.200	\$0.020-\$0.900	N/A
Total Awards	\$14.304	\$20.605	\$14.000	-\$6.605

State Table: Environmental Health Funding

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	2013 +/-2012
Alabama	\$164,043	\$215,945	\$256,690	\$40,745
Alaska	--	--	--	\$0.000
Arizona	\$537,316	\$143,949	\$189,135	\$45,186
Arkansas	--	\$90,000	--	-\$90,000
California	\$6,721,893	\$5,458,088	\$4,995,899	-\$462,189
Colorado	\$866,783	\$726,802	\$734,896	\$8,094
Connecticut	\$1,753,132	\$1,189,500	\$956,448	-\$233,052
Delaware	--	--	--	\$0.000
District of Columbia	\$2,298,437	\$354,877	\$1,814,017	-\$1,459,140
Florida	\$2,383,742	\$1,699,937	\$1,533,163	-\$166,774
Georgia	\$1,957,271	\$475,770	\$969,866	\$494,096
Hawaii	\$700,887	\$585,514	\$523,003	-\$62,511
Idaho	\$101,878	--	--	\$0.000
Illinois	\$1,178,012	\$698,295	\$603,604	-\$94,691
Indiana	\$965,182	\$366,616	\$371,777	\$5,161
Iowa	\$1,221,780	\$755,465	\$731,253	-\$24,212
Kansas	\$1,171,580	\$597,010	\$435,827	-\$161,183
Kentucky	\$920,077	\$425,000	\$328,200	-\$96,800
Louisiana	\$1,948,437	\$1,118,510	\$891,813	-\$226,297
Maine	\$2,033,314	\$1,639,751	\$1,320,514	-\$319,237
Maryland	\$3,710,641	\$3,184,276	\$2,477,037	-\$707,239
Massachusetts	\$2,689,015	\$2,030,165	\$1,423,564	-\$606,601
Michigan	\$1,695,947	\$1,216,609	\$715,859	-\$500,750
Minnesota	\$3,042,963	\$2,384,717	\$1,536,369	-\$848,348
Mississippi	\$918,241	\$522,241	\$464,614	-\$57,627
Missouri	\$2,221,300	\$1,648,771	\$1,222,161	-\$426,610
Montana	\$796,924	\$379,612	\$354,200	-\$25,412
Nebraska	\$139,750	\$165,710	\$166,675	\$965
Nevada	\$591,697	\$10,000	\$10,000	\$0.000
New Hampshire	\$1,555,945	\$1,302,209	\$1,229,864	-\$72,345
New Jersey	\$1,761,740	\$1,165,371	\$926,759	-\$238,612
New Mexico	\$2,325,836	\$1,639,420	\$1,198,414	-\$441,006
New York	\$6,160,778	\$4,993,300	\$4,149,859	-\$843,441
North Carolina	\$1,512,355	\$748,076	\$593,661	-\$154,415
North Dakota	\$99,757	\$2,851	--	-\$2,851
Ohio	\$1,174,929	\$568,674	\$690,742	\$122,068
Oklahoma	\$838,050	\$306,272	\$534,689	\$228,417
Oregon	\$3,028,125	\$2,222,574	\$1,928,532	-\$294,042
Pennsylvania	\$1,910,437	\$1,240,804	\$915,343	-\$325,461
Rhode Island	\$1,419,372	\$973,879	\$920,631	-\$53,248
South Carolina	\$1,123,483	\$872,097	\$560,300	-\$311,797
South Dakota	--	--	--	\$0.000
Tennessee	\$500,000	\$350,001	\$500,000	\$149,999
Texas	\$1,341,118	\$492,057	\$388,840	-\$103,217
Utah	\$1,620,995	\$1,521,187	\$1,126,147	-\$395,040
Vermont	\$1,669,146	\$1,241,206	\$1,000,261	-\$240,945
Virginia	\$980,444	\$128,415	\$769,654	\$641,239
Washington	\$4,331,024	\$3,090,031	\$2,515,190	-\$574,841
West Virginia	\$396,000	\$397,000	\$370,862	-\$26,138
Wisconsin	\$2,699,909	\$1,918,705	\$1,355,069	-\$563,636
Wyoming	--	--	--	--
Territories				

CDC FY 2015 Congressional Justification

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	2013 +/-2012
American Samoa	--	--	--	\$0.000
Guam	--	--	--	\$0.000
Marshall Islands	--	--	--	\$0.000
Micronesia	--	--	--	\$0.000
Northern Marianas	--	--	--	\$0.000
Puerto Rico	\$487,739	\$441,920	\$423,453	-\$18,467
Palau	--	--	--	\$0.000
Virgin Islands	--	\$1,000	--	-\$1,000
Subtotal, States	\$79,179,685	\$53,257,259	\$46,701,401	-\$6,555,519
Subtotal, Territories	\$487,739	\$442,920	\$423,453	-\$19,467
Total	\$79,667,424	\$53,700,179	\$47,125,793	-\$6,574,986

For additional information: <http://wwwn.cdc.gov/fundingprofiles/fundingprofilesria/>

INJURY PREVENTION AND CONTROL

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$138.943	\$150.839	\$188.699	+\$37.860
PHS Evaluation Transfer	\$0.000	\$0.000	\$5.605	+\$5.605
Total Request	\$138.943	\$150.839	\$194.304	+\$43.465
FTEs	217	217	217	0
Intentional Injury	\$93.195	\$92.242	\$107.847	+\$15.605
Rape Prevention (non-add)	\$38.256	\$38.932	\$44.537	+\$5.605
Gun Violence Prevention Research (non-add)	\$0.000	\$0.000	\$10.000	+\$10.000
NVDRS	\$3.421	\$11.333	\$23.570	+\$12.237
Injury Prevention Activities	N/A ²	\$29.023	\$44.646	+\$15.623
Unintentional Injury	\$32.708	\$8.619	\$8.619	\$0.000
Injury Control Research Centers	\$9.619	\$9.622	\$9.622	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² The Injury Prevention Activities budget line was created in the FY 2014 Omnibus bill by combining the All Other Intentional Injury and the All Other Unintentional Injury (minus elderly falls) budget lines; therefore, the amount for Injury Prevention Activities for FY 2013 is N/A. Amounts for All Other Intentional and All Other Unintentional Injury are accounted for in the FY 2013 Final column. The estimated total amount for Injury Prevention Activities, comparably adjusted, for FY 2013 would be \$26.734 million.

Summary

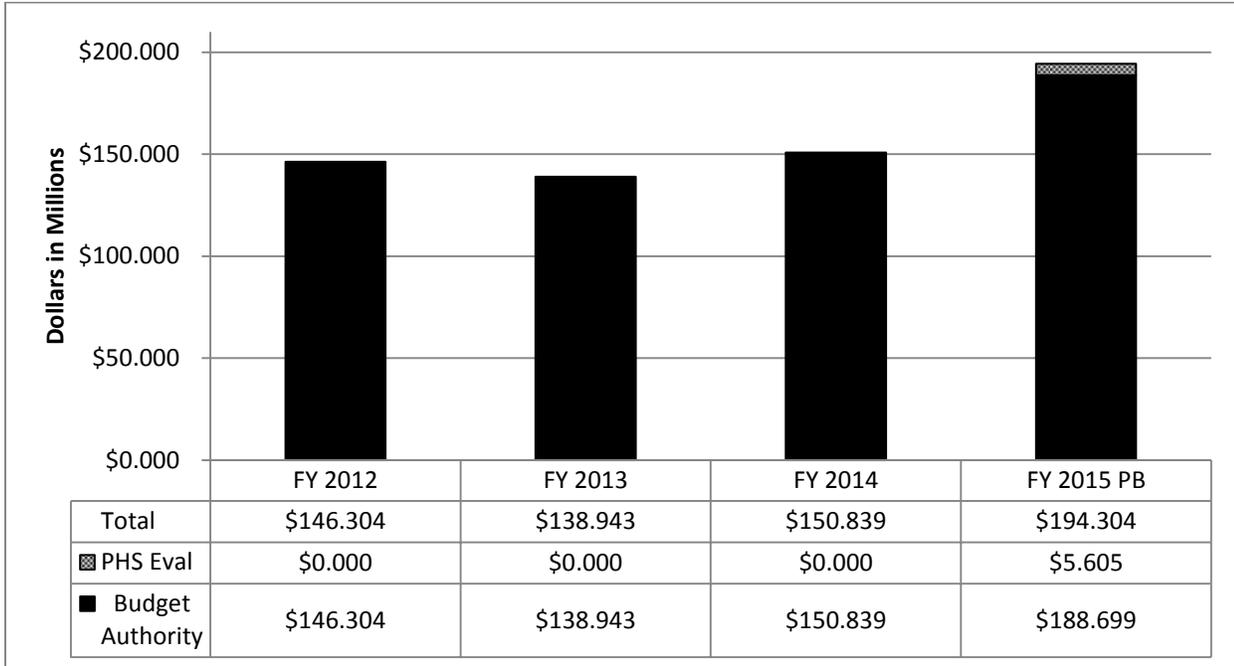
CDC is the nation’s leading authority on [violence and injury prevention](#)²³⁰. CDC keeps Americans safe by researching the best ways to prevent violence and injuries, using science to create real-world solutions to keep people safe, healthy, and productive. This budget supports the prevention of injuries and violent acts that occur outside of the workplace.

CDC's FY 2015 request of **\$194,304,000** for Injury Prevention and Control, including \$5,605,000 in Public Health Service (PHS) Evaluation Transfer Funds, is \$43,465,000 above the FY 2014 Enacted level. Funds will be used to support the President’s *Now is the Time* initiative and sustain injury prevention activities and programs. The increase will allow for expansion of the Core Violence and Injury Prevention Program and intensive state-level [prescription drug overdose prevention](#)²³¹ efforts through interventions directed at addressing key drivers of the epidemic; expansion of the National Violent Death Reporting System to all 50 states and Washington, D.C. to better understand the circumstances surrounding violent deaths; objective research into the causes and prevention of gun violence; and evaluation of interventions and strategies designed to prevent sexual violence.

²³⁰ <http://www.cdc.gov/injury/>

²³¹ <http://www.cdc.gov/homeandrecreationalafety/overdose/index.html>

Injury Prevention and Control Funding History¹



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Intentional Injury Prevention

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	
			President Budget	2015 +/-2014
Rape Prevention – total (non-add)	\$38.256	\$38.932	\$44.537	+\$5.605
Rape Prevention – PHS Evaluation (non-add)	\$0.000	\$0.000	\$5.605	+\$5.605
Gun Violence Prevention Research (non-add)	\$0.000	\$0.000	\$10.000	+\$10.000
Budget Authority	\$93.195	\$92.242	\$102.242	+\$10.000
PHS Evaluation Transfer	\$0.000	\$0.000	\$5.605	+\$5.605
Total	\$93.195	\$92.242	\$107.847	+\$15.605

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC’s Intentional Injury Prevention program works to prevent youth violence and bullying, child maltreatment, teen dating violence, sexual violence, intimate partner violence, suicide, and firearm-related injuries and deaths nationally. In 2010, over 16,000 individuals died as a result of a homicide and over 38,000 individuals committed suicide. Youth violence was especially prevalent, with over 4,600 homicides and over 585,000 non-fatal physical assaults treated in emergency departments for youth between the ages 15 and 24 in the year 2010.

Violence affects lives throughout the lifespan—in 2010, approximately 50 children per hour were victims of child maltreatment and more than 1,500 children died as a result of child maltreatment in the United States. Children who are maltreated are at higher risk for serious health problems as adults, including obesity, heart disease, and chronic obstructive pulmonary disease. In addition, children who experienced maltreatment are more likely to smoke and to engage in high-risk sexual behaviors later in life.

To improve our understanding of why violence continues to occur, CDC collects data through the National Intimate Partner and Sexual Violence Survey (NISVS) reporting system so researchers internal and external to CDC have a stable data source to track trends at the state and national level and evaluate program effectiveness. CDC identifies and evaluates new interventions to prevent violence-related injuries and deaths, which cost our nation approximately \$107 billion a year in medical and other costs.

CDC implements violence prevention activities through state and local public health agencies, universities, and non-governmental organizations throughout the country. For example, CDC supports [the Core Violence and Injury Prevention Program](#)²³² (Core VIPP), which builds state health department capacity to address violence and unintentional injuries. The Core VIPP program serves as an effective mechanism through which to implement violence and injury prevention interventions. Core VIPP activities include identifying public health burden focus areas through surveillance data and identifying and implementing (with collaborators) interventions to address the problem. For instance, all Core VIPP grantee programs work with their state’s Early Childhood Home Visiting Programs and partner with state Community Based Child Abuse Prevention (CBCAP) agencies.

Budget Request

CDC’s FY 2015 request of **\$107,847,000** for Intentional Injury Prevention, including \$5,605,000 in PHS Evaluation Transfer funds, is \$15,605,000 above the FY 2014 Enacted level. This includes \$10,000,000 for gun violence prevention research. With the increase of \$5,605,000 from the PHS Evaluation Transfer funds to the Rape Prevention and Education (RPE) program, CDC will fund evaluation activities to improve sexual violence prevention nationwide.

²³² <http://www.cdc.gov/injury/stateprograms/>

In FY 2015, the Violence Prevention program will:

- Work with 28 high-risk communities across the country to implement evidence-informed youth violence prevention strategies through the [Striving to Reduce Youth Violence Everywhere](#)²³³ (STRYVE) program and National Centers of Excellence in Youth Violence Prevention
- Collaborate with 50 states and five territories to implement evidence-informed sexual violence prevention strategies through the RPE program
- Directly support five states in implementing evidence-informed child maltreatment prevention strategies and provide training and technical assistance in the form of tailored webinars and resource materials to 20 additional states through the [Essentials for Childhood](#)²³⁴ initiative
- Expand the implementation of evidence-informed intimate partner and teen dating violence prevention strategies by supporting ten states through the [DELTA FOCUS](#)²³⁵ program and four communities through the [Dating Matters](#)²³⁶ program
- Continue to provide national data on intimate partner and sexual violence to states and researchers through the NISVS surveillance system
- Conduct research into the causes and prevention of gun violence, focusing on those questions with the greatest potential for public health impact

Gun Violence Prevention Research

In addition to the over 30,000 firearm-related homicides and suicides each year, more than 58,000 non-fatal firearm injuries from assault or self-harm are treated in hospital emergency departments annually. Together, they account for more than \$47.2 billion each year in medical and lost productivity costs to the United States.

The President's plan, [Now is the Time](#)²³⁷, calls for research on gun violence prevention to equip Americans with needed information about this public health issue. To address the numerous gaps in the evidence base for firearm injury prevention, CDC will support research into the causes and prevention of gun violence. These activities will be informed by the research agenda Consensus Report developed by the Institute of Medicine and the National Research Council in 2013 (*Priorities for Research to Reduce the Threat of Firearm-Related Violence*). The Consensus Report sets forth research questions including, among others:

- Issues related to youth access to firearms (including possession and carrying)
- Improved understanding of risk factors (individual and environmental) for firearm violence
- Examining the risks and benefits of firearm ownership (including safe storage practices)

Rape Prevention and Education (RPE) and Evaluation of Sexual Violence Prevention Activities

More than one million women report being raped each year and one in five women reported having been raped in their lifetime. Among men, one in 71 men reported having been raped in their lifetime. To address sexual violence, CDC promotes healthy relationships and supports rape prevention in coordination with state and local partners. Annually, the [Rape Prevention and Education](#)²³⁸ (RPE) program funds health departments in states, territories, and Washington, D.C. to work with rape crisis centers, state sexual assault coalitions, and others to advance the primary prevention of sexual violence.

²³³ <http://www.cdc.gov/violenceprevention/stryve/index.html>

²³⁴ <http://www.cdc.gov/violenceprevention/childmaltreatment/essentials/index.html>

²³⁵ <http://www.cdc.gov/violenceprevention/deltafocus/index.html>

²³⁶ <http://www.cdc.gov/violenceprevention/datingmatters/index.html>

²³⁷ <http://www.whitehouse.gov/issues/preventing-gun-violence>

²³⁸ <http://www.cdc.gov/violencePrevention/RPE/index.html>

With FY 2013 funding, the program:

- Educated more than 1.8 million students
- Answered 340,000 hotline calls
- Conducted over 105,000 trainings across the nation

In FY 2015, grantees will implement a range of activities, which include implementing culturally-relevant prevention strategies based on the best available evidence; conducting educational seminars and professional training; and leveraging resources through partnerships. For example, state health department grantees will support educational seminars and training programs for students and campus personnel to reduce sexual assault at colleges and universities and create a culture where sexual violence is not tolerated. Grantees will also operate state and community hotlines, develop statewide sexual violence prevention plans, and build state and local capacity for program planning and implementation.

In FY 2014, CDC will competitively award approximately five to seven academic or research institutions for a four- to five-year period. Funded institutions will partner with RPE grantees, collect data, and evaluate strategies to prevent sexual violence. These evaluations will build the evidence base in sexual violence prevention and will scale up evidence-based efforts throughout the RPE program. In FY 2015, the increase from the PHS Evaluation Transfer Funds for RPE will continue these efforts and support other evaluation activities to improve sexual violence prevention activities nationwide.

Rape Prevention and Education Grant Table¹

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget ²	2015 +/-2014
Number of Awards	57	55	55	0
- New Awards	57	55	0	-55
- Continuing Awards	0	0	55	+55
Average Award	\$0.572	TBD	\$0.580	N/A
Range of Awards	\$0.005–\$3.880	TBD	\$0.035–\$3.010	N/A
Total Awards	\$32.601	TBD	\$31.896	N/A

¹Average award amounts and range of award estimated on current funding formula and are subject to change based on available funding, and a new five-year funding opportunity announcement to be released in FY 2014. Beginning in FY 2014, RPE grantee awards included base funding of \$150,000 for all 50 states, Washington, D.C., and Puerto Rico, and \$35,000 for territories. RPE grantees within the 50 states, Washington, D.C., and Puerto Rico will also receive additional funds beyond their base funding based on population.

²Not inclusive of FY 2015 PHS Evaluation Transfer Funds.

Domestic Violence Prevention Enhancements and Leadership through Alliances (DELTA)

Over the course of a year, more than 12 million women and men are victims of rape, physical violence, or stalking by an intimate partner in the United States. CDC continues to support the Domestic Violence Prevention Enhancements and Leadership through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS) program through a five-year competitive cooperative agreement awarded in FY 2013. Through DELTA FOCUS, ten funded state domestic violence coalitions support the implementation and evaluation of intimate partner violence (IPV) primary prevention strategies at the state and local level and address the structural determinants of health at the outer layers of the social ecological model. DELTA FOCUS emphasizes evaluation, building the evidence base, training and mentoring, and the role of local coalitions in preventing violence. For example, DELTA FOCUS grantees can build on lessons learned from Delaware’s DELTA program that worked with a variety of stakeholders to create a 12-session curriculum, *Developing Healthy Relationships*. The Delaware Department of Education approved this curriculum as a model instructional unit for Delaware health teachers to use in elementary and high school classrooms across the state. DELTA FOCUS will enhance the spread of prevention strategies by ensuring grantees are engaged with the larger national violence prevention

field and are sharing their work and products through a national resource center. Successes, challenges, and lessons learned from these programs will inform how to develop and improve the infrastructure for primary prevention of intimate partner violence.

In FY 2015, DELTA FOCUS grantees will continue implementing and evaluating intimate partner violence primary prevention strategies. Grantees will address community and societal level factors to prevent intimate partner violence, including increasing gender equity in schools and within faith communities and educational initiatives to promote healthy relationships.

Domestic Violence Prevention Enhancement and Leadership Through Alliances Focusing on Outcomes for Communities United with States (DELTA FOCUS) Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	10	10	10	0
- New Awards	10	0	0	0
- Continuing Awards	0	10	10	0
Average Award	\$0.391	\$0.391	\$0.391	\$0.000
Range of Awards	\$0.344–\$0.410	\$0.344–\$0.410	\$0.344–\$0.410	N/A
Total Awards	\$3.907	\$3.907	\$3.907	\$0.000

Dating Matters®

Middle school youth in low-income, high-crime, urban environments are at increased risk for dating violence. There is little evidence, however, about how to prevent dating violence within this population. CDC’s Dating Matters® program addresses gaps in research and practice by developing strategies tailored to youth in communities at higher risk for violence. CDC funds four local health departments serving the cities of [Baltimore, Maryland](#); Chicago, Illinois; Fort Lauderdale, Florida; and Oakland, California through a competitive five-year (FY 2011- FY 2015) cooperative agreement to establish Dating Matters® programs. Communities focus on prevention activities for 11- to 14-year-old youth in urban communities at higher risk for dating violence. Activities include implementing:

- School curricula for dating violence prevention
- Parent-directed programs targeting home risk factors for teen dating violence, such as low parental monitoring
- Communications campaigns to reinforce messages about the importance of healthy relationships

Funded communities also work with CDC to conduct cross-site evaluations to improve the program. In FY 2013, more than 6,000 youth participated in a school-based dating violence prevention program (6-10 sessions) and nearly 3,000 participated in the outcome evaluation survey, which showed high levels of previous dating violence perpetration and victimization among the youth who have dated. Results and analysis of this survey will be released in 2014.

Implementation of Dating Matters® in the four demonstration cities will be completed in FY 2015. The evaluation will continue through FY 2018 and will follow youth through high school to monitor the long-term effectiveness of the program. In FY 2015, CDC will continue planning for the dissemination of Dating Matters® strategies to other urban communities by developing scalable training and technical assistance tools and building the capacity of additional communities to implement the program. Dissemination strategies may include seed funding and/or partnering with other CDC programs (such as DELTA FOCUS and RPE) and federal agency partners (such as the Department of Education or the Department of Justice). At the conclusion of the

demonstration phase of the program (FY 2011- FY 2015), CDC estimates that up to 100,000 students and adults will have participated in Dating Matters®.

Dating Matters® Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	4	4	4	0
- New Awards	0	0	0	0
- Continuing Awards	4	4	4	0
Average Award	\$0.338	\$0.350	\$0.350	\$0.000
Range of Awards	\$0.338	\$0.350	\$0.350	N/A
Total Awards	\$1.352	\$1.400	\$1.400	\$0.000

Essentials for Childhood: Actions to Create Safe, Stable, Nurturing Relationships

A recent CDC study found that the lifetime estimated financial costs associated with one year of confirmed cases of child maltreatment—physical abuse, sexual abuse, psychological abuse, and neglect—totals \$124 billion. Further, CDC research shows Medicaid expenditures associated with child maltreatment costs the Medicaid system an estimated \$5.9 billion per year due in part to higher utilization of health care services, including inpatient and outpatient care. CDC is committed to preventing child maltreatment before it begins, thereby eliminating the associated financial burdens. In FY 2013, CDC funded health departments in five states—Colorado, California, Massachusetts, North Carolina, and Washington—to implement CDC’s comprehensive child maltreatment prevention recommendations, *Essentials for Childhood: Steps to Create Safe, Stable, and Nurturing Relationships*. Funded state health departments are implementing strategies based on the best available scientific evidence to improve child well-being and to prevent child maltreatment.

In FY 2015, CDC’s Essentials for Childhood initiative will continue to support the five state health departments to implement and evaluate a comprehensive child maltreatment prevention suite of interventions. With state health department leadership, communities will promote safe, stable, and nurturing relationships and environments. They will do so by raising awareness of and strengthening commitment to preventing child maltreatment, using data to inform actions, creating the context for healthy children and families through norms change and programs, and implementing evidence-informed policy strategies.

Essentials for Childhood Grant Table

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	5	5	5	0
- New Awards	5	0	0	0
- Continuing Awards	0	5	5	0
Average Award	\$.175	\$0.175	\$0.175	\$0.000
Range of Awards	\$0.175	\$0.175	\$0.175	N/A
Total Awards	\$0.873	\$0.873	\$0.873	\$0.000

Striving to Reduce Youth Violence Everywhere (STRYVE)

Through a competitive five-year (FY 2011-FY 2015) cooperative agreement, CDC funds four local health departments (Boston, Massachusetts Public Health Commission; Monterey County Health Department in

Salinas, California; Multnomah County Health Department in Portland, Oregon; and Houston, Texas Department of Health and Human Services) to prevent youth violence through STRYVE. Health department activities include:

- Developing comprehensive youth violence prevention plans
- Implementing appropriate programs and practices
- Measuring improvements in organizational and community capacity
- Developing evaluation plans
- Determining the resources necessary for sustaining programs

In FY 2015, CDC will fund four local health departments through the STRYVE program. STRYVE grantees will bring together organizations from multiple sectors including public health, education, criminal justice, and business to prevent youth violence in high-risk communities. Multnomah County, Oregon and Houston, Texas are implementing Crime Prevention Through Environmental Design (CPTED), an evidence-based strategy to deter criminal behavior through environmental designs, such as improved lighting to promote security surveillance, the use of landscaping to identify public and private space, and using design to alter remote and isolated areas, since these are places where violence may be more easily concealed. All four sites are implementing curriculum-based violence prevention programs, and Monterey County, California is implementing an evidence-based bullying prevention program. The health departments are tracking changes in morbidity and mortality associated with youth violence and risk and protective factors over the course of the five-year grant period to measure impact. Grantees also are working to identify plans for sustainability to continue activities even after CDC funding ends.

Striving to Reduce Youth Violence Everywhere (STRYVE) Grant Table

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	4	4	4	0
- New Awards	0	0	0	0
- Continuing Awards	4	4	4	0
Average Award	\$0.225	\$0.225	\$0.225	\$0.000
Range of Awards	\$0.225	\$0.225	\$0.225	N/A
Total Awards	\$0.900	\$0.900	\$0.900	\$0.000

National Centers of Excellence in Youth Violence Prevention

CDC funds the National Centers of Excellence in Youth Violence Prevention (YVPCs; formerly [Academic Centers for Excellence](#)²³⁹) through competitive five-year cooperative agreements in two funding cycles: FY 2010 – FY 2014 (University of Chicago, Virginia Commonwealth University, University of Michigan, and the University of North Carolina at Chapel Hill) and FY 2011— FY 2015 (Johns Hopkins University and the University of Colorado at Boulder). These universities serve as local, regional, and national resources for developing and applying effective violence prevention strategies in communities. The YVPCs connect academic and community resources to implement and evaluate comprehensive approaches to prevent youth violence. Each YVPC implements and formally evaluates interventions in its local community.

Select YVPC Projects Currently Underway

YVPCs	Funded Activities
Virginia Commonwealth University	Implementing and evaluating a combined school and parenting program to prevent youth violence in three high-risk communities in Richmond, Virginia.

²³⁹ <http://www.cdc.gov/violenceprevention/ace/index.html>

YVPCs	Funded Activities
University of Michigan	Implementing and evaluating several place-based initiatives in a high-risk neighborhood in Flint, Michigan to reduce urban blight, improve the physical spaces in which youth live, and empower youth to be engaged in their communities.
University of Colorado	Implementing and evaluating an evidence-based program package in the high-risk Denver neighborhood of Montbello, Colorado to promote positive youth development and reduce youth violence.
University of Chicago	Implementing and evaluating a coordinated set of activities to impact community norms and attitudes, neighborhood social organization, behavior of high-risk adolescents and young adults, and at-risk children and families in elementary and middle school in the Humboldt Park neighborhood of Chicago, Illinois.
Johns Hopkins University	Implementing and evaluating a street outreach intervention with the goal of reducing fatal and non-fatal shootings in four high-crime neighborhoods in Baltimore, Maryland.
University of North Carolina	Implementing and evaluating a multi-level youth violence prevention initiative in the high-poverty, rural county of Robeson, North Carolina.

From 2007 through 2010, the Johns Hopkins University YVPC, in partnership with the Baltimore City Health Department, applied the Safe Streets model with the goal of reducing fatal and non-fatal shootings in four high-crime neighborhoods in Baltimore, Maryland. The YVPC assessed the impact of the program on fatal and non-fatal shootings in those communities, and found the program was associated with significant reductions in homicides and/or non-fatal shootings in three communities. Specifically, the program was associated with a 56% reduction in homicides in the Cherry Hill neighborhood and a 26% reduction in the McElderry Park neighborhood. Ellwood Park’s program was associated with a 34% reduction in nonfatal shootings.

In FY 2015, CDC will continue to work with the YVPCs to build communities’ capacities to put science into action to prevent youth violence. In addition, CDC will fund four new YVPCs. This funding supports university-community partnerships, which provide a unique and important opportunity to prevent violence and create safer, healthier communities.

National Centers of Excellence in Youth Violence Prevention

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final¹	Enacted	President Budget	2015 +/-2014
Number of Awards	6	6	6	0
- New Awards	0	0	0	0
- Continuing Awards	6	6	6	0
Average Award	\$1.040	\$1.040	\$1.040	\$0.000
Range of Awards	\$1.040	\$1.040	\$1.040	N/A
Total Awards	\$6.238	\$6.238	\$6.238	\$0.000

National Violent Death Reporting System

(dollars in millions)	FY 2015			
	FY 2013 Final ¹	FY 2014 Enacted	President Budget	2015 +/-2014
Budget Authority	\$3.421	\$11.333	\$23.570	+\$12.237

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [National Violent Death Reporting System](#)²⁴⁰ (NVDRS) is critical to CDC’s efforts to prevent violence. The system equips funded states, researchers, and CDC to better understand the circumstances surrounding violent deaths. NVDRS is the only state-based surveillance (reporting) system that pools information from multiple data sources into a usable, anonymous database. These sources include hospitals, state and local medical examiners, coroners, law enforcement, crime labs, and vital statistics. NVDRS covers all types of violent deaths—including homicides, suicides, and child maltreatment fatalities—in all settings and for all age groups. In the case of suicides, NVDRS may include data on whether there was a history of depression or other mental health problems; recent problems with a job, finances, or relationships; or the recent death of a family member. Such data is far more comprehensive than what is available elsewhere. States use NVDRS data for:

- Targeting violence prevention resources
- Development and implementation of violence and suicide prevention programs
- Strategic planning

Budget Request

CDC’s FY 2015 request of **\$23,570,000** for the National Violent Death Reporting System is \$12,237,000 above the FY 2014 Enacted level. This funding supports the President’s gun violence prevention plan, [Now is the Time](#)²⁴¹, by providing nationwide data to better understand how and when firearms are used in violent deaths and to inform future research and prevention strategies. When firearms are used in homicides or suicides, NVDRS collects anonymous data, including the type of firearm used, whether the firearm was stored loaded or locked, and details on youth gun access.

In FY 2015, CDC’s NVDRS program will:

- Expand to all 50 states and Washington, D.C. to collect data as part of the NVDRS system and provide technical assistance to help grantees monitor and report their state data
- Ensure NVDRS data support and translate into violence prevention activities by increasing dissemination and use of NVDRS data at the national level by working with states to produce standard analyses/reports on a range of topics (including intimate partner homicides, homicides followed by suicide, and suicides of different groups such as veterans)
- Link NVDRS data with other data sources, such as child fatality review reports and adult protective services reports

CDC continues to improve the NVDRS system by promoting greater functionality and improved access to data. In 2013, the National Violent Death Reporting System (NVDRS) transitioned to a national web-based system where all participating states now enter information through the web, whereas information had previously been

²⁴⁰ <http://www.cdc.gov/violenceprevention/nvdrs/index.html>

²⁴¹ <http://www.whitehouse.gov/issues/preventing-gun-violence>

collected from 18 different locally-run databases. NVDRS data is available online to the general public through CDC’s [WISQARS](#)²⁴² (Web-based Injury Statistics Query and Reporting System).

With the \$7.9 million increase in funding received for NVDRS in FY 2014, CDC will expand the number of states beyond the 18 states currently funded. Funds also will be used to reduce the burden of participation and improve data exchange through enhancements of the web-based platform and to strengthen scientific support that CDC provides to the states and for the system as a whole. With the \$23.57 million proposed for FY 2015, CDC will complete expansion of NVDRS to all 50 states and to Washington, D.C. This expansion, and increase in average per-grantee funding, will allow CDC to adequately fund all states not previously funded for NVDRS, including many of the most highly-populated states. For the first time, prevention researchers, practitioners, and policymakers will be able to gauge the magnitude, trends, and characteristics of violent deaths at the national, state and local levels. These data will inform the development, implementation, and evaluation of violence prevention strategies, which will ultimately save lives. The expansion will allow CDC to provide greater scientific and programmatic support to all states, including enhancements of training, orientation for new users, data analysis, dissemination, and evaluation. Funding will also support system enhancements to improve overall data collection, increase system responsiveness, and allow CDC to better identify and report on national trends on different types of homicides, including mass shootings, as well as trends seen in particular populations.

NVDRS collects and shares data to support decision making at the federal, state, and local level. For example, Oregon used NVDRS data to identify that almost 50% of men 65 years of age or older who died by suicide were reported to have had depressed mood before death, while only a small proportion were receiving treatment. This suggests screening and treatment for depression may save lives. As a result, Oregon developed primary care recommendations in 2006 to better integrate with mental health services so that suicidal behavior and ideation are diagnosed and older adults receive appropriate treatment, which were implemented as part of the State’s “Healthy Aging” efforts. The recommendations included increasing the confidence and competence of primary care providers and other clinicians to identify, assess, and treat older adult suicide behavior and depression. In Oregon, the suicide rates among males 65 and older decreased approximately 8% between 2007 and 2010.

In addition, CDC is collaborating with the Department of Defense (DoD) to link NVDRS and DoD Suicide Event Report (DoDSER) data. This collaborative project is expected to result in a number of products. In addition to ongoing comprehensive surveillance on suicides among current/former military personnel, CDC and DoD defined multiple research projects that include analysis of suicides among active duty U.S. Army personnel that uses data from both systems and non-fatal suicidal behavior among active duty U.S. Army personnel.

National Violent Death Reporting System (NVDRS) Grant Table¹

(dollars in millions)	FY 2013	FY 2014	FY 2015	2015
	Final ¹	Enacted	President Budget	+/-2014
Number of Awards	18	TBD	51	N/A
- New Awards	0	TBD	51	N/A
- Continuing Awards	18	0	TBD	N/A
Average Award	\$0.203	TBD	\$0.362	N/A
Range of Awards	\$0.121–\$0.253	TBD	\$0.189–\$1.10	N/A
Total Awards	\$3.662	TBD	\$18.471	N/A

¹Average award amounts and range of awards are estimated on current structure and are subject to change pending the results of the new funding opportunity announcement in FY 2014. In FY 2013, CDC used 100% of the NVDRS appropriation to support NVDRS awards.

²⁴² <http://www.cdc.gov/injury/wisqars/>

Injury Prevention Activities

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	
			President Budget	2015 +/-2014
Budget Authority	N/A ²	\$29.023	\$44.646	+\$15.623
Total	N/A	\$29.023	\$44.646	+\$15.623

¹ These activities were funded in the All Other Intentional and All Other Unintentional Injury lines in FY 2013.

² Amount for Injury Prevention Activities for FY 2013 is N/A, since amounts for All Other Intentional and All Other Unintentional Injury already have been accounted for within their respective areas of this budget narrative. The projected total amount, comparably adjusted, for FY 2013 would be \$26.734 million.

Overview

Injuries kill more than 180,000 people each year—that’s one death every three minutes. Regardless of sex, race, or economic status, violence and injuries affect everyone. CDC works to prevent injuries and violence through a host of programs spanning surveillance, development and evaluation of recommendations, and implementation of effective programs. Areas of focus:

- [Prescription drug overdose](#)²⁴³
- [Motor vehicle injury](#)²⁴⁴
- [Child injury](#)²⁴⁵
- [Suicide](#)²⁴⁶

The Core Violence and Injury Prevention Program (Core VIPP) supports interventions across violence and injury topics, including these areas of focus.

Budget Request

CDC’s FY 2015 request of **\$44,646,000** for Injury Prevention Activities is \$15,623,000 above the FY 2014 Enacted level. In FY 2015, CDC will expand the Core VIPP program to additional states with a high burden of prescription drug abuse. Currently, 16 of the 20 States funded through the Core VIPP Program focus on the prevention of prescription drug abuse, but many of the States with a high burden do not receive funding from CDC

Prescription Drug Overdose

[Prescription Drug Overdose](#)²⁴⁷ (PDO) represents a growing public health concern, as evidenced by the fact that more than 60 people die every day in the United States from prescription drug overdoses, most of which involve prescription opioid pain relievers. In addition, PDO deaths have increased four-fold between 1999 and 2010, and now outnumber deaths from all illicit drugs—including cocaine and heroin—combined. Abuse of opioid pain relievers claimed over 16,600 lives in 2010, resulted in over 400,000 emergency department visits in 2011, and costs health insurers an estimated \$72 billion annually in medical costs.

²⁴³ <http://www.cdc.gov/homeandrecreationalafety/overdose/index.html>

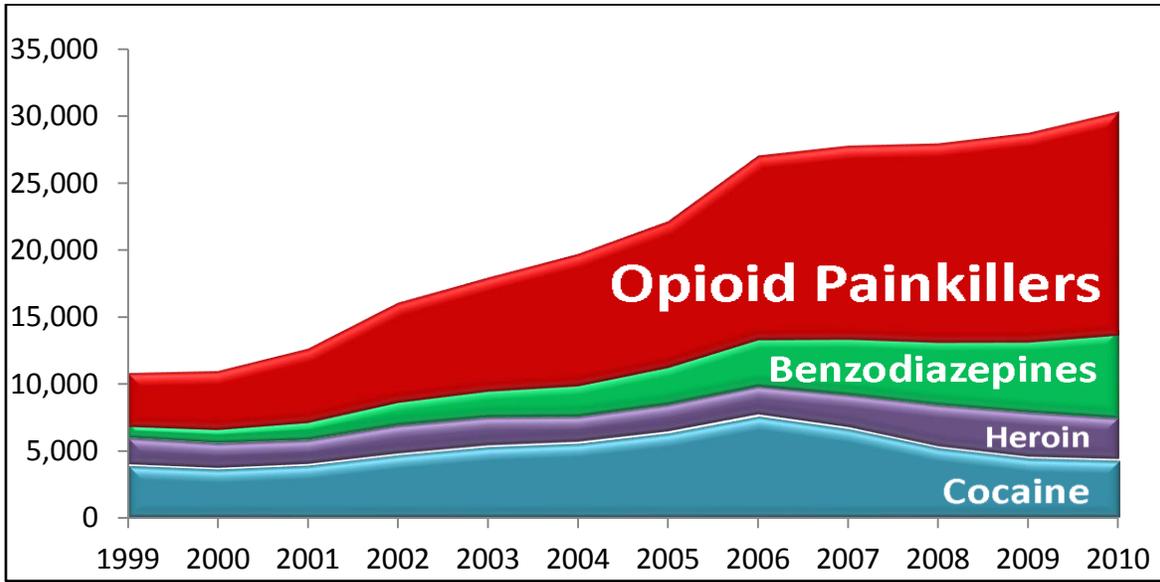
²⁴⁴ <http://www.cdc.gov/motorvehiclesafety/>

²⁴⁵ <http://www.cdc.gov/safekid/>

²⁴⁶ <http://www.cdc.gov/violenceprevention/suicide/>

²⁴⁷ <http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/index.html>

Overdose deaths involving opioid painkillers have quadrupled since 1999



CDC leverages its scientific and public health expertise to assist federal, state, and local partners in their collective efforts to address the main drivers of the epidemic of prescription drug overdoses—high-risk prescribing and high-risk patients. Within the past year, CDC published numerous peer-reviewed [publications](#)²⁴⁸ providing critical insight into the epidemic, including:

- Identifying clinical practices that contribute to prescription drug abuse and overdose
- Evaluating pain clinic laws and other policies to identify effective prevention strategies
- Examining the dramatic increase in overdoses among women, a previously under-recognized demographic

This essential research is helping shape a national, as well as state and local, response to this growing epidemic in the United States. Additionally, CDC is commencing funding two to four states in FY 2014 for a three-year period to implement foundational state-based strategies to curb prescription drug overdose. These strategies include the implementation of innovative insurer strategies, the maximization of state-based prescription drug monitoring programs, and evaluation of programs and policies directed at prescription drug overdose prevention.

Core Violence and Injury Prevention Program (Core VIPP)

Core VIPP funds states to implement and evaluate evidence-based strategies using the best available data and work to reduce the burden of injuries in our nation. CDC leverages the Core VIPP infrastructure as a mechanism to implement effective violence and injury prevention interventions, including the expanded focus on prescription drug overdose prevention. For instance, in 2013, 16 of the 20 Core VIPP-funded states identified prescription drug overdose as one of their priority areas. In Ohio, CDC leveraged relationships developed through Core Violence and Injury Prevention Program and through work done in conjunction with the Association of State and Territorial Health Officials to collaborate with local decision makers to address prescription drug overdose within the state. CDC scientists provided expert consultation to Ohio’s state health officer and other key state officials to develop prescribing guideline recommendations for Ohio’s Opiate Task Force. Recommendations developed during the consultation were instrumental to the implementation of Ohio’s statewide prescribing guidelines for opioid use in chronic pain and emergency department guidelines on opioid

²⁴⁸ <http://www.cdc.gov/homeandrecreationalafety/overdose/pubs.html>

prescribing. CDC supports both the Association of State and Territorial Health Officials and the National Governors Association to assist in the coordination of state efforts to address prescription drug overdose.

Core VIPP is funded by the Unintentional Injury Prevention, the Intentional Injury Prevention, and the Injury Prevention Activities budget lines. All 20 currently-funded states receive funding for the Base Integration Component, which allows states to select four priority areas in which to focus their injury prevention activities based on state needs while also requiring essential activities—such as surveillance and evaluation—to ensure program effectiveness. States receiving Base Integration Component funding also were eligible to compete for additional funding through expanded Core VIPP components:

Expanded Core VIPP Components

Components	Activities Receiving Additional Funding
Falls in older adults ²⁴⁹	Three Core VIPP states receive additional funding to prevent falls in older adults by integrating and linking clinical and community-based programs.
Motor Vehicle Child Injury Prevention ²⁵⁰	Four Core VIPP states receive additional funding for activities to reduce motor vehicle-related injuries among children ²⁵¹ and teens ²⁵² .
Regional Network Leaders	Five Core VIPP states receive additional funding to provide expanded support to both funded and unfunded states within their geographic regions to maximize sharing of information and strategies among states.
Surveillance Quality Improvement	Four Core VIPP states receive additional funding for activities to improve the overall quality of injury data.

In FY 2015, all 20 Core VIPP-funded states will strengthen their injury and violence prevention programs with a focus on the following components:

- Building a public health infrastructure
- Collecting and analyzing data
- Implementing and evaluating prevention strategies
- Providing education

Also in FY 2015, CDC will expand the Core VIPP by \$15.6 million to include additional states with a high burden of prescription drug overdose (as determined by state drug overdose deaths). In doing so, CDC will continue to collaborate on prescription drug overdose prevention efforts with SAMHSA to ensure a coordinated federal response to the epidemic. To curb the devastating effects of this epidemic, increased investment in FY 2015 will equip more states to improve infrastructure as means to prevent injuries and violence through Core VIPP’s Base Integration Component, with the requirement that one of each state’s four injury prevention focus areas be PDO. Some Core VIPP states (both current and possibly new states), selected based on PDO burden and readiness to implement effective interventions, will receive additional funding and scientific assistance from CDC to focus intensely on implementing PDO-specific interventions, including:

- Enhancing insurance innovations such as patient review and restriction programs
- Strengthening programs and policies for improving clinical practice and preventing overdose
- Providing state-focused analysis and recommendations to enhance states’ PDO prevention efforts

²⁴⁹ <http://www.cdc.gov/HomeandRecreationalSafety/Falls/index.html>

²⁵⁰ <http://www.cdc.gov/motorvehiclesafety/>

²⁵¹ http://www.cdc.gov/Motorvehiclesafety/Child_Passenger_Safety/index.html

²⁵² http://www.cdc.gov/Motorvehiclesafety/Teen_Drivers/index.html

Core Violence and Injury Prevention Program Grant Table¹

(dollars in millions)	FY 2015			
	FY 2013 Final ¹	FY 2014 Enacted	President Budget	2015 +/-2014
Number of Awards	20	20	TBD	N/A
- New Awards	0	0	TBD	N/A
- Continuing Awards	20	20	TBD	N/A
Average Award	\$0.342	\$0.343	TBD	N/A
Range of Awards	\$0.150–\$0.803	\$0.150–\$0.813	TBD	N/A
Total Awards	\$6.835	\$6.865	\$19.465	+\$12.600

¹All 20 Core VIPP grantees are funded for the Base Integration Component of Core VIPP. Select states are funded for additional components above the Base Integration Component. See the state table for funding details.

Motor Vehicle Injuries and Deaths

[Motor vehicle crashes](#)²⁵³ are the leading cause of death in the first three decades of an American’s life. To prevent motor vehicle-related injuries and death, CDC supports and guides state health departments by providing expertise and insight into their activities and analyses. CDC ensures implementation of effective interventions and program evaluation; analysis of crash-related injury data; and provides guidance on effective programs such as [alcohol ignition interlocks](#)²⁵⁴ and [graduated driver licensing systems](#)²⁵⁵. CDC collaborates with a number of organizations, including the National Highway Traffic Safety Administration, other federal agencies, state health departments, American Indian/Alaska Native tribes, and academic institutions.

Strategies focus on key areas including:

- Preventing [alcohol-impaired driving](#)²⁵⁶
- Promoting [seat belts](#)²⁵⁷ and [car seat/booster seat](#)²⁵⁸ use
- Improving [teen driver safety](#)²⁵⁹
- [Tribal motor vehicle](#)²⁶⁰ injury prevention
- [Older adult mobility](#)²⁶¹

In FY 2015, CDC will assist states with the development and implementation of effective programs to address motor vehicle-related injuries in key areas, including older adult mobility. CDC will begin to focus on improving safe mobility for older adults and work to better understand the transition from driving to not driving among older adults. For instance, CDC is developing a tool for older adults allowing them to assess their own mobility. For tribal motor vehicle injury prevention, CDC is developing a manual of best practices from CDC’s successful Tribal Motor Vehicle Injury Prevention Program (TMVIPPP). As an example of success through TMVIPPP and a cooperative agreement between the California Rural Indian Health Board’s Injury Prevention program and the Yurok Tribal Police Department, the Yurok Tribe of Klamath, California observed an increase in the use of child safety seats from 53.0% to 60.4% and in the use of seatbelts from 75.2% to 81.0% within one year. CDC will be

²⁵³ <http://www.cdc.gov/motorvehiclesafety/>

²⁵⁴ http://www.cdc.gov/Motorvehiclesafety/Impaired_Driving/index.html

²⁵⁵ <http://www.cdc.gov/ParentsAreTheKey/licensing/index.html>

²⁵⁶ http://www.cdc.gov/Motorvehiclesafety/Impaired_Driving/index.html

²⁵⁷ <http://www.cdc.gov/motorvehiclesafety/seatbelts/index.html>

²⁵⁸ http://www.cdc.gov/Motorvehiclesafety/Child_Passenger_Safety/index.html

²⁵⁹ http://www.cdc.gov/Motorvehiclesafety/Teen_Drivers/index.html

²⁶⁰ <http://www.cdc.gov/Motorvehiclesafety/native/index.html>

²⁶¹ http://www.cdc.gov/Motorvehiclesafety/Older_Adult_Drivers/index.html

expanding its reach to tribal communities by partnering with the Federal Highway Administration. Through this partnership, CDC will continue to support tribal communities for motor vehicle injury prevention.

CDC also will continue to guide states by providing expert feedback on planned activities and implementation strategies through Core VIPP since all 20 Core VIPP states identified motor vehicle injury prevention as a priority area. This will build on previous successes such as those achieved in Nebraska. The Drive Smart Nebraska Coalition is a collaborative initiative of public and private agencies working together in developing and implementing evidence-based strategies to increase seat belt use statewide and protect teen drivers. The Coalition is collaborating on the development and implementation of a coordinated education campaign designed to raise awareness of seat belt use. Key campaign activities include a *Saved By* website to collect stories from individuals who were “saved by” their seat belt. In addition, Nebraska implemented the Teens in the Driver Seat program in schools. The program addresses the special issues of teen drivers and includes a parent education component, which is expected to result in improved safe driving among teen drivers.

Suicide Surveillance, Research, and Prevention

Suicide is the tenth leading cause of death in the United States among all age groups and is estimated to cost \$41.2 billion in combined medical and work loss costs²⁶². With FY 2015 funding, CDC will expand its efforts to prevent suicide by improving surveillance, research, and the development and evaluation of evidence-based strategies to prevent suicide. This funding will help CDC expand resources and support for fatal and non-fatal surveillance systems for self-directed violence, including collection of data at the national, state, and local levels, which leads to more relevant information for decision makers at the state and local level. This important data and research will help CDC develop and determine the efficacy and effectiveness of strategies to prevent suicidal behavior and expand the number of evidence-based prevention strategies to prevent suicide. This funding will also allow CDC to continue to develop a deeper understanding through research of how promoting and strengthening connectedness may impact suicidal behavior. For example, in 2014, CDC continued efforts to evaluate two interventions, LET’s CONNECT and The Senior Connection, to promote and strengthen individual, family, and community connectedness, a key protective factor of interest in suicide prevention. LET’s CONNECT links adolescents who are identified as at risk for suicidal behavior with natural (e.g. parent, family member) and community mentors. The Senior Connection seeks to link socially disconnected seniors with a volunteer peer companion. In 2015, outcomes of randomized controlled trials are expected that will inform the practice of suicide prevention among two particularly vulnerable populations—adolescents and older adults.

²⁶² <http://www.cdc.gov/injury/wisqars/index.html>

Unintentional Injury Prevention

(dollars in millions)		FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
	Budget Authority	\$32.708	\$8.619	\$8.619	\$0.000
	Total	\$32.708	\$8.619	\$8.619	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

Unintentional injuries are the leading cause of death for individuals ages 1–44 in the United States and are projected to cost more than \$81 billion annually in medical costs. CDC’s Unintentional Injury program promotes safety by tracking unintentional injuries to identify opportunities for prevention and by developing and evaluating recommendations for effective programs and policies for issues including:

- [Traumatic brain injury](#)²⁶³
- [Older adult falls](#)²⁶⁴

Interventions in these areas are implemented at the state level through various mechanisms including Core VIPP.

Budget Request

CDC’s FY 2015 request of **\$8,619,000** for Unintentional Injury Prevention is level with the FY 2014 Enacted level. In FY 2015, CDC will conduct surveillance, identify effective interventions, and work toward implementation of strategies to prevent and address injuries including traumatic brain injuries and older adult falls.

Traumatic Brain Injury Prevention

To reduce [traumatic brain injuries](#)²⁶⁵ (TBI), including concussions, CDC conducts surveillance, develops and shares educational materials and clinical guidelines, and supports prevention interventions. In 2012, CDC’s Injury Center’s Board of Scientific Counselors established the [Pediatric Mild TBI Guideline Workgroup](#)²⁶⁶. Comprised of leading experts in the field of TBI, the workgroup is leading the development of a clinical guideline for use in doctor’s offices and emergency departments to assist health care professionals with diagnosis of and care for children and adolescents with mild TBI (a term used to describe a level of severity for a brain injury that can cause a person to experience confusion, disorientation, loss of memory around the time of the injury, or a brief loss of consciousness, among other potential conditions). Also, in partnership with the National Football League (NFL), CDC launched [Heads Up to Clinicians: Addressing Concussion in Sports among Kids and Teens](#)²⁶⁷ in FY 2012. This free, online course provides guidance to healthcare professionals and clinicians on TBI diagnosis and management, and has become required training for U.S. Olympic Team medical staff. In just the last three years, CDC trained over 1.5 million high school and youth sports coaches on how to identify and respond appropriately to concussions or other serious TBIs among young athletes through a number of targeted online Heads Up training courses.

Further, CDC’s expertise in TBI prevention is informing Core VIPP activities. Activities underway within the Core VIPP states include conducting TBI surveillance and developing state-level estimates of TBI, providing guidance

²⁶³ <http://www.cdc.gov/traumaticbraininjury/>

²⁶⁴ <http://www.cdc.gov/HomeandRecreationalSafety/Falls/index.html>

²⁶⁵ <http://www.cdc.gov/traumaticbraininjury/>

²⁶⁶ http://www.cdc.gov/traumaticbraininjury/MTBI_pediatric.html

²⁶⁷ <http://www.cdc.gov/concussion/HeadsUp/clinicians/index.html>

to ensure TBI-related policies are informed by accurate research, and supporting the development and dissemination of the latest science on the risk factors, burden, impact, and outcomes associated with TBI. For example, the Core VIPP-funded Massachusetts Department of Public Health (MDPH) worked with the Massachusetts School Health Program and the Massachusetts Interscholastic Athletic Association (MIAA) to provide support and information to schools across the state to implement regulations on the identification and management of concussion in school sports during the 2011-2012 school year. To date, 78% of the schools and school districts required to provide confirmation of their compliance have confirmed that policies are in place that comply with the MDPH regulations. MDPH plans to expand their outreach to charter schools, which are not MIAA members.

In FY 2015, CDC will continue to support TBI prevention efforts related to surveillance and program implementation through the Core VIPP program. CDC will also continue collaborating in the development of new pediatric mild TBI guidelines to assist in proper TBI diagnosis and treatment, including continued partnership with the American Academy of Pediatrics to ensure wide adoption and dissemination of these guidelines. Together, these activities will help prevent TBI and mitigate their impact if they occur, thus reducing the burden of these often fatal and life-altering injuries.

Older Adult Falls

CDC helps older adults stay healthy and independent by using the best available scientific data to identify effective programs and determine optimal strategies to promote widespread adoption of these programs. [Falls](#)²⁶⁸ are preventable with better screening by healthcare providers and participation by older adults in exercise programs that improve physical strength and balance. But while providers report being aware their older patients are at risk for falls, they likewise report a lack of awareness as to how to assess fall risk. To address this gap, CDC developed the [Stopping Elderly Accidents, Deaths and Injuries \(STEADI\) toolkit](#)²⁶⁹. This toolkit and pocket guide helps healthcare providers assess risk of falls among older adults and address identified risk factors through treatment or referrals to appropriate falls prevention programs, such as exercise-based programs or referrals to a physical therapist.

Three Core VIPP states receive funding from CDC to implement the strategies in this toolkit. Early success indicators show positive outcomes. For example, the New York State Department of Health is partnering with United Health Services (UHS), a large healthcare system, to implement STEADI in primary care practices. STEADI has been implemented in thirteen UHS primary care practices in one county and UHS has modified their system-wide Electronic Health Record system to prompt physicians and office staff to perform annual assessments on patients 65 and older and to track outcomes. As a result, patients over 65 in participating practices are screened annually for fall risk and referred to appropriate treatments or programs. All participating practices are seeing an increase in the number of fall risk assessments performed and patient plans of care developed. The number of risk assessments performed on patients 65 years of age and older in the initial pilot site grew from 39% to 97% within five months. It is expected that each participating state will see more clinicians adopting STEADI, expanding the number of participants in fall prevention programs in the selected communities, thereby resulting in improved functional ability among program participants.

In FY 2015, CDC will complete work with research partners to evaluate the success of the work with the Core VIPP states and to develop implementation guides and tools that others can use in the future.

²⁶⁸ <http://www.cdc.gov/HomeandRecreationalSafety/Falls/index.html>

²⁶⁹ <http://www.cdc.gov/homeandrecreationalafety/Falls/steadi/index.html>

Injury Control Research Centers

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015	2015
			President Budget	+/-2014
Budget Authority	\$9.619	\$9.622	\$9.622	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

One person in the United States dies every three minutes from an injury or violent act. Americans under the age of 45 years are more likely to die from violence and injuries than from any other cause. However, not all injuries have evidence-based prevention solutions. CDC’s Injury Control Research Centers (ICRCs) research and evaluate ways to improve injury prevention practices and determine the health and economic impacts of injury and violence prevention efforts to fill gaps in the evidence base. ICRCs conduct research on priority injury topics, including prescription drug overdose, traumatic brain injury, motor vehicle injuries, and violence against children and youth. The academic institutions that comprise the ICRCs provide a high caliber of scientific competency, regional and national leadership in the field, and training for future injury researchers and the broader public health community. To develop and share interventions, ICRCs collaborate with state and local health agencies (including Core VIPP grantees), community partners, and other non-governmental organizations. Decision makers across the United States rely on ICRC research to shape federal, state, and local programs and policies.

Current ICRC Projects

Grantee	Project
Emory University (Georgia)	Valuing Child Maltreatment Outcomes for Use in Economic Evaluations
Johns Hopkins University (Maryland)	Housing Characteristics and Child Injury Risks: A New Tool for Researchers and Policymakers
University of North Carolina (North Carolina)	Understanding the Role of Substance Use in Intimate Partner Violence
Washington University (Missouri)	Veterans, Trauma, and Battering Behavior: Developing a Proactive Community Response to Violence Prevention
Columbia University (New York)	Translating a Falls Behavior Program to Urban Seniors with Mobility Disability
Nationwide Children's Hospital (Ohio)	Evaluating the Effectiveness/Outcomes of State Level Concussion Policies
University of Iowa (Iowa)	Implementation and Outcome Evaluation of Iowa’s Anti-bullying Legislation
University of Michigan (Michigan)	A Brief Prescription Opioid Overdose Intervention for At-Risk Urban Opioid Users
University of Rochester (New York)	Structure, Policy, and Suicide Variability across Communities
West Virginia University (West Virginia)	Concurrent Drug, Alcohol, and Decedent Characteristics in Deaths Due to Opioids

Budget Request

CDC's FY 2015 request of **\$9,622,000** for Injury Control Research Centers is level with the FY 2014 Enacted level.

Currently CDC supports 11 ICRCs to conduct research and evaluation activities related to health and the economic impact of injury and violence as well as the improvement of injury prevention practices. When implemented in states and communities, the program and policy efforts built from ICRC research and evaluation findings will lead to reductions in injuries and violence. For example, research conducted by the Iowa ICRC was used by decision makers to inform Iowa’s Graduated Drivers Licensing (GDL) law, which is an effective intervention to reduce the number of car crashes involving teen drivers. In addition the Emory ICRC is investigating a school-based bullying prevention intervention program designed to nurture healthy development by cultivating resiliency, self-efficacy, and coping skills. Analyses from initial data collection showed that victimization appears to undermine the protective effects of an individual’s self-efficacy. Additional follow-up analyses are planned, and these results stand to inform how both students and adults are educated on how to prevent and respond to bullying.

In FY 2015, CDC will continue to collaborate with the ICRCs to conduct injury and violence prevention research to fill key gaps in the evidence base for prevention. CDC will provide strategic direction to the ICRCs and to the field of injury prevention research, including priority injury topics such as TBI, violence against children and youth, motor vehicle-related injuries, and prescription drug overdose. CDC will share key findings from injury and violence prevention research from the ICRCs to benefit the broader public health community.

Injury Control Research Centers Program Grant Table

(dollars in millions)	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	11	11	11	0
- New Awards	0	4	0	-4
- Continuing Awards	11	7	11	+4
Average Award	\$0.795	\$0.836	\$0.836	\$0.000
Range of Awards	\$0.795	\$0.836	\$0.836	N/A
Total Awards	\$8.741	\$9.202	\$9.202	\$0.000

State Table: Core State Injury Program^{1, 2, 3, 4}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$0	\$0	TBD	TBD
Alaska	\$0	\$0	TBD	TBD
Arizona	\$180,621	\$180,621	TBD	TBD
Arkansas	\$0	\$0	TBD	TBD
California	\$0	\$0	TBD	TBD
Colorado	\$803,029 ^{b,c,d}	\$813,029 ^{b,c,d}	TBD ^{b,c,d}	TBD
Connecticut	\$0	\$0	TBD	TBD
Delaware	\$0	\$0	TBD	TBD
Florida	\$250,000	\$250,000	TBD	TBD
Georgia	\$0	\$0	TBD	TBD
Hawaii	\$150,000	\$150,000	TBD	TBD
Idaho	\$0	\$0	TBD	TBD
Illinois	\$0	\$0	TBD	TBD
Indiana	\$0	\$0	TBD	TBD
Iowa	\$0	\$0	TBD	TBD
Kansas	\$278,623 ^a	\$278,623 ^a	TBD ^a	TBD
Kentucky	\$247,814	\$247,814	TBD	TBD
Louisiana	\$0	\$0	TBD	TBD
Maine	\$0	\$0	TBD	TBD
Maryland	\$294,057 ^a	\$294,057 ^a	TBD ^a	TBD
Massachusetts	\$427,388 ^{a,b}	\$427,388 ^{a,b}	TBD ^{a,b}	TBD
Michigan	\$0	\$0	TBD	TBD
Minnesota	\$246,454	\$246,454	TBD	TBD
Mississippi	\$0	\$0	TBD	TBD
Missouri	\$0	\$0	TBD	TBD
Montana	\$0	\$0	TBD	TBD
Nebraska	\$299,693 ^d	\$299,693 ^d	TBD ^d	TBD
Nevada	\$0	\$0	TBD	TBD
New Hampshire	\$0	\$0	TBD	TBD
New Jersey	\$0	\$0	TBD	TBD
New Mexico	\$0	\$0	TBD	TBD
New York	\$675,000 ^{c,d}	\$685,000 ^{c,d}	TBD ^{c,d}	TBD
North Carolina	\$428,062 ^{a,b}	\$428,062 ^{a,b}	TBD ^{a,b}	TBD
North Dakota	\$0	\$0	TBD	TBD
Ohio	\$250,000	\$250,000	TBD	TBD
Oklahoma	\$250,000	\$250,000	TBD	TBD
Oregon	\$525,000 ^c	\$534,975 ^c	TBD ^c	TBD
Pennsylvania	\$250,000	\$250,000	TBD	TBD
Rhode Island	\$250,000	\$250,000	TBD	TBD
South Carolina	\$0	\$0	TBD	TBD
South Dakota	\$0	\$0	TBD	TBD
Tennessee	\$247,686	\$247,686	TBD	TBD
Texas	\$0	\$0	TBD	TBD
Utah	\$332,422 ^b	\$332,422 ^b	TBD ^b	TBD
Vermont	\$0	\$0	TBD	TBD
Virginia	\$0	\$0	TBD	TBD
Washington	\$449,114 ^{a,d}	\$449,114 ^{a,d}	TBD ^{a,d}	TBD
West Virginia	\$0	\$0	TBD	TBD
Wisconsin	\$0	\$0	TBD	TBD
Wyoming	\$0	\$0	TBD	TBD

	FY 2013 Final	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Territories				
American Samoa	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0
Marshall Islands	\$0	\$0	\$0	\$0
Micronesia	\$0	\$0	\$0	\$0
Northern Mariana Islands	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0
Republic Of Palau	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0
Total	\$6,834,963	\$6,864,938	TBD	TBD

¹ CFDA NUMBER: 93.136 Discretionary

² This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://wwwn.cdc.gov/Fundingprofiles/FundingProfilesRIA/>

³ Note all Core VIPP grantees receive funding for the Base Integration Component of the Core VIPP program. A select group of states participating in the Base Integration Component were awarded funding for additional components under the Core VIPP program. These included: a- Regional Network Leaders, b -Surveillance Quality Improvement, c -Older Adult Falls Prevention and d -Motor Vehicle Injury Prevention. For more information on these additional components please go to <http://www.cdc.gov/injury/stateprograms/index.html>

⁴ Core VIPP funding for FY 2015 will include an increase for FY 2015 proposed with the President's Budget to address prescription drug overdose

State Table: Rape Prevention and Education^{1,2}

	FY 2013 Final	FY 2014 Enacted^{3,4,5}	FY 2015 President's Budget^{3,4,5}	Difference +/- 2014
Alabama	\$497,862	TBD	TBD	TBD
Alaska	\$73,978	TBD	TBD	TBD
Arizona	\$665,799	TBD	TBD	TBD
Arkansas	\$303,725	TBD	TBD	TBD
California	\$3,880,409	TBD	TBD	TBD
Colorado	\$523,846	TBD	TBD	TBD
Connecticut	\$372,282	TBD	TBD	TBD
Delaware	\$93,530	TBD	TBD	TBD
District of Columbia	\$62,676			
Florida	\$1,958,363	TBD	TBD	TBD
Georgia	\$1,009,075	TBD	TBD	TBD
Hawaii	\$141,690	TBD	TBD	TBD
Idaho	\$163,280	TBD	TBD	TBD
Illinois	\$1,336,451	TBD	TBD	TBD
Indiana	\$675,359	TBD	TBD	TBD
Iowa	\$317,311	TBD	TBD	TBD
Kansas	\$297,184	TBD	TBD	TBD
Kentucky	\$451,993	TBD	TBD	TBD
Louisiana	\$472,200	TBD	TBD	TBD
Maine	\$138,363	TBD	TBD	TBD
Maryland	\$601,379	TBD	TBD	TBD
Massachusetts	\$682,008	TBD	TBD	TBD
Michigan	\$1,029,490	TBD	TBD	TBD
Minnesota	\$552,462	TBD	TBD	TBD
Mississippi	\$309,077	TBD	TBD	TBD
Missouri	\$623,812	TBD	TBD	TBD
Montana	\$103,058	TBD	TBD	TBD
Nebraska	\$190,237	TBD	TBD	TBD
Nevada	\$281,292	TBD	TBD	TBD
New Hampshire	\$137,125	TBD	TBD	TBD
New Jersey	\$915,772	TBD	TBD	TBD
New Mexico	\$214,486	TBD	TBD	TBD
New York	\$2,018,443	TBD	TBD	TBD
North Carolina	\$993,225	TBD	TBD	TBD
North Dakota	\$70,058	TBD	TBD	TBD
Ohio	\$1,201,654	TBD	TBD	TBD
Oklahoma	\$390,744	TBD	TBD	TBD
Oregon	\$399,048	TBD	TBD	TBD
Pennsylvania	\$1,323,092	TBD	TBD	TBD
Rhode Island	\$109,636	TBD	TBD	TBD
South Carolina	\$481,782	TBD	TBD	TBD
South Dakota	\$84,806	TBD	TBD	TBD
Tennessee	\$661,017	TBD	TBD	TBD
Texas	\$2,619,186	TBD	TBD	TBD
Utah	\$287,889	TBD	TBD	TBD
Vermont	\$65,178	TBD	TBD	TBD
Virginia	\$833,394	TBD	TBD	TBD
Washington	\$700,435	TBD	TBD	TBD
West Virginia	\$193,010	TBD	TBD	TBD
Wisconsin	\$592,362	TBD	TBD	TBD
Wyoming	\$58,708	TBD	TBD	TBD

	FY 2013 Final	FY 2014 Enacted^{3,4,5}	FY 2015 President's Budget^{3,4,5}	Difference +/- 2014
Territories				
American Samoa	\$0	TBD	TBD	TBD
Guam	\$18,839	TBD	TBD	TBD
Marshall Islands	\$6,860	TBD	TBD	TBD
Micronesia	\$11,161	TBD	TBD	TBD
Northern Mariana Islands	\$5,033	TBD	TBD	TBD
Puerto Rico	\$388,082	TBD	TBD	TBD
Republic Of Palau	\$0	TBD	TBD	TBD
Virgin Islands	\$11,432	TBD	TBD	TBD
Subtotal States	\$32,159,241	TBD	TBD	TBD
Subtotal Territories	\$441,407	TBD	TBD	TBD
Total	\$32,600,648	TBD	TBD	TBD

¹ CFDA NUMBER: 93.136 Discretionary

² This State Table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://www.cdc.gov/Fundingprofiles/FundingProfilesRIA/>

³ Beginning in FY 2014, RPE grantee awards will include base funding of \$150,000 for all 50 states, D.C., and Puerto Rico, and \$35,000 for territories. RPE grantees within the 50 states, Washington, D.C., and Puerto Rico will also receive additional funds beyond their base funding based on population. The RPE funding formula was revised by the Violence Against Women Reauthorization Act of 2013.

⁴ FY 2014 and FY 2015 award amounts will change based on available funding and a new five-year funding opportunity announcement to be released in FY 2014.

⁵ FY 2015 figures exclude separate proposed funding from PHS Transfer Funds for evaluation of Rape Prevention and Education activities.

State Table: National Violent Death Reporting System^{1,2,3}

	FY 2013 Final	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Alabama	\$0	TBD	TBD	TBD
Alaska	\$148,884	TBD	TBD	TBD
Arizona	\$0	TBD	TBD	TBD
Arkansas	\$0	TBD	TBD	TBD
California	\$0	TBD	TBD	TBD
Colorado	\$200,294	TBD	TBD	TBD
Connecticut	\$0	TBD	TBD	TBD
District of Columbia	\$0	TBD	TBD	TBD
Delaware	\$0	TBD	TBD	TBD
Florida	\$0	TBD	TBD	TBD
Georgia	\$238,804	TBD	TBD	TBD
Hawaii	\$0	TBD	TBD	TBD
Idaho	\$0	TBD	TBD	TBD
Illinois	\$0	TBD	TBD	TBD
Indiana	\$0	TBD	TBD	TBD
Iowa	\$0	TBD	TBD	TBD
Kansas	\$0	TBD	TBD	TBD
Kentucky	\$203,571	TBD	TBD	TBD
Louisiana	\$0	TBD	TBD	TBD
Maine	\$0	TBD	TBD	TBD
Maryland	\$233,647	TBD	TBD	TBD
Massachusetts	\$221,964	TBD	TBD	TBD
Michigan	\$244,943	TBD	TBD	TBD
Minnesota	\$0	TBD	TBD	TBD
Mississippi	\$0	TBD	TBD	TBD
Missouri	\$0	TBD	TBD	TBD
Montana	\$0	TBD	TBD	TBD
Nebraska	\$0	TBD	TBD	TBD
Nevada	\$0	TBD	TBD	TBD
New Hampshire	\$0	TBD	TBD	TBD
New Jersey	\$186,332	TBD	TBD	TBD
New Mexico	\$172,519	TBD	TBD	TBD
New York	\$0	TBD	TBD	TBD
North Carolina	\$238,833	TBD	TBD	TBD
North Dakota	\$0	TBD	TBD	TBD
Ohio	\$253,793	TBD	TBD	TBD
Oklahoma	\$192,592	TBD	TBD	TBD
Oregon	\$184,806	TBD	TBD	TBD
Pennsylvania	\$0	TBD	TBD	TBD
Rhode Island	\$121,429	TBD	TBD	TBD
South Carolina	\$200,204	TBD	TBD	TBD
South Dakota	\$0	TBD	TBD	TBD
Tennessee	\$0	TBD	TBD	TBD
Texas	\$0	TBD	TBD	TBD
Utah	\$191,726	TBD	TBD	TBD
Vermont	\$0	TBD	TBD	TBD
Virginia	\$225,010	TBD	TBD	TBD
Washington	\$0	TBD	TBD	TBD
West Virginia	\$0	TBD	TBD	TBD
Wisconsin	\$202,759	TBD	TBD	TBD
Wyoming	\$0	TBD	TBD	TBD

	FY 2013 Final	FY 2014 Enacted	FY 2015 President Budget	Difference +/-2014
Territories				
American Samoa	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0
Marshall Islands	\$0	\$0	\$0	\$0
Micronesia	\$0	\$0	\$0	\$0
Northern Mariana Islands	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0
Republic Of Palau	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0
Total	\$3,662,110	TBD	TBD	TBD

¹ CFDA NUMBER: 93.136 Discretionary

² This State Table is a snapshot of selected programs that fund states (and in some cases local, tribal, and territorial grantees). For a more comprehensive view of grant and cooperative agreement funding to grantees by jurisdiction, visit <http://www.cdc.gov/Fundingprofiles/FundingProfilesRIA/>

³ New FOA will be recompeted in FY 2014. Award amounts for newly-funded states are to be determined; amounts for currently-funded states are subject to change.

OCCUPATIONAL SAFETY AND HEALTH

(dollars in millions)	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
NIOSH Discretionary Total	\$323.059	\$332.860	\$280.590	-\$52.270
Budget Authority (non-add)	\$212.335	\$220.860	\$0.000	-\$220.860
PHS Evaluation Transfer (non-add)	\$110.724	\$112.000	\$280.590	+\$168.590
EEOICPA – Mandatory ²	\$50.984	\$49.933	\$55.358	+\$5.425
World Trade Center – Mandatory ²	\$230.680	\$268.180	\$281.941	+\$13.761
Total Request	\$604.723	\$650.973	\$617.889	-\$33.084
FTEs	1,131	1,131	1,131	0
Occupational Safety and Health				
- National Occupational Research Agenda	\$111.333	\$112.000	\$100.954	-\$11.046
- All Other Occupational Safety and Health	\$211.726	\$220.860	\$179.636	-\$41.224

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² Reductions in FY 2013 and FY 2014 reflect the sequester of mandatory funds.

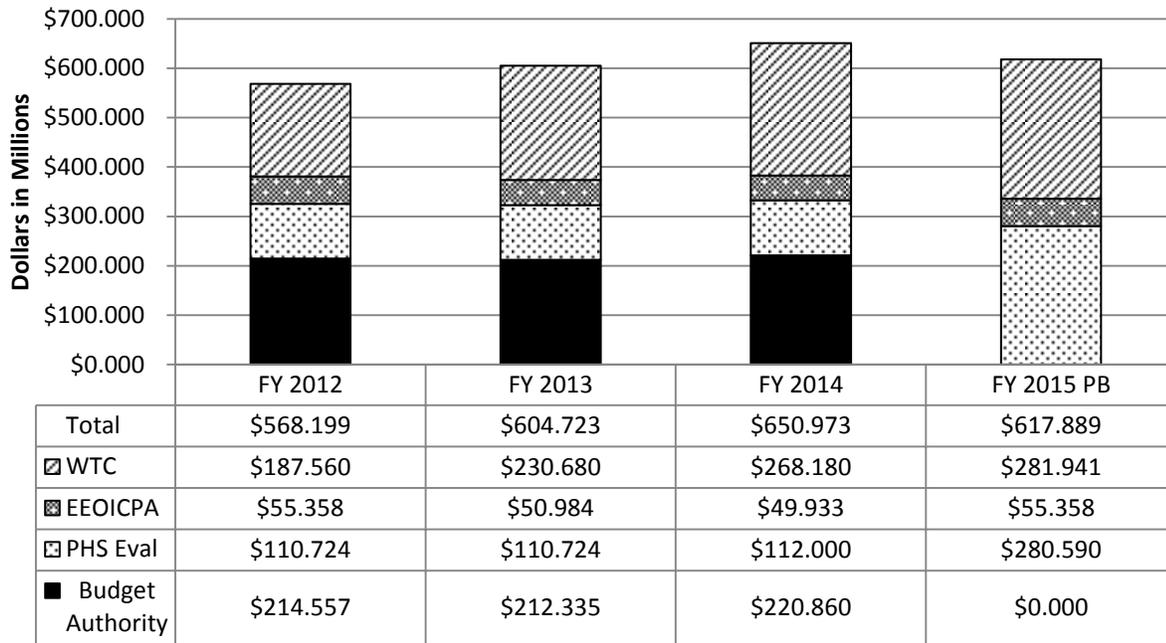
Summary

CDC's [Occupational Safety and Health](#)²⁷⁰ efforts help protect the nation's 155 million workers and provide the only dedicated federal investment for research needed to prevent injuries and illnesses that cost the United States \$250 billion annually. Research efforts are aligned under the National Occupational Research Agenda (NORA), which uses partnerships to maximize the impact of occupational safety and health research. CDC's All Other Occupational Safety and Health activities involve areas such as surveillance, Health Hazard Evaluations, and basic laboratory research. CDC also receives mandatory funding for the Energy Employees Occupational Illness Compensation Program Act and the World Trade Center Health Program.

CDC's FY 2015 request of **\$617,889,000** for Occupational Safety and Health is an overall decrease of \$33,084,000 from the FY 2014 Enacted level. This request includes an increase of \$13,761,000 above the FY 2014 Enacted level in mandatory funding for the World Trade Center Health Program for the addition of certain cancers to the list of related conditions and the program inclusion of responders from the Shanksville, Pennsylvania, and Pentagon sites. The FY 2015 request also includes \$55,358,000 in mandatory funding for the Energy Employees Occupational Illness Compensation Program Act. The FY 2015 request is a decrease of \$52,270,000 in discretionary funds, eliminating funding for the NORA Agriculture, Forestry and Fishing sector; Education and Research Centers; and the National Mesothelioma Registry and Tissue Bank.

²⁷⁰ <http://www.cdc.gov/niosh/>

National Institute for Occupational Safety and Health (NIOSH) Funding History^{1,2}



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² Reductions in FY 2013 and FY 2014 reflect the sequester of mandatory funds.

National Occupational Research Agenda (NORA)

(dollars in millions)		FY 2013 Final ¹	FY 2014 Enacted	FY 2015	
				President Budget	2015 +/-2014
	Budget Authority	\$0.609	\$0.000	\$0.000	\$0.000
	PHS Evaluation Transfer	\$110.724	\$112.000	\$100.954	-\$11.046
	Agriculture, Forestry, Fishing (non-add)	\$21.845	\$24.000	\$0.000	-\$24.000
	Total Request	\$111.333	\$112.000	\$100.954	-\$11.046

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [National Occupational Research Agenda](#)²⁷¹ (NORA) provides guidance to the occupational safety and health community on research priorities within nine industry sectors: agriculture, forestry, and fishing; construction; healthcare and social assistance; manufacturing; mining; oil and gas; services; public safety; wholesale and retail trade; and transportation, warehousing, and utilities.

All intramural and extramural projects CDC funds under NORA must be consistent with research-to-practice principles, such as focusing on research with a high probability for short- or long-term impact; bringing innovative interventions to the commercial market; transferring knowledge and products to employers, workers, and policymakers; and evaluating programs using qualitative or quantitative data.

NORA research identifies health and safety risks and recommends prevention measures. Recent accomplishments include:

- Identified the quantitative relationship between exposure to diesel exhaust and lung cancer mortality in miners, which the International Agency for Research on Cancer cited in its designation of diesel engine exhaust as a human carcinogen.
- Showed that a large percentage of workplace homicides among female workers are perpetrated by intimate partners and noted the critical role of workplace violence prevention programs.
- Provided new recommended exposure limits and risk management practices to control work-related exposures to carbon nanotubes and carbon nanofibers in order to reduce certain work-related lung effects.
- Developed guidance on engineering controls and safe practices for handling engineered nanomaterials in research laboratories and developed partnerships with private companies to evaluate manufacturing process controls.
- Developed the Hearing Protection Device Well-Fit™ system, an economical, practical tool that will allow hearing conservation professionals and millions of exposed workers to quickly identify proper hearing protection devices and troubleshoot non-effective wear.

Budget Request

CDC's FY 2015 request of **\$100,954,000** for NORA is an overall decrease of \$11,046,000 from the FY 2014 Enacted level and reflects elimination of the Agriculture, Forestry and Fishing (AgFF) program, a reduction of \$24,000,000. AgFF is one of 10 current CDC sectors. Although this program has made positive contributions, given the relation to CDC's mission and the ability to have a national impact on improved outcomes, the AgFF has been proposed for elimination in a limited-resource environment. CDC will use FY 2015 funds to address high priority occupational hazards in the other nine industry sectors, as well as emerging issues that may require new approaches to prevention, such as nanotechnology. Examples of high-priority occupational hazards include

²⁷¹ <http://www.cdc.gov/niosh/nora/>

chemicals used or generated in healthcare establishments, noise in manufacturing, and stress in public safety. The request also includes \$11,150,000 for nanotechnology research.

Mine Safety

NORA will also provide funding for intramural and extramural research in the mining sector to address key areas such as disaster prevention and response, respiratory-dust hazards, communication and tracking, oxygen supply, refuge alternatives, and training. CDC's Mining Research program also collaborates with partners in industry, labor, academia, and government to conduct research on health hazards, safety hazards, and disaster prevention in mining.

In FY 2015, CDC will target a new project in Spokane designed to characterize the burden of disease and opportunities for health promotion among western miners. Researchers will conduct health surveillance, including assessments of respiratory and cardiovascular function, and develop strategies to formally integrate worker health promotion into an occupational health surveillance program. This work will have a significant and direct impact on improving the health of metal and nonmetal mineworkers, as formal health surveillance and health promotion systems do not currently exist for this industry. It will also provide critical data to inform research planning for the development of exposure assessment methods and engineering controls in these mines.

A 5-year history of mining research funding and FTE by type of mine research, in particular the proportion of resources dedicated to coal and metal/non-metal research, is presented below.

Fiscal Year	Total Mining		Coal		Metal/Non-metal		Stone, Sand, & Gravel	
	Funding	FTE	Funding	FTE	Funding	FTE	Funding	FTE
2010	\$ 53.705	235	\$ 30.323	132	\$ 14.248	62	\$ 9.134	41
2011	\$ 52.687	237	\$ 26.702	126	\$ 14.523	59	\$ 11.462	52
2012	\$ 52.360	220	\$ 26.719	122	\$ 14.962	56	\$ 10.679	42
2013	\$ 49.638	208	\$ 21.701	110	\$ 15.115	57	\$ 12.822	41
2014	\$ 49.638	212	\$ 20.715	104	\$ 15.944	64	\$ 12.979	44

Funding in Millions. FY 2014 Figures are estimates. The CDC Investment by sector is driven by demand factors, including surveillance data such as a 3-year moving average of industry fatality and injury data and the sector population.

Nanotechnology

CDC provides national and international leadership on worker exposure to nanoparticles and nanomaterials. In FY 2015, \$11 million will help businesses and government agencies develop effective risk-management programs. CDC's Nanotechnology Research Center will work with private sector partners to conduct eight field investigations that will provide evidence of effective interventions to control worker exposure, with specific prevention recommendations for employers that will support sustainable economic growth and job creation through increased investments in nanotechnology. These activities build on advancements achieved to date under the CDC nanotechnology research program, with many critical issues still to be addressed, such as surveillance and risk management.

NORA Grants

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	116	116	96	-20
- New Awards	18	34	34	0
- Continuing Awards	98	82	62	-20
Average Award	\$0.473	\$0.507	\$0.383	-\$0.124
Range of Awards	\$0.020–\$5.750	\$0.020–\$5.750	\$0.020–\$5.750	N/A
Total Grant Awards	\$54.969	\$58.800	\$36.800	-\$22.000

CDC funds occupational safety and health research grants that address a wide range of NORA topics, including hazards for home healthcare workers and fall protection for construction workers. CDC uses a competitive, peer-reviewed process to award grants. Grantees are typically located in academic settings. These grants add to the occupational safety and health scientific evidence base and contribute to translating research into practice to prevent injury, disease, and death in the workplace. The reduction in the number of grants for FY 2015 reflects the elimination of the Agriculture, Forestry and Fishing grants from the FY 2015 budget.

All Other Occupational Safety and Health

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted ²	President Budget	2015 +/-2014
Budget Authority	\$211.726	\$220.860	\$0.000	-\$220.860
PHS Evaluation Transfer	\$0.000	\$0.000	\$179.636	+\$179.636
Education and Research Centers (non-add)	\$23.516	\$27.519	\$0.000	-\$27.519
National Mesothelioma Registry and Tissue Bank (non-add)	\$0.000	\$1.109	\$0.000	-\$1.109
All Other Occupational Safety and Health (non-add)	\$110.267	\$107.941	\$95.345	-\$12.596
Total Request	\$211.726	\$220.860	\$179.636	-\$41.224

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² In 2013, ~\$4M for BSS funding resides in Other OSH line item and is reflected with PPT in FY 2014 and 2015.

Overview

CDC's All Other Occupational Safety and Health activities comprise public health activities that cut across NORA industry sectors, providing tools for state-based occupational safety and health programs. These activities include the Health Hazard Evaluation program, which responds to requests to determine if workers are exposed to workplace hazards, and CDC's efforts to conduct and support occupational safety and health surveillance. A recent accomplishment in this program includes development of a portable tool for rapidly measuring worker exposure to fumigants in the field. This single method can detect and measure up to seven fumigants within 11 minutes. The instrument and its methods can be used on site to protect shipyard workers and customs agents by detecting and measuring fumigant pesticides applied in shipping containers and to protect emergency responders by assessing exposure to chemical agents.

Also included in Other Occupational Safety and Health activities is NIOSH's Personal Protective Technology program. An estimated 20 million workers who use Personal Protective Equipment will benefit from CDC's research on respirators and other personal protective technologies. Through audits and certified respirator decisions, CDC is able to improve the quality and inventory of respiratory protection for workers in multiple industries. In FY 2013, CDC completed 462 certified respirator decisions, including 261 new approvals, and 242 complete respirator audits.

A 5-year history of the funding and FTE supported by Other Occupational Safety and Health Research, broken down by industry and location, is presented below.

Industry	FY 2009 ¹	FY 2010 ¹	FY 2011 ¹	FY 2012 ¹	FY 2013 ¹	FY 2014 ^{1,2}	Primary Location of Work	FTEs ³
Agriculture, Forestry and Fishing	\$2.18	\$4.05	\$3.52	\$0.95	\$0.53	\$0.72	AK, OH,WV, GA, PA	4
Construction	\$3.33	\$3.12	\$3.84	\$4.10	\$4.12	\$4.42	OH, WV, WDC, GA, PA	22
Healthcare and Social Assistance	3.861	\$3.17	\$3.03	\$3.04	\$2.72	\$5.33	OH, WV, GA, PA	32
Manufacturing	\$7.95	\$6.79	\$7.46	\$9.65	\$8.83	\$9.71	OH, WV, GA, PA	55
Mining	\$1.20	\$2.14	\$2.22	\$1.37	\$1.47	\$2.28	WV, PA	5
Oil and Gas	\$0.33	\$0.26	\$0.27	\$0.39	\$0.36	\$0.38	AK, CO	2
Public Safety	\$2.45	\$3.54	\$3.33	\$3.20	\$3.84	\$6.66	OH, WV, GA, PA	33
Services	\$4.51	\$4.43	\$5.14	\$3.55	\$2.59	\$2.78	OH, WV, GA	24
Transportation, Warehousing and Utilities	\$3.30	\$2.20	\$2.40	\$2.64	\$2.39	\$2.56	AK, OH, WV, GA	15

Industry	FY 2009 ¹	FY 2010 ¹	FY 2011 ¹	FY 2012 ¹	FY 2013 ¹	FY 2014 ^{1,2}	Primary Location of Work	FTEs ³
Wholesale and Retail Trades	\$0.99	\$1.27	\$1.23	\$1.23	\$0.92	\$0.99	OH, WV, GA	7
All Sectors	\$53.77	\$53.75	\$51.41	\$52.40	\$50.64	\$60.60	AK, CO, GA, OH, WV, WDC, PA	319
Total Other OSH	\$83.85	\$84.71	\$83.84	\$82.52	\$78.40	\$96.43	AK, CO, GA, OH, WV, WDC, PA	522

¹ Dollars in millions.

² In FY 2014, the Personal Protective Technology disease line was moved to a non-add under All Other OSH disease line.

³ FTEs are based upon FY 2013 employees, but staffing has remained stable over this period of reporting.

Budget Request

CDC’s FY 2015 request of **\$179,636,000** for All Other Occupational Safety and Health is \$41,224,000 below the FY 2014 Enacted level and includes elimination of funding for the Education and Research Centers and the National Mesothelioma Registry and Tissue Bank. The National Mesothelioma Registry and Tissue Virtual Bank developed a strong infrastructure to support basic and applied research related to mesothelioma. Although the elimination impacts the numbers and types of tissues collected and shared for future research, currently available specimens will continue to be available for research. The FY 2015 request also eliminates the Education Research Centers (ERCs). The ERC program is proposed for elimination given the resource-constrained environment. Originally created almost 40 years ago, the ERC program addressed the limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. The ERCs’ reach and impact have grown substantially across the nation since the program’s inception, increasing awareness of the importance of coursework specializing in these areas. Although the FY 2014 budget does not include funding for the federal portion of these grants, CDC will continue to provide scientific and programmatic expertise to the ERCs as requested. CDC will use FY 2015 funding to support public health tools, such as state-based surveillance, Health Hazard Evaluations, and exposure assessment research.

CDC will continue to provide funding and expertise necessary for states to understand and prevent work-related risks. CDC will fund 14 states to build state health department capacity to conduct occupational safety and health surveillance and to develop intervention and prevention programs. These investments will also support nine state surveillance programs that track and target interventions for state-specific priorities, such as:

- Occupational fatalities
- Work-related asthma
- Silicosis
- Teen injuries
- Truck driver health
- Hospital worker injuries
- Temporary worker health

Also in FY13, NIOSH and its partners re-launched the National Campaign to Prevent Falls in Construction. For 2008-2010, falls were the leading cause of death in the construction industry. Below are some highlights from the eight state grantees which represent programmatic and public health impacts.

State Based Grantees—Campaign to Prevent Falls in Construction

Grantee	Highlights
California Department of Public Health	Created an award winning digital story highlighting the findings and the importance of fall protection. This educational intervention was disseminated to 2,000 employers and 5,000 stakeholders.
Colorado Department of Public Health and Environment	Worked with partners to disseminate fall prevention and other injury prevention issues via social media outlets.
Massachusetts Department of Public Health	Developed fall prevention brochures, in which 13,000 copies have been ordered by over 47 municipalities.
Michigan State University	Distributed fall prevention materials and developed two Hazard Alerts which were sent to approximately 1,000 general contractors, construction trade associations, construction labor unions and health and safety specialists.
North Carolina State Department of Health & Human Services	Proposed an evidence-based practice to reduce construction-related fatalities which is one of several industrial sectors with an elevated fatality rate in NC.
New Jersey Department of Health & Senior Services	Conducted evaluation research to determine barriers to the use of fall protection in small residential construction companies. This research will help formulate recommendations for injury prevention practices.
New York State Department of Health	Participated in a wide range of promotion, outreach activities including the dissemination of campaign posters and cards, in English and Spanish, to federal and state government stakeholders, safety and health professionals, labor union and activist organization representatives and the public.
Oregon Health Authority	Published 4 toolbox talk guides which were sent to the 199 subscribers of the OR-FACE e-publications listserv. Average monthly external web page views increased nearly three-fold from 347 to 995 per month, and one toolbox guide in particular, 7-foot scaffold fall, was downloaded 74 and 157 times in March and April, respectively.

With funds requested for FY 2015, CDC will respond to requests for assistance through the Health Hazard Evaluation program to determine if workers are exposed to hazardous materials or harmful conditions and whether these exposures are affecting worker health. In 2013, CDC conducted 229 workplace evaluations through the Health Hazard Evaluation program. This program is the nation's sentinel for identifying emerging or previously unrecognized occupational health threats. CDC will evaluate workplace environments and employee health by reviewing records and conducting on-site environmental sampling, performing epidemiologic surveys and medical testing, and making recommendations to reduce workplace hazards.

Reporting exposure results to individuals and industry quickly and inexpensively—without compromising scientific quality—is essential. Toward that end, CDC will conduct intramural and extramural research to develop direct reading instruments and techniques that can be deployed readily in the field or easily read without further sample processing. These direct-reading methods allow for faster identification of hazards and more rapid intervention to protect the safety and health of workers. CDC will develop new methods to measure dusts, gases and vapors, aerosols, noise, radiation, and other hazards in the workplace. These methods provide occupational health professionals with fundamental tools that produce reliable, replicable results.

In FY 2015, CDC will provide funding for Personal Protective Technology (PPT) Program activities that support PPT research, conformity assessment, and respirator certification activities. Funding will also support evaluation of product performance for personal protective equipment used by 20 million workers in all industry sectors to protect them from job hazards. CDC will conduct intramural and extramural research on PPT, including research to advance state-of-the-art technology to understand and improve protection, usability, comfort, fit, and user acceptance, with an emphasis on personal protective equipment for fire fighters and healthcare workers, as well as escape technology for miners. CDC will develop PPT standards and test methods and will pursue continuous improvement of the respirator certification program to support new requirements and requirements under development. These new standards update the agency's requirements for testing and certification of respiratory protective devices to keep workers safe.

CDC funds grants for occupational safety and health activities that provide research and tools for public health professionals and other partners. CDC funds state-based grants to build occupational safety and health. Examples of other grants in this category include statistical method development for analyzing industrial hygiene data and analysis of work-related injury, disease, and death surveillance data from U.S. workers. CDC uses a competitive, peer-reviewed process to award grants. Grantees are typically located in academic settings or state health departments. The FY 2015 grant table reflects the elimination of the NIOSH Educational Research Center Grants (17), as well as the National Mesothelioma Registry and Tissue Virtual Bank.

All Other Occupational Safety and Health Grants

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	65	65	47	-18
- New Awards	5	16	16	0
- Continuing Awards	60	49	31	-18
Average Award	\$0.522	\$0.430	\$0.233	-\$0.197
Range of Awards	\$0.020-\$1.659	\$0.020-\$1.800	\$0.020-\$1.349	N/A
Total Grant Awards	\$33.957	\$37.952	\$10.952	-\$27.000

Energy Employees Occupational Illness Compensation Program Act (EEOICPA)

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget	2015 +/-2014
	EEOICPA – Mandatory ²	\$50.984	\$49.933	\$55.358	+\$5.425
	Total Request	\$50.984	\$49.933	\$55.358	+\$5.425

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² Reductions in FY 2013 and FY 2014 reflect the sequester of mandatory funds.

Overview

Energy Employees Occupational Illness Compensation Program Act (EEOICPA) is a mandatory federal program that provides compensation to Department of Energy employees or survivors of employees who have been diagnosed with a radiation-related cancer, beryllium-related disease, or chronic silicosis because of their work in producing or testing nuclear weapons. CDC conducts dose reconstructions to estimate an employee’s occupational radiation exposure for certain cancer cases, considers and issues determinations on petitions for adding classes of workers to the Special Exposure Cohort (SEC), and provides administrative support to the Advisory Board on Radiation and Worker Health (ABRWH). The Department of Labor uses CDC's estimates in making compensation determinations.

In FY 2013, CDC completed 2,626 dose reconstructions and submitted them to the Department of Labor; received 8 SEC petitions; and supported 39 meetings of the ABRWH, its Subcommittees, and Work Groups. Based on the recommendations of the ABRWH, the HHS Secretary has added 102 classes of employees to the SEC as of September 30, 2013.

Budget Request

CDC’s FY 2015 estimate of **\$55,358,000** in mandatory funding for EEOICPA is \$5,425,000 above the FY 2014 Enacted level. As mandated by EEOICPA, CDC will use this funding to:

- Estimate 3,000 radiation dose reconstructions to support the Department of Labor's adjudication of claims
- Evaluate estimated 12 petitions to add classes of employees to the SEC
- Provide administrative and technical support for the ABRWH.
- Publicize—to the extent possible—information it has acquired related to radiation exposure at facilities involved with nuclear weapons production, testing, and disposal, and will support health effects research using these data

In accordance with EEOICPA, in FY 2015, CDC will complete radiation dose reconstructions for all claims requiring such information to permit final adjudication of the claim. CDC will use radiation monitoring information provided by the Department of Energy and any relevant information provided by claimants to develop a dose reconstruction report. CDC expects the number of dose reconstructions completed each year to remain approximately level at an estimate of 3,000 in 2015.

CDC will also evaluate petitions to add classes of employees to the SEC and to present the evaluation reports to the ABRWH, which makes recommendations to the HHS Secretary concerning whether a class of employees should be added to the SEC. CDC determines whether a petition qualifies for evaluation and, if so, develops an evaluation report. CDC will engage the ABRWH to assist in reviewing SEC evaluation reports and the scientific validity and quality of dose reconstruction efforts.

World Trade Center Health Program

(dollars in millions)		FY 2013	FY 2014	FY 2015	
		Final ¹	Enacted	President Budget ³	2015 +/-2014
	World Trade Center – Mandatory ²	\$230.680	\$268.180	\$281.941	+\$13.761
	Total Request	\$230.680	\$268.180	\$281.941	+\$13.761

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² Reductions in FY 2013 and FY 2014 reflect the sequester of mandatory funds.

³ Federal portion of WTC Health Program.

Overview

The September 11, 2001 terrorist attacks in New York, New York, at the Pentagon in Arlington, Virginia, and in Shanksville, Pennsylvania required extensive response, recovery, and cleanup activities. Thousands of responders and survivors were exposed to toxic smoke, dust, debris, and psychological trauma. The James Zadroga 9/11 Health and Compensation Act of 2010 (P.L. 111-347) created the [World Trade Center \(WTC\) Health Program](#)²⁷² to provide health benefits to eligible responders and survivors beginning on July 1, 2011. Pursuant to this statute, the WTC Health Program provides monitoring and treatment benefits to eligible responders and survivors, conducts research on WTC-related health conditions, and maintains a health registry to collect data on victims of the September 11, 2001 terrorist attacks. By October 2013, the WTC Health Program had enrolled a total of approximately 66,200 eligible responders and survivors. In FY 2013, the WTC Health Program has paid claims for eligible treatment, including medication, for more than 19,000 of these responders and survivors.

WTC Health Program Enrollment

Membership	Sept. 30, 2012	Dec. 31, 2012	March 31, 2013	June 30, 2013	Sept. 30, 2013
New Members since July 2011 ²⁷³	1,998	2,572	2,933	3,514	4,268
Total Members ²⁷⁴	63,286	64,038	64,447	64,614	65,366

²⁷² <http://www.cdc.gov/wtc/index.html>

²⁷³ New members enrolled under the Zadroga Act requirements (adjustments are made each quarter to account for member records changes), including Pentagon and Shanksville, PA responders who are counted with Nationwide Members if they live outside of the New York City metropolitan area.

²⁷⁴ New members and members enrolled prior to 7/1/2011 (adjustments are made each quarter to account for member records changes).

WTC Health Program Paid Claims

Healthcare Services ²⁷⁵	Sept. 30, 2012	Dec. 31, 2012	March 31, 2013	June 30, 2013	Sept. 30, 2013
Members who had monitoring or screening exams	28,528	29,081	25,971	24,286	25,563
Members who had diagnostic evaluations ²⁷⁶	19,153	21,487	21,446	20,577	13,374
Members who had out-patient treatment	15,026	14,607	17,175	15,062	15,220
Members who had in-patient treatment	57	116	123	111	128
Members who received medications	13,961	16,645	16,296	16,084	16,274

Budget Request

CDC’s FY 2015 estimate of **\$281,941,000** in mandatory funding for the WTC Health Program is \$13,761,000 above the FY 2014 Enacted level. Funds support the treatment of cancer, as well as the increase in enrollment, including responders from the Shanksville, Pennsylvania and Pentagon sites, who became eligible to enroll in the WTC Health Program in May 2013.

Mandatory funding will support:

- Monitoring and treatment services, including services for certain types of cancer, for responders and survivors in the WTC Health Program
- Infrastructure costs for the Clinical Centers of Excellence (CCEs) and the Nationwide Provider Network (NPN) to support clinical activities
- Infrastructure costs for the Data Centers
- Extramural research projects
- Outreach and education projects
- WTC Health Registry activities
- WTC Health Program Scientific/Technical Advisory Committee

The WTC Health Program provides monitoring and treatment services via a fee-for-service model of delivery. In FY 2015, CDC will renew the intra-agency agreement with the Centers for Medicare and Medicaid Services (CMS) to reimburse the CCEs and the NPN for clinical services provided to the WTC Health Program members. The WTC Health Program provides health care benefits through CCEs, which work as a clinical consortium, and the NPN according to standardized medical monitoring protocols and, programmatic policies and procedures across the clinical sites. This standardization and the fee-for-service model enable the WTC Health Program to track claims-level data for monitoring and treatment, analyze the data for program compliance, and report on spending at a

²⁷⁵ Based on claims for services that were paid during the previous 12-month period (numbers fluctuate between quarterly updates due to annual submitted claims).

²⁷⁶ For determining if a member has a WTC condition and for certifying that health condition.

more detailed level across the WTC Health Program. The WTC Health Program also engages with labor representatives and members of the New York City community to ensure awareness of emerging issues.

In FY 2015, CDC will continue contracts with seven CCEs and the NPN to provide administrative and member services that support the provision of health care benefits, and three contracts with Data Centers to provide data collection and analysis. Additionally, CDC will use FY 2015 funds to continue research projects and epidemiologic studies to help answer critical questions about physical and mental health conditions related to the September 11, 2001 terrorist attacks.

A portion of the FY 2015 funds will continue the cooperative agreement with the New York City Department of Health and Mental Hygiene for the WTC Health Registry activities. The WTC Health Registry will continue to provide a central, unified database to help assess health effects among persons impacted by exposures to the WTC disaster.

FY 2015 funds will also support the WTC Health Program Scientific/Technical Advisory Committee (STAC). Upon request from the WTC Program Administrator, the STAC will make recommendations regarding additional eligibility criteria, the addition of new health conditions to the list of covered conditions, and research priorities. The STAC plays a critical role in the WTC Health Program, as evidenced by the addition of cancers to the List of WTC-Related Health Conditions in October 2012.

GLOBAL HEALTH

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$362.792	\$416.801	\$464.301	+\$47.500
Total Request	\$362.792	\$416.801	\$464.301	+\$47.500
FTEs	1,005	1,005	1,005	0
Global HIV/AIDS	\$125.254	\$128.735	\$128.735	\$0.000
Global Immunization	\$159.469	\$200.892	\$210.892	+\$10.000
-Polio Eradication	\$110.346	\$150.928	\$160.928	+\$10.000
-Global Measles and Other Vaccine-Preventable Diseases	\$49.123	\$49.964	\$49.964	\$0.000
Parasitic Diseases and Malaria	\$23.725	\$24.421	\$24.421	\$0.000
Global Public Health Protection	\$54.344	\$62.753	\$100.253	+\$37.500
-Global Disease Detection and Emergency Response	\$44.839	\$45.470	\$45.470	\$0.000
-Global Public Health Capacity Development	\$9.505	\$17.283	\$9.783	-\$7.500

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and FY 2014 amounts are comparable to FY 2015 to account for the Center for Global Health reorganization.

Summary

CDC [engages internationally](#)²⁷⁷ to protect the health of the American people and save lives worldwide. CDC supports efforts around the globe to detect epidemic threats earlier, respond more effectively, and prevent more avoidable catastrophes. With scientists and health experts embedded in countries around the globe, CDC works with partners to adapt scientific evidence into policies and public health actions—strengthening public health capacity and impact in partner countries.

CDC’s FY 2015 request of **\$464,301,000** for Global Health is \$47,500,000 above the FY 2014 Enacted level. CDC proposes an increase of \$45,000,000 for global health security activities to accelerate progress in preventing the introduction and spread of global health threats. The FY 2015 Budget also includes an increase of \$10,000,000 to support the Global Polio Eradication Initiative and partner efforts to stop all wild poliovirus transmission and any new vaccine-derived polioviruses by the end of 2015. A \$7,500,000 decrease eliminates dedicated funding to assist other nations in setting up and strengthening National Public Health Institutes.

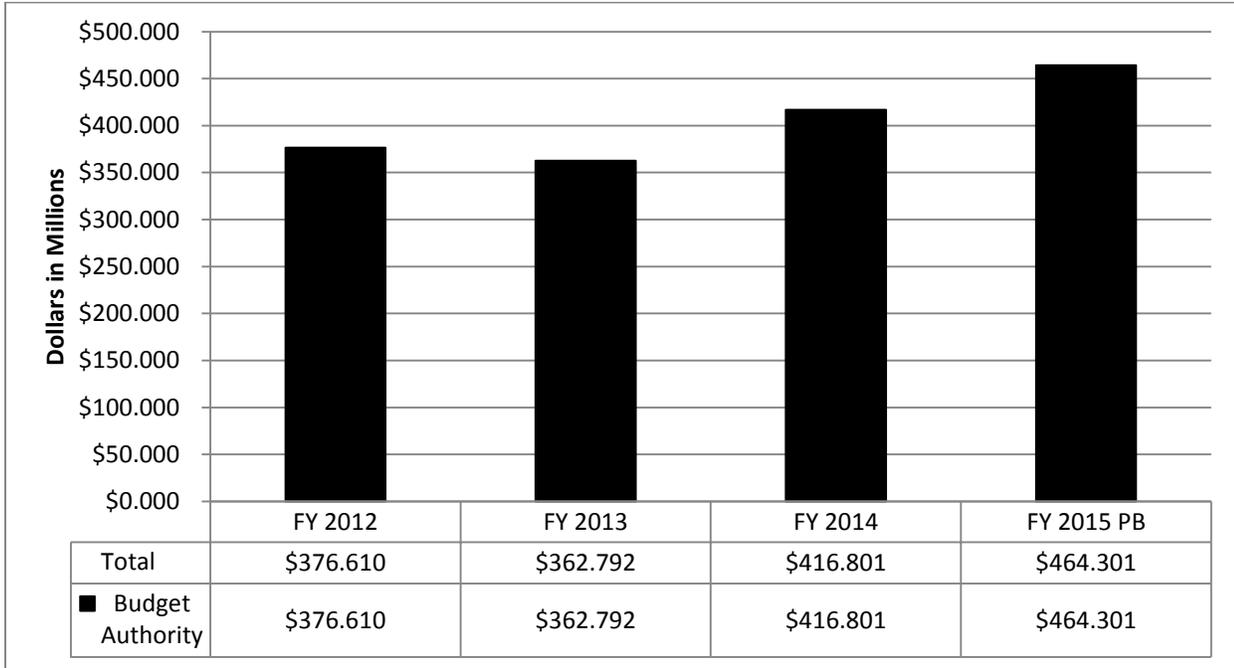
CDC will lead other nations to manage emerging threats, enhance early disease detection, improve disease confirmation, and respond effectively to epidemics and other public health catastrophes.

CDC’s request for Global Health aligns with national and international goals:

- [The Global Health Security Agenda](#)
- [The U.S Government’s National Security Strategy](#)
- [President’s Emergency Plan for AIDS Relief](#)
- [President’s Malaria Initiative](#)
- [National Strategy for Countering Biological Threats](#)
- [The HHS Global Health Strategy](#)

²⁷⁷ <http://www.cdc.gov/globalhealth/index.html>

Global Health Funding History^{1,2}



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and FY 2014 amounts are comparable to FY 2015 to account for the Center for Global Health reorganization.

Global HIV/AIDS

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$125.254	\$128.735	\$128.735	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

As the public health leader in preventing and controlling diseases, CDC plays an essential [role in implementing](#)²⁷⁸ the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). CDC uses its technical expertise in public health science and long-standing partnerships with ministries of health (MOH) and global partners to build strong national programs and sustainable public health systems that meet the needs of each country, allowing an effective response to the HIV/AIDS epidemic. CDC provides HIV/AIDS [scientific and programmatic support](#)²⁷⁹ and mentoring through its headquarters in Atlanta and its 45 offices in Africa, Asia, Central America, South America, and the Caribbean.

Globally, in 2012, 35.3 million people were living with HIV. While there were 2.3 million new HIV infections, it marks a 33% reduction since 2001. Sub-Saharan Africa remains most severely affected region, accounting for 70% of all new HIV infections.

Access to life-saving antiretroviral treatment is expanding through the support of U.S. government agencies. AIDS is no longer a virtual death sentence in the developing world, especially in sub-Saharan Africa. AIDS-related deaths dropped by 30% (1.6 million in 2012) since the peak in 2005 as access to antiretroviral treatment increased. By the end of 2012, some 9.7 million people in low- and middle-income countries were accessing antiretroviral therapy, an increase of nearly 20% in just one year and representing 61% of all who were eligible in 2012 under the 2010 World Health Organization (WHO) HIV treatment guidelines. In 2013, the WHO established new HIV treatment guidelines with evidence showing the HIV prevention benefits of treatment. Under these new guidelines, 9.7 million people on antiretroviral treatment represented only 34% of the 28.3 million people currently eligible in 2013.

CDC’s Global HIV/AIDS Priorities

- Increase** MOH and indigenous workforce capacity.
- Expand** high impact prevention programs to halt new infections.
- Strengthen** core health systems including high-quality laboratory capacity.
- Conduct** operational research and expenditure analysis linked to results for improved program effectiveness.
- Support** data-driven programming for improved decision-making and rapid course correction.

Some countries have already reached a critical programmatic tipping point at which the increase in the number of people on life-saving treatment outpaces the number of new HIV infections annually. These countries are within sight of an epidemic transition in which there is a decrease in the absolute numbers of people living with HIV. Although tremendous progress has been made, and we have the tools needed to create an AIDS-free generation, we still have many challenges to overcome. Preventing new infections is critical in order to stem the global HIV/AIDS epidemic. U.S. government-supported HIV programs give communities devastated by HIV/AIDS a chance at recovery and help establish a more stable political, societal, and economic environment.

²⁷⁸ <http://www.cdc.gov/globalaids/global-hiv-aids-at-cdc/default.html>

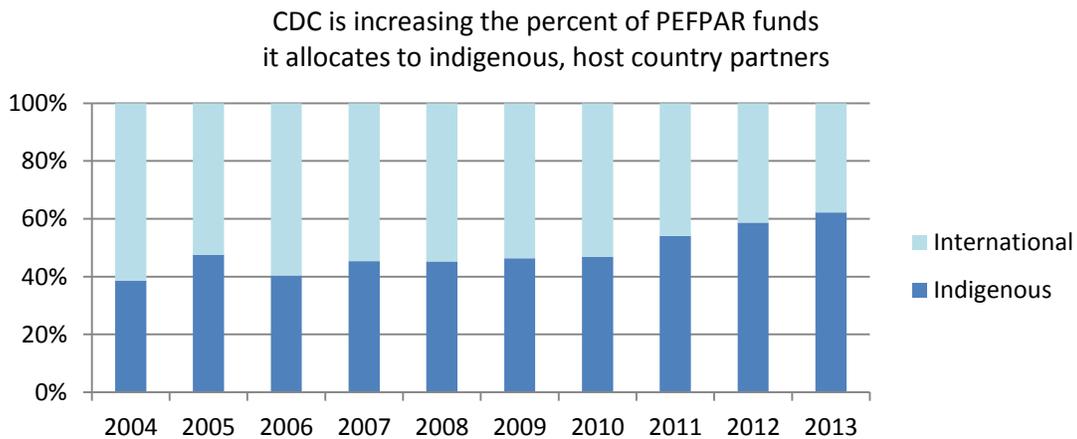
²⁷⁹ <http://www.cdc.gov/globalaids/>

CDC is following the recommendations from an Institute of Medicine report and implementing the [PEPFAR Blueprint for Creating an AIDS-free Generation](#).²⁸⁰ Specifically, CDC is accelerating transition to country leadership and management of programs by increasing the number of cooperative agreements to MOH and other indigenous partners. CDC uses cooperative agreements to boost country capacity by pairing PEPFAR funding with the specific needs of the host country and unique characteristics of the local epidemic. Over time, as local capacity grows, funding is gradually transitioned away from U.S. domestic and international partners to host country partners. CDC is also moving more countries closer to programmatic and epidemic tipping points and increasing program efficiency through innovation and greater integration of services. Additionally, CDC is increasing collaboration with bilateral and multilateral partners such as the Global Fund to assure complementary, high-impact programming. To support the goal of an AIDS-free generation, CDC is scaling up three interventions proven to be pivotal in reducing the spread of new HIV infections. These interventions include antiretroviral therapy among HIV-infected patients, preventing mother-to-child HIV transmission, and increasing voluntary medical male circumcisions.

Budget Request

CDC’s FY 2015 request of **\$128,735,000** for global HIV/AIDS is level with the FY 2014 Enacted level. In addition to its base appropriation, CDC receives interagency funding transfers to implement PEPFAR from the Department of State’s Global Health Programs appropriation. Requested funds allow CDC to use its technical expertise in public health science and long-standing relationships with MOH to accelerate progress toward achieving an AIDS-free generation.

In FY 2015, CDC will work closely with all U.S. government, PEPFAR-implementing agencies. CDC will leverage public health expertise in disease control and prevention and public health science to ensure program activities are well coordinated, data driven, and produce the greatest health impact and most efficient use of available resources. CDC will focus on supporting partner countries to lead, manage, coordinate, and gradually transition to financing the efforts needed to achieve an AIDS-free generation. This will ensure that the AIDS response is effective and sustainable. In FY 2013, CDC invested the majority of its global HIV resources (59%) in MOH and other local partners—far more than in U.S. or international partners. This trend is now accelerating as investments in workforce development, infrastructure, and systems take hold, increasing the momentum toward local implementation. In FY 2015, CDC will focus more on technical assistance and systems strengthening, such as quality improvement, supportive supervision, and sustainable management of the country response to the HIV epidemic.



²⁸⁰ <http://www.pepfar.gov/documents/organization/201386.pdf>

Scaling-Up Combination HIV Prevention Services to Reduce New Infections and Save More Lives

CDC's HIV prevention approach consists of three strategies: antiretroviral treatment for HIV-positive persons, prevention of mother-to-child transmission of HIV, and voluntary male medical circumcision. These strategies are effective at reducing the number of AIDS-related deaths and preventing new infections. CDC scientists and programmatic experts provide on-site guidance to MOH and other indigenous organizations to expand and improve combination HIV prevention services. In FY 2015, CDC's scientists and experts will train local health professionals; share protocols and approaches; and help local partners design programs that reach high risk, vulnerable populations.

Ensuring High Quality HIV/AIDS Services

More HIV/AIDS services are transitioning to in-country management. This provides an opportunity to ensure quality service delivery and accountability of resources. In FY 2015, CDC staff will conduct regular site visits to programs using a systematic approach and closely monitor expenditures via a PEPFAR-wide system. CDC's efforts will strengthen individual programs and its documentation of best practices will benefit all PEPFAR-supported countries.

Strengthening Health Systems

Partner countries must have strong health systems to fully address the HIV epidemic, including high-quality laboratory services, modern disease tracking systems, and a well-trained workforce. A systems approach is increasingly important as PEPFAR pivots from an emergency U.S. program to long-term, in-country leadership. In FY 2015, CDC experts will help PEPFAR countries design, manage, and evaluate public health systems. CDC will also provide daily, on-site mentorship to over 1,600 locally employed staff who are assuming an increased responsibility for the management of their national HIV/AIDS response. An example of this is CDC's Strengthening Laboratory Management Toward Accreditation (SLMTA) initiative, which was launched in 2009 and, as of September 2013, has 499 laboratories in 39 countries implementing SLMTA and trained 1,644 laboratory managers. This comprehensive training program teaches management tasks and routines required to operate a laboratory effectively and efficiently, and to deliver quality and reliable results.

Global Immunization

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$159.469	\$200.892	\$210.892	+\$10.000
Global Immunization				
-Polio Eradication	\$110.346	\$150.928	\$160.928	+\$10.000
-Global measles and other vaccine-preventable diseases	\$49.123	\$49.964	\$49.964	\$0.000
Total	\$159.469	\$200.892	\$210.892	+\$10.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC's [global immunization program](#)²⁸¹ protects the health of Americans and global citizens. The number of children dying each year has fallen below 8.8 million for the first time in documented history, largely due to introduction of new and underutilized vaccines and strengthened systems to deliver vaccines around the world. Polio cases have dropped by more than 99% since 1988, measles deaths declined by 74% from 2000 through 2010, and more than 2.5 million vaccine-preventable disease deaths are averted each year through routine immunization. CDC is committed to building on the successes of the [Global Polio Eradication Initiative](#)²⁸² and [Measles and Rubella Initiative](#)²⁸³ to achieve global polio eradication, measles elimination, and sustain the gains made by these programs.

CDC and Global Immunization Initiatives

What CDC Provides	Global Goals and Aims	Eradicating polio	Reducing global deaths from measles and rubella	Ending epidemic meningitis in Sub-Saharan Africa	Accelerating the introduction of pneumococcal and rotavirus vaccines and region-specific vaccines such as cholera and typhoid	Strengthening immunization systems in priority countries through technical assistance, monitoring and evaluation, social mobilization, and vaccine management
Epidemiological and laboratory surveillance expertise for vaccine-preventable disease		✓	✓	✓	✓	✓
Expertise for immunization policy development		✓	✓	✓	✓	✓
Immunization campaign planning, implementation, monitoring, and evaluation		✓	✓	✓	✓	
Outbreak preparedness and response for vaccine-preventable disease		✓	✓	✓	✓	
Immunization system strengthening		✓	✓	✓	✓	✓
Expertise for introducing new vaccines		✓				✓
Training to improve the host country's ability to address vaccine preventable diseases		✓	✓	✓	✓	✓

²⁸¹ <http://www.cdc.gov/globalhealth/immunization/>

²⁸² <http://www.polioeradication.org>

²⁸³ <http://www.measlesrubellainitiative.org>

CDC's global immunization activities primarily focus on children under five years of age in developing countries who are at the highest risk for illness and death from polio, measles, and other vaccine-preventable diseases. Although the United States reduced its vaccine-preventable disease burden through its strong immunization programs, the nation remains at risk because vaccine-preventable diseases continue spreading and could eventually affect unimmunized people in the United States.

Local, Rapid Response

In Afghanistan and Pakistan, CDC helped create district-level response teams and trained officials in how to use real-time data. Now local vaccine teams are able to reach nomadic people and scattered settlements that they used to miss.

Childhood immunization is one of the most cost-effective public health interventions available today. Estimates show that global polio eradication could save up to \$50 billion by 2035 in direct and indirect costs averted, including treatment costs, immunization program costs, and lost productivity due to paralytic polio. Measles mortality prevention is one of the best buys in global health. Vaccination programs are clearly valuable investments when compared with the high cost of imported measles in the United States. For example, an outbreak of imported measles in Utah in 2011 with only 9 cases cost nearly \$300,000.

Budget Request

CDC's FY 2015 request of **\$210,892,000** for global immunization is \$10,000,000 above the FY 2014 Enacted level to support polio eradication. Vaccines save lives, prevent disease, and are much more cost effective than hospitalizations. Working closely with public health partners, CDC continues to help reduce health disparities and works toward creating a wo

orld without vaccine-preventable disease, disability, and death. The increase supports the Global Polio Eradication Initiative and partner efforts towards the goal of stopping all wild poliovirus transmission and any new vaccine-derived polioviruses by December 2014 and certifying the end of all wild poliovirus transmission and any new vaccine-derived polioviruses by December 2018.

This increase will be used to:

- Increase funding to four of CDC's global immunization cooperative agreements which enable UN agencies to direct polio eradication efforts, reduce measles and rubella mortality, and strengthen immunization systems.
- Geographically expand the systematic sampling of sewage for polioviruses to verify that all residual transmission in endemic areas has ended.

Polio Eradication

CDC is [the lead scientific agency](http://www.cdc.gov/polio/why/)²⁸⁴ for U.S. efforts toward global [polio](#)²⁸⁵ eradication. CDC contributed substantially to the more than 99% decline in global polio cases from more than 350,000 cases reported

²⁸⁴ <http://www.cdc.gov/polio/why/>

annually in 1988 to 403 cases reported in 2013, only 160 of which came from the remaining endemic countries. This decrease represents a decline of nearly two-thirds from the 650 cases reported in 2011. India was one of the four remaining endemic countries in 2010. Three years have passed since India's last case of wild polio and its WHO region, South-East Asia, is expected to be certified as polio-free in March 2014. India's success shows that eradication is possible even in challenging circumstances—we must not weaken global efforts to finish the job.

Type 3 poliovirus has not been detected in Asia since April 2012. Polio remains endemic in Afghanistan, Nigeria, and Pakistan. CDC will continue working in close collaboration with WHO, UNICEF, Rotary International, Bill and Melinda Gates Foundation, other U.S. government agencies, and MOH in FY 2015 to achieve polio goals.

Providing Scientific and Programmatic Expertise

CDC provides epidemiologic, laboratory, and programmatic support to WHO and UNICEF to develop, monitor, and evaluate programs and strengthen national level surveillance capacity. CDC serves as the global polio reference laboratory for 145 national facilities, which include responsibilities such as retaining the retention of the world's few remaining poliovirus stocks and leading safe handling and bio-containment procedures. CDC will continue to provide expertise in virology, diagnostics, and laboratory procedures in FY 2015. In addition, CDC will ensure quality assurance, diagnostic confirmation, and genomic sequencing of samples obtained worldwide.

Improving National Ownership, Oversight, and Accountability

CDC scientists help local health officials and community leaders develop and implement strategies to interrupt circulation of wild poliovirus. Based on best practices developed in India, CDC established several important benchmarks to improve the performance of polio programs and achieving greater efficiency.

CDC and its partners must:

- Track the spread of polio
- Improve the quality of supplemental immunization activities
- Strengthen routine immunization services
- Respond to, and aggressively stop, polio outbreaks
- Verify data used to certify polio eradication in all WHO regions

Continuing the Success of STOP

CDC works with national counterparts on short- and long-term assignments through WHO or UNICEF country offices, establishing and jointly coordinating the [Stop Transmission of Polio](http://www.cdc.gov/polio/stop/)²⁸⁶ (STOP) program. This effort has trained and deployed more than 2,000 public health professionals to work on polio surveillance; data management; campaign planning and implementation; program management; and communications in high-risk countries. Over 300 public health professionals will be trained and placed in the most high risk countries for polio infection in FY 2015, such as South Sudan, Afghanistan, Pakistan, Nigeria, Democratic Republic of Congo, and Chad.

Expanding the Environmental Surveillance Strategy

The global poliovirus environmental surveillance strategy is vital to the success of polio eradication. In FY 2015, CDC will geographically expand the systematic sampling of sewage for polioviruses to verify that all residual

²⁸⁵ <http://www.cdc.gov/polio/>

²⁸⁶ <http://www.cdc.gov/polio/stop/>

transmission in endemic areas has ended. This expanded sewage sampling will be especially important in the Middle East, Nigeria, and across West, Central, and East Africa where sewage sampling alerted officials in 2013 to the circulation of poliovirus before any paralysis symptoms occurred. Sewage sampling will also document that viruses caused by oral polio vaccine are eliminated—a key step as the use of oral polio vaccine is gradually replaced by injectable polio vaccine.

Guiding the Polio Eradication Endgame Strategy

As the world nears polio eradication, CDC provides expertise, recommendations, and implementation guidance for the comprehensive [Polio Eradication Endgame Strategy for 2013–2018](#).²⁸⁷ By the end of FY 2015, CDC will work within the Global Polio Eradication Initiative partnership to reach several benchmarks:

- Switch from trivalent to bivalent oral polio vaccines, with an estimated goal of purchasing at least 254 million doses of oral polio vaccine in FY 2015
- Introduction of inactivated poliovirus vaccine into the routine childhood vaccination schedule
- Cessation of using all three types of oral polio vaccine
- Completion of the plans and procedures for laboratory containment of wild polioviruses and eventual global eradication
- Sustain the global standard for laboratories to detect and confirm the presence of poliovirus in samples in 21 days, which is down from 42 days in 2010.

Measles and Rubella, New Vaccine Introduction, and Immunization System Strengthening

CDC provides vaccine funding and on-the-ground expertise to reduce deaths from measles. The agency's efforts build on a 74% decline from 2000–2010 and the estimated 9.6 million measles deaths averted through vaccination during that same timeframe. In addition, supplemental, disease-specific immunization campaigns, such as for polio and measles, improve immunization delivery systems for all recommended vaccines.

Guiding U.S. and Global Efforts

CDC is the lead U.S. government, scientific agency for the Measles and Rubella Initiative. Since 2001, the initiative supported distribution of more than 41 million insecticide-treated bed nets for malaria prevention, 144 million doses of de-worming medicine, 207 million doses of polio vaccine, and 289 million doses of vitamin A. CDC experts help countries set up their own laboratories and disease tracking systems, which reduces the number of measles and rubella cases imported into the United States. CDC also operates one of three specialized laboratories in a global network for measles and rubella. Today, the global network includes more than 690 laboratories and provides the foundation for expansion and support to other vaccine-preventable diseases such as rotavirus, Japanese encephalitis, yellow fever, human papilloma virus (HPV), and invasive bacterial diseases.

Providing Scientific and Programmatic Expertise

CDC provides scientific expertise and consultation to WHO, UNICEF, and MOH to strengthen immunization systems and prepare for new vaccine introduction. For example, routine immunization systems were strengthened to facilitate the introduction of a rotavirus vaccine as well as pilot an oral cholera vaccine in Haiti in mid-2013. Successful introduction of new vaccines in developing countries requires strong immunization programs that deliver high quality, effective vaccines. Strong immunization programs sustain the gains of polio and measles initiatives and efficiently partner with other public health interventions, such as insecticide-treated

²⁸⁷ <http://www.polioeradication.org/resourcelibrary/strategyandwork.aspx>

bed nets, vitamin A supplementation, and screening and treatment for HIV. CDC identifies high-impact, cost-effective interventions by developing and testing interventions in high-risk countries with large numbers of unimmunized children.

Ensuring High Vaccination Coverage

As a partner of the Measles and Rubella Initiative, CDC remains committed—along with WHO, UNICEF, American Red Cross, United Nations Foundation, and Global Alliance for Vaccines and Immunization—to reducing the global disease burden of measles, rubella, and congenital rubella syndrome. Efforts to achieve the goal of reducing global measles-related deaths to 38,850 in FY 2015 require high levels of population immunity. CDC will focus on achieving and maintaining high levels of population immunity by ensuring high vaccination coverage with two doses of measles- and rubella-containing vaccines, thereby guiding a country’s plans for introducing a second dose of these vaccines. CDC will monitor disease trends using laboratory-based surveillance and evaluating programmatic efforts to develop and maintain plans for outbreaks and case management. CDC will build public support for these vaccines through social mobilization campaigns and will conduct research needed to support cost-effective and improved vaccination and diagnostic tools.

Global Immunization Cooperative Agreements

CDC’s global immunization cooperative agreements enable UN agencies to direct polio eradication efforts, reduce measles and rubella mortality, and strengthen immunization systems. The FY 2013 partners were WHO, UNICEF, UN Foundation, PAHO, and KidRisk. In FY 2013, sequestration reduced immunization awards by \$6 million, forcing CDC to reduce its support for oral polio vaccine purchase by over 50%. In FY 2015, CDC will fund four awards through single eligibility, competitive cooperative agreements to UN agencies. CDC will select recipients based on their ability to plan and execute program objectives in high risk countries where polio, measles, and other high impact vaccine preventable diseases remain endemic or a threat.

Global Immunizations Cooperative Agreements

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Number of Awards	5	4	4	0
- New Awards	2	0	0	0
- Continuing Awards	3	4	4	0
Average Award	\$16.896	\$25.800	\$27.285	+\$1.485
Range of Awards	\$0.400–\$36.058	\$5.000–\$45.000	\$8.000–\$48.000	N/A
Total Awards	\$84.480	\$103.200	\$109.140	+\$5.940

Parasitic Diseases and Malaria

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$23.725	\$24.421	\$24.421	\$0.000

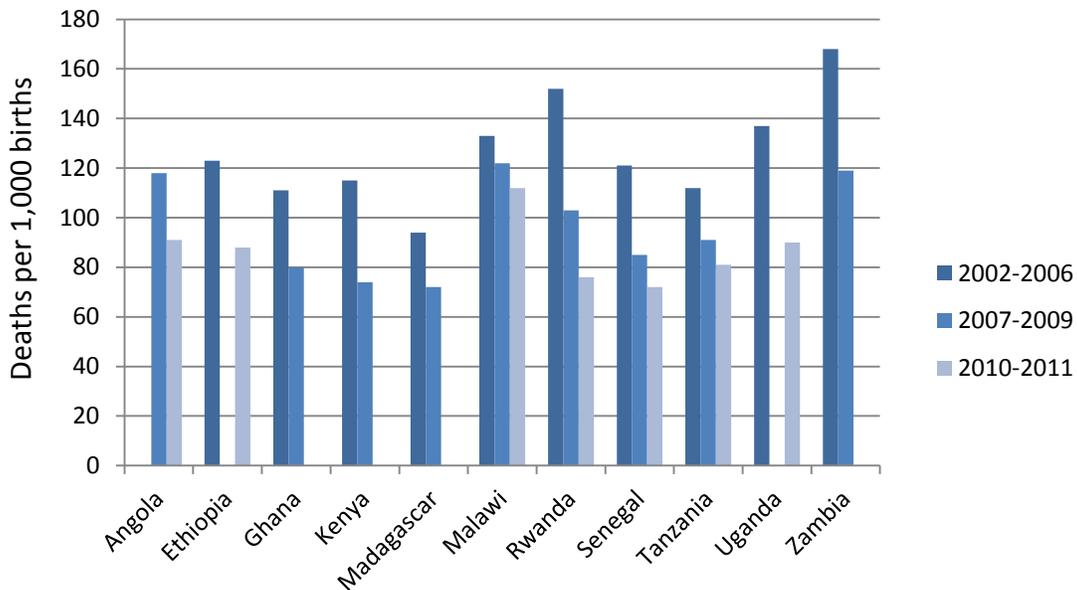
¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and FY 2014 amounts are comparable to FY 2015 to account for the Center for Global Health reorganization.

Overview

CDC supports prevention, control, elimination, diagnosis, and treatment of a wide range of parasitic diseases that threaten the health of individuals in the United States and globally. CDC has more than 180 highly trained medical officers, epidemiologists, public health advisors/analysts, statisticians, health scientists, entomologists, and laboratory scientists based at CDC headquarters and in the field. These public health professionals provide reference diagnostic services; advice on case management of parasitic disease; laboratory and epidemiological research; and health program monitoring and evaluation. CDC uses knowledge and experience gained from helping to eliminate malaria from the United States to further develop and apply the science around successful elimination of parasitic diseases. CDC is also a key implementing partner for the President’s Malaria Initiative.

Deaths among children less than five years of age decreased by 16–50% in the President’s Malaria Initiative countries surveyed.



Budget Request

CDC’s FY 2015 request of **\$24,421,000** for parasitic diseases and malaria is level with the FY 2014 Enacted level. Within this total, \$10,660,000 is provided for malaria prevention efforts, level with FY 2014 Enacted. In addition to funding requested through the base appropriation, CDC will leverage funds it receives for the prevention and control of parasitic diseases and malaria from the United States Agency for International Development, the Bill and Melinda Gates Foundation, and other non-federal sources. Requested funds are needed for CDC to continue

providing vital scientific leadership in the United States and around the world to prevent, control, and eliminate parasitic diseases and malaria.

Parasitic Diseases in the United States

CDC detects and prevents sickness and death in the [United States from parasitic infections](#),²⁸⁸ which are not isolated to communities in low-income countries. CDC maintains the national parasitic disease reference laboratories, including an online, [interactive diagnostic resource](#)²⁸⁹ and national surveillance system for notifiable parasitic diseases. Diagnostic capacity for parasitic diseases at the state-level has been declining in recent years. States and counties rely on these CDC systems to monitor, accurately diagnose, and treat parasitic diseases. CDC also provides 24/7 expert consultation to health departments, physicians, hospitals, and laboratories that treat or diagnose infected people.

In 2012, CDC national reference labs tested more than 10,600 specimens from U.S. residents and government overseas staff for parasitic diseases and responded to 549 telediagnosis inquiries. CDC also received 2,138 requests for assistance via e-mail, phone or mail with most of the requests (1,553) coming from health professionals. CDC expects the demand for its reference laboratory and consultation services to continue in FY 2015 due to increases in global interconnectedness (e.g. travel, imports), domestic parasitic infections, and declining state capacity.

CDC prevents, treats, and monitors malaria among U.S. travelers and visitors. Last year, the agency responded to over 6,000 inquiries via its 24/7 hotline, many of them urgent requests related to life-saving diagnosis and treatment. CDC also develops parasitic disease and malaria prevention guidelines for the [Health Information for International Travel](#)²⁹⁰—an annual reference guide for U.S. citizens traveling overseas. In FY 2015, CDC will further define the U.S. populations most at risk for parasitic infections, provide diagnostic support, and provide otherwise unavailable drugs for treatment to health care providers. CDC will also improve awareness, prevention and control of parasitic diseases, including issuing alters on malaria prevention for travelers, and providing guidance on how to prevent transmission of parasitic diseases from mother to baby, through blood transfusion or organ/tissue transplantation, or through ingestion of contaminated foods.

Global Malaria

CDC is a [global leader](#)²⁹¹ on the prevention and treatment of malaria. CDC provides scientific expertise to 34 endemic countries to improve laboratory systems, case management, diagnostics, prevention programming, and data collection. CDC also jointly implements the [Presidents Malaria Initiative](#)²⁹² with the U.S. Agency for International Development for 19 focus countries.

Working with Ministries of Health and Local Partners

CDC works with MOH and other partners to prevent and control malaria and other parasitic diseases. In FY 2015, CDC will help MOH and partner countries conduct laboratory-based research and epidemiological evaluations in support of malaria control interventions. These interventions include insecticide treated nets, indoor residual spraying, durable wall linings, preventive treatment of pregnant women, novel drugs,

Improving Real-Time Assistance

CDC is adding video capability to its parasitic disease consultation system to improve real-time assistance to physicians and health care providers.

²⁸⁸ <http://www.cdc.gov/parasites/npi.html>

²⁸⁹ <http://www.cdc.gov/dpdx/>

²⁹⁰ <http://wwwnc.cdc.gov/travel/page/yellowbook-home-2014>

²⁹¹ http://www.cdc.gov/malaria/malaria_worldwide/cdc_activities/index.html

²⁹² http://www.cdc.gov/malaria/malaria_worldwide/cdc_activities/pmi.html

insecticides, vaccines, and delivery systems. Other areas of focus for CDC include studying how cases are diagnosed and treated and developing new prevention approaches that can be adopted by WHO, MOH, and other partners. CDC will also develop and evaluate new rapid and simple field methods to test the quality of antimalarial drugs.

Maintaining a Global Reference Insectary

CDC maintains a [global reference insectary](#)²⁹³ to support progress in controlling parasitic diseases, including malaria. The facility, along with CDC research and expertise, increases understanding of mosquito and other insect vectors that transmit disease; informs how to manage and mitigate insecticide resistance; and facilitates successful field implementation of vector-control interventions. In FY 2015, CDC will increase testing of long-lasting insecticide-treated mosquito nets for durability and retention of insecticidal effectiveness, monitor levels of insecticide resistance among mosquitoes in President's Malaria Initiative countries, and assess new vector control methods and insecticides.

Implementing and Providing Scientific Leadership to President's Malaria Initiative

CDC provides scientific leadership and advice to the U.S. Global Malaria Coordinator and is a key implementer of monitoring and evaluation, surveillance, and operations research activities in the 19 President's Malaria Initiative-focus African countries and in the Greater Mekong Sub-region (i.e., Cambodia, Laos, Myanmar, Thailand, Vietnam, and China's Yunnan Province). With CDC assistance, global malaria prevention and control programs will continue to scale up and implement cost-effective interventions, such as intermittent preventive treatment in pregnancy, insecticide-treated bed nets, indoor residual spraying, and artemisinin combination therapy. CDC's efforts help accelerate progress towards President's Malaria Initiative targets related to intervention coverage and reductions in malaria-related mortality. In FY 2015, CDC experts will also provide scientific evidence and evaluation to inform the next five-year plan for the President's Malaria Initiative. Central to this effort is continuing to developing the evidence on insecticide resistance, bed net durability, and effectiveness of additional malaria control efforts, such as mass screening and treatment.

Neglected Tropical Diseases

CDC reduces illness, disability, and disfigurement caused by [neglected tropical diseases](#).²⁹⁴ Much of CDC's work is focused on the control or elimination of lymphatic filariasis (elephantiasis is a symptom), onchocerciasis (river blindness), trachoma (granular conjunctivitis), schistosomiasis (informally known as Bilharzia), three soil-transmitted helminthes (worm-like organisms), and eradication of Guinea worm. CDC provides expertise in surveillance, diagnostics, monitoring, and evaluation to U.S. government agencies, MOH programs, and global partners—including assisting WHO on development of policy and guidelines and in certifying elimination of disease transmission. CDC also conducts research to improve program delivery. For example, CDC and partners developed an approach to assess whether the interruption of lymphatic filariasis transmission has occurred in a specific area. In FY 2015, CDC will help countries in Africa and elsewhere conduct transmission assessment surveys for lymphatic filariasis and other neglected tropical diseases; develop and evaluate new diagnostic tools; and conduct critical research to build the evidence base for program and policy decisions and to accelerate progress.

²⁹³ http://www.cdc.gov/malaria/tools_for_tomorrow/research_resources.html

²⁹⁴ <http://www.cdc.gov/globalhealth/ntd/diseases/index.html>

Global Public Health Protection

(dollars in millions)

	FY 2013 Enacted ^{1,2}	FY 2014 Request ²	FY 2015 Request	2015 +/-2014
Budget Authority	\$54.344	\$62.753	\$100.253	+\$37.500
Global Public Health Protection				
-Global Disease Detection and Emergency Response	\$44.839	\$45.470	\$45.470	\$0.000
-Global Public Health Capacity Development	\$9.505	\$17.283	\$9.783	-\$7.500
Total	\$54.344	\$62.753	\$100.253	+\$37.500

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2013 and FY 2014 amounts are comparable to FY 2015 to account for the Center for Global Health reorganization.

Overview

CDC provides epidemic intelligence and response capacity for early warning about international disease threats and develops country-level capacities to ensure emergency preparedness and response to incidents of local and international importance. Building the capacity for a country to detect and respond to a potential disease outbreak or public health emergency before an event occurs helps contain dangerous pathogens as they emerge, thereby saving lives, protecting the global and U.S. economies, and preventing the spread of disease across borders. CDC works with partners to build strong, nimble, and sustained public health systems by focusing on the foundational capacities of applied epidemiology, surveillance, policy development, informatics and health information systems, evaluation, research, and laboratory systems. Programmatically, CDC ensures global health protection by implementing the International Health Regulations; establishing Field Epidemiology Training Programs and Global Disease Detection Centers (GDD); and responding to public health emergencies. In FY 2015, CDC expects to begin full-scale Global Health Security program implementation.

Budget Request

CDC's FY 2015 request of **\$100,253,000** for Global Public Health Protection is a net increase of \$37,500,000 above the FY 2014 Enacted level. A \$7,500,000 decrease eliminates dedicated funding to assist other nations in setting up and strengthening National Public Health Institutes. The funding for this new program is available through 2015. Within this total, \$45,000,000 is requested to expand Global Health Security activities. These activities are similar to existing CDC global health activities that will be substantially expanded in 2014 and 2015. Over the next five years, United States global health security partners together commit to working with at least 30 partner countries (containing at least 4 billion people) to prevent, detect, and respond to infectious disease threats, whether naturally occurring or caused by accidental or intentional releases of dangerous pathogens.

Global Health Threats Remain

More than 80 countries are unable to report **full implementation** of the International Health Regulations.

Global **laboratory capacity** is insufficient to address all known and emerging pathogens.

Training of new **epidemiologists** and other **healthcare workers** is too slow.

New threats such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV) and H7N9 influenza continue to spread.

In addition to its base appropriation, CDC receives interagency funding transfers from the United States Agency for International Development, the U.S. Department of Health and Human Services, U.S. Department of State, and the U.S. Department of Defense to further global health protection.

Global Health Security

Launched February 13, 2014, the Global Health Security Agenda brings the United States and partners around the world together to protect populations from pandemic threats, economic loss, instability, and loss of life. The increase of \$45 million in FY 2015 will allow CDC to expand demonstration projects in support of this new Agenda to accelerate progress toward a world safe and secure from infectious disease threats in partnership with other nations, international organizations and public and private stakeholders.

Epidemic threats to national security arise at unpredictable intervals and from unexpected sources. Because these threats do not recognize national borders, the health of people overseas directly affects America's safety and prosperity, with far-reaching implications for economic security, trade, the stability of foreign governments, and the well-being of U.S. citizens at home. If we are to save lives and protect U.S. health security, CDC must accelerate efforts to build out the systems and workforce needed to better respond to and manage a range of disease threats.

CDC will build upon successful efforts and expedite progress to prevent the introduction and spread of global infectious disease threats by setting a new course to close gaps in select countries. With the support of WHO, the 194 States Parties to the [International Health Regulations](#)²⁹⁵ have been working to enhance national, regional, and global public health security. The new Global Health Security implementation will be part of the larger U.S. Global Health Security Agenda, which seeks to build broad-based international support through a series of high-level and technical engagements with partner countries and multilateral organizations. This program will also build on pilot-level work conducted in 2013 by CDC and partners, including the Department of State and Department of Defense. These agencies conducted two successful pilot programs with Vietnam and Uganda across key areas of the GHS Agenda, including strengthening laboratory systems, improving emergency operation center capacity, training the public health workforce, and moving toward real-time data sharing in health emergencies of international concern.

Over time, Global Health Security efforts will develop capacity to achieve three key goals:

1. Prevention of avoidable catastrophes
 - Improve global food and drug safety
 - Slow the spread of antimicrobial drug resistance
 - Strengthen biosafety and biosecurity
 - Strengthen immunization capacity
 - Ensure border safety and the protection of global migration
2. Early threat detection
 - Establish a global laboratory network capable of detecting all Public Health Emergencies of International Concern
 - Strengthen monitoring systems to identify public health threats
 - Train and deploy disease detectives and laboratory scientists
 - Launch a global information sharing platform and a bioinformatics system
 - Develop and deploying novel diagnostics

²⁹⁵ <http://www.cdc.gov/globalhealth/ihregulations.htm>

3. Effective response

- Create an interconnected global network of Emergency Operations Centers (EOC)
- Establish functional, rapid response teams worldwide
- Operate a global reagent resource
- Develop response communications and planning for crisis management
- Strengthen global reference laboratories

Low-income country partners will contribute at least 10% (in-kind or financial) of total costs during the first year, with countries averaging 50% by 2025. Middle-income countries will contribute at least 10% (in-kind or financial) of total costs during the first year, and more than 90% by 2025. After establishing a new baseline of capacity, U.S. investments will be reduced to a maintenance level as participating nations assume greater financial responsibility to sustain their own global health security activities. To improve effectiveness and efficiency of USG resources, an agency or multiple agencies will be responsible for specific GHS measures and performance outcomes.

While many U.S. agencies make important investments in global health security, CDC is considering ways to better structure and align existing investments to ensure progress in the areas of improved and accelerated prevention, detection, and response. For example, in 2014 CDC and Department of Defense's Defense Threat Reduction Agency (DTRA) committed to joint activities in support of the GHS Agenda in 10 additional countries. Other donor countries and international health organizations are also exploring ways to increase and leverage the impact of existing global health investments and possible sources of new support.

In FY 2015, CDC will partner with up to ten countries to create sustainable programs that increase leadership capacity and provide the resources necessary to manage emerging threats, enhance early detection, improve confirmation, and ensure highly effective responses to global epidemics and other public health catastrophes. CDC will fund awards through both competitive and non-competitive agreements, with a focus on Ministries of Health (MOH), academic institutions, and private sector entities in up to ten countries. Some countries may receive multiple awards—such as MOH, universities, and non-governmental organizations—addressing different focus areas. CDC will select countries based on risk of emerging epidemics, a history of working effectively with CDC, and a commitment to contributing their own resources to joint efforts.

Global Public Health Capacity Development

CDC protects the health and well-being of Americans and populations around the world by building public health capacity in countries to prevent disease, disability, and death. CDC ensures global health security by establishing [Field Epidemiology Training Programs](http://www.cdc.gov/globalhealth/fetp/)²⁹⁶ (FETP), supporting improved country capacity, and advancing non-communicable disease prevention and control. Through FETPs, CDC establishes a network of disease detectives around the globe that are the first line of defense in detecting and responding to outbreaks in their respective countries as well as neighboring countries. In 2012, FETP residents conducted more than 400 confirmed outbreak investigations, strengthened over 630 surveillance systems, and provided specific recommendations for improvements through scientific investigations and evaluations.

CDC generally supports an FETP for five years, with gradual transfer of responsibility and costs to ensure that the country can sustain the program after CDC staff are no longer present. Countries with now fully independent FETPs include Australia, Mexico, and Peru. Examples of countries receiving limited CDC support and making progress to becoming fully independent include Brazil, Ghana, Philippines, and Zimbabwe.

²⁹⁶ <http://www.cdc.gov/globalhealth/fetp/>

In FY 2015, CDC will continue to develop epidemiologic and surveillance workforce capacity and support the systems essential for effective outbreak response in more than 40 countries. Trained public health workers gather and analyze health data in-country to identify and respond to disease outbreaks and other public health threats, provide an evidence base to control well-known and emerging diseases and to promote health diplomacy and global health security.

The FETP tiered training model with beginner (six months), intermediate (nine months), and advanced (two years) programs has proven successful for ensuring epidemiologists are available at all public health workforce levels. CDC will build on this success by expanding the reach of the FETP to district and local levels in up to five countries. These activities will help create a systematic use of evidence for decision-making.

CDC will strengthen the capabilities of all FETP graduates to respond to national and global priorities such as emerging new diseases, polio elimination, and immunization, and will expand distance learning and self-paced training modules to reach more residents. Regional networks are essential for sharing lessons learned by providing a platform for CDC and countries to support one another to improve health. CDC will expand partnerships with four regional FETP networks in geographic areas of strategic importance to provide shared training and capacity building opportunities; staff multi-country outbreak response teams; and expand the partnership and collaboration capacity of individual country programs.

To meet the needs of countries not in a position to start their own FETP, CDC will work with existing programs to enroll residents from neighboring countries. For example, South Sudan sends residents to the Kenya FETP; Iraqi graduates from the Jordan FETP have returned home to start a new FETP in Iraq; Haiti sends residents to the Central America FETP; and the Thailand FETP trains residents from throughout the Southeast Asia region. CDC will continue to leverage existing FETP programs in up to five partner countries to train residents from neighboring countries. In addition, CDC will strengthen partnerships with other U.S. government agencies, private foundations, universities, and others to improve health impact among the public health workforce. These partnerships will help countries improve their health program's efficiency and effectiveness, organizational performance, and governance through improved management capacity.

Global Disease Detection and Emergency Response

CDC's [Global Disease Detection](http://www.cdc.gov/globalhealth/gdder/gdd/default.htm)²⁹⁷ (GDD) program is comprised of 10 strategically positioned centers, an operation center at CDC headquarters, and international partner networks. CDC also provides outbreak response to countries requesting assistance. In 2012, CDC responded to 209 global disease outbreaks via GDD Centers and through coordination with the GDD Operations Center and other CDC programs. These outbreaks included anthrax, viral hemorrhagic fever, and cholera. CDC also discovered six new disease threats in 2012.

Populations affected by natural disaster, war, famine, and civil strife are especially vulnerable to diseases. This vulnerability is compounded when health and other government infrastructure has been damaged or is not functioning effectively. CDC's international emergency response programs provide humanitarian assistance based on requests from other U.S. government agencies, United Nations agencies, and non-governmental organization partners. In 2012, CDC provided assistance to over 120 humanitarian missions in 39 countries, including a Hepatitis E outbreak in South Sudan. In 2014, CDC continues to provide assistance in outbreak detection and response related to Syria refugee populations throughout the region.

The GDD and international emergency response programs at CDC will continue to fulfill CDC's mission of protecting the health of U.S. citizens and the global community from urgent public health threats. During FY 2015, CDC anticipates GDD and emergency response programs will provide rapid response to at least 100

²⁹⁷ <http://www.cdc.gov/globalhealth/gdder/gdd/default.htm>

disease outbreaks, which will likely include febrile encephalitis, novel influenza, viral hemorrhagic fever, and cholera. CDC will expand and enhance core public health capacities in rapid outbreak response, strengthen surveillance and national laboratory systems, and train public health and other professionals in GDD Centers.

CDC’s Global Disease Detection centers in China, Egypt, Guatemala, Kenya, and Thailand detect dangerous pathogens through focused, population-based disease tracking. CDC’s Global Disease Detection centers in Bangladesh, India, and South Africa are strengthening their national surveillance and laboratory systems to begin conducting population-based surveillance. CDC will provide rapid health and nutrition assessment; disease tracking; epidemic investigation; disease prevention and control; program evaluation; and emergency preparedness training to assist MOH, other U.S. government agencies, and non-governmental partners.

CDC collaborates with international and non-governmental relief organizations to provide data-driven, evidence-based public health intervention and guidance during humanitarian emergencies to decrease associated illness and death. CDC will strengthen strategic relationships with these entities to improve response times and effectiveness of interventions. Growing concerns with global health security also requires strengthening partnerships among Department of Defense, Department of State, United States Agency for International Development, and National Security staff to promote coherent, coordinated policies and programs.

In FY 2015, CDC will fund 39 awards through both competitive and non-competitive agreements to increase capacity to detect and control emerging infectious disease outbreaks and to prevent or reduce illness, injury, and death related to humanitarian emergencies. CDC awards agreements through funding opportunity announcements with an objective review process, and a single-eligibility justification cooperative agreement with the MOH in a particular country or a United Nations agency. Examples of partners include Emory University; Georgia Institute of Technology; iMMAP; International Rescue Committee; WHO; UNICEF; United Nations High Commissioner on Refugees; Antares; Herzog Hospital; Columbia University; Association of Schools of Public Health; and American Society of Microbiology.

Global Disease Detection and Emergency Response Cooperative Agreements

(dollars in millions)	FY 2013 Final¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Number of Awards	36	33	33	0
- New Awards	8	3	10	+7
- Continuing Awards	28	30	23	-7
Average Award	\$0.328	\$0.332	\$0.332	\$0.000
Range of Awards	\$0.002–\$2.008	\$0.002–\$2.008	\$0.002-\$2.008	N/A
Total Awards	\$11.796	\$10.958	\$10.958	\$0.000

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$1,278.870	\$1,371.198	\$1,317.375	-\$53.823
Total Request	\$1,278.870	\$1,371.198	\$1,317.375	-\$53.823
FTEs	580	580	580	0
Public Health Preparedness and Response				
- State and Local Preparedness and Response Capability	\$630.198	\$662.849	\$617.026	-\$45.823
- CDC Preparedness and Response Capability	\$155.522	\$157.532	\$157.532	\$0.000
- Strategic National Stockpile	\$493.150	\$550.817	\$542.817	-\$8.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

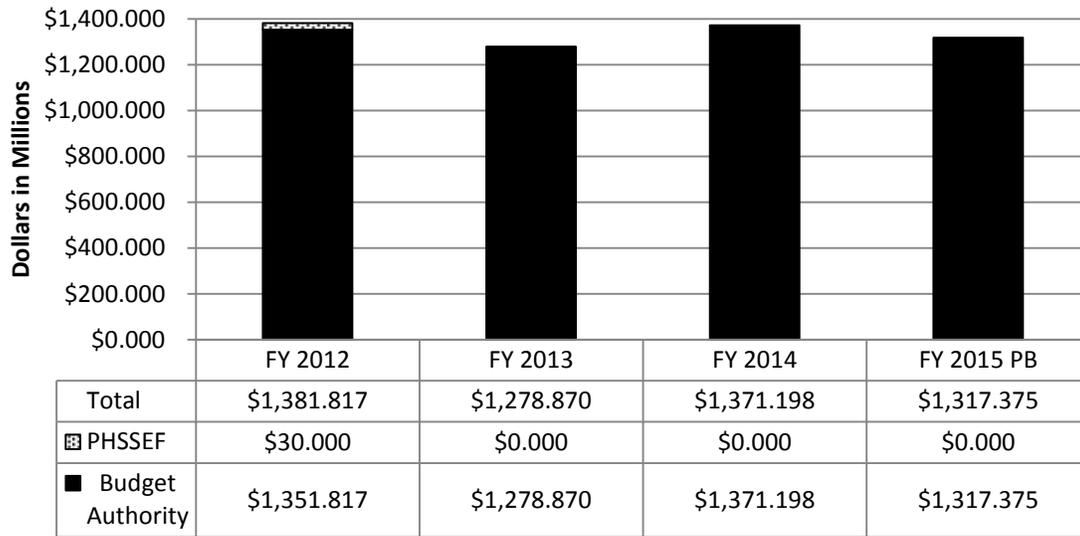
CDC's Public Health Preparedness and Response activity works 24/7 to ensure the security, safety, and health of the United States from public health threats that are foreign and domestic, intentional and naturally occurring. CDC provides life-saving responses to chemical, biological, radiological, and nuclear threats, as well as other disasters, outbreaks, and epidemics.

CDC protects Americans' health and safety by:

- Supporting state and local health departments' public health preparedness capability improvement through grants and training
- Responding to public health emergencies and emergency response activations
- Working 24/7 to respond to calls from medical professionals and the general public about health related emergencies and public health issues
- Overseeing and regulating laboratories that import and possess the most deadly pathogens and toxins to ensure they are safeguarded
- Providing comprehensive situational awareness by overseeing a national laboratory network and building national tracking and surveillance systems
- Ensuring an available supply of medical countermeasures by maintaining the Strategic National Stockpile

CDC's FY 2015 request of **\$1,317,375,000** for Public Health Preparedness and Response is \$53,823,000 below the FY 2014 Enacted level. This request includes level funding for CDC Preparedness and Response Capability, an \$8,000,000 reduction to the Strategic National Stockpile, and a \$45,823,000 reduction to the State and Local Preparedness and Response Capability that supports the Public Health Emergency Preparedness cooperative agreement and other activities.

Public Health Preparedness and Response Funding History^{1,2}



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

² FY 2012 includes funds from the Public Health and Social Services Emergency Fund (PHSSEF)

Strategic National Stockpile 10-Year Funding History

Fiscal Year	Dollars (in millions)
2004	\$397.640
2005	\$466.700
2006	\$524.339
2007	\$496.348
2008	\$551.509
2009	\$570.307
2010	\$595.661
2011	\$591.001
2012	\$533.792
2013	\$477.577

State and Local Preparedness and Response Capability

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$630.198	\$662.849	\$617.026	-\$45.823

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC helps communities prepare for, respond to, and recover from hazards that jeopardize our nation’s health security. Whether natural (H7N9 influenza), accidental (West, Texas chemical explosion) or intentional (Boston, Massachusetts bombings), these threats require robust preparedness, response, and recovery capabilities. As directed by [Presidential Policy Directive \(PPD\) 8: National Preparedness and the Pandemic](#)²⁹⁸ and [Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 \(PAHPRA\)](#),²⁹⁹ CDC’s State and Local Preparedness and Response Capability supports national standards for public health preparedness planning at the state, local, and territorial levels. Through the [Public Health Emergency Preparedness \(PHEP\) cooperative agreement](#),³⁰⁰ CDC helps public health agencies strengthen their abilities to respond to all types of public health incidents and build more resilient communities.

Main Areas of Public Health Preparedness Funding

Funding	Activity
Base	Funding used by awardees to address jurisdictional improvement of 15 nationally recognized priority capability standards contained within Public Health Preparedness Capabilities: National Standards for State and Local Planning ³⁰¹
Cities Readiness Initiative	Funding to build and sustain medical countermeasure dispensing and distribution capability for 72 high-population metropolitan statistical areas deemed at greater risk for public health threats
Level-1 Chemical Laboratories	Funding for 10 labs capable of rapidly detecting and characterizing chemical threats and functioning as surge capacity laboratories for the CDC

CDC continues to look for ways to reduce the administrative burden on awardees. In FY 2012, CDC aligned its PHEP cooperative agreement with the HHS Hospital Preparedness Program (HPP) cooperative agreement (funded within the Public Health and Social Services Emergency Fund) to strengthen public health and healthcare system preparedness collaboration and reduce duplication. The current, five-year joint cooperative agreement provides financial resources and expert advice to help public health agencies and healthcare systems achieve national standards for public health and healthcare preparedness. Building upon the HPP-PHEP alignment, CDC is pursuing PHEP program alignment with other federal preparedness programs as a way to reduce state and local awardee administrative burden, optimize resources, ensure alignment with national strategies and priorities, better coordinate grant administration and management, and eliminate redundancies. Grant alignment accomplishments include shared language between the Homeland Security Grant Program

²⁹⁸ <http://www.dhs.gov/presidential-policy-directive-8-national-preparedness>

²⁹⁹ <http://beta.congress.gov/bill/113th-congress/house-bill/307?q=%7B%22search%22%3A%5B%22113-5%22%5D%7D>

³⁰⁰ <http://www.cdc.gov/phpr/coopagreement.htm>

³⁰¹ http://www.cdc.gov/phpr/capabilities/DSLRL_capabilities_July.pdf

(HSGP) and joint HPP-PHEP FY 2013 continuation guidance that promotes collaborative state and local planning between emergency management, public health, and the healthcare system.

Budget Request

CDC’s FY 2015 request of **\$617,026,000** for State and Local Preparedness and Response Capability is \$45,823,000 below the FY 2014 Enacted level. This reduction will decrease grants funded through the Public Health Emergency Preparedness (PHEP) cooperative agreement that support state, territorial, and local public health departments. Since 2002, the PHEP cooperative agreement has provided nearly \$9 billion to public health departments across the nation to upgrade their ability to effectively respond to a wide range of public health threats. CDC’s continued support of public health departments through PHEP will focus on capability sustainment. The budget also reflects the elimination of the Academic Centers for Public Health Preparedness. CDC will continue to support research and training for public health preparedness through the research agenda of the OPHPR Science Office.

Recent PHEP Investments Improved State and Local Capacity

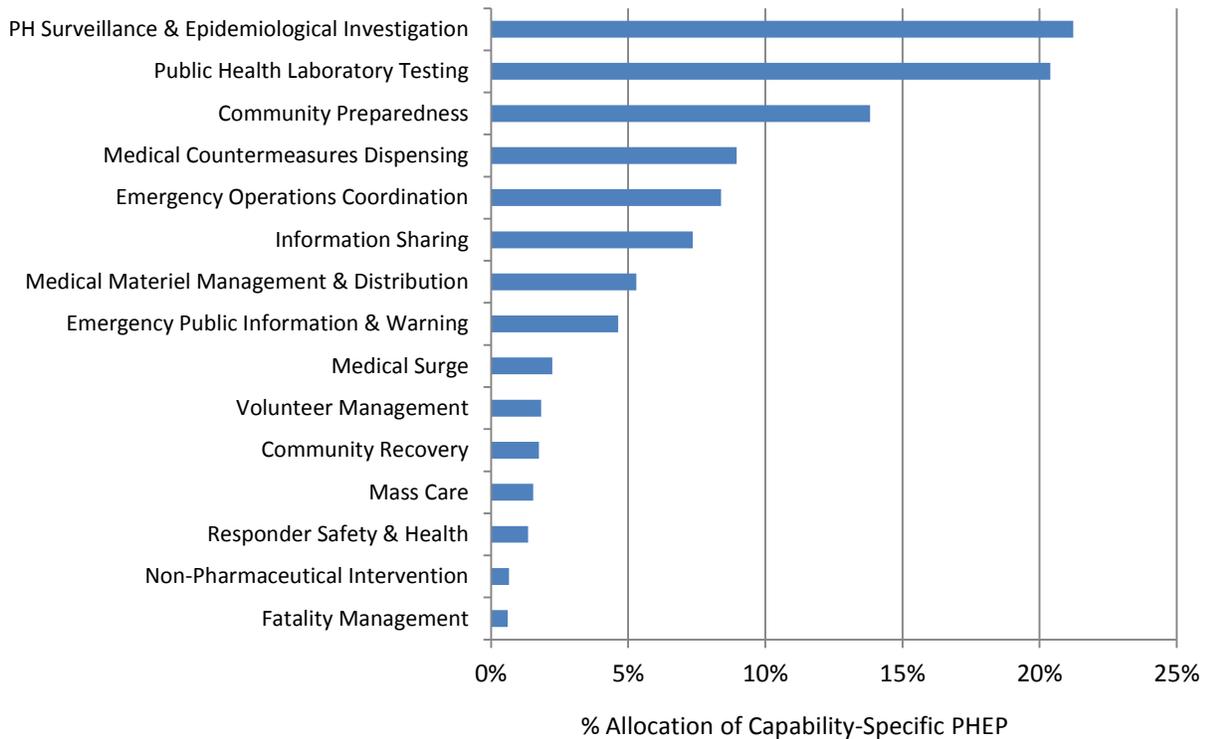
Location	Highlight
Indiana	During the multi-state meningitis outbreak , Indiana relied on its preparedness resources to identify over 1,500 persons exposed to tainted steroids and investigate 91 identified cases and 11 deaths.
New York	During Hurricane Sandy , New York City communicated through the Health Alert Network with more than 5,000 contacts to share critical information. As part of a coordinated response, state health department staff was embedded in the local emergency operations center, displaced patients were tracked throughout the city's shelters, and more than 40,000 wellness checks were conducted with the help of the National Guard and local partners.
Boston	Within 10 minutes of the Boston Marathon Bombing , the Health Alert Network was activated, providing emergent information to all hospitals in the State. Massachusetts activated its Emergency Operations Center, fatality management procedures, and its crisis management system
Texas	Texas Department of State Health Services immediately respond to the fertilizer plant explosion in West, Texas and three Ambulance Bus Strike Teams, two mortuary trailers, and one Type 2 Mobile Medical Unit were deployed to assist with treatment and recovery efforts (funding was provided jointly with HPP).
Alaska	The Alaska Department of Health and Social Services Emergency Operations Center (DHSS EOC) was virtually activated and remained active for 6 weeks. The EOC led the State coordination for healthcare related issues resulting from spring flooding in communities along the Yukon River.
Florida	Plans, procedures, and resources (personnel) developed with PHEP funds supported a local Florida public health system to determine the prevalence of Dengue Fever within their community.
New Mexico & Utah	Environmental samples were brought to the Utah public health laboratory by the FBI for testing after a woman cooked and drank an elixir that reportedly contained ricin . The PHEP funded New Mexico Level I Chemical Laboratory was able to confirm the presence of ricinine , a marker for the Castor seed, which also contains ricin.

Enhancement of Public Health Preparedness Capability and Capacity

CDC supports key public health preparedness capabilities identified in [Public Health Preparedness Capabilities: National Standards for State and Local Planning](#)³⁰², which are aligned to the 31 Core Capabilities of the [National Preparedness Goal](#)³⁰³ to improve coordination among federal, state, and local public health, healthcare, and emergency management programs. In addition to funding, CDC experts share knowledge, useful practices, and lessons learned—along with the tools and resources needed for capability improvement, measurement, and effectiveness—to help close preparedness gaps and maintain state, local, and national capabilities. CDC will continue to coordinate with other federal agencies on The National Health Security Preparedness Index™, a comprehensive annual measure of health security and preparedness at national and state levels.

PHEP awardees use funding to address self-identified needs. In 2015, public health departments will determine their jurisdictional priorities for capability sustainment through use of the HHS Capabilities Planning Guide, risk assessment tools, opportunities for improvement identified through exercises, and performance measurement findings.

FY 13 PHEP Allocations across the 15 Preparedness Capabilities



Supporting State, Territorial and Local Public Health Preparedness Programs

In FY 2015, CDC will fund 62 state, territorial and local public health departments through a non-competitive, formula-based, joint HPP-PHEP cooperative agreement. This funding also includes direct assistance to grantees provided through the Career Epidemiology Field Officer (CEFO) Program. CEFO personnel are assigned to states

³⁰² http://www.cdc.gov/phpr/capabilities/DSLRCapabilities_July.pdf

³⁰³ <http://www.fema.gov/national-preparedness-goal>

by request and are funded by PHEP. As of January 2012, there were 32 CEFOs in 24 states. These assignments are based on an initial two-year placement, and states have the option to renew the request annually.

Public Health Emergency Preparedness Grants (All PHEP awards combined)^{1,2}

(dollars in millions)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	62	62	62	0
- New Awards	0	0	0	0
- Continuing Awards	62	62	62	0
Average Award	\$9.431	\$9.877	\$9.363	-\$0.514
Range of Awards	\$0.323-\$39.704	\$0.325-\$41.853	\$0.323-\$39.317	N/A
Total Grant Awards	\$584.697	\$612.400	\$580.527	-\$31.873

¹ Individual grantee funding levels may change depending on programmatic decisions made when calculating funding for the Cities Readiness Initiative, LRN-C Level 1 funding, and other programs funded through the PHEP cooperative agreement. FY 2014 awards are estimates until final calculations are complete.

² FY 2015 estimates are based on currently anticipated funding. Recalculations may be necessary based on additional strategy planning for FY 2015.

PHEP Base

In FY 2015, PHEP base funding will ensure public health departments are emergency-ready. The PHEP cooperative agreement supports the [National Response Framework \(NRF\)](#)³⁰⁴, which guides how the nation responds to infectious disease outbreaks; natural disasters; biological, chemical, and radiological incidents; and acts of terrorism. As mandated by 319C-1 of the Public Health Service (PHS) Act, CDC allocates funding according to a base-plus-population formula, which includes a guaranteed minimum amount (i.e., a funding floor). Awardees provide funding to local and tribal health departments to support preparedness staff such as laboratorians and epidemiologists; preparedness resources such as redundant communication systems, training and exercise programs; and other essential services. The program demonstrates increased preparedness using performance measures and related evaluation and assessment data, as well as evidence-based benchmarks.

Public Health Emergency Preparedness Grants (Base PHEP funding Subtotal)^{1,2,3}

(dollars in millions)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	62	62	62	0
- New Awards	0	0	0	0
- Continuing Awards	62	62	62	0
Average Award	\$8.444	\$8.948	\$8.376	-\$0.572
Range of Awards	\$0.323-\$33.493	\$0.325-\$36.224	\$0.323-\$33.106	N/A
Total Grant Awards	\$523.510	\$555.654	\$519.340	-\$36.314

¹ Individual grantee funding levels may change depending on programmatic decisions made when calculating funding for the Cities Readiness Initiative, LRN-C Level 1 funding, and other programs funded through the PHEP cooperative agreement. FY 2014 awards are estimates until final calculations are complete.

² Included in 'All PHEP awards combined' grant table.

³ FY 2015 estimates are based on currently anticipated funding. Recalculations may be necessary based on additional strategy planning for FY 2015.

Cities Readiness Initiative

Cities Readiness Initiative (CRI) supports local medical countermeasure distribution and dispensing planning in the nation's 72 largest metropolitan statistical areas (MSA), which contain over 50% of the U.S. population. This

³⁰⁴ http://www.fema.gov/media-library-data/20130726-1914-25045-1246/final_national_response_framework_20130501.pdf

capability for large metropolitan public health departments to respond to a large-scale bioterrorist event is essential and therefore CDC has prioritized this grant in FY 2015. CDC proposes to return the CRI funding to the FY 2013 levels and will fund MSAs in all 50 states and four directly-funded localities using a population-based formula to strengthen their ability to quickly and effectively distribute and dispense medical countermeasures from the Strategic National Stockpile in response to emergencies.

Public Health Emergency Preparedness Grants (CRI Subtotal)^{1, 2, 3}

(dollars in millions)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	54	54	54	0
- New Awards	0	0	0	0
- Continuing Awards	54	54	54	0
Average Award	\$0.942	\$0.859	\$0.820	-\$0.039
Range of Awards	\$0.162-\$5.159	\$0.170-\$4.578	\$0.162-\$5.159	N/A
Total Grant Awards	\$50.842	\$46.401	\$50.841	+\$4.440

¹Individual grantee funding levels may change depending on programmatic decisions made when calculating funding for the Cities Readiness Initiative, LRN-C Level 1 funding, and other programs funded through the PHEP cooperative agreement. FY 2014 awards are estimates until final calculations are complete.

²Included in 'All PHEP awards combined' grant table.

³FY 2015 estimates are based on current anticipated funding. Recalculations may be necessary based on additional strategy planning for FY 2015.

Chemical Laboratories

In FY 2015, the PHEP cooperative agreement will fund 10 Level-1 chemical laboratories, which will improve states' ability to detect and respond to toxic chemical agents, including mustard agents, nerve agents, and other dangerous industrial chemicals. States allocate funding to support staffing and equipping the lab, maintain critical instrumentation in a ready-state, staff training and proficiency testing, and support participation in local, state, and national exercises. Level-1 labs provide local and regional analytical assets as well as national surge capacity for CDC during a major public health security incident by analyzing large numbers of patient samples in response to large-scale exposure incidents, decreasing the time needed to provide appropriate life-saving countermeasures.

Public Health Emergency Preparedness Grants (Level 1 Chemical Labs Subtotal)^{1, 2}

(dollars in millions)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	10	10	10	0
- New Awards	0	0	0	0
- Continuing Awards	10	10	10	0
Average Award	\$1.035	\$1.035	\$1.035	\$0.000
Range of Awards	\$0.808-\$1.603	\$0.808-\$1.603	\$0.808-\$1.603	N/A
Total Grant Awards	\$10.345	\$10.345	\$10.345	\$0.000

¹Individual grantee funding levels may change depending on programmatic decisions made when calculating funding for the Cities Readiness Initiative, LRN-C Level 1 funding, and other programs funded through the PHEP cooperative agreement. FY 2014 awards are estimates until final calculations are complete.

²Included in 'All PHEP awards combined' grant table.

CDC Preparedness and Response Capability

(dollars in millions)

	FY 2013 Final1	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$155.522	\$157.532	\$157.532	\$0.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC’s Preparedness and Response Capability supports critical infrastructure and cross-cutting research to facilitate rapid response to public health emergencies in the following ways:

- Directs public health response efforts
- Detects sources of disease outbreaks and food-borne diseases
- Develops tests to rapidly detect biological, chemical, and radiological agents
- Regulates laboratories handling the most dangerous infectious agents and toxins
- Develops risk and emergency communication
- Conducts health hazard evaluations and assesses hazardous substances
- Creates emergency response plans
- Developing and maintaining secure IT systems that monitor potential threats

Budget Request

CDC’s FY 2015 request of **\$157,532,000** for CDC Preparedness and Response Capability is level with the FY 2014 Enacted level. At this funding level, CDC will maintain such programs as the Emergency Management Program, Laboratory Response Network, regulation of select agents and toxins, and BioSense 2.0.

Emergency Management Program

The Emergency Management Program allows better coordination of experts responding to small-scale outbreaks and large-scale public health emergencies. Without this vital resource, CDC’s ability to protect the public’s health during emergencies would be delayed or ineffective. Public health emergencies demand immediate attention, and it is critical to continually improve procedures so that they can be implemented anytime to ensure CDC’s public health and medical expertise are available to respond quickly to any emergency. On October 2013, CDC became the first federal agency to receive full accreditation from the Emergency Management Accreditation Program (EMAP) through rigorous independent review and evaluation, representing the program’s dedication to continually enhancing response capabilities to public health emergencies.

CDC is committed to the following goals in 2015:

- Provide public health and medical expertise for an estimated 19,500 inquiries from hospitals, health departments, international agencies, other countries, airlines, cruise ships, and the general public
- Support global health security by providing fellowship opportunities that develop the emergency management capacity of international partners
- Sustain professional credentialing of the Emergency Management Program
- Offer education and career development for Emergency Management Specialists

CDC’s approach to public health preparedness, response, and recovery is rooted in scientific evidence. CDC is studying the factors that lead to rapid, complete community recovery following disasters to determine if specific policies or interventions contribute to better physical and mental health outcomes. CDC is also examining responder organizations to see which factors aid in or detract from a coordinated response across the public health system.

Laboratory Response Network

The Laboratory Response Network is a coordinated network of public health and other laboratories for which CDC provides standard assays and protocols for testing biological and chemical terrorism agents. In FY 2015, CDC will improve detection of tularemia and smallpox by developing and deploying improved assays, which also bolsters CDC’s testing capability for unknown emerging pathogens. In addition, CDC’s fully implemented Quality Management System will support the completion of FDA’s submission requirements of a new assay for the detection of Rickettsia species (parasite that causes typhus, Rocky Mountain spotted fever, and other tick-, flea-, and lice-borne diseases).

Regulation of Select Agents and Toxins

CDC regulates the possession and importation of dangerous agents and toxins in the United States. Requested funds are needed for CDC to regulate and inspect the 284 entities that possess select agents and toxins in the United States. CDC’s [Etiologic Agent Import Permit Program](#)³⁰⁵ regulates the importation of agents, hosts, and vectors that cause disease. In addition, CDC will continue to process more than 1,500 permits for the importation of infectious biological agents, infectious substances, and vectors of human disease into the United States annually.

BioSense 2.0

CDC’s [BioSense 2.0](#)³⁰⁶ is a secure, cloud-based, system for state and local public health departments and federal agencies to monitor all-hazards events using emergency department data. Users of the system watch for changes in potential health problems before they become widespread outbreaks. BioSense 2.0 provides additional value in allowing public health departments to meet the Centers for Medicare & Medicaid Services Meaningful Use requirements for [syndromic surveillance](#)³⁰⁷. CDC sought feedback from state and local health departments about system improvements and identified the capabilities needed in BioSense 2.0 during the 2010 system redesign. The intent of the redesign was to fill an identified void, not to compete with efforts already underway. Accordingly, there is no requirement for jurisdictions to dismantle existing systems to participate or continue to participate in the program.

In FY 2015, CDC will fund 34 state and local health departments through the BioSense 2.0 cooperative agreement. The grant improves local, state, regional, and national situational-awareness.

BioSense Grants

(dollars in millions)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	2015 +/-2014
Number of Awards	35	34	34	0
- New Awards	0	0	0	0
- Continuing Awards	35	34	34	0
Average Award	\$0.196	\$0.200	\$0.200	\$0.000
Range of Awards	\$0.100–\$0.275	\$0.100–\$0.300	\$0.100–\$0.300	N/A
Total Grant Awards	\$6.871	\$7.084	\$7.084	\$0.000

Beyond these 34 grantees, the BioSense 2.0’s [community of users](#)³⁰⁸ continues to grow. From 2012 to 2013, the number of data use agreements signed by state and local health departments as a commitment to provide emergency department data rose significantly. Consequently, increasing amounts of emergency department

³⁰⁵ <http://www.cdc.gov/od/eaipp/docs/overviewbrochure.pdf>

³⁰⁶ <http://www.cdc.gov/biosense>

³⁰⁷ <http://www.cdc.gov/ehrmeaningfuluse/Syndromic.html>

³⁰⁸ <https://sites.google.com/site/biosenseredesign/>

data are becoming available, giving decision-makers faster and more complete situational-awareness information about the public's health at local, state, regional, and national levels. CDC will also explore inclusion of additional data sources in BioSense 2.0, such as ambulatory care.

Strategic National Stockpile

(dollars in millions)

	FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
Budget Authority	\$493.150	\$550.817	\$542.817	-\$8.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The [Strategic National Stockpile](#)³⁰⁹ (SNS) manages and delivers life-saving medical countermeasures (MCMs) during a public health emergency. It is the largest federally owned repository of pharmaceuticals, critical medical supplies, [Federal Medical Stations \(FMS\)](#)³¹⁰, and medical equipment available for rapid delivery to support federal, state, and local response to health security threats. If a biological, chemical, or nuclear event happened tomorrow, the SNS is the only federal resource readily available to respond once local MCM supplies are depleted.

Strategic procurement and stockpiling of MCMs is necessary to protect American health and save lives. Some MCMs are not commercially available due to small supplies and limited use. Additionally, U.S. pharmaceutical supply chains run on a just-in-time model, often containing no more than a 30-day-supply of pharmaceuticals under normal conditions. As a result, products that are commercially available may not exist in necessary quantities or be positioned in ways that allow rapid distribution and use during emergencies.

CDC ensures SNS assets are available and ready for use by:

- Procuring, storing, maintaining, and replacing SNS MCM assets, valued in excess of \$5.9 billion
- Supporting the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) with subject matter expertise and data to inform strategic MCM requirements and procurement decisions
- Providing guidance, training, exercise support, and assistance to state and local partners who will receive and dispense SNS MCMs in an emergency response
- Establishing and strengthening public-private partnerships to integrate private resources into public health response plans for effective dispensing of SNS MCMs
- Fostering dialog and developing [guidance and tools](#)³¹¹ for the integration of healthcare partners into public health response planning

Recent SNS Response Efforts

Date	Response
August 2012	Deployed two, 250-bed FMS sets and 10 staff to Louisiana to support the response to Hurricane Isaac
October 2012	Deployed seven, 250-bed FMS sets and 26 staff to New York and New Jersey to support the response to Hurricane Sandy
November 2012	Deployed botulism treatment to California quarantine station to replenish supplies following botulism outbreak
January 2013	Deployed botulism treatment to Texas quarantine station to replenish supplies following botulism outbreak

³⁰⁹ <http://www.cdc.gov/phpr/stockpile/stockpile.htm>

³¹⁰ <http://blogs.cdc.gov/cdcworksforyou24-7/2012/11/up-and-running-in-48-hours-how-federal-medical-stations-help-people-after-natural-disasters-like-hurricane-sandy/>

³¹¹ <http://www.cdc.gov/phpr/healthcare/about.htm>

Budget Request

CDC's FY 2015 request of **\$542,817,000** for the SNS is \$8,000,000 below the FY 2014 Enacted level. This level will prioritize replacement of expiring items that rank the highest on formulary priorities, based on an annual review of the SNS and result in efficiencies from improved procurement. CDC works to continually improve our capability to deliver SNS assets to affected areas during public health emergencies. For example in 2013, CDC implemented an interagency agreement with the Defense Logistics Agency (DLA) for procurement support. This new partnership, formalized in July 2013, continues the trend of improving SNS cost efficiency through strategic procurement partnerships. Access to existing DLA contract pricing and its procurement system is expected to yield reduced procurement costs and has already decreased delivery times for MCM orders by 75%. CDC has always sought to maximize the effectiveness of resources and investments, and is even more focused on doing so in the current fiscal environment.

CDC collaborates with the PHEMCE to prioritize and adjust the SNS formulary based on current threats and funding. PHEMCE is responsible for defining and prioritizing requirements for public health emergency MCMs and establishing deployment and use strategies for SNS products. Furthermore, CDC is engaged with PHEMCE in maintaining a five-year budget plan that takes into consideration requirements and costs of SNS products through their entire lifecycle. CDC will coordinate with PHEMCE to prioritize and identify which expiring products need to be replaced to maintain current capabilities with available funding.

CDC will also set up formal [partnership agreements](#)³¹² with government, private, faith-based, and community-based organizations in FY 2015. These partnerships for MCM dispensing will enhance community resilience and business continuity efforts while strengthening CDC's capacity to support a public health response with efficient distribution channels.

In FY 2015, nearly 80% of requested funds will go toward purchasing and maintaining MCMs designed to help respond to and recover from public health events. The remaining 20% of this funding will support:

- Science and research activities
- Response operations
- Oversight functions
- Development and sustainment of state and local public health capabilities
- Activities to strengthen collaboration between public health and healthcare

CDC will continue to provide training and exercise support in FY 2015 to sustain and improve state and local capabilities critical to the effective dispensing of stockpiled MCMs. In FY 2013, SNS staff trained 1,415 individuals through 61 training opportunities and introduced new blended training offerings incorporating online learning components with hands on training to reduce costs and enhance flexibility. Similarly, SNS exercise staff supported 25 exercises at the federal, state, and local level, including 16 state level exercises utilizing SNS training material to exercise plans under realistic conditions providing hands on experience and evaluation of state and local capabilities and partnerships for MCM dispensing.

SNS activities and goals for FY 2015

Activities	Goals
Procure, store, maintain, and replace MCMs	<ul style="list-style-type: none"> - Complete modernization of SNS inventory management system and evaluate effectiveness and improvements of new capabilities - Execute prioritized procurement plan to maintain critical SNS MCM capabilities

³¹² http://www.cdc.gov/phpr/partnerships/story_closedPODs.htm

Activities	Goals
Support PHEMCE	<ul style="list-style-type: none"> - Improve inventory modeling and projections to support better and faster decisions - Deliver an annual report to PHEMCE on the status of SNS materiel to ensure tracking of identified priorities
Provide guidance, training, exercise support, and assistance	<ul style="list-style-type: none"> - Train more than 1,000 individuals at the state and local level to support distribution and dispensing of SNS assets - Provide effective and thorough evaluation of state and local capabilities to receive and utilize SNS assets
Public / private partnerships	<ul style="list-style-type: none"> - Establish new partnerships with private sector partners, and move current partners into pilot and planning phases for nationwide participation
Public health / healthcare collaboration	<ul style="list-style-type: none"> - Host 2 new engagements to identify locality and sector specific challenges - Publish new tools or guidance for planning and integration of healthcare resources and requirements in a response

State Table: Public Health Emergency Preparedness (PHEP) Program Funding³¹³

	FY 2013 Final¹	FY 2014 Enacted²	FY 2015 President Budget³	Difference +/-2014
Alabama	\$8,609,718	\$9,051,891	\$8,542,262	-\$509,629
Alaska	\$3,987,619	\$4,256,787	\$4,036,532	-\$220,255
Arizona	\$11,209,189	\$11,720,782	\$11,118,980	-\$601,802
Arkansas	\$6,43,717	\$6,706,614	\$6,397,565	-\$309,049
California	\$39,704,132	\$41,852,852	\$39,316,946	-\$2,535,906
Colorado	\$9,259,900	\$9,684,857	\$9,188,925	-\$495,932
Connecticut	\$7,519,140	\$7,813,206	\$7,468,700	-\$344,506
Delaware	\$4,309,494	\$4,382,862	\$4,296,822	-\$86,040
Florida	\$27,466,901	\$29,026,658	\$27,201,564	-\$1,825,094
Georgia	\$15,155,658	\$15,963,275	\$15,018,939	-\$944,336
Hawaii	\$4,763,065	\$4,870,129	\$4,743,868	-\$126,261
Idaho	\$4,904,757	\$5,042,450	\$4,882,634	-\$159,816
Illinois	\$16,171,811	\$16,984,571	\$16,028,779	-\$955,792
Indiana	\$10,943,177	\$11,505,398	\$10,851,673	-\$653,725
Iowa	\$6,587,966	\$6,887,483	\$6,544,974	-\$342,509
Kansas	\$6,558,282	\$6,798,579	\$6,518,017	-\$280,562
Kentucky	\$8,206,827	\$8,595,416	\$8,145,587	-\$449,829
Louisiana	\$8,557,781	\$8,950,422	\$8,493,803	-\$456,619
Maine	\$4,646,029	\$4,778,228	\$4,627,282	-\$150,946
Maryland	\$10,764,852	\$11,187,492	\$10,683,372	-\$504,120
Massachusetts	\$12,467,088	\$12,979,630	\$12,374,683	-\$604,947
Michigan	\$16,056,680	\$16,912,692	\$15,917,196	-\$995,496
Minnesota	\$10,710,499	\$11,142,898	\$10,635,647	-\$507,251
Mississippi	\$6,530,372	\$6,818,608	\$6,488,495	-\$330,113
Missouri	\$10,527,224	\$11,025,077	\$10,442,704	-\$582,373
Montana	\$4,269,302	\$4,367,769	\$4,255,339	-\$112,430
Nebraska	\$5,225,461	\$5,385,174	\$5,199,687	-\$185,487
Nevada	\$6,515,662	\$6,726,462	\$6,477,550	-\$248,912
New Hampshire	\$4,743,037	\$4,861,625	\$4,724,458	-\$137,167
New Jersey	\$14,993,348	\$15,636,993	\$14,869,271	-\$767,722
New Mexico	\$6,494,648	\$6,673,229	\$6,465,587	-\$207,642
New York	\$18,687,686	\$19,618,462	\$18,529,583	-\$1,088,879
North Carolina	\$14,008,193	\$14,910,965	\$13,873,622	-\$1,037,343
North Dakota	\$3,987,619	\$4,256,787	\$4,036,532	-\$220,255
Ohio	\$17,281,814	\$18,265,400	\$17,119,004	-\$1,146,396
Oklahoma	\$7,499,619	\$7,835,737	\$7,446,677	-\$389,060
Oregon	\$7,729,601	\$8,057,715	\$7,675,535	-\$382,180
Pennsylvania	\$18,810,406	\$19,883,780	\$18,631,142	-\$1,252,638
Rhode Island	\$4,447,206	\$4,520,693	\$4,432,352	-\$88,341
South Carolina	\$9,289,583	\$9,720,387	\$9,224,307	-\$496,080
South Dakota	\$4,074,534	\$4,256,787	\$4,063,044	-\$193,743
Tennessee	\$10,742,988	\$11,296,820	\$10,653,428	-\$643,392
Texas	\$34,758,426	\$36,831,382	\$34,403,556	-\$2,427,826
Utah	\$6,368,151	\$6,609,822	\$6,329,145	-\$280,677
Vermont	\$3,987,619	\$4,256,787	\$4,036,532	-\$220,255
Virginia	\$14,188,481	\$14,820,503	\$14,075,565	-\$744,938
Washington	\$11,495,351	\$12,049,443	\$11,400,450	-\$648,993
West Virginia	\$5,243,236	\$5,426,058	\$5,217,085	-\$208,973

³¹³CFDA NUMBER(s): 93-069 [Discretionary]

	FY 2013 Final¹	FY 2014 Enacted²	FY 2015 President Budget³	Difference +/-2014
Wisconsin	\$11,128,783	\$11,639,872	\$11,048,524	-\$591,348
Wyoming	\$3,987,619	\$4,256,787	\$4,036,532	-\$220,255
Cities/Counties				
Chicago	\$9,577,708	\$9,854,475	\$9,541,804	-\$312,671
Los Angeles County	\$19,078,070	\$20,086,182	\$18,947,292	-\$1,138,890
New York City	\$17,840,704	\$18,680,075	\$17,731,816	-\$948,259
Washington, D.C.	\$6,277,908	\$6,337,792	\$6,269,416	-\$68,376
Territories				
American Samoa	\$373,838	\$380,448	\$372,899	-\$7,549
Guam	\$501,025	\$519,025	\$498,473	-\$20,552
Marshall Islands	\$373,200	\$379,754	\$372,271	-\$7,483
Micronesia	\$419,098	\$429,762	\$417,586	-\$12,176
Northern Marianas	\$353,703	\$358,511	\$353,021	-\$5,490
Palau	\$323,206	\$325,284	\$322,912	-\$2,372
Puerto Rico	\$7,141,090	\$7,511,883	\$7,088,510	-\$423,373
Virgin Islands	\$421,983	\$432,906	\$420,435	-\$12,471
Subtotal, States	\$522,011,251	\$547,104,296	\$518,190,456	-\$28,913,840
Subtotal, Cities/Counties	\$52,774,390	\$54,958,524	\$52,490,328	-\$2,468,196
Subtotal, Territories	\$9,937,143	\$10,337,573	\$9,846,107	-\$491,466
Total	\$584,696,784	\$612,400,393	\$580,526,891	-\$31,873,502

For additional information (data available through FY 2013): <http://wwwn.cdc.gov/fundingprofiles/fundingprofilesria/>

¹This state table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees).

²Individual grantee funding levels may change depending on programmatic decisions made when calculating funding for the Cities Readiness Initiative, LRN-C Level 1 funding, and other programs funded through the PHEP cooperative agreement. FY 2014 awards are estimates until final calculations are complete.

³FY 2015 estimates are based on current anticipated funding. Recalculations may be necessary based on additional strategy planning for FY 2015.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

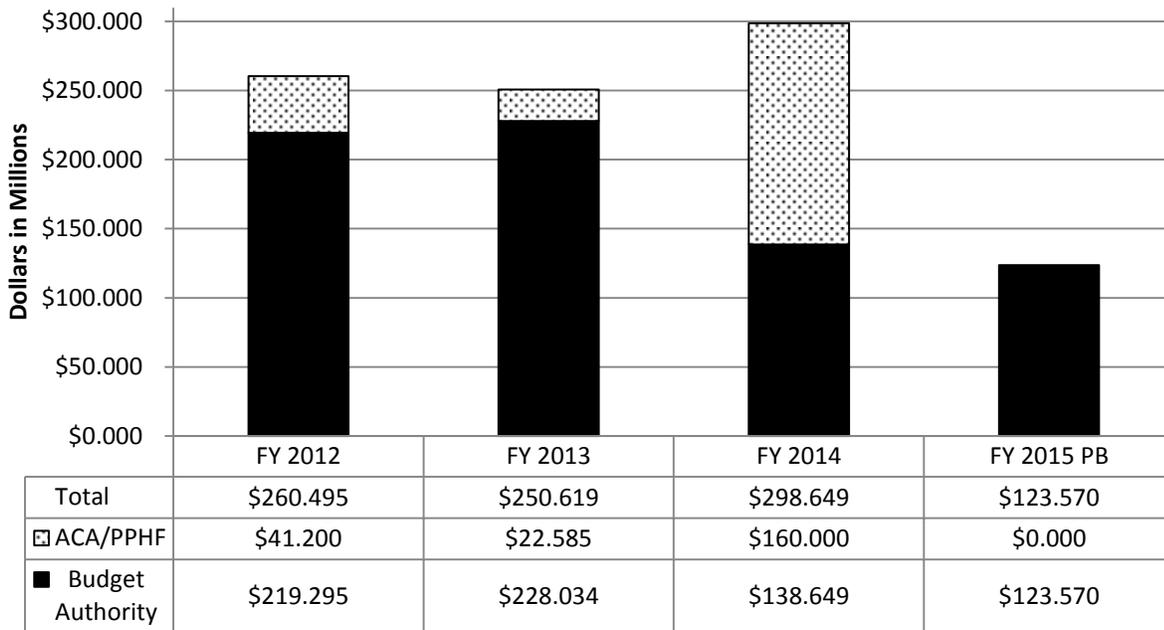
(dollars in millions)		FY 2013 Final ¹	FY 2014 Enacted	FY 2015 President Budget	2015 +/-2014
	Budget Authority	\$228.034	\$138.649	\$123.570	-\$15.079
	ACA/PPHF	\$22.585	\$160.000	\$0.000	-\$160.000
	Total Request	\$250.619	\$298.649	\$123.570	-\$175.079
	FTEs	2,260	2,260	2,260	0
CDC-Wide					
	- Buildings and Facilities	\$23.648	\$24.000	\$10.000	-\$14.000
	- Public Health Leadership and Support	\$113.603	\$114.649	\$113.570	-\$1.079
	- Preventive Health Block Grant Program	\$75.406	\$160.000	\$0.000	-\$160.000
	ACA/PPHF (non-add)	\$0.000	\$160.000	\$0.000	-\$160.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Summary

CDC's FY 2015 request of **\$123,570,000** for CDC-Wide Activities and Program Support is \$175,079,000 below the FY 2014 Enacted level. This request continues the FY 2014 proposed elimination of Preventive Health and Health Services Block Grant. These remaining activities support a range of mission-critical activities and programs across CDC.

Figure: CDC-Wide Funding History¹



¹ FY 2012 and FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Buildings and Facilities Budget Request

(dollars in millions)	FY 2013	FY 2014	FY 2015	
	Final ¹	Enacted	President Budget	2015 +/-2014
Budget Authority	\$23.684	\$24.000	\$10.000	-\$14.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

CDC established the buildings and facilities (B&F) program over 20 years ago to replace, sustain, improve, and repair existing facilities and to construct new facilities to meet CDC’s mission. The principal B&F activity is mission support, serving approximately 15,000 CDC staff—FTE and non-FTE—who occupy CDC-controlled space around the world.

Budget Request

CDC’s FY 2015 request of **\$10,000,000** for Buildings and Facilities is \$14,000,000 below the FY 2014 Enacted level. This request will support and sustain critical repairs and improvements (R&I) to ensure continued condition improvement through new budgetary resources, and carryover funds. CDC will also use these funds for long-term capital projects. As many non-Atlanta campuses are approaching a half century or more in age, specifically the National Institute for Occupational Safety and Health (NIOSH) Cincinnati research campus, R&I and capital needs are expected to increase. This request is sufficient to maintain CDC's portfolio Condition Index at 90 or higher for laboratory, laboratory support, and critical infrastructure assets, and fund additional, mission critical R&I projects.

CDC regularly updates its Sustainable Design and High Performance Building Guidelines to reflect changes in federal, state, and local requirements and statutes; changes in technology or industry standards; and adjustments to CDC goals and priorities. Potential projects generated by building assessments are incorporated into the annual facilities business plans. CDC also conducts an analysis of potential on-site renewable energy systems and incorporation of innovative building strategies as part of the existing building assessments. CDC continues to meet or exceed the energy conservation, water conservation, and sustainable practices performance targets. CDC’s building inventory currently includes five U.S. Green Building Council (USGBC) “Leadership in Energy and Environmental Design” (LEED) certified projects. An additional two projects are registered for certification but are not certified at this time.

In 2015, CDC will continue to focus on sustainability with all facilities design, construction, and maintenance. CDC will make a number of upgrades and changes to operations in the coming year that reflect best practices in environmental responsibility. CDC also plans to upgrade several facilities with the goal of lowering energy consumption and costs using:

- HVAC and related systems, at campuses nationwide, and
- Cooling roof coatings for several buildings to ensure better insulation

CDC’s internal Capital Investment Review Board, comprised on CDC leaders across the organization, meets quarterly to assess the most current R&I project list. Currently, CDC has more than \$35,000,000 in pending projects, many of which can be supported with the FY 2015 request and carryover balances.

The project categories are:

Category	Definition
Emergency	An area of contingency planning that supports items that may fall into other categories but may not have been identified previously due to urgent and critical nature of an event, crisis, etc.
Fire & Life Safety	Engineering projects that improve or sustain Safety, Fire & Life Safety Code compliance through repairs and improvements.
Security	Projects that improve or sustain the condition and functionality of physical and IT security features of an asset. This category includes automated control systems that currently reside within the IT security architecture.
Condition Index	The Federal Real Property Council asset performance metric "Condition Index," which is a well-known and widely used general measure of a constructed asset's condition at a specific point in time. CI is the ratio of the asset's repair needs to its Functional Replacement Value. R&I projects are prioritized to maintain an asset's CI.
Program Support	Customer-driven projects that support specific mission-related activities to sustain or improve scientific and research support systems and activities, installation of scientific equipment, reasonable accommodations requests, and similar activities.
Space Utilization	Initiatives undertaken to increase space utilization of an asset and promote efficiency of use. Examples include: building demolition/disposal, special studies, space alterations that promote increased utilization, alterations necessary for hoteling/teleworking, etc.
Other	Specific activities that support the Buildings and Facilities Program, such as strategic and campus-level planning, project development studies, building evaluation reports, facilities-related National Environmental Policy Act and Historic Preservation Act compliance, and similar projects.

Repairs and Improvements Projects

Project Category	FY 2013 (# and estimated cost) ¹	FY 2014 (# and estimated cost)	FY 2015 (# and estimated cost)
Emergency	1 project; \$1,000,000	1 project; 1,000,000	1 project; \$1,000,000
Fire & Life Safety	23 projects; \$3,578,865	23 projects; \$7,103,146	2 projects; \$2,000,000
Security	7 project; \$1,297,000	5 projects; \$1,150,000	1 project; \$100,000
Condition Index	70 projects; \$20,934,438	85 projects; \$14,960,627	48 projects; \$22,582,920
Program Support	10 projects; \$862,000	22 projects; \$2,562,500	7 projects; \$7,000,000
Space Utilization	15 projects; \$1,573,500	1 project; \$1,891,903	N/A
Other	1 project; \$500,000	13 projects; \$4,645,000	5 projects; \$2,650,000
Total	127 projects; \$29,745,803	150 projects; \$33,313,176	64 projects; \$35,332,920

¹Data reflect full 2013 fiscal year funding and costs associated with a project are only accounted for in one year on the table.

Federal Real Property Council Performance Metrics

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	Impact	Explanation
Mission Dependency		
Mission Dependency	Positive	R&I funds are used for mission-critical and mission-dependent facilities in accordance with CDC's Condition Index (CI) Sustainment strategy. Repair funds are used to sustain buildings in an operational status. Improvement funds are used to modify space to bring it into compliance with current codes and reduce over-utilized space.
Facility Utilization		
Utilization Status	Positive	R&I funds are used for laboratories and other critical facilities in accordance with CDC's asset business plans.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition allowing their continued effective designated use and to improve an asset's functionality or efficiency, thus maintaining or improving the utilization of the asset.
Facility Condition	Neutral	R&I funding supports CDC's sustainment and improvement strategy to maintain a portfolio CI of 90 or better.
Sustainment and Improvement Strategy	Neutral	A strategy of capital replacement of non-performing assets with R&I funding at appropriate levels and prioritization of critical assets and projects will allow CDC to achieve a portfolio-wide CI of 90 over the 2010–2020 planning horizon.
Facility Cost		
Operations and Management (O&M) Cost	Neutral	CDC anticipates an unquantified impact on O&M costs resulting from appropriate R&I funding. Appropriate R&I appropriations and the Working Capital Fund ensure plants and equipment are operated and maintained in accordance with manufacturers' warranties and will maximize energy and operating efficiencies.

NIOSH Facilities

CDC completed the planning phase, including program requirements and a project development study, for consolidating the NIOSH Cincinnati Research Facilities (Taft, Taft North, and Hamilton buildings) into one central location with the intent of purchasing new property. NIOSH Cincinnati is currently located on two campuses, eight miles apart. These facilities are 60 years old and have significant deficiencies in both space configuration and the condition of building systems. A new, central location will reduce recurring costs associated with operating two separate campuses. CDC is conducting environmental condition and impact analyses and engineering and interior layout evaluations of potential buildings/properties, in addition to developing cost estimates for design/renovation of potential buildings in case a new location is not cost effective.

Mine safety research at the Lake Lynn site has not been conducted since 2008 when the roof collapsed. Mine safety research including underground research, tunnel safety, and mine rescue is conducted at other facilities in the United States. These locations also serve as training and research resources for federal and state agencies. This budget request redirects existing resources, intended for a new mine safety research center, to support other CDC facility requirements.

Federal Real Property Council Performance Metrics

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	Impact	Explanation
Mission Dependency		
Mission Dependency	Positive	R&I funds are used for mission-critical and mission-dependent facilities in accordance with CDC's Condition Index (CI) Sustainment strategy. Repair funds are used to sustain buildings in an operational status. Improvement funds are used to modify space to bring it into compliance with current codes and reduce over-utilized space.
Facility Utilization		
Utilization Status	Positive	R&I funds are used for laboratories and other critical facilities in accordance with CDC's asset business plans.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition allowing their continued effective designated use and to improve an asset's functionality or efficiency, thus maintaining or improving the utilization of the asset.
Facility Condition	Neutral	R&I funding supports CDC's sustainment and improvement strategy to maintain a portfolio CI of 90 or better.
Sustainment and Improvement Strategy	Neutral	A strategy of capital replacement of non-performing assets with R&I funding at appropriate levels and prioritization of critical assets and projects will allow CDC to achieve a portfolio-wide CI of 90 over the 2010–2020 planning horizon.
Facility Cost		
Operations and Management (O&M) Cost	Neutral	CDC anticipates a positive, but unquantified impact on O&M costs resulting from appropriate R&I funding. Appropriate R&I appropriations and the Working Capital Fund ensure plants and equipment are operated and maintained in accordance with manufacturers' warranties and will maximize energy and operating efficiencies.

Public Health Leadership and Support

(dollars in millions)	FY 2015			
	FY 2013 Final ¹	FY 2014 Enacted	President Budget	2015 +/-2014
Budget Authority	\$113.603	\$114.649	\$113.570	-\$1.079

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Overview

The Public Health Leadership and Support line funds CDC’s Office of the Director, urgent and emergent public health response activities, and offices that provide agency-wide support and leadership. These funds are essential to CDC's ability to manage with efficiency, transparency, and accountability. In addition to day-to-day agency management, these funds are used to provide technical support health organizations and officials in the field. Some offices providing agency-wide support are also partially or fully funded by the Public Health Scientific Services budget.

Budget Request

CDC’s FY 2015 request of **\$113,570,000** for public health leadership and support represents a decrease of \$1,079,000 below the FY 2014 Enacted level. CDC will reduce administrative costs to account for the decrease. Some activities described below are partially or fully funded by public health scientific services (PHSS).

Office for State, Tribal, Local and Territorial Support (OSTLTS)

CDC's Office for State, Tribal, Local and Territorial Support will improve the capacity and performance of state, tribal, local, and territorial public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public’s health. This includes, but is not limited to:

- Increasing the percentage of nationally accredited state, tribal, local, and territorial public health agencies
- Increasing the percentage of health departments that implement performance-improvement initiatives to achieve greater efficiency and effectiveness of population-based programs and services

CDC works with internal and external stakeholders such as health departments and national public health organizations to identify and implement improvements in services and support to the field, and to identify and address barriers in the public health system for which CDC can contribute to a solution. CDC’s OSTLTS also facilitates cross-cutting activities to collaborate with health officials in the field to inform CDC's public health activities, conduct joint problem-solving, and facilitate decision-making. CDC will identify and implement ways that can increase and improve its services and support to improve public health at all levels.

The National Public Health Improvement Initiative, which will be eliminated in FY14 due to no Congressional FY 2014 funding, was the primary federal funding source for a cooperative agreement program to directly support health departments in achieving national public health accreditation by the Public Health Accreditation Board (PHAB). In FY13, CDC invested approximately \$36.65M in health departments, national organizations to provide capacity building assistance, and PHAB; in FY14, the investment dropped to approximately \$2.27M, which will be used to maintain CDC’s support for the PHAB accreditation program as well as limited CDC support for national organizations that provide technical assistance and resources to health departments for accreditation readiness and performance improvement.

Without a coordinated national initiative founded on the provision of technical and financial assistance, the number of health departments achieving accreditation is expected to slow over time after those currently in the queue are accredited, as some health departments postpone or are not able to apply for accreditation due to

lack of resources or the inability to meet national standards. In addition, grantee health departments may not be able to maintain their Performance Improvement Managers, who comprised a unique national network of 73 subject matter experts focused on improving the effectiveness and efficiency of all public health investments in their health departments and coordinating accreditation efforts. Examples of initiative achievements as of February 2014 are provided in the performance narrative. Final results will be available after the end of the current project period, which is September 2014.

Office of the Director

Funds requested in FY 2015 will support CDC's efforts to provide efficient, transparent, and accountable public health leadership to the nation. At CDC, this is accomplished through several offices that provide leadership and services agency-wide.

Office of the Chief of Staff

The Office of the Chief of Staff provides support to the Director and also manages all executive secretariat functions across CDC, such as:

- Controlled correspondence
- Review/clearance of non-scientific documents
- Government Accountability Office engagements and recommendations
- Office of Inspector General engagements and recommendations
- HHS/Immediate Office of the Secretary Liaison
- Records management

Communications Office

The Communications Office provides support to all CDC programs to provide accessible, accurate, relevant, and timely health information and interventions to protect and promote the health of individuals, families, and communities. Examples of communication activities:

Activities	Examples
Develop and produce communication materials	Produce broadcast, audio, and video material; writer-editor services; multi-lingual services; audio and video public service announcements, and related content
Ensure media accuracy	Review CDC data, research, guidelines, and actions presented through various media channels
Manage new media	Manage CDC's internet, intranet, Twitter, Facebook, and other social media sites
Consult with CDC programs	Develop strategies to help CDC employees communicate more effectively with partners and the public.
Manage CDC's national toll-free contact center	Provide timely, accurate, and consistent science-based information on a variety of disease prevention and health promotion topics

Policy Office

The Policy Office advises CDC leadership, and provides agency-wide support to:

- Build relationships with external organizations to advance public health agendas, with a special emphasis on state and local health agencies
- Develop and implement the National Prevention Strategy
- Monitor public health implications at federal, state, and local levels and disseminate key information inside and outside CDC

Science Office

The Science Office provides leadership in advancing the quality and integrity of CDC science, and provides agency-wide leadership on scientific and medical matters. The Science office will:

- Develop policies related to intramural and extramural research to ensure CDC science activities and staff maintain the highest standards of scientific integrity and ethics
- Provide oversight of scientific clearance of CDC publications and promote best practices in external peer review
- Promote and strengthen common scientific culture for enhanced information exchange internally and externally including activities such as:
 - [Public Health Grand Rounds](#)³¹⁴
 - [Vital Signs](#)³¹⁵
 - [CDC Science Clips](#)³¹⁶

Office of Minority Health and Health Equity

The Office of Minority Health and Health Equity, includes the Office of Women’s Health and the Diversity Management Program, provides leadership for CDC-wide policies, strategies, planning and evaluation to eliminate health disparities. This Office will:

- Monitor and report on the health status of vulnerable populations and the effectiveness of health protection programs
- Provide decision support to CDC executives in allocating resources to programs of surveillance, research, intervention, and evaluation
- Coordinate CDC’s response to White House Executive Orders and HHS health disparity initiatives.
- Initiate strategic partnerships with governmental, non-governmental, national, and regional organizations
- Provide guidance and oversight to the agency-wide implementation of the CDC Diversity Plan

Office of Equal Employment Opportunity

The Office of Equal Employment Opportunity provides agency leadership on all matters related to equal employment opportunity (EEO), alternative dispute resolution, and reasonable accommodations. This office will:

- Provide oversight for complaints processing, adjudication Section processes and adjudication of EEO complaints

³¹⁴ <http://www.cdc.gov/about/grand-rounds/>

³¹⁵ <http://www.cdc.gov/vitalsigns/>

³¹⁶ <http://www.cdc.gov/phlic/sciclips/>

- Ensure alternative dispute resolution is available to all CDC and ATSDR employees for the purpose of resolving conflict or disputes informally and confidentially
- Establish and maintain a work environment in which persons with disabilities receive full and fair consideration for any job for which they apply
- Provide reasonable accommodation to employees with disabilities in order to perform their essential job functions

Office of Infectious Diseases

The Office of Infectious Diseases (OID) provides agency-wide leadership to promote and facilitate science, programs, and policies to reduce the burden of infectious diseases in the United States and globally. OID includes the office of the Deputy Director for Infectious Diseases and, as a stand-alone unit, the Influenza Coordination Unit. OID works to:

- Provide strategic leadership to and enhance coordination among CDC's three infectious disease national centers
- Work with internal and external partners to advance infectious disease prevention programs and priorities
- Provide national and global leadership and expertise in preventing and controlling infectious diseases by developing a strong foundation for advancing public health research
- Build capacity with partners throughout the world to protect Americans at home and abroad

Office of Noncommunicable Diseases, Injury and Environmental Health

The Office of Noncommunicable Diseases, Injury and Environmental Health provides agency-wide strategic direction and leadership for the prevention of noncommunicable diseases, injury, disabilities, and environmental health hazards in the United States and globally. This office works to:

- Enhance collaboration and innovation across noncommunicable diseases, injury prevention, disabilities and environmental health
- Promote and support the prevention of noncommunicable diseases, injury, disabilities, and environmental health-related science, policies and programs
- Identify, facilitate, and promote collaboration, innovation, and new initiatives related to the prevention of noncommunicable diseases, injury, disability, and environmental health

CDC Washington Office

The CDC Washington Office provides advice and support to the CDC Director and CDC programs on legislative and policy issues. The Office:

- Builds Congressional relations, including notifying Congress of breaking public health developments and providing technical reviews as requested by Congress on public health policy and legislative initiatives
- Tracks and analyzes legislation impacting CDC programs and coordinates preparation of CDC testimony and witnesses for hearings
- Builds relations with government agencies and other organizations to advance policy agendas, with an emphasis on federal agencies

Office of the Chief Operating Officer

Appropriations, Legislation, and Formulation Office

The Appropriations, Legislation, and Formulation Office, prepares CDC's budget in accordance with the Department of Health and Human Services (HHS), Office of Management and Budget (OMB), and Congressional requirements. This office provides broad support to the agency, including:

- Providing oversight, direction, and guidance for all aspects of CDC's budget formulation processes
- Coordinating development and implementation of long-term budget plans and strategies
- Developing materials for, and participating in, budget reviews and hearings before HHS, OMB, and Congress
- Representing the agency before HHS, OMB, and Congress regarding budgetary policy and appropriations issues and requirements

Affordable Care Act Prevention and Public Health Fund

(dollars in millions)	ACA/PPHF	FY 2013	FY 2014	FY 2015	2015
		Final ¹	Enacted	President Budget	+/-2014
		\$0.000	\$160.000	\$0.000	-\$160.000

¹ FY 2013 levels have been made comparable to FY 2014 Enacted to reflect the permanent realignment of the BSS budget line.

Preventive Health and Health Services Block Grant

The FY 2015 budget request continues the elimination of the Preventive Health and Health Services Block Grant (PHHSBG) program which was proposed in FY 2014.

These activities may be more effectively and efficiently implemented through the State [Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health](#)³¹⁷ program which provides resources to states to coordinate activities across categorical funding streams, as well as Affordable Care Act Prevention and Public Health Fund investments. Elimination of this program provides an opportunity to find savings, while enhancing functionality for core chronic diseases. When the PHHSBG was first authorized in 1981, there were minimal resources within CDC’s budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity, and many states did not receive funding from CDC to support prevention of chronic disease. However, since 1981, categorical programs at CDC have grown to over \$1 billion annually and the PHHSBG now represents a much smaller percentage of state budgets when compared to total available CDC funding.

³¹⁷ <http://www.cdc.gov/chronicdisease/about/statepubhealthactions-prevcd.htm>

WORKING CAPITAL FUND

In the FY 2012 appropriation bill for Labor, Health and Human Services, Education and Related Agencies (LHHS), Congress authorized CDC to establish a Working Capital Fund to achieve greater efficiency and transparency in support of agency-wide business services. The Working Capital Fund is a revolving fund with extended availability and serves as the sole funding mechanism for centralized business services support across CDC. Services rendered under the Working Capital Fund are performed at pre-established rates to cover the full cost of business operations and investments (i.e., capital expenses). In the FY 2013 LHHS appropriation bill, Congress authorized CDC to transfer amounts appropriated for business services for fiscal year 2013 to the Working Capital Fund to facilitate implementation.

Appropriations Language and Citations

Provided further, that CDC may establish a Working Capital Fund, with the authorities equivalent to those provided in 42 U.S.C. § 231, to improve the provision of supplies and service. (Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2012).

To facilitate the implementation of the Working Capital Fund (“WCF”) authorized in Public Law 112–74, on or after October 1, 2013, unobligated balances of amounts appropriated for business services for fiscal year 2013 shall be transferred to the WCF: Provided, That on or after October 1, 2013, the CDC shall transfer other amounts available for business services to other CDC appropriations consistent with the benefit each appropriation received from the business services appropriation in fiscal year 2013: Provided further, That assets purchased with funds appropriated for or reimbursed to business services in this or any other Act may be transferred to the WCF and customers billed for depreciation of those assets: Provided further, That CDC shall, consistent with the authorities provided in 42 U.S.C. § 231, ensure that the WCF is used only for administrative support services and not for programmatic activity funding: Provided further, That CDC shall notify the Committees on Appropriations of the House of Representatives and the Senate not later than 15 days prior to any transfer made under the authority provided in this section. (Consolidated and Further Continuing Appropriations Act, 2013).

Overview

In a WCF environment, business service offices (BSOs) provide services to CDC programs. The WCF bills programs for the services consumed based on pre-established rates. Prior to the WCF, CDC received a direct appropriation for Business Services Support (BSS).

FY 2015 WCF Operating Budget

The WCF Governance Board, described below, approves the annual operating budget for the WCF. If there are unforeseen requirements (e.g., Department mandates) that require additional support, the Board will make recommendations on how to fund these requirements during the fiscal year.

The WCF operational budget includes the following:

- Service line operational budgets
- Restricted reserves; and
- Unrestricted reserves.

The WCF reserves are not constrained by the fiscal year cycle. Restricted reserves include amounts that will be used for capital IT infrastructure investments and accrued annual leave, while unrestricted reserves can be used to offset any unforeseen, one-time cost during the fiscal year. The Board will determine a target between two and four percent of WCF annual operating revenue to collect for the unrestricted reserves.

During calendar year 2014 the WCF board will approve the final operating budget for FY 2015. The FY 2014 operating budget was \$512 million. Details are provided in the supporting information appendix of this justification. The planned budget does not fully fund the Rent, Utilities, Operations and Maintenance service line in FY 2014. The Board may decide to use the reserve to cover this gap or carry forward the balance into the future fiscal year. In future years, CDC will have the operational data needed to report additional detail as requested.

FY 2014 and FY 2015 WCF Estimates¹

	FY 2014 Estimate ²	FY 2015 Estimate
CDC Budget Authority	\$405,756,798	\$405,756,798
CDC Other Sources	\$92,594,360	\$92,594,360
Agency for Toxic Substances and Disease Registry (ATSDR)	\$10,262,394	\$10,262,394
Energy Employees Occupational Illness Compensation Program Act	\$3,133,670	\$3,133,670
Health Reform - Prevention and Public Health Fund (PPHF)	\$20,262,996	\$20,262,996
Intra-Departmental Delegations of Authority (IDDA) Total	\$36,306,765	\$36,306,765
PEPFAR	\$33,999,000	\$33,999,000
Other IDDA's	\$2,307,765	\$2,307,765
Vaccines for Children	\$22,628,535	\$22,628,535
IAA Revenue	\$13,852,021	\$13,852,021
Grand Total	\$512,203,179	\$512,203,179

¹FY 2014 estimates are based on FY 2013 consumption

²World Trade Center Health Program will begin contributions to the CDC Working Capital fund in FY 2015, estimates are not available at this time

Objectives

Objectives of the WCF include:

- Achieve greater transparency and viability of business services support by establishing a standard process for developing and reviewing rates and reporting on the actual costs of services. WCF rates are intended to reflect the total cost of service provision, which promotes full cost recovery for each service within the Fund. CDC’s WCF will be included as part of HHS’ annual CFO audit.
- Allow CDC Center directors, as the majority-voting members on the Board, to determine the scope of WCF services, associated rates, and service levels. Establishing a governance structure that allows customers to have direct representation on the Board fosters a decision-making process that incorporates customer input and closely aligns to customer needs. Board members bear the ultimate responsibility of presiding over the WCF operating budget.
- Increase awareness and accountability for usage of business services resulting in a strong financial incentive for Centers. Providing customers with visibility into their consumption promotes more efficient use of program funding.
- Effectively plan for and finance long-term capital investments. As the WCF structure allows for the accumulation of funds for future capital investments, the WCF will finance mission-critical investments and improvements over time. This will impact changes in funding levels.
- Improve the effectiveness of CDC’s business services by establishing WCF and service-specific performance measures and goals. Establishing performance measures and goals for the WCF and within service lines will allow customers and service providers to evaluate how well services are meeting the needs of the agency and identify opportunities for improvement. Aligning these performance goals with the strategic goals of the agency will show how WCF activities are contributing to the achievement of agency goals as well.

Governance Structure

The WCF Governance Board provides a structured and effective governance process for all aspects of the budgeting for the WCF. The Board will ensure senior level engagement and oversight and promote transparency. In accordance with FY 2012 conference report language, CDC Center directors serve as the majority of voting members on the WCF Governance Board and will preside over the Fund’s operations.

The Board determines the scope and level of services to be included in the WCF, and related prices and rates, aligning business services support with the programs they support. The Board approves key fund design decisions and approves any IT capital investments that support WCF service provision.

Scope

WCF encompasses a portfolio of business services in the following major categories:

Categories	Services
Human Resources	Services include developing and managing the recruitment, hiring, and selection of CDC employees and contractors. Additional services include the management of CDC’s human resources program and policies. Prior to FY 2014, these services were funded by the PHLs direct appropriation.
Safety, Security and Asset Management Services	Safety and Security services include providing global and physical security to CDC employees located at headquarters, employees travelling overseas, employees assigned overseas, and foreign visitors to CDC campuses. Additional services include developing policy and training for the Agency staff on occupational safety, lab safety, and hazardous waste disposal. Asset Management services include conducting real property and space management activities; operating and maintaining CDC’s facilities; and managing operating and capital leases, utilities, operation and maintenance contracts, and the administrative costs of the Office of Safety, Security, and Asset Management. Additional services include developing CDC policy and procedures for logistics management, including accountable property, supplies, transportation, and shipping. Repairs and improvements and buildings and facilities capital projects are not included in the WCF service portfolio and will continue to be funded from the Buildings and Facilities budget line.
Financial Management and Oversight Services	Services include the administration of CDC’s budget and related financial and accounting functions to ensure compliance with regulatory and legislative requirements and providing leadership, guidance, and advice on operational budget and financial matters. Travel related audit and payment services are also included in this category. Activities provided are coordinated with HHS, OMB, and Congress.
IT Services, Support, and Infrastructure	Services include maintenance of personal computing hardware and software; customer service support; administration of mainframe, infrastructure software, application, and server hosting; and oversight of networking and IT security.
Procurement and Grants Services	Services include the management and coordination of CDC acquisition, assistance, and management activities; and the coordination and administration of contracts, purchase orders, grants, and cooperative agreements.
Management Analysis Support Services	Services include agency policy development, management, and consultation activities; management of the internal controls program; and management of federal advisory committee activities. Additional compliance services include monitoring and oversight of agency and program measures in the area of sustainability.

Categories	Services
Centralized Administrative Services	Services encompass administrative services provided in support of CDC programs that are not aligned to specific service providers including Department mandates.

Internal Controls

The OMB Circular A-123 and GAO Standards for Internal Controls in the Federal Government define the framework for internal controls in the federal government. The WCF internal control assessment process details activities to be performed by various stakeholders to ensure potential risks are identified, monitored, and mediated throughout the process. The WCF internal control assessment process aligns with CDC’s internal controls program and is designed to help the WCF meet the following internal controls objectives:

- Effectiveness of WCF operations;
- Reliability of financial reporting; and
- Compliance with applicable laws and regulations.

CDC will monitor operational and financial performance of the WCF. In addition to operational reporting, the WCF will produce reports that focus on the Fund’s financial status and activities will also be included as part of CDC financial statements. In accordance with the CFO Act, WCF financial performance will be audited on an annual basis as part of HHS’ CFO audit. Financial metrics will serve as key inputs into the evaluation of efficiency of WCF operations.

Retained Earnings

The WCF will maintain a balance of retained earnings that is not constrained by the fiscal year cycle. Retained earnings in the Fund are comprised of restricted and unrestricted retained earnings. The target range is two to four percent of operating revenue.

Restricted Retained Earnings

Restricted retained earnings include funding for capital investments and accrued annual leave for WCF employees. Each fiscal year, the Board will review a five-year capital investment plan. In addition, the Fund will retain a sufficient amount of reserves to pay accrued annual leave for all employees of the WCF.

Unrestricted Retained Earnings

Unrestricted retained earnings include funding used to finance unforeseen, one-time costs. Examples include costs associated with providing enhanced service levels and costs associated with discontinuing services. In an effort to stabilize rates throughout the fiscal year, unrestricted retained earnings may also be used to absorb the impact of unanticipated price fluctuations that service providers may experience during the year.

CDC imposed a cap on the level of unrestricted earnings that the Fund is allowed. CDC's WCF will target a goal of two to four percent of WCF annual operating revenue to cover unrestricted earnings. Throughout the fiscal year, the level of unrestricted retained earnings will be monitored to ensure that the level of reserves remains in compliance with the policy.

REIMBURSEMENTS AND TRUST FUNDS

(dollars in millions)	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
Reimbursements and Trust Funds	\$948.086	\$948.086	\$810.611
PHS Evaluation Transfer	\$0.000	\$0.000	\$0.000
ACA/PPHF	\$0.000	\$0.000	\$0.000
Total	\$948.086	\$948.086	\$810.611

Authorizing Legislation: PHS A §§ 214, 301, 306(b)(4), 311, 353; Consolidated Appropriations Act, 2012 (P.L. 112-74)

Summary

CDC's FY 2015 request of **\$810,611,000** for reimbursements and trust funds is a decrease of \$137,475,000 below the FY 2014 level.

(dollars in millions)	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
Reimbursements and Trust Funds	\$948.086	\$948.086	\$810.611

CDC's reimbursable activities provide scientific and programmatic expertise to other agencies and organizations. CDC has a long history of partnering with other federal agencies in the shared interest of improving public health and prevention programs. Examples of these activities include:

- 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 scientific and programmatic expertise in areas such as genetic diseases, laboratory tests, investigations, development of worker safety guidance, and training and model screening programs.
- CDC will continue the association between the Epidemiology Program at Department of Veterans Affairs (VA) and the National Center for Health Statistics (NCHS). NCHS will perform searches of the National Death Index (NDI) for VA in research and surveillance studies. The Epidemiology Program conducts research and surveillance studies on the health of veterans to understand the causes and patterns of their health and illnesses. The data and research findings from these studies help VA health professionals improve healthcare practices for veterans. The findings also help VA leadership and Congress improve health policies for veterans.
- CDC will continue to work with the U.S. Agency on International Development (USAID) on various projects including the Emerging Pandemic Threats (EPT) program. The EPT program emphasizes early identification of, and response to, dangerous pathogens in animals before they can become significant threats to human health. These efforts are critical to the sustainability of long-term pandemic prevention and preparedness. They will help develop better predictive models for identification of future viral and other biological threats.
- In addition to reimbursable agreements and user fees, CDC receives funds from Cooperative Research and Development Agreements (CRADAs) to enhance and facilitate collaboration between the agency's laboratories and various partners. CDC provides research personnel, laboratory facilities, materials, equipment, supplies, intellectual property, and other in-kind contributions, and uses the income from CRADAs to continue to improve programs.

SUMMARY TABLE

(dollars in millions)	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
Department of Agriculture 6 Agreements: NHANES Dietary Recall Component, 2011-2012 NHIS Food Security Status Questions. 4 Agreements to support the Outbreak, Plant Health Inspection, and Food Safety and Inspection Services.	\$8,460	\$8,460	\$118,484
Department of Commerce 5 Agreements: Federal Interagency Forum on Aging-Related Statistics, National Death Index, Support for the Production of the America's Children Report and Other Related Publications.	\$2,650	\$2,650	\$1,250
Department of Defense 1 Agreement: National Death Index. 25 Agreements to Support the Design and Deployment of the Healthcare Safety Network & Electronic Disease Surveillance System for Saudi Arabia National Guard. Various agreements with the Navy for the Border Infectious Disease Surveillance Project (BIDS). Survey and diagnose cases of Febrile Respiratory Illnesses (FRI) on the Mexican border; clothing and studies. 13 Agreements to Support the Design and Deployment of the Healthcare Safety Network & Electronic Disease Surveillance System for Saudi Arabia National Guard. Various agreements with the Navy to Border Infectious Disease Surveillance Project (BIDS). Survey and diagnose cases of Febrile Respiratory Illnesses (FRI) on the Mexican border; clothing and studies.	\$62,722	\$62,722	\$56,112
Department of Energy 6 Agreements regarding Occupational and Environmental Risk; Waterborne Contamination and Diseases. 2 Agreements to assist with Energy Related Analytical Epidemiologic Research, and School Associated Violent Death Studies.	\$5,492	\$5,492	\$3,822
Department of Health and Human Services To carry out activities under Section 241 of the Public Health Services (PHS) Act. 71 Agreements to perform various projects, provide ongoing participation in clinical laboratory improvement, develop questions for the National Health Interview Survey. Also, 1 agreement for a Prescription Drug Overdose evaluation. 15 Children's and Aging Forums, Vital Statistics Program and NHANES.	\$662,955	\$662,955	\$409,914
Department of Homeland Security 39 Agreements for Design & Development of Rapid Methods for AMR Susceptibility Testing for Potential BT Agents.	\$11,036	\$11,036	\$8,272
Department of Housing and Urban Development 1 Agreement: Support for the Production of the Older Americans Report: Key Indicators of Well Being Report and Other Related Publications.	\$5	\$5	\$5
Department of Interior 2 Agreement to support the Prevention and Control of Viral Hepatitis Infection in the Pacific Region.	\$50	\$50	\$1,026
Department of Justice 5 Agreements: Support for the Production of the America's Children Report and Other Related Publications. 4 Agreements for 2009 National HIVP Clinical Indicator of Sexual Violence Surveillance System.	\$1,222	\$1,222	\$1,324
Department of Labor 1 Agreement: Support for the Production of the America's Children Report and Other Related Publications. 3 Agreements to provide NIOSH responsibilities under the Energy Employees Occupational Illness Compensation Program Act.	\$4,150	\$4,150	\$2,194

(dollars in millions)	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
Department of State 5 Agreement for Field Assignee to assist with various States: Delaware and Iowa and Laboratory Testing.	\$5,088	\$5,088	\$10,426
Department of Veterans Affairs 5 Agreements: National Death Index, Federal Interagency Forum on Aging - Related Statistics. 10 Agreements for the Development of Electronic Surveillance and Control of Nosocomial Infections and Antibiotic Resistance. Salary & Benefits for Robert Gaynes.	\$2,718	\$2,718	\$2,208
Centers for Medicaid and Medicare Services (CMS) 2 Agreement to Collaborate with CMS on public health issues.	\$2,419	\$2,419	\$2,419
Environmental Protection Agency 1 Agreements: Forum on Aging Statistics, Forum on Child and Family Statistics. 6 Agreements to Collaborate Studies Occupational and Environmental Risk; Waterborne Contaminant and Diseases. 3 Agreements to Collaborate Studies Occupational and Environmental Risk; Waterborne Contaminant and Diseases.	\$6,619	\$6,619	\$4,424
Federal Emergency Management Agency 4 Agreements for Emergency Responses; and Public Health Assessment of Air Quality in Temporary Housing. 1 Agreements for Emergency Responses; and Public Health Assessment of Air Quality in Temporary Housing.	\$623	\$623	\$1,067
Food and Drug Administration 3 Health & Nutrition Exam Survey, Resource Data Center	\$1,150	\$1,150	\$865
Non-Federal Agencies 4 Agreements: Oral HPV Testing with Ohio State University, Asthma Supplement to the National Ambulatory Medical Care Survey with MERCK.	\$750	\$750	\$500
National Institutes of Health 38 Q-bank database, National Death Index, Collection and Analysis of Mental Health Data, Federal Forum on Child and Family Statistics, Federal Interagency Forum on Aging Statistics, National Survey of Family Growth, Cycle 6, Analytic Services from the National Committee on Vital and Health Statistics, Improving Economic Measures on NHIS, Consumer-Centric Health Care Questions and the National Health Interview Survey, SLAITS/Children's Health Survey, National Health Care Quality Report, NHIS Questions on Children's Mental Health, SLAITS Survey of Children with Special Health Care Needs, Dietary Supplement and Nutritional Biochemistry Component, Stroke Warning Signs, NHANES Allergy Component, Diabetes questions, Kidney Component, National Adult Immunization Survey, Arthritis Supplement, Administration of the National Home Health Aid Survey/National Home and Hospice Care Survey, Assessing Mass Casualty & Bioterrorism, Augmenting the NCHS Surveys for Cancer Care Surveillance, Critical Pediatric Resources Availability.	\$30,200	\$30,200	\$31,300
Other 56 Agreements for surveillance and Standardization of Genetic Testing. In addition numerous/various agreements with others such as USAID, WHO, UN, Peace Corp, Exec Office of the President, FBI, Department of Education, Department of Transportation, NASA, Census Bureau, John Hopkins, Coast Guard, Consumer Product Safety, State of Oregon, National Cancer Institute and State Department of Health in Florida, Wisconsin, Wyoming, Iowa, Mississippi, Louisiana and Hawaii, etc. Further, agreements that have to with funding for the President's Malaria Initiative and Emerging Pandemic Threats, as well work in tuberculosis; maternal and child health; immunization; neglected tropical diseases; and water, sanitation	\$158,064	\$158,064	\$112,079

CDC FY 2015 Congressional Justification

(dollars in millions)	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
and hygiene. Also, agreements for viral hepatitis work as well as the Emerging Pandemic Threats program.			
User Fees	\$10,500	\$10,500	\$9,476
TOTAL	\$948,086	\$948,086	\$810,610

PERFORMANCE

IMMUNIZATION AND RESPIRATORY DISEASES

PERFORMANCE

Program: Section 317 Immunization Program and Program Implementation and Accountability

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.2.1c: Achieve and sustain immunization coverage in children 19 to 35 months of age for one dose of MMR vaccine. (Intermediate Outcome)	FY 2012: 91% (Target Exceeded)	90%	90%	Maintain
1.2.1h: Achieve and sustain immunization coverage of at least 90% in children 19-35 months of age for at least 4 doses of pneumococcal conjugate vaccine (Intermediate Outcome)	FY 2012: 82% (Target Not Met)	90%	90%	Maintain
1.2.1i: Achieve and sustain immunization coverage of at least 80% in children 19- to 35-months of age for 2-3 doses of rotavirus (Intermediate Outcome)	FY 2012: 69% (Target Exceeded)	68%	71%	+3
1.2.2a: Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of Tdap (tetanus and diphtheria toxoids and acellular pertussis) (Intermediate Outcome)	FY 2012: 85% (Target Exceeded)	83%	86%	+3
1.2.2b: Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose of meningococcal conjugate vaccine (MCV4) (Intermediate Outcome).	FY 2012: 74% (Target Exceeded)	78%	81%	+3
1.C: Number of states (including the District of Columbia) achieving 65% coverage for 1 birth dose of hepatitis B vaccine (19–35 months of age) (Output)	FY 2012: 41 (Target Exceeded)	45	50	+5
1.D: Number of states (including the District of Columbia) achieving 30% coverage for influenza vaccine (6–23 months of age) (Output)	FY 2012: 43 (Target Exceeded)	36	40	+4
1.E: Number of states (including the District of Columbia) achieving 25% coverage for ≥ 3 doses of human papillomavirus vaccine (13–17 years of age) (Output)	FY 2012: 47 (Target Exceeded)	51	51	Maintain
1.F: Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose of Tdap vaccine (13–17 years of age) (Output)	FY 2012: 51 (Target Exceeded)	51	51	Maintain
1.G: Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose of meningococcal conjugate vaccine (13–17 years of age) (Output)	FY 2012: 48 (Target Exceeded)	50	50	Maintain

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.3.1b: Increase the percentage of adults aged 65 and older who are vaccinated against pneumococcal disease (Intermediate Outcome)	FY 2012: 60% (Target Not Met)	73%	76%	+3
1.3.2b: Increase the percentage of pneumococcal vaccination among non-institutionalized high-risk adults ages 18 to 64 (Intermediate Outcome)	FY 2012: 30% (Target Not Met)	36%	39%	+3
1.3.3a: Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Intermediate Outcome)	FY 2013: 42% (Target Not Met)	50%	53%	+3

Performance Trends: Immunization continues to be one of the most cost-effective public health interventions. CDC supports the implementation of state-based immunization programs making vaccines available to vulnerable children, adolescents, and adults. Since the adoption of this strategy in 1962, the United States has experienced record high childhood vaccination levels and record low levels of vaccine-preventable diseases (VPDs). In 2009, for each birth cohort vaccinated against 13 diseases (diphtheria, haemophilus influenzae type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella) in accordance with the routine childhood immunization schedule, the United States saved 42,000 lives, \$13.6 billion in direct medical costs and prevented 20 million cases of disease. Overall, an estimated \$3.00 is saved in direct medical costs for every \$1 invested in vaccines for VPDs (Table 1)³¹⁸.

Table 1: Cost-effectiveness of Childhood Vaccines

Vaccine:	Cost Savings: for every \$1 spent on an individual vaccine
Diphtheria-Tetanus-acellular Pertussis (DTaP)	saves \$47.80
Measles, Mumps, and Rubella (MMR)	saves \$23.30
Inactivated Polio (IPV)	saves \$8.60
Haemophilus influenzae type b (Hib)	saves \$4.90
Hepatitis B	saves \$2.40
Varicella	saves \$2.00
Pneumococcal (PCV7)	saves \$1.50
Childhood series (9 vaccines) ¹	saves \$10.00

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

CDC achieved levels near or above national (Healthy People 2020) targets for most of the routinely recommended childhood vaccinations. Since FY 2008, measles, mumps, and rubella (MMR) vaccinations have met or exceeded 90 percent coverage rates, and CDC will maintain this performance target in FY 2015. Rotavirus vaccine coverage increased by ten percentage points from 59 percent in FY 2010 to 69 percent in FY 2012. Coverage of pneumococcal conjugate vaccine (PCV) decreased slightly from 83 percent in FY 2010 to 82 percent in FY 2012 (Measures 1.2.1). Although CDC did not meet targeted coverage rates for PCV, strategies to improve

³¹⁸ <https://cdc.confex.com/cdc/nic2011/webprogram/Paper26209.html>

the fourth dose of PCV coverage are in place and are similar to those used to improve the uptake of other vaccines. Strategies include provider assessment and feedback, use of reminder notifications, immunization information systems, and regular assessment of coverage levels in the National Immunization Survey.

CDC exceeded targets for both adolescent performance measures in FY 2012. Tetanus, diphtheria and pertussis (Tdap) vaccine coverage increased from 74 percent in FY 2010 to 85 percent in FY 2012, and meningococcal conjugate vaccine (MCV4) coverage increased from 65 percent in FY 2010 to 74 percent in FY 2012 (Measures 1.2.2). This is a result of CDC’s efforts to promote awareness of adolescent immunization recommendations, by providing education and training to both public and private providers to bolster adolescent vaccination rates.

The number of states achieving targeted coverage levels for childhood and adolescent vaccinations continues to increase, contributing to overall sustained or improved vaccination coverage. For select adolescent vaccinations, almost every state achieved targeted coverage levels in FY 2012. In many instances, CDC exceeded its targets and is on track to meet or exceed FY 2015 targets (Measures 1.C-1.G).

During the past decade, vaccination coverage levels among older adults increased slightly as CDC implemented national strategies and partnered with state and local public health departments to promote adult immunization among healthcare providers and state and local governments. CDC targets are based on HP 2020 goals; however, CDC did not meet the coverage targets for adult pneumococcal adult vaccination. Vaccinations for adults 65 and older have fluctuated within the range of 60 to 62 percent over the past four years (Measure 1.3.1b). The percentage of pneumococcal vaccinations among high-risk adults increased from 17 percent in FY 2009 to 28 percent in FY 2010 and to 30 percent in FY 2011, which exceeded the CDC target by nine percentage points. CDC did not meet the vaccination target in FY 2012, although the percentage of high risk adults vaccinated remained at 30 percent. CDC will develop a new measure in FY 2016 that accounts for recent changes in Advisory Committee on Immunization Practices (ACIP) recommendations (Measure 1.3.2b). CDC developed measure 1.3.3a in FY 2012 to reflect the universal influenza vaccination recommendation. The new measure aligns with CDC’s ACIP updated recommendation (as of 2010) for the seasonal influenza vaccine. From FY 2011 to FY 2013, seasonal influenza vaccinations increased slightly.

Addressing barriers to adult immunization and increasing adult vaccination rates requires different strategies from those used to bolster childhood coverage. Adult vaccination recommendations are typically not included in the routine adult preventive care schedule. Further, efforts to increase adult vaccination coverage must include a variety of providers, including general practice doctors, OB-GYN practitioners, other specialists and pharmacists. CDC's efforts to improve adult vaccination coverage rates include:

- increasing patient and provider education to improve demand
- implementing system changes in practitioner office settings to reduce missed opportunities for vaccinations
- enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations
- expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics

Performance Measures for Long Term Objective: Improve vaccination safety and effectiveness

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.5.2: Increase the number of associations between vaccines and adverse health events evaluated to ensure the safety of vaccines used in the U.S. (Outcome)	FY 2012: 354 pairs (Baseline)	363 pairs	375 pairs	+12

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.H: Percentage of Vaccine Events Reporting System (VAERS) reports received electronically (Output)	FY 2013: 29% (Target Not Met)	45%	35%	-10

Performance Trends: A strong vaccine safety monitoring system is essential to ensure that the nation’s vaccines are safe. CDC is the nation’s lead public health agency responsible for providing a safe, effective vaccine supply for all licensed vaccines approved for use in the United States. CDC’s vaccine safety findings and recommendations inform the vaccine policy decisions of other federal agencies and the Department of Health and Human Services (HHS) advisory committees, advance vaccine safety science through published findings in medical and scientific literature, and inform the public of vaccine safety concerns through CDC’s website, partnerships, and public health messages. CDC’s Vaccine Safety Datalink System (VSD) and Vaccine Adverse Event Reporting System (VAERS) are vital for rapid detection and accurate assessment of vaccine risks, and allow for monitoring the relationships between adverse health events and vaccines.

In FY 2012, the vaccine-adverse event pair findings increased to 354 over FY 2011 findings (Measure 1.5.2). CDC findings include:

- an increased risk for febrile seizures in young children following simultaneous vaccination with trivalent inactivated influenza vaccine (TIV) and 13-valent pneumococcal (PCV-13) vaccine in the 2010-2011 influenza season
- a lower increased risk of seizures with measles-containing vaccines when administered at 12 to 15 months of age
- receiving trivalent inactivated influenza vaccine during pregnancy is not associated with increased risk of adverse events in the 42 days after vaccination, supporting its safety for the mother
- the number of immunogens a child receives from vaccination in the childhood series is not associated with neurodevelopmental disorders
- an association between rotavirus vaccine and a one in 20,000 chance of intussusception
- no associated significant adverse health outcomes with human papillomavirus (HPV) vaccine in a recent evaluation

From 2001 to 2012, the number of diseases for which there are childhood vaccines increased from 10 to 16 and the number of reports submitted to VAERS more than doubled from 15,000 to 33,000. As such, CDC tracks adverse events reported electronically and early detection of possible vaccine-adverse events. HHS received approximately 32 percent of adverse events reported electronically in FY 2012, but only 29 percent in FY 2013 (Measure 1.H). Electronic reporting to VAERS increased during the 2009-2010 H1N1 influenza pandemic, but has not continued to increase as CDC anticipated. Therefore, CDC reduced the FY 2015 target relative to the FY 2014 target. Incorporating a standardized data structure for electronic reporting by vaccine manufacturers in collaboration with FDA is expected to further improve reporting upon completion by FY 2017. Increased electronic reporting improves program decision-making by increasing the timeliness, quality, and quantity of VAERS reports, especially those from healthcare providers and vaccine manufacturers. CDC and the U.S. Food and Drug Administration (FDA) are continuing to develop and implement automation initiatives and IT enhancements that are expected to increase electronic reporting to VAERS and early detection of events.

Program: Influenza Planning and Response

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.6.1: Increase the number of public health laboratories monitoring influenza virus resistance to antiviral drugs (Output)	FY 2012: 18 (Target Exceeded)	18	18	Maintain
1.K: Number of Epidemiology and Laboratory Capacity (ELC) supported laboratorians and influenza coordinators in state and local public health departments (Output)	FY 2013: 93 (Target Exceeded)	70	70	Maintain
1.L: Number of influenza diagnostic kits and virus reference panels distributed domestically and internationally (Output)	FY 2013: 1,978 (Target Not Met)	2,100	2,100	Maintain
1.M: Number of virus specimens received and characterized annually from global National Influenza Centers for use in determining vaccine strain selection (Output)	FY 2013: 10,203 (Target Not Met)	11,000	11,000	Maintain

Performance Trends: CDC exceeded the FY 2012 target of 12 domestic public health programs monitoring influenza virus resistance to antiviral drugs, a 600 percent increase from the 2009 baseline of three (Measure 1.6.1). Resistance monitoring results in more rapid detection and reporting to the affected states, and allows for more timely data for case investigations. Timeliness is critical to identify and contain possible clusters of resistant strains and prevent transmission.

In FY 2010 and FY 2011, CDC enhanced state and local capacity to gather influenza epidemiology and laboratory data essential for systematic and accurate surveillance of seasonal and novel influenza viruses. In FY 2012, with a return to pre-pandemic funding levels, CDC provided support to state and select local health departments to carry out year-round influenza surveillance and laboratory diagnostics for seasonal and novel influenza viruses. CDC accomplished this by providing training and resources to grantees to increase their subject matter expertise. In FY 2013, 93 Epidemiology and Laboratory Capacity (ELC) supported laboratorians and influenza coordinators were present in state and local health departments to provide the necessary capacity to monitor and identify influenza threats (Measure 1.K). CDC may revise this output measure to more accurately reflect the intent of this measure for the FY 2016 President's Budget.

As a World Health Organization Collaborating Center for Influenza, CDC has enhanced global capacity to monitor influenza viruses and inform vaccine policy and antiviral treatment recommendations.

- In FY 2012, CDC provided 2,245 influenza diagnostic kits and virus reference panels to ensure the availability of timely diagnostic resources domestically and globally (Measure 1.L). While CDC exceeded the 2012 target, CDC maintained future targets at 2,100 units. CDC achieved higher than expected results in FY 2012 due to prolonged expanded surveillance activities related to the 2009 H1N1 pandemic, and FDA approved revisions related to the configuration of diagnostic kits. In FY 2013, CDC provided 1,978 kits and panels. The main reasons for this decrease is that there were 125 fewer WHO kits sent out due to a change in distribution from a "push to a pull" approach. In addition, low inventory of the RT-PCR kits for the end of CY 2013 has resulted in a more closely controlled and limited distribution than normal.

- In FY 2013, CDC processed 10,203 specimens. Influenza activity is unpredictable with variability from year to year. The estimated target number of specimens received and characterized each year by CDC is based on a severe influenza season with highest level of influenza activity. The 2012-2013 influenza season was moderate to severe and the number of specimens received was very close to but did not exceed the target number. Data obtained from the characterization of these specimens was sufficient for virologic surveillance and influenza vaccine strain selection. CDC expects to process approximately 11,000 influenza virus specimens in FY 2015 (Measure 1.M). Investments in laboratory technologies have increased CDC's capacity to monitor circulating influenza viruses. Worldwide characterization of these specimens is essential to the production of each season's influenza vaccine. It also aids in informing vaccine policies and recommendations as well as decisions regarding potential vaccines for novel viruses with pandemic potential.

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

PERFORMANCE

Program: Domestic HIV/AIDS Prevention and Research

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

Contextual Indicators	Most Recent Result	FY 2015 Target
2.1.1: Decrease the annual HIV incidence (Outcome)	FY 2010: 47,500	36,450
2.1.2: Reduce the HIV transmission rate per 100 persons living with HIV (Outcome)	FY 2010: 4.15	3.2
2.1.3: Increase the percentage of people living with HIV who know their serostatus ¹ (Outcome)	FY 2010: 84.2%	90.0%

¹ Some results have been updated based on improved methodologies.

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.1.8: Reduce the proportion of persons with an HIV diagnosis at later stages of disease within three months of diagnosis (Outcome)	FY 2011: 24.9% (Target Exceeded)	21.0%	19.1%	-1.9%
2.1.7: Increase the proportion of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active (Outcome) ²	FY 2011: 86.8% (Target Not Met)	N/A	86.9%	N/A

Per the HHS Secretary's memo (4/11/12) on implementing a common set of core indicators to be implemented across federal agencies, CDC revised this indicator definition in the FY 2014 President's Budget to conform with the cross-agency definition.

² Targets and results are set and reported biennially.

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

Contextual Indicators	Most Recent Result	FY 2015 Target
2.2.1: Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis (Contextual Indicator)	FY 2011: 79.8% (Historical Actual)	85.0%

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.2.2: Increase the percentage of HIV-infected persons in CDC-funded counseling and testing sites who were referred to Partner Services to confidentially notify and provide HIV testing and prevention services to partners who may be infected (Outcome)	FY 2011: 77.4% (Target Exceeded)	78.0%	79.5%	+1.5%
2.2.3: Increase the percentage of HIV-infected persons in CDC-funded counseling and testing sites who were referred to HIV prevention services to reduce risk of HIV transmission to others (Outcome)	FY 2011: 64.0% (Target Met)	67.0%	67.0%	Maintain
2.2.4: Increase the number of states that report all CD4 and viral load values for HIV surveillance purposes (Output)	FY 2013: 36+D.C. (Target Exceeded)	36	37	Maintain
2.2.6: Reduce the number of new AIDS cases among adults and adolescents per 100,000 population (Outcome)	FY 2011: 12.4 (Target Not Met)	11.3	11.1	-0.2

Targets and results are set and reported biennially.

Performance Trends: Since the advent of improved HIV treatments in the mid-1990s, the numbers of people with HIV who develop AIDS and die of AIDS-related complications have dropped dramatically. The number of deaths among people with AIDS decreased from more than 50,000 a year in 1995 to approximately 16,000 in 2010. However, this success means that the number of people who have the virologic potential to transmit HIV and the number of people in need of HIV care and treatment is growing. The estimated number of people living with HIV increased nine percent from 2006 to 2010 to a total of 1,144,500 people. To reduce HIV transmission, it is necessary to: (1) expand HIV testing to reduce undiagnosed HIV infection; (2) ensure that people living with HIV receive partner services and risk reduction interventions and are linked and retained in medical care; (3) ensure that persons with HIV receiving medical care receive and adhere to effective HIV treatment; and (4) reduce the risk of acquiring HIV among uninfected persons.

Preventing a single case of HIV infection saves an estimated \$402,000 in lifetime HIV medical care and treatment costs for infections that are diagnosed early.³¹⁹ About 50,000 people contract HIV each year, and while the lifetime medical care and treatment costs for these individuals total up to \$19 billion, prevention has significantly reduced the nation’s HIV treatment costs. Between 1991 and 2006, HIV prevention and treatment efforts in the United States averted an estimated 350,000 HIV infections and saved more than \$125 billion in direct medical costs.³²⁰ A 2011 study assessed the cost effectiveness of CDC-funded prevention programs conducted by health departments and found that they are cost-saving.³²¹ Reducing the number of HIV infections ensures significant cost-savings for the federal government, which spent an estimated \$14.1 billion on healthcare for people living with HIV in 2011.³²²

Despite this progress, the number of new HIV infections, HIV-related morbidities, and disparities experienced by racial and ethnic minorities, low income persons, gay and bisexual men and others at increased risk remain

³¹⁹ Farnham PG, et al. Estimating lifetime HIV treatment costs in the United States: Early versus late entry into care. Poster presented at the 34th Annual Meeting of the Society for Medical Decision Making, Phoenix AZ, October 17 – 20, 2012.

³²⁰ Farnham P, et al. Medical costs averted by HIV prevention efforts in the United States, 1991–2006. *JAIDS* 2010. 54:565-7.

³²¹ Lasry, A., et al., A model for allocating CDC’s HIV prevention resources in the U.S. *Health Care Manag Science*, 2011. 14(1): 115-124.

³²² Kaiser Family Foundation. U.S. Federal Funding for HIV/AIDS: The President’s FY 2012 Budget Request. October 2011. Available at <http://www.kff.org/hivaids/upload/7029-07.pdf>. Accessed on 1/5/2012.

unacceptably high. In July 2010, the Administration released the National HIV/AIDS Strategy (NHAS) which established new priorities for preventing HIV infection, improving the health of people living with HIV, and reducing HIV-related disparities. In December 2013, the administration released a report showing promising progress for eight of nine national goals, although significant challenges remain.

Reducing HIV incidence is a shared NHAS and CDC priority. HIV incidence declined significantly from approximately 130,000 cases per year in the mid-1980s to approximately 50,000 cases per year in 2010 due to numerous federal, state, local government and community response efforts (Contextual Indicator (CI) 2.1.1)). While the annual number of new HIV infections has remained relatively stable for the past decade, HIV incidence declined among certain groups (e.g., injection-drug users), but increased among young men who have sex with men (MSM). CDC's analysis of HIV incidence data from 2008 to 2010 reveals signs of an encouraging decrease in new HIV infections among heterosexual black women, which contributed to an overall decrease among heterosexual women. Since the number of people living with HIV has increased as a result of new treatments, HIV incidence alone is no longer an adequate indicator of HIV prevention programs' effectiveness. HIV transmission rates, which are calculated based on the number of people living with HIV, declined by 45% over the last 12 years from an estimated 7.5 transmissions per 100 persons living with HIV in 1997 to 4.15 transmissions in 2010 (CI 2.1.2).

Ensuring that people with HIV are aware of their serostatus and are diagnosed earlier in the course of infection are key strategies for improving the health of those infected and for preventing HIV transmission to others. Data for 2012 indicate all CDC-funded HIV testing programs conducted more than 3.5 million HIV tests and further increased routine HIV testing in health care and community settings while identifying about 14,000 previously undiagnosed cases of HIV infection. CDC's Expanded Testing Initiative prevented 3,381 new HIV infections in its first three years and saved an estimated \$1.2 billion in direct medical costs.³²³ Those living with HIV who know their serostatus increased from 80.9% in 2006 to 84.2% in 2010 (CI 2.1.3). In 2011, 24.9% of persons diagnosed with HIV were diagnosed late in the course of infection, a slight improvement over 2010 results (Measure 2.1.8).

When an individual tests positive for HIV, appropriate medical care and confidential partner notification services are critical to reducing the risk of future HIV transmission. CDC data from 19 state and local jurisdictions with laboratory reporting of CD4 and viral load test results demonstrate progress on increasing linkage to care compared to an earlier national estimate. From 2006 to 2011, the percentage of people diagnosed with HIV who were linked to care within three months of diagnosis increased from an estimated 65.0% to 79.8% (CI 2.2.1). CDC will be better able to assess national progress as more state and local jurisdictions provide complete CD4 and viral load data in the coming years. CDC also increased referrals to Partner Services for people diagnosed with HIV in publically-funded HIV testing sites from 71.9% in 2010 to 77.4% in 2011, exceeding the 2011 target (Measure 2.2.2). CDC slightly increased referrals for these individuals to other HIV prevention services from 61.8% in 2010 to 64% in 2011 (Measure 2.2.3). CDC prioritized these services in its new health department funding agreement that began in 2012, and is providing expert advice and assistance to grantees to further improve performance in these areas.

CDC monitors the HIV and AIDS epidemic through the national HIV surveillance system, using the data to direct prevention efforts and provide researchers, policymakers, and the public with a timely understanding of the U.S. HIV epidemic. HIV and AIDS case surveillance data meet high standards for completeness of reporting (more than 80 % of diagnosed cases are reported). All 50 states had mature, confidential name-based HIV surveillance systems in 2011 enabling CDC to incorporate HIV surveillance data from more states in its analyses. CDC is also working in collaboration with state health departments to better monitor the effects of HIV medical care through expanded reporting of CD4 and viral load test results. As of August 2013, 36 states and the District of Columbia required reporting of all CD4 and viral load values, exceeding the target (Measure 2.2.4). CDC programs seek to reduce progression from HIV infection to AIDS and monitor disease progression using surveillance data. The AIDS rate dropped from 12.3 per 100,000 population in 2009 to 11.5 per 100,000 in 2010

³²³ Hutchinson A et al. 2012). Return on public health investment: CDC's Expanded HIV Testing Initiative. JAIDS 2012. 59: 281-6.

but unexpectedly rose to 12.4 cases per 100,000 in 2012 (Measure 2.2.6). This increase may reflect data estimation challenges resulting in a re-estimation of the data and year to year fluctuations as additional data is reported to CDC. The increase may also reflect a rise in HIV testing as evidenced by the increasing percentage of people living with HIV who know that they are infected.

Scientific reviews document that school health programs can positively impact health-risk behaviors, health outcomes, and educational outcomes. CDC-led studies demonstrate that school health programs can also be cost effective. For example, every dollar invested in school-based HIV, sexually transmitted infections (STI), and pregnancy prevention efforts saves \$2.65 in medical and social costs. These efforts address NHAS imperatives to provide age-appropriate HIV and STI education for all Americans. The percentage of students who ever had sexual intercourse decreased significantly from 54.1% in 1991 to 47.4% in 2011. Condom use during most recent sexual intercourse among sexually active students increased from 46.2% in 1991 to 60.2% in 2011. Although CDC did not meet its FY 2011 target, 86.8% of adolescents in grades 9 to 12 abstained from sexual intercourse or used condoms if currently sexually active (Measure 2.1.7). CDC strategies to improve performance for this measure focus on strengthening the health infrastructure of state and local education agencies and addressing critical health issues including HIV/AIDS, STIs, and teen pregnancy prevention in schools. In the long term, CDC estimates the proportion of adolescents in grades 9 to 12 who abstain from sexual intercourse or use condoms if sexually active will increase as a result of these strategies.

Program: Viral Hepatitis

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.6.1: Reduce the rate of new cases of hepatitis A (per 100,000 population) (Outcome)	FY 2011: 0.4 (Target Exceeded)	0.4	0.4	Maintain
2.6.2: Reduce the rate of new cases of hepatitis B (per 100,000 population) (Outcome)	FY 2011: 0.9 (Target Exceeded)	0.9	0.9	Maintain
2.6.4: Increase the number of state and local health departments reporting acute viral hepatitis data of sufficient quality to be included in national surveillance reports ¹ (Output)	FY 2012: 7 (Target Not Met)	9	9	Maintain

¹As of FY 2013, CDC expanded the scope of this measure to also include chronic viral hepatitis, which is reflected in FY 2014 and FY 2015 targets.

Performance Trends: In the United States, hepatitis A, B, and C viruses (HAV, HBV, and HCV) are the main causes of viral-induced hepatitis. An estimated 3.5–5.5 million people are chronically infected with HBV or HCV, and at elevated risk for cirrhosis, liver cancer, and early death.

Before the 1996 implementation of Advisory Committee on Immunization Practices (ACIP) recommendations for hepatitis A immunization, an estimated 271,000 infections and 100 deaths occurred as a result of acute liver failure attributed to HAV each year. Through the implementation of effective immunization strategies, nationwide HAV incidence decreased approximately 95% since 1995. The 2011 rate of 0.4 cases per 100,000 almost achieves the Healthy People 2020 target of 0.3 cases per 100,000 and is the lowest rate of new cases recorded to date. CDC expects that the expansion of 2006 recommendations for routine hepatitis A vaccination, which now include all children in the United States aged 12–23 months, will reduce hepatitis A rates even further (Measure 2.6.1).

Similar declines in hepatitis B incidence occurred among all age groups, but are greatest among children under 15 years of age. Hepatitis B incidence is well below the Healthy People 2020 target of 1.5 cases per 100,000, and the 2011 rate of 0.9 cases per 100,000 is the lowest rate of new cases ever recorded (Measure 2.6.2).

Declines over the past decade are linked to a successful vaccination strategy and increases in screening and awareness. More than 95% of pregnant women in the United States are screened for HBV infection during pregnancy, reducing perinatal transmission risk. Due to the successful child vaccination strategy, 95% of new cases are now among adults. The number of persons with chronic HBV infection remains high—between 800,000 and 1.4 million. CDC provided technical analyses to the ACIP to expand recommendations for adult hepatitis B vaccination to include persons with diabetes aged 20–59, given the increased risk of HBV infection in this population.

Data from prospective and retrospective Hepatitis C cohorts indicate an estimated 20% of infected persons will develop cirrhosis 20 years after infection and up to five percent will die from HCV-related liver disease. Modeling studies forecast increases in morbidity and mortality among persons with chronic hepatitis C as they age with the disease. These models project that during the next 40–50 years, 1.76 million persons with untreated HCV infection will develop cirrhosis, with a peak prevalence of one million cases occurring from the mid-2020s through the mid-2030s. Further, approximately 400,000 will develop hepatocellular carcinoma. Of persons with hepatitis C who do not receive needed care and treatment; approximately one million will die from HCV-related complications. Projections from a CDC model indicate that the 2012 expansion of HCV screening and care to include routine one-time screening of all persons born between 1945 to 1965 (in addition to risk-based screening) will reduce hepatitis C related deaths by 82,300 at a cost of \$15,700 per quality-adjusted life year (QALY) gained. For these reasons, CDC and the US Preventive Services Task Force recommend that all persons in this birth cohort receive a one-time screening for HCV. Through the Prevention and Public Health Fund, CDC supported 35 sites for chronic hepatitis B and C testing and referral to care in 2012 and 2013, with over 45,000 tests conducted in the first year.

CDC assists states in improving viral hepatitis surveillance to provide more complete demographic information on individuals with acute and chronic viral hepatitis infection. In CY 2013, CDC revised its measure to include state and local health departments reporting quality assured chronic viral hepatitis data. In 2013, seven jurisdictions completed the enhanced reporting needed for national reports of acute hepatitis A, B, and C, and chronic HBV and HCV infection, down from eight jurisdictions reporting in 2011. These are New York State, Florida, Massachusetts, Michigan, Washington, Philadelphia, and San Francisco (Measure 2.6.4).

Program: Sexually Transmitted Infections

Performance Measures for Long Term Objective: Reduce pelvic inflammatory disease in the United States

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.7.1: Reduce pelvic inflammatory disease in the U.S. as measured by initial visits to physicians in women aged 15-44 years (NDTI) (Outcome)	FY 2012: 106,000 (Target Not Met)	98,800	97,933	-867
2.7.2a: Reduce the percentage of high-risk women aged 16–20 infected with chlamydia (Outcome) ¹	FY 2012: 12.40% (Target Exceeded)	12.11%	11.93%	-0.18
2.7.2b: Reduce the percentage of high-risk women aged 21–24 infected with chlamydia (Outcome) ¹	FY 2012: 8.9% (Target Not Met)	8.60%	8.46%	-0.14
2.7.4a: Reduce the rate of gonorrhea per 100,000 population in women aged 16–20 (Outcome)	FY 2012: 618.5 (Target Exceeded)	587.60	572.9	-14.7
2.7.4b: Reduce the rate of gonorrhea per 100,000 population in women aged 21–24 (Outcome)	FY 2012: 545.3 (Historical Actual)	524.2	519.61	-4.59

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.7.4c: Increase the proportion of gonorrhea patients who are treated with a CDC-recommended antibiotic regimen for gonorrhea (Outcome)	FY 2012: 80.8% (Historical Actual)	N/A	85%	N/A
2.7.5: Reduce the racial disparity of gonorrhea in women aged 16–24 (is black: white) (Outcome)	FY 2012: 12.4 :1 ratio (Target Exceeded)	11.2:1 ratio	10.6 :1 ratio	-0.6
2.7.6a: Increase the proportion of sexually active women aged 16–20 enrolled in Medicaid health plans who are screened for chlamydial infection (Outcome)	FY 2012: 53.5% (Target Not Met)	59.7%	61.1%	+1.4
2.7.6c: Increase the proportion of sexually active women aged 21–24 enrolled in Medicaid health plans who are screened for chlamydial infection (Outcome)	FY 2012: 63.6% (Target Not Met but Improved)	70.9%	73.2%	+2.3
2.7.6b: Increase the proportion of sexually active women aged 16–20 enrolled in commercial health plans who are screened for chlamydial infection (Outcome)	FY 2012: 41.1% (Target Not Met)	47.2%	48.8%	+1.6
2.7.6d: Increase the proportion of sexually active women aged 21–24 enrolled in commercial health plans who are screened for chlamydial infection (Outcome)	FY 2012: 49.2% (Target Not Met but Improved)	56.7%	59.2%	+2.5

¹In FY 2013 CDC improved the calculation of data for these measures, increasing the stability of estimates over time

Performance Measures for Long Term Objective: Eliminate congenital syphilis

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.9.1: Reduce the incidence of primary & secondary syphilis in women aged 15–44 (per 100,000 population) (Outcome)	FY 2012: 2.1 (Target Exceeded)	1.8	1.7	-0.1
2.9.2: Reduce the incidence of congenital syphilis (per 100,000 live births) (Outcome)	FY 2012: 7.8 (Target Exceeded)	7.2	6.7	-0.5
2.9.3: Increase percentage of pregnant women screened for syphilis at least one month before delivery (Outcome)	FY 2011: 83.0% (Target Exceeded)	81.9%	84.0%	+2.1

Performance Trends: As CDC’s new 5-year cooperative agreement with state, local, and territorial STD programs will begin in FY 2014, CDC will review all of the measures and targets above, as well as new measures for the cooperative agreement in early 2014. CDC may propose revisions, updates, and new measures for the FY 2016 President’s Budget.

CDC assures the provision of quality sexually transmitted infection (STI) services in both the public and private sectors through technical and financial assistance and training. CDC establishes screening recommendations and works with partners and healthcare providers to encourage adherence to these standards. Monitoring progress in screening and reducing disease burden informs programmatic priorities and resource allocation.

Screening improvements and investments in other STI prevention strategies will not only avert infections and improve national health outcomes but will prove cost-effective due to the high, and increasing, economic burden associated with STIs and their sequelae.³²⁴ Reductions in gonorrhea and syphilis from 1990 to 2003 greatly reduced the economic burden of these diseases with \$6.5 billion in estimated savings (2010 dollars). Published estimates of the cost-effectiveness of Chlamydia screening in sexually active young women range from \$2,500–\$37,000 per QALY.

CDC’s long-term objectives are to reduce pelvic inflammatory disease (PID) and eliminate congenital syphilis. PID is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Infections due to Chlamydia trachomatis and Neisseria gonorrhea are major causes of PID. The number of initial visits to physicians in women aged 15–44 years diagnosed with PID increased from 100,000 in 2009 (baseline) to 106,000 in 2012 (Measure 2.7.1).

Reported chlamydial infections rates among women have increased annually since the late 1980s, when the United States established public programs for screening and treatment of women to avert PID and related complications. In part, this reflects expanded chlamydia screening activities, the use of increasingly sensitive diagnostic tests, and increased emphasis on case reporting from providers and laboratories, and improvements in reporting systems. However, the increase may also reflect a true increase in morbidity. Data from a randomized controlled trial of Chlamydia screening in a managed care setting suggested that screening programs can lead to as much as a 60% reduction in PID incidence (Measures 2.7.1-2.7.6).

In previous years, CDC restricted the Chlamydia prevalence estimates for females entering the National Job Training Program to those states with greater than 100 tests among females aged 16-24 years. However, since estimates are stratified by age (16-20 and 21-24 years), in FY 2013 CDC began applying the same restriction (greater than 100 tests) within each age group, which will improve the stability of estimates over time (Measures 2.7.2a and 2.7.2b).

CDC is collaborating with the health care sector to increase adherence to existing recommendations and developing tools for providers to increase awareness and assist with Chlamydia screening implementation. In FY 2012, the median Chlamydia test positivity rate among women aged 16–24 years was 11.0% among those who were tested during visits to selected family planning clinics (range: 5.5% to 19.4%). Chlamydia test positivity among women aged 16–24 years screened in family planning clinics increased in most HHS regions during 2007–2012.

- Among sexually-active women aged 16–20 years enrolled in Medicaid health plans, Chlamydia screening rates decreased from 54.9 % in 2011 to 53.5% in 2012 (Measure 2.7.6a).
- Among sexually-active women aged 21–24 years enrolled in Medicaid health plans, Chlamydia screening rates increased from 63.4% in 2011 to 63.6% in 2012 (Measure 2.7.6c).
- Among sexually-active women aged 16–20 years in commercial plans, Chlamydia screening rates decreased from 41.5% in 2011 to 41.1% in 2012 (Measure 2.7.6b).
- Among sexually-active women aged 21–24 years in commercial plans, Chlamydia screening rates increased from 48.4% in 2011 to 49.2% in 2012 (Measure 2.7.6d).

³²⁴ Chesson HW, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. *Perspectives on Sexual and Reproductive Health* 2004, 36(1): 11–19. Also: Maciosek, M, et al. Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis. *American Journal of Preventive Medicine*, 2006; (31) 1, 52–61.

Following a 74% decline in the rate of reported gonorrhea during 1975–1997, the overall gonorrhea rate decreased to 98.1 cases per 100,000 population in 2009—the lowest rate since recording of gonorrhea rates began. From 2009 to 2012, the rate has increased slightly to 107.5 per 100,000 populations, with a total of 334,826 cases reported in the United States in 2012. The increase in gonorrhea rates during 2011–2012 was observed among both men and women, among all racial/ethnic groups, and in all regions of the United States. It is possible that this increase could be a result of communication and media efforts to increase provider awareness of the potential emergence of antibiotic resistant gonorrhea. Among certain populations, however, the rate far exceeds the national average. In FY 2012, among women aged 16-20, the rate of gonorrhea per 100,000 population was 618.5 and among women aged 21-24, the rate of gonorrhea per 100,000 population was 545.3. The black: white ratio among gonorrhea in women aged 16-24 was 12.4:1 in 2012 (Measures 2.7.4a-c). In FY 2014, CDC added a new measure tracking the proportion of gonorrhea patients who are treated with a CDC-recommended antibiotic regimen for gonorrhea. In FY 2012, 80.8% of gonorrhea patients received treatment with a CDC-recommended antibiotic regimen (Measure 2.7.5).

During 2011-2012, the primary and secondary syphilis rate remained unchanged among women aged 15-44 (2.1 cases per 100,000 population; Measure 2.9.1). CDC has a target of 1.70 for FY 2015 and may adjust targets for 2016.

Congenital syphilis is a preventable disease which could be eliminated through consistent and effective antenatal screening and treatment of infected pregnant women. Elimination of congenital syphilis would contribute to reductions in lost pregnancies and preterm/low birth weight infants. After an 18% increase in the rate of congenital syphilis during 2006-2008, the rate of congenital syphilis decreased 25% during 2008-2012 from 10.4 to 7.8 cases per 100,000 live births, exceeding the 2012 target of 18.5 per 100,000 live births (Measure 2.9.2). In 2012, a total of 322 cases were reported, a decrease from 358 cases in 2011. As a result of data from 2009-2011, CDC has a target of 6.7 for FY 2015 and may adjust targets for FY 2016. Program:

Tuberculosis

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.8.1: Decrease the rate of cases of tuberculosis among U.S.-born persons (per 100,000 population). (Outcome)	FY 2012: 1.5 (Preliminary)	1.5	1.5	Maintain
2.8.2: Increase the percentage of newly diagnosed TB patients who complete treatment within 12 months (where <12 months of treatment is indicated) (Outcome)	FY 2010: 85.4% (Target Not Met)	88.0%	88.0%	Maintain
2.8.3: Increase the percentage of culture-positive TB cases with initial drug susceptibility results reported. (Outcome)	FY 2011: 95.7% (Target Exceeded)	95.0%	95.0%	Maintain
2.8.4: For contacts to sputum acid-fast bacillus smear-positive TB cases who have started treatment for newly diagnosed latent TB infection, increase the proportion of TB patients who complete treatment. (Outcome)	FY 2009: 67.4% (Target Not Met but Improved)	70.0%	70.0%	Maintain
2.T: Number of state public health laboratories participating in the TB Genotyping Network (Output)	FY 2012: 50 (Target Met)	50	50	Maintain

Performance Trends: Effective control efforts by CDC and its 68 state and local partners contributed to the lowest number of U.S. Tuberculosis (TB) cases (9,945 cases in 2012, or 3.2 per 100,000 population and 1.5 for U.S. born population) since national reporting began in 1953 (Measure 2.8.1). Reflecting program effectiveness, the United States consistently ranks among the lowest TB incidence countries in the world.

TB drug resistance is increasing globally; the World Health Organization (WHO) estimates that between 220,000 and 400,000 cases of drug-resistant TB occurred in 2011. However, the number of drug resistant cases in the United States remains stable at less than one percent of all cases (approximately 100 cases per year). CDC monitors key TB controls, including treatment completion within one year, timely laboratory reporting, and testing of all TB patients for HIV to ensure coordinated care and other prevention activities. CDC works with state and local TB programs to monitor performance on these indicators, ensuring that essential prevention, control, and laboratory activities contribute to elimination (defined as a case rate of less than one case per million population). TB treatment completion is the most effective way to reduce the spread of TB and prevent its complications. Therefore, increasing the proportion of patients who complete treatment is the highest priority for CDC's TB Elimination program. In 2010, 85.4% of patients completed a curative course of treatment for TB (Measure 2.8.2), below the target of 88% but not statistically significant. However, this is a considerable increase over the 1994 baseline of 67.6%. Because completion of therapy is harder for vulnerable populations, CDC provides additional assistance to programs serving vulnerable populations (i.e. persons affected by homelessness, incarceration, substance abuse) or individuals traveling across borders. For example, upon request, CDC assists state and local health departments in responding to TB outbreaks.

CDC also supports efforts in public health laboratories to use Advanced Molecular Detection tools to genetically map TB specimens to develop a database to better understand and halt the spread of the disease. CDC has met its target of 50 participating state public health laboratories (Measure 2.T). Other laboratories also contributed to the effort, including labs in Washington, D.C., Puerto Rico, and the Pacific Islands.

Research funded by CDC through the TB Trials Consortium identified a new regimen for treatment for latent TB infection (LTBI) in 2011. The new regimen requires three months of treatment, instead of nine, and therefore, is more likely to be completed. CDC published new guidelines for the regimen the day following the publication of these research results and in FY 2013 began evaluating implementation of this new regimen.

Treatment for LTBI to prevent TB disease costs a fraction of curing a case of TB disease. Direct medical costs of LTBI screening and treatment are approximately \$261 to \$390 per person (2010 dollars). The direct medical cost of curing TB disease is approximately \$5,010 per case of drug-susceptible TB disease treated by directly observed therapy. Costs rise if the case of disease requires hospitalization (\$23,800) or if treatment of a multidrug-resistant strain is necessary (\$18,800 to \$171,600), or hospitalization for an extensively drug-resistant TB case (approximately \$605,000 each). For individuals at high risk for TB, the benefits of screening for LTBI and completion of treatment outweigh the costs if treatment reduces the risk of—and costs associated with—TB disease and hospitalization.

EMERGING AND ZONOTIC INFECTIOUS DISEASES

PERFORMANCE

Program: Core Infectious Diseases

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.5.2: Increase the percentage of laboratory reports on reportable conditions that are received through electronic means nationally (Outcome)	FY 2013: 62 % (Baseline)	65%	70%	+5

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.E: Establish state TickNet sites to collect and submit data for Lyme and other tick-borne diseases (Output)	FY 2013: 16 (Target Met)	16	16	Maintain

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.2.3: Decrease the proportion of hospitals with carbapenem-resistant Klebsiella spp. or Escherichia coli (E.coli) healthcare-associated infections (Outcome)	CY 2012: 6.9% (Baseline)	6.7%	6.5%	-0.5

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.3.3: Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR) ¹ (Outcome)	CY 2012: 0.56 (Target Exceeded)	0.4	0.35	-0.05
3.3.2a: Reduce the incidence (per 100,000 population) of healthcare associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections ² (Outcome)	CY 2012: 18.74 (Baseline)	12.18	10.83	-1.35

¹ The Standardized Infection Ratio (SIR) is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN).

² This measure was revised from an estimated total number of invasive MRSA cases to reflect the incidence of healthcare associated invasive MRSA cases. Results and targets have been changed to match the revised measure.

Core Infectious Diseases Performance Trends: Advancing national implementation of Electronic Laboratory Reporting (ELR) is a priority in CDC health reform and Affordable Care Act (ACA) efforts. ELR replaces paper-based reporting, which results in more rapid reporting to public health labs; reduces the reporting burden on

clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. This yields cost savings for clinical and public health and promotes rapid control of infectious disease outbreaks.

The previous measure in the FY 2014 President's Budget focused on increasing the quantity of laboratories reporting ELR as an indicator for ELR implementation. However, CDC considers the volume of total lab reports (paper, fax, ELR, etc.) sent to public health departments using ELR to be a more meaningful indicator of progress. CDC proposed a new measure that tracks its efforts to increase the volume of ELR transmissions and target laboratories that handle large volumes of total lab reports. This will substantially improve public health surveillance through increased use of ELR for reportable results from each jurisdiction's highest reporting labs. As of CY 2013, electronic laboratory reports accounted for 62 percent of laboratory reports for reportable conditions received (Measure 3.5.2).

Vector-borne Performance Trends: Tick-borne diseases have increased in the United States for most of the last decade. For example, reported cases of Lyme disease increased from 23,763 cases reported in FY 2002 to 33,097 in FY 2011 then decreased to 30,381 in FY 2012. Cases of spotted fever rickettsiosis, including Rocky Mountain spotted fever, rose to 2,802, up from 1,104 confirmed cases reported in FY 2002. Reducing the impact of tick-borne diseases demands increased capacity to better identify risks and respond effectively using tailored prevention strategies. Since FY 2010, CDC has consistently met or exceeded the target number of TickNet sites with 16 sites in FY 2013 (Measure 3.E). TickNet sites increase local and national capacity and collaboration for improved reporting and analysis of state and regional trends in tick-borne diseases. These sites also facilitate multi-state field evaluations of interventions aimed at reducing disease burden. CDC uses the results from these evaluation efforts to inform program strategy and aid in the establishment of national prevention goals based on validated intervention methods and approaches.

Antimicrobial Resistance Performance Trends: Carbapenem-resistant pathogens are resistant to almost all drugs and pose immediate infection threats to vulnerable, hospitalized patients, contributing to 40 percent of infected patients' deaths. They spread rapidly between healthcare settings because infected patients often receive medical care in more than one hospital and in long-term care facilities such as nursing homes. *Klebsiella pneumoniae* spp and *Escherichia coli* (*E.coli*) are the most common carbapenem-resistant pathogens found in central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and surgical site infections (SSI). Through collaboration with state health agencies and other partners, CDC assesses the scope of the problem and prioritizes strategies to contain the spread of resistant pathogens before they become an epidemic. In CY 2012, 6.9 percent of hospitals reporting into CDC's National Healthcare Safety Network (NHSN) reported carbapenem-resistant *Klebsiella* spp or *E. coli* infections (Measure 3.2.3). CDC's data collection methodology changed for CY 2012 when CDC expanded the measure scope to include all hospitals (acute care and long term acute care facilities) reporting at least one healthcare-associated infection (CLABSI, CAUTI, or SSI) with emerging carbapenem-resistance in *Klebsiella* spp or *Escherichia coli* (*E.coli*) to NHSN.

Healthcare-Associated Infections (HAIs) Performance Trends: CDC aggressively combats HAIs in all healthcare settings where patients receive clinical care. CDC's evidence-based guidelines are the standard of care for HAI prevention. HAIs, such as CLABSI, CAUTI, SSI, and methicillin-resistant *Staphylococcus aureus* (MRSA) infections, are preventable with adherence to CDC guidelines. National incidence of healthcare-associated invasive MRSA infections (hospital onset and healthcare-associated invasive MRSA in other healthcare settings, e.g., dialysis centers) declined from CY 2011 (20.06) to CY2012 (18.74). In 2012, CDC revised the MRSA measure, baseline and targets from an estimated total number of invasive MRSA cases to the incidence of healthcare-associated invasive MRSA cases (Measure 3.3.2a). In CY 2012, CLABSIs decreased 44 percent to 0.56 SIR nationally in hospitals when compared to the 2008 baseline (Measure 3.3.3). Reducing HAIs across healthcare settings supports national progress toward the HHS National Action Plan to Prevent HAIs: Roadmap to Elimination five-year targets.

Program: Food Safety

Performance measures for Long Term Objective: Protect Americans from infectious diseases – foodborne illnesses.¹

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.1.1b: Reduce the incidence ¹ of infection with three key foodborne pathogens: <i>Escherichia coli</i> O157:H7 (Outcome)	FY 2012: 1.11 (Target Not Met)	0.9	0.85	-0.05
3.1.1c: Reduce the incidence of infection with three key foodborne pathogens: <i>Listeria monocytogenes</i> . (Outcome)	FY 2012: 0.26 (Target Met)	0.24	0.23	-0.01
3.1.1d: Reduce the incidence of infection with three key foodborne pathogens: <i>Salmonella</i> species. (Outcome)	FY 2012: 16.37 (Target Not Met)	13.3	12.98	-0.32
3.F: Cumulative number of states providing reports of confirmed norovirus outbreaks to Calicinet (Output)	FY 2012: 28 (Historical Actual)	32	34	+2

¹CDC aligns its Food Safety targets with national targets for Healthy People 2020 objectives.

Performance Trends: Concerted prevention efforts by CDC, regulatory partners, and private industry have resulted in significant progress in reducing the incidence of major foodborne infections over the last 15 years. For example, between FY 2012 and the 1996-1998 baseline, the incidence of *Listeria* infection and the incidence of *Escherichia coli* (*E. coli*) O157:H7 infection decreased. Data show mixed results for progress towards FY 2012 targets, however. Incidence of *E. coli* O157:H7 infection increased from 0.98 to 1.11, just above the target of less than one case per 100,000 population (Measure 3.1.1b).

The reason for this increase in *E. coli* O157:H7 is unclear, but may be due in part to large multi-state outbreaks in 2012, including one linked to spinach and spring mix and another associated with raw clover sprouts. CDC will continue to work closely with the Food and Drug Administration (FDA), the United States Department of Agriculture (USDA) Food Safety and Inspection Service (FSIS), state and local agencies, and food industries to prevent and control outbreaks by quickly implementing effective interventions.

CDC met its FY 2012 target of 0.26 cases per 100,000 for the reduction of *Listeria* infections (Measure 3.1.1c). Previous efforts by the processed meat/hotdog industry proved important in reducing *Listeria* contamination. Some of the more recent success may be attributed to CDC's *Listeria* Initiative, an enhanced surveillance program developed to improve outbreak detection and decrease response time, in which 47 states and D.C. participate as of FY 2012. The 2012 multi-state outbreak of *Listeria* associated with Ricotta Salata cheese resulted in 22 documented illnesses, 20 related hospitalizations, and four deaths. From a longer-term perspective, from 1998 to 2008, there were 24 *Listeria* outbreaks reported, resulting in 359 illnesses, 215 hospitalizations, and 38 deaths. These examples indicate the need to implement the *Listeria* Initiative in all states.

Although an improvement from FY 2011, CDC did not meet its FY 2012 target of 13.93 cases per 100,000 for the *Salmonella* infection rate (Measure 3.1.1d). *Salmonella* remains the most commonly reported infection in FoodNet and the most common cause of large multistate outbreaks. *Salmonella* is a complicated pathogen for CDC, regulatory agencies and industry to control and prevent. A number of important actions to prevent *Salmonella* infections are forthcoming. For example, public health surveillance and foodborne illness outbreak investigations led by CDC have informed: 1) the FDA in developing its proposed produce and preventive control rules that aim to reduce illnesses caused by pathogens in produce and in processed foods; 2) USDA's efforts to improve the safety of poultry products; 3) food industry leaders to develop new strategies to reduce

contamination of food, and 4) consumers who can better understand their role in making food more safe. CDC also engages in regular collaboration with FDA and USDA to measure progress. Collectively, CDC anticipates these activities will result in reductions in the incidence of Salmonella illnesses in the US over the coming years.

Using the CaliciNet outbreak surveillance system, CDC has increased the number of states with public health laboratories certified to detect and characterize norovirus—the most frequent cause of foodborne illness—by supporting state and territorial public health laboratories. Calcinet received a total of 1,346 reported norovirus outbreaks in FY 2013, of which 192 (14.3%) were foodborne. In particular, one of the five CaliciNet Regional Outbreak Support Centers reported 31 (16.1%) of the foodborne outbreaks.

Program: National Healthcare Safety Network

Performance measure for National Healthcare Safety Network

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.3.4: Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (Output)	FY 2013: 12,400 (Target Exceeded)	13,500	17,000	+3,500

Performance Trends: CDC’s National Healthcare Safety Network (NHSN) is the national healthcare-associated infection (HAI) tracking system, providing a single integrated reporting system to detect HAIs, protect patients from infection, and drive HAI prevention at the local, state, and national levels. CDC exceeded its FY 2013 target to increase the number of facilities reporting to NHSN (Measure 3.3.4). CDC extended tracking capacity from 11,900 facilities in December 2012 to over 12,400 facilities through November 2013; this includes expansion of reporting to more than 1,750 inpatient rehabilitation and long-term acute care facilities, as well as additional types of HAIs reported from acute care hospitals (e.g., *Clostridium difficile* infections, MRSA bacteremia). Since FY 2012, CDC has nearly tripled the number of healthcare facilities reporting data for HAI prevention and is positioned to exceed its FY 2014 target and meet its FY 2015 target. To simplify reporting for healthcare facilities and improve the accuracy of data reported, CDC supports electronic reporting of HAI data by increasing the number of facilities using electronic data sources to detect and report HAIs. NHSN informs CDC’s strategic efforts to provide timely, accurate, and valid data across healthcare settings that can be used at the local, state, and national levels to assess HAI trends, improve the quality of care, benchmark progress, and strengthen HAI prevention. NHSN data are also used by partners such as the Centers for Medicare and Medicaid Services to fulfill quality reporting programs, FDA to improve medication and product safety and AHRQ to evaluate implementation strategies.

Program: Quarantine and Migration

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
3.4.2: Increase the proportion of applicants for U.S. immigration screened for tuberculosis by implementing revised tuberculosis technical instruction (TB TI). (Outcome)	FY 2012: 78 % (Target Exceeded)	85%	100%	+15
3.4.4: Increase of the percentage of immigrants and refugees with a "Class A or B medical notification for tuberculosis" who undergo medical follow-up after arrival in U.S (Outcome)	FY 2012: 82% (Target Exceeded)	85%	85%	Maintain

Performance Trends: CDC ensures that immigrants, refugees, and other travelers receive required medical screening, health education, and disease treatment before entering or leaving the United States.

In FY 2012, CDC screened 78 percent of United States-bound immigrants per the 2007 Tuberculosis technical instruction (TB TI) (Measure 3.4.2). CDC has exceeded its targets since FY 2008, resulting in the identification and treatment of at least 1,000 cases of Tuberculosis (TB) yearly in refugees and immigrant populations, yielding more than \$30 million in annual U.S. healthcare savings. In FY 2012, CDC implemented a revised TB medical screening system per the 2007 technical instructions for all immigration applicants in Argentina, Azerbaijan, Cameroon, Canada, Central African Republic, Chad, Chile, Costa Rica, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Guyana, Honduras, Latvia, Monaco, Nicaragua, Singapore, Suriname, Gambia, United Kingdom, and Zimbabwe.

Since FY 2009, CDC has exceeded its targets for immigrants and refugees with a "Class A or B medical notification for TB" who underwent medical follow-up after arrival in the U.S. (Measure 3.4.4). In FY 2012, CDC increased medical follow-ups to 82 percent, up from 78 percent in FY 2011, and exceeding the FY 2012 and FY 2013 targets. CDC has set more ambitious targets for FY 2014 and FY 2015.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

PERFORMANCE

Chronic Disease Prevention and Health Promotion

Contextual Indicators for Chronic Disease Prevention and Health Promotion: Reduce the leading causes of chronic disease-related death and disability.

Contextual Indicator	Most Recent Result	FY 2015 Target
Coronary Heart Disease: Reduce the annual age-adjusted rate of coronary heart disease deaths (per 100,000 population).	FY 2010: 113.6	108.6
Stroke: Reduce the annual age-adjusted rate of stroke deaths (per 100,000 population).	FY 2010: 39.1	36.4
Diabetes: Reduce the annual age-adjusted rate of diabetes-related deaths (per 100,000 population).	FY 2010: 70.7	68.5

Chronic diseases are the leading causes of death and disability in the United States, and account for 70% of all deaths annually (almost 1.7 million). These diseases also cause major limitations in daily living for approximately one out of every 10 people. The contextual indicators track long-term health outcomes influenced by CDC's Chronic Disease Prevention and Health Promotion program.

Over the past decade, CDC has worked to improve cardiovascular health and reduce coronary heart disease and stroke mortality through its support of cross-cutting public health strategies and leveraging resources to develop partnerships that promote healthy lifestyle behaviors, environments and communities. CDC has also established relationships between clinical practices and the community to improve healthcare quality.

From 2000 to 2010, the annual age-adjusted rate of coronary heart disease steadily declined from 186.9 to 113.6 per 100,000. During the same timeframe, the annual age-adjusted rate of stroke deaths declined from 60.8 to 39.1 per 100,000. From 2005 to 2010, the age-adjusted rate of diabetes-related deaths also declined from 77.0 to 70.7 per 100,000. This trend is the first time in a decade the rate has significantly improved. Prior to 2005, the diabetes-related death rates consistently ranged between 76.0 per 100,000 and 78.0 per 100,000.

CDC attributes these successes to improvements in contributing factors including: reductions in per capita cigarette smoking, improvements in the integration of clinical and other preventive services, expansion of clinical and community-based resources, support for self-management of chronic diseases and conditions, and advancement of environmental approaches to promote health and reinforce healthy behaviors. CDC's inter-related programs focus not only on specific diseases, but also on those risk factors that contribute to chronic diseases and conditions at all stages of life.

Program: Tobacco Prevention and Control

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.6.2: Reduce per capita cigarette consumption in the U.S. per adult age 18+. (Outcome)	FY 2012: 1,196 (Target Not Met but Improved)	986	903	-83

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.6.3: Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers. (Intermediate Outcome)	FY 2012: 18.1% (Target Met)	18.0%	17.0%	-1
4.6.4: Increase proportion of the U.S. population that is covered by comprehensive state and/or local laws making workplaces, restaurants, and bars 100% smoke-free (no smoking allowed, no exceptions). (Intermediate Outcome)	FY 2012: 48.9% (Target Not Met but Improved)	57.7%	58.5%	+0.8
4.6.5: Reduce the proportion of adolescents (grade 9 through 12) who are current cigarette smokers. (Intermediate Outcome)	FY 2012: 14.0% ¹ (Target Exceeded)	N/A ²	17.6%	N/A ²
4.C: Number of calls received by Tobacco Cessation Quitlines. (Output)	FY 2012: 1,379,301 (Target Not Met but Improved)	1,500,000	1,500,000	Maintain
4.D: Number of persons provided cessation counseling and/or medications by Tobacco Cessation Quitlines. (Output)	FY 2012: 459,396 (Target Not Met but Improved)	499,500	499,500	Maintain
4.G: Number of requests from state health departments and other organizations (e.g. local health departments) for advertising campaign materials through the Media Campaign Resource Center. (Output)	FY 2013: 800 (Target Exceeded)	800	825	+25

¹ NYTS data, which captures youth smoking prevalence in the interim years of YRBSS reporting.

² The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source, which tracked closely with YRBSS. Due to variance in results that developed between the two data sets after FY 2011, CDC began setting and reporting targets based only on YRBSS as of FY 2014.

Performance Trends: Reducing tobacco use is a CDC priority. It is also an HHS Agency Priority Goal (2014-2015) to which CDC, Food and Drug Administration, National Institutes of Health, Substance Abuse and Mental Health Services Association, and others contribute (<http://www.performance.gov/>). Effective tobacco control programs, implemented through evidence-based tobacco control policies, significantly prevent and reduce tobacco use. The per capita cigarette consumption among adults in the United States declined from 1,507 to 1,196 between FY 2008 and FY 2012, demonstrating that current smokers are smoking fewer cigarettes (Measure 4.6.2). CDC estimates cigarette consumption will continue to decrease through FY 2015. Additionally, the percentage of current adult smokers decreased from 20.6% in 2009 to 18.1% in FY 2012 (Measure 4.6.3). Cigarette use among adolescents declined sharply from 1997 to 2003; however, the rate of decline slowed over the last decade, fluctuating between 20.0% and 23.0% from 2003 to 2007 and then declining from 20.0% to 14.0% from FY 2007 to FY 2012 (Measure 4.6.5). The six percentage point decrease from FY 2007 to FY 2012 is due to slight variance in results between the Youth Risk Behavior Surveillance System (YRBSS) and the National Youth Tobacco Survey (NYTS), which tracked closely from FY 2007 to FY 2011. Given the variance, YRBSS will be the sole data source beginning in FY2014, which is reflected in the FY 2015 target of 17.6%.

The percentage of the United States population covered by comprehensive state and/or local laws that make workplaces, restaurants, and bars 100% smoke-free has increased significantly since FY 2005. Between FY 2005

and FY 2012, the population covered by smoke-free laws increased by 35.4 percentage points so that 48.9% are now covered (Measure 4.6.4). On average, smoke-free policies in states and communities contribute to a 17% reduction in heart attack hospitalizations.

In addition to providing evidence to inform policy, system, and environmental changes, CDC also provides direct assistance to tobacco users through National Tobacco Quitlines. In 2012, CDC launched the first ever national tobacco prevention media campaign, *Tips from Former Smokers*, on national TV, radio, print, digital and out-of-home media to have former smokers share the real consequences of smoking and encourage smokers to quit. The campaign generated 207,519 additional calls (a 132% increase) to 1-800-QUIT NOW compared to corresponding weeks in 2011, achieving a total of more than 365,000 calls to the Quitlines between March and June 2012. In FY 2012, the tobacco Quitlines received 14% more calls and provided cessation counseling and/or medications to 10% more people than in FY 2011 (Measures 4.C and 4.D).

Building on the success of the *Tips* campaign, CDC launched a new round of advertisements in April 2013, and completed a post-campaign evaluation in June 2013. CDC based FY 2013 and FY 2014 targets on the full post-evaluation of the 2012 campaign which resulted in an estimated 1.6 million new quit attempts among U.S. adult smokers. CDC's full evaluation of the 2013 campaign will inform future estimates and allow CDC to account for any potential reductions in campaign funding and the impact on hardened smokers. FY 2014 and FY 2015 targets are flat in anticipation of reduced campaign impact and do not include enhanced funding for increased local advertising. Comprehensive *Tips* campaign results will be available in spring 2014.

FY 2014 and FY 2015 targets for Measures 4.C and 4.D reflect changes to data collection methodology in FY 2013. CDC previously set targets based on projected Quitline calls relative to dedicated Quitline and promotion funding. Since CDC now has actual call volume data, CDC sets targets based on historical call volume, which provides a better estimate.

Requests for tobacco cessation advertising materials more than doubled over the past year, largely due to the National Tobacco Education Campaign launched in March 2012. In FY 2013, health departments and other organizations made 800 requests for materials, more than a third more requests than in FY 2012. Due to the impact of the *Tips* campaign, CDC expects requests for advertising campaign materials to increase slightly through FY 2015 (Measure 4.G). Examples of the materials CDC provided includes the *Tips from Former Smokers* campaign, the *Heart Stopper* (2011) and *Destiny* (2012) Public Service Announcements from the Office of the Surgeon General, and the many campaigns contributed to the Media Campaign Resource Center by states and communities.

Program: Nutrition, Physical Activity, and Obesity

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.11.7: Increase the proportion of infants that are breastfed at 6 months. (Intermediate Outcome)	FY 2009: 47.8% (Target Exceeded)	57.3%	58.9%	+1.6
4.11.8: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older (cup equivalents per 1,000 calories). ¹ (Intermediate Outcome)	FY 2009: 0.83 (Baseline)	N/A ¹	1.01	N/A ¹
4.11.9: Increase the proportion of adults (age 18 and older) that engage in leisure-time physical activity. (Intermediate Outcome)	FY 2012: 70.2% (Target Exceeded)	71.0%	71.4%	+0.4

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.11.10: Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese. ¹ (Intermediate Outcome)	FY 2012: 34.9% (Target Met)	34.4%	N/A ¹	N/A ¹
4.12.1: Increase in the number of states with nutrition standards for foods and beverages provided in early care and education centers. (Output)	FY 2012: 23 (Target Exceeded)	29	36	+2
4.12.4: Increase the number of states with physical education standards that require children in early care and education centers to engage in vigorous- or moderate-intensity physical activity. (Output)	FY 2012: 6 (Target Not Met but Improved)	14	16	+2

¹Targets and results are set and reported biennially.

Performance Trends: Obesity increases the risk of many diseases, including heart disease, stroke, high blood pressure, and some cancers. In FY 2012, 34.9% of adults and 16.9% of children and adolescents (ages two to 19 years) were obese according to the National Health and Nutrition Examination Survey (NHANES) (Measure 4.11.10). After decades of increasing rates, recent data show a plateau in obesity among adults and adolescents, and decreases in obesity rates among low-income, preschool-age children. CDC is working with state health departments, schools, early care and education providers and a number of non-government organizations to reduce obesity by improving access to healthier food and place to be physically active.

CDC promotes effective strategies for improving dietary quality, physical activity, and reducing obesity including: creating environments that support breastfeeding; improving access to fruits, vegetables and healthy beverages; increasing access to safe places and opportunities to be physically active; and fostering partnerships to improve dietary quality in worksites, hospitals and schools.

CDC invests in population-level approaches to improve breastfeeding practices, access to healthier foods and physical education practices and standards.

- **Breastfeeding:** Research indicates mothers who receive quality maternity care that includes support for breastfeeding are more likely to breastfeed. Breastfed babies are at a decreased risk for health complications, such as obesity, diabetes, respiratory and ear infections, and sudden infant death syndrome. Results for the FY 2009 birth cohort show that 47.8% of U.S. infants were breastfed at six months of age, compared to 44.4% in FY 2008 (Measure 4.11.7). Increases in the percent of infants who are breastfed at six months are moving towards the Healthy People 2020 objective of 60.6%. CDC expects breastfeeding duration to increase, especially as more hospitals (a) adopt standards monitored with the National Survey of Maternity Practices in Infant Nutrition and Care; and (b) invest in making their facilities baby-friendly. In 2008, less than two percent of births occurred in baby-friendly hospitals; in the last four years, that number has more than tripled to six percent.
- **Nutrition:** In FY 2009, the daily vegetable consumption among the U.S population over age two accounted for less than one cup (0.83) per 1,000 calories (Measure 4.11.8). CDC estimates this will increase to a full cup by 2015. CDC is working with state leaders, health professionals, food retail owners, farmers, education staff, and community members to create greater access to quality and affordable fruit and vegetables nationwide to increase fruit and vegetable consumption. Many states are working with CDC to establish policies to increase fruit and vegetable consumption by making it easier to get fruits and vegetables in communities, schools, and child care centers.

- **Physical activity:** The proportion of adults that engage in some leisure-time physical activity increased by seven percentage points between FY 2008 and FY 2012, exceeding the FY 2012 target (Measure 4.11.9). CDC is working with communities, businesses, early care and education centers, and schools to increase the number of people who participate in at least 150 minutes of physical activity a week by implementing policies that create more safe spaces to exercise.
- **Physical education and nutrition standards:** In FY 2011, the first year CDC monitored states' performance on nutrition and physical education standards in early care and education centers, as outlined in the Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education, five states met the physical education standards and nine states met the nutrition standards. FY 2012 results show one additional state met the physical education standards (Measure 4.12.4) and 14 additional states met the nutrition standards, a significant increase from FY 2011 (Measure 4.12.1). CDC's FY 2014 and FY 2015 targets for Measure 4.12.1 reflect a change to the Federal Child and Adult Care Food Program in CY 2012, calling for states to review and revise their regulations, resulting in an immediate increase in the number of states meeting the nutrition standards.

Program: School Health

Performance Measures for Long-Term Objective: Improve the health and well-being of youth and prepare them to be healthy adults.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.12.5: Increase the number of states that have developed and adopted a state-level multi-component physical education policy for schools. ¹ (Output)	FY 2012: 6 (Historical Actual)	8	N/A ¹	N/A ¹
4.12.6: Increase the percentage of secondary schools that promote healthy food and beverages per Institute of Medicine standards for meals served outside of school meal programs. ¹ (Outcome)	FY 2012: 56.2% (Historical Actual)	65.0%	N/A ¹	N/A ¹

¹Targets and results are set and reported biennially.

Performance Trends: Childhood obesity has almost tripled in the past 30 years. In the late 1970s, the prevalence of childhood obesity was 6.5% for children ages 6-11 and 5.0% for adolescents ages 12-19. Prevalence of obesity among children and adolescents aged 2–19 continued to increase from 18.1% to 18.4% between 2007-2008 and 2009-2010. In 2010, approximately 17% (or 12.5 million) of children and adolescents ages two to 19 years were obese.

CDC seeks to increase physical fitness and promote positive health outcomes in children and adolescents by increasing the quality and quantity of physical education provided in K-12 schools. CDC introduced Measure 4.12.5 in FY 2013 to track the establishment of policies that align with CDC’s *School Health Guidelines to Promote Healthy Eating and Physical Activity* and the recommendations of the American Heart Association and the National Association for Sport and Physical Education. In FY 2012, six states established the requisite number and composition of multi-component policies between FYs 2010 and 2012, a 20% increase over baseline. The FY 2014 target represents a 60% increase over baseline in two years. This measure tracks a high standard for state physical education and physical activity policy adoption, and progress will likely be incremental in the first years of program implementation. CDC expects increased progress before the end of the five year funding period and will increase future targets accordingly.

CDC supports the improvement of nutrition environments in K-12 schools and the positive health outcomes in children and adolescents. Foods sold outside of the food service program (competitive foods) are widely

available in schools through a variety of venues and are the primary source of low nutrient dense foods (junk foods) in schools. Students attending schools that sell junk foods and sugar-sweetened beverages have lower intake of fruits, vegetables, and milk at lunch and higher daily percentage of calories from total fat and saturated fat. For Measure 4.12.6, CDC will leverage The Healthy Hunger-Free Kids Act of 2010, which authorizes the United States Department of Agriculture (USDA) to establish federal nutrition standards for all competitive foods sold during the school day. Based on Institute of Medicine (IOM) standards that extend beyond the USDA requirement, CDC will track the percentage of schools limiting student purchases to any of the following snack foods or beverages from vending machines, school stores, canteens, or snack bars: candy, salty snacks that are not low in fat, baked goods that are not low in fat, and soda pop or fruit drinks that are not 100% juice. Given the multiple components of this measure at the school building or district level, CDC expects modest progress through FY 2014. In FY 2010 (baseline year), 50.5% of secondary schools sold only nutritious foods outside of the school food service program.

Program: Heart Disease and Stroke

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.11.5: Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (<140/90). ¹ (Intermediate Outcome)	FY 2010: 46.0% (Target Not Met)	50.0%	N/A ¹	N/A ¹
4.11.6: Reduce consumption of sodium in the population aged 2 years and older (milligrams per day). ¹ (Intermediate Outcome)	FY 2010: 3,463 (Target Not Met) ²	2,940	N/A ¹	N/A ¹
4.N: Increase the number of blood pressure screenings provided by the WISEWOMAN program. (Output)	FY 2012: 47,121 (Target Not Met)	48,500	50,000	+1,500
4.O: Increase the total number of evidence-based tools disseminated to promote sodium and hypertension reduction and awareness. (Output)	FY 2013: 86 (Target Exceeded)	101	119	+18

¹Targets and results are set and reported biennially.

²The 2010 result for Measure 4.11.6 differs in the FY 2014 and 2013 budgets due to a change in computational methodology. CDC used the NHANES-based data reported in the USDA "What We Eat in America" report for the FY 2013 budget. For the FY 2014 budget, CDC reported the 2010 result from the more current NHANES-based Vital Signs report.

Performance Trends: Hypertension affects one in three adults, and is a modifiable risk factor for heart disease, stroke, and other chronic diseases. It also contributes to one out of every seven deaths in the U.S., including nearly half of all cardiovascular disease-related deaths. Although CDC did not meet its target for the proportion of adults with high blood pressure who have it controlled in 2010, the proportion has increased slightly since FY 2008 from 45.0% to 46.0% (Measure 4.11.5). FY 2012 results will be available in June, 2014. With the launch of the CDC/Centers for Medicare and Medicaid Services (CMS) Million Hearts[®]™ Initiative in FY 2012, federal, state, local, and public/private efforts are coalescing to promote the "ABCS" of clinical prevention (aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation).

CDC's Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program completed 24,150 blood pressure screenings during the first half of 2012. From July 1, 2012 to June 30, 2013 the WISEWOMAN Program provided 47,121 cardiovascular disease (CVD) screenings. During this period the WISEWOMAN Program reported 9,920 cases of high blood pressure, 6,538 cases of high cholesterol, 4,009 cases of diabetes, and 6,898 smokers among participants (Measure 4.N). FY 2014 and FY 2015 targets account for

extended effects of FY 2013 Sequestration as well as a new grant cycle. While the program will still provide cardiovascular health screening services, new grantees will not deliver the same level of screening and intervention as experienced grantees during the first year or so of funding. The WISEWOMAN program will continue its exemplary work to increase screening capacity by leveraging and expanding partnerships and draw upon the expertise and resources of entities with similar goals to improve cardiovascular health.

About 90% of Americans consume more sodium than is recommended for a healthy diet. Between FY 2008 and FY 2010, sodium consumption slightly increased from 3,330 milligrams per day to 3,463 milligrams per day, much higher than the recommended 1,500 milligrams per day (Measure 4.11.6). CDC revised its FY 2014 target for sodium intake to 2,940 milligrams per day due to a change in computational methodology. CDC used the National Health and Nutrition Examination Survey (NHANES)-based data reported in the USDA “What We Eat in America” (WWEIA) report for the FY 2013 budget. The WWEIA report removed a downward adjustment for sodium added while cooking. This methodological change resulted in a slight increase in the reported mean sodium intake. This revision also affected the FY 2010 results reported in the FY 2014 and FY 2013 Presidents’ Budget (budget). For the FY 2014 budget, CDC reported the FY 2010 result from the more-current NHANES-based “Vital Signs” report.

CDC disseminated 86 evidence-based tools to promote sodium and hypertension reduction as of FY 2013; exceeding the FY 2013 target and continuing a trend of disseminating more tools annually since 2009 (Measure 4.O). Examples include:

- Guides for sodium reduction in hospitals, schools, worksites, and congregate populations; and fact sheets for consumers and parents;
- Bilingual (English and Spanish) Fotonovelas intended for integration into community health worker programs related to controlling blood pressure in Hispanic/Latino communities.

Complementing these evidence-based tools, CDC also disseminated products translating research to practice, including:

- Heart Disease Data Trends and Maps/Interactive Atlas of Heart Disease and Stroke;
- The Salt e-update, a bi-weekly email communication to approximately 400 stakeholders sharing current work in the field of sodium reduction.

Finally, CDC published a biomarker measurement of sodium from a urine calibration study identifying variation in sodium excretion among adults aged 18 to 39 years, especially among African-Americans. Additional analyses suggest spot urine samples can be used to estimate average sodium intake among groups. Based on 1988-2010 estimates from spot urine samples, mean sodium intake among U.S. adults aged 20 to 59 years remains high. This, along with 53 other publications, is available on CDC’s website, with an additional 88 publications in progress.

Program: Diabetes

Performance Measures for Long Term Objective: Improve prevention, detection, and management of diabetes.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.11.3: Increase the proportion of the diabetic population with an A1c value less than 7% ^{1,2} (Outcome)	FY 2010: 53.5% (Baseline)	55.6%	N/A ¹	N/A ¹

¹Targets and results are set and reported biennially.

²This measure uses data that is based on four-year averages to improve the precision of the estimates through larger sample sizes. Most recent results for FY 2010 reflect data from 2007-2010. Targets are based on Healthy People 2020, which were set in 2010.

Performance Trends: The higher one’s hemoglobin A1c (A1c), the higher the risk of developing complications related to diabetes. In general, for every percentage point reduction in A1c levels (e.g., from nine percent to eight percent), the risk of developing eye, kidney, or nerve disease decreases by 40%. National Health and Nutrition Examination Survey data show that from 2007-2010, approximately 53.5% of the diabetic population had an A1c value less than seven percent, the upper threshold for acceptable diabetes management and control (Measure 4.11.3). CDC detected a change in the A1c distribution from 2007-2010 compared to 1999-2006 and temporarily withdrew 2007-2010 results in November 2011. However, after rigorous evaluation and careful data quality analyses, CDC could not identify a cause for the shift. Therefore, CDC re-released the results in March 2012 with no changes.

CDC-funded grantees focus on working with health systems to increase access to and delivery of care for people with diabetes to prevent complications. CDC funded the North Carolina State Department of Health Diabetes Education Recognition Program (NC DERP) to assist local health departments in 1) establishing Diabetes Self-Management Education (DSME) programs and 2) gaining recognition from the American Diabetes Association (ADA). Since 2007, NC DERP has successfully gained ADA recognition for 58 DSME programs in the state. In 2013, 1,687 patients were seen through these programs. Overall the NC DERP has seen a total of 7,000 patients since 2007.

Program: Cancer Prevention and Control

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.9.1: Decrease the incidence rate of late-stage breast cancer diagnosis in women ages 50 to 74 (per 100,000). (Intermediate Outcome)	FY 2010: 101.0 (Target Exceeded)	100.5	99.5	-1
4.9.2: Increase the percent of adults age 50 to 75 receiving colorectal cancer screenings. ^{1,2} (Intermediate Outcome)	FY 2012: 65.1% ³ (Target Not Met)	70.0%	N/A ¹	N/A ¹
4.9.4: Increase the percentage of CDC-funded state cancer registries that electronically receive physician cancer reports from Electronic Health Record (EHR)/Electronic Medical Record (EMR) systems. (Output)	FY 2013: 0.0% (Baseline)	16.0%	27.0%	+11%
4.K: Number of breast cancer screenings provided by the National Breast and Cervical Cancer Early Detection Programs (NBCCEDP). (Output) ²	FY 2012: 347,042 (Target Exceeded)	351,351	301,492	-49,859
4.L: Number of breast cancer cases detected by National Breast and Cervical Cancer Early Detection Programs (NBCCEDP) (Output) ²	FY 2012: 5,905 (Target Exceeded)	5,799	4,952	-847
4.M: Number of Colorectal Cancer Control Program (CRCCP) grantees promoting the use of patient navigation and support as an evidence-based strategy to increase colorectal cancer screening rates. (Output)	FY 2012: 21 (Target Exceeded)	21	19	-2

Targets and results are set and reported biennially.

²Targets reflect combined budget authority and ACA/PPHF funding.

³2012 rates cannot be compared to rates before 2011 due to a change in BRFSS sampling methodology, which now includes cell phone users.

Performance Trends: Although recommended by the U.S. Preventive Services Task Force, screening rates for breast, cervical, and colorectal cancers remain low. Women over the age of 50 are at highest risk for breast cancer and benefit the most from screening. The incidence of late-stage diagnosis among women ages 50–74 has decreased annually from 106.7 per 100,000 women in FY 2008 to 101.0 per 100,000 women in FY 2010, exceeding CDC's FY 2010 target (Measure 4.9.1). When compared to those not screened among this age group, mammography screening reduces breast cancer deaths by 17%. Through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), CDC provides access to breast and cervical cancer screening and diagnostic services to low-income, uninsured, or underinsured women.

Since 2008, the number of breast cancer screenings and the number of breast cancers detected through the NBCCEDP has consistently increased, providing 1,644,253 breast cancer screenings and detecting 27,270 cases of breast cancer between 2008 and 2012. In FY 2012, the NBCCEDP provided 347,042 screenings for breast cancer and detected 5,905 cases, exceeding 2011 levels (Measures 4.K and 4.L). The NBCCEDP serves approximately 11.7% of women eligible for breast cancer screening and approximately 8.2 percent of women eligible for cervical screening. Targets are based on total funding requested (FY 2015) for budget authority and PPHF, which will result in almost 50,000 fewer breast cancer screenings provided to low-income, underserved women; and almost 850 fewer breast cancers detected through the program. Implementation of the Affordable Care Act will afford greater access to coverage for cancer screening services, and is expected to reduce the size of the NBCCEDP-eligible population in 2014 and 2015. As a result, CDC anticipates serving a larger proportion of the eligible population than currently served through the NBCCEDP. Therefore, CDC will continue to provide direct screening to eligible women and link women to needed care.

Colorectal cancer is the second most commonly diagnosed cancer and the second leading cause of cancer deaths among both men and women in the United States. The rate of colorectal cancer screening increased between FY 2008 and FY 2012, with 65.1% of adults aged 50–75 screened in 2012 compared to 63.1% in 2008 (Measure 4.9.2).

CDC's Colorectal Cancer Control Program grantees promote evidence-based strategies, such as patient/provider reminder systems, to increase access to and delivery of colorectal cancer screening for underserved populations. Patient navigation guides an individual through the process of completing colorectal cancer screening and is associated with improving patients' adherence to screening process. The number of grantees promoting the use of patient navigation and support has increased annually from 17 in FY 2010 to 21 in FY 2012 (Measure 4.M). Reduced funding in FY 2015 may result in the elimination of up to five grantees (reduced from 29 to 24). In FY 2015, CDC anticipates that at least 19 of the funded grantees (80%) will successfully implement patient navigation to help increase population-level screening at FY 2014 funding levels.

The new cancer demonstration will include NBCCEDP's target population of low income, high risk women as well as a broader focus on increasing population-level breast, cervical and colorectal cancer screening. CDC will closely follow the project to assess the impact on screening rates. Since grantees can choose where and how to focus their funding, it is unknown at this time how many will include breast, cervical, and/or colorectal cancer screening, and to what degree.

Cancer reporting from providers to State Cancer Registries is included in CMS Stage 2 Meaningful Use criteria. Electronic reporting from physician Electronic Health Records to cancer registries is one of six options to achieve Meaningful Use criteria and receive CMS payment incentives. Enhanced use of Electronic Health Records by state registries will improve the timeliness, completeness and quality of cancer data reported, particularly from non-hospital facilities. Enhanced data will improve cancer surveillance, encourage development of comprehensive cancer control programs, and plan health care interventions designed to reduce cancer incidence or improve early detection. Implementation of Meaningful Use will significantly increase the number of reports received for each case by the central registry. FY 2014–2015 targets are ambitious because this is a

new initiative being undertaken within an environment of limited state and federal resources. Physician incentives for meeting Meaningful Use criteria will facilitate the National Program of Cancer Registries meeting these targets (Measure 4.9.4).

Program: Oral Health

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.7.1: Increase the proportion of the people served by community water systems who receive optimally fluoridated water. ¹ (Intermediate Outcome)	FY 2012: 74.6% (Target Not Met but Improved)	76.5%	N/A ¹	N/A ¹

Targets and results are set and reported biennially.

Performance Trends: For 65 years, community water fluoridation has been a safe and healthy way to effectively prevent tooth decay. CDC has recognized water fluoridation as one of 10 great public health achievements of the 20th century. CDC works with national partners, states, communities, and water operators to ensure the U.S. population has access to optimally fluoridated water to prevent tooth decay. CDC is working toward the Healthy People 2020 objective of 79.6% of the population on public water systems who receive optimally fluoridated water. Fluoridation of public water systems increased from 62.1% in 1992 to 74.6% in 2012 (Measure 4.7.1). In FY 2011, the Department of Health and Human Services (HHS) proposed reducing the recommended national level of fluoride in drinking water to 0.7 mg/L to prevent tooth decay while reducing the chance for children's teeth to develop dental fluorosis. The previous U.S. Public Health Service recommendations for fluoride levels ranged from 0.7mg/L to 1.2 mg/L. The final recommendations to reduce the optimal fluoride level will be publicly available in 2014, and will incorporate public comment and HHS Federal Panel responses. CDC, in collaboration with the National Institute of Dental and Craniofacial Research (NICDR), has enhanced surveillance of dental caries (tooth decay) and dental fluorosis in the National Health and Nutrition Examination Survey (NHANES) to monitor the impact of these changes to fluoride level recommendations.

Program: Safe Motherhood and Infant Health

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.8.3: Increase the number of evidence-based findings disseminated annually that inform practice to improve maternal, infant, and reproductive health outcomes. ¹ (Output)	FY 2013: 112 (Target Exceeded)	120	125	+5
4.8.4: Increase the number of reporting areas that provide optimal data for assessing safe sleep practices using the Pregnancy Risk Assessment Monitoring System (PRAMS). (Intermediate Outcome)	FY 2013: 17 (Target Met)	19	21	+2

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.8.5: Reduce birth rates among adolescent females aged 15 to 19 years (per 1,000 births). (Contextual Indicator)	FY 2012: 29.4 (Target Exceeded)	26.8	25.2	-1.6

¹This change in text is in line with the CDC’s Reproductive Health strategic plan to inform clinical and public health practice.

Performance Trends: As a leader in population-based reproductive, maternal and child health, CDC strengthens the evidence base for effective interventions that improve both maternal and infant health. The birth rate for teenagers aged 15-19 dropped six percent in 2012 from 31.3 births per 1000 women in 2011 to 29.4 births per 1,000 women, the lowest rate ever reported for the U.S. (Measure 4.8.5). The annual societal cost of teen childbearing in 2010 was approximately \$9.4 billion, down approximately \$1.5 billion from 2008. In 2010, CDC identified and funded ten communities with significantly higher than average teen birth rates. The teen birth rate in these communities decreased from 71.8 per 1,000 in FY 2009 to 68.3 per 1,000 in FY 2011.

The availability of data through the Pregnancy Risk Assessment Monitoring System (PRAMS) allows CDC and states to monitor changes in maternal and child health status and indicators (e.g., unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, and infant health), identify groups of women and infants at high risk for health problems, and measure progress toward goals in improving the health of mothers and infants. In FY 2013, 41 sites (40 states and New York City) collected data using PRAMS, which represents 78% of live births in the United States. In FY 2016, CDC will realign the core set of questions to allow all sites to measure safe sleep practices in order to evaluate community-based infant death prevention recommendations for reducing sudden unexpected infant deaths. Currently only 17 sites collect additional data for assessing safe sleep practices (Measure 4.8.4).

Translation and dissemination of epidemiologic research findings is vital to ensuring that evidence-based findings are integrated into health care practices. CDC strengthened the evidence base and enhanced state and local capacity in maternal and child health by increasing the annual dissemination of evidence-based findings from 80 in 2009 to 112 in 2013, totaling more than 500 findings disseminated during the five-year period (Measure 4.8.3). These findings summarized: contraception safety and frequency of use for women with chronic medical conditions; the importance and safety of vaccinations for infections, such as H1N1, for pregnant and postpartum women; and the important role of social determinants in the risk of maternal morbidity.

Program: Arthritis

Performance Measures for Long Term Objective: Reduce pain and disability and improve quality of life among people affected by arthritis.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
4.11.1: Reduce the age-adjusted percentage of adults (age 18+) diagnosed with arthritis that are physically inactive in states funded by the CDC Arthritis Program. ^{1,2,3} (Outcome)	FY 2011: 28.9% (Baseline)	N/A ¹	27.8%	N/A ¹

Targets and results are set and reported biennially.

²This measure has been revised from the FY 2013 President’s Budget to account for the re-competition of the funding announcement, resulting in a new five-year cooperative agreement with 12 states (seven continuing from the prior project period).

³For measures with BRFSS as the data source, FY 2011 results reflect methodological changes to improve sampling and weighting. Shifts in prevalence estimates for 2011 might not represent trends in risk factor prevalence in the population but merely reflect improved methods of measuring risk factors.

Performance Trends: Moderate physical activity is a proven and safe self-management strategy for people with arthritis. Benefits include significant improvements in reducing pain level and enhancing function, mobility, and

quality-of-life. Adults with arthritis have significantly higher rates of physical inactivity than adults without arthritis. FY 2011 baseline data for physical activity levels show almost 29% of adults diagnosed with arthritis in states funded by CDC were physically inactive (Measure 4.11.1). To increase the level of physical activity among people with arthritis, the CDC and its 12 funded state arthritis programs, along with national partners (e.g., Arthritis Foundation, National Association of Chronic Disease Directors), will improve knowledge of appropriate physical activity through health communication messages and increased access, availability, and participation in proven physical activity programs for people with arthritis. Evidence-based interventions and programs include "Walk with Ease", the Arthritis Foundation Exercise Program and "Physical Activity. The Arthritis Pain Reliever," a health communications campaign for use by state health departments, partners, and other community organizations. These programs demonstrate reduced symptoms and improved function and physical activity behaviors among adults with arthritis.

BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

PERFORMANCE

Child Health and Development

Performance Measures for Long-Term Objective: Prevent birth defects and developmental disabilities

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
5.1.5a: Increase the proportion of all children with autism spectrum disorders (ASDs) who receive a first evaluation by 36 months of age ¹ (Outcome)	FY 2013: 41.3% (Target Met)	N/A	41.8%	N/A
5.1.5b: Increase the proportion of children with low SES with autism spectrum disorders (ASDs) who receive a first evaluation by 36 months of age ² (Outcome)	FY 2011: 37.3% (Historical Actual)	N/A	37.3%	N/A
5.1.5c: Increase the proportion of children of minority race/ethnicity (non-white) with autism spectrum disorders (ASDs) who receive a first evaluation by 36 months of age ¹ (Outcome)	FY 2013: 37.7% (Target Met)	N/A	38.3%	N/A
5.1.5d: Increase the proportion of children of low SES and minority race/ethnicity: with autism spectrum disorders (ASDs) who receive a first evaluation by 36 months of age ¹ (Outcome)	FY 2011: 36.3% (Historical Actual)	N/A	37.8%	N/A
5.1.7: Increase the proportion of CDC-funded, state-based birth defects surveillance programs that disseminate surveillance data within 2 years of data collection (Outcome)	FY 2013: 64%	71%	71%	Maintain
5.1.8: Increase the percentage of primary care providers who (a) screen women of reproductive age for risky alcohol use and (b) provide appropriate, evidence-based interventions to reduce alcohol-exposed pregnancy for those at risk (Outcome)	a) FY 2013: 36.2% (Target Not Met) b) FY 2013: 34.9% (Target Met)	a) 40% b) 36%	a) 41% b) 37%	a) +1.0 b) +1.0
5.1.9 Increase the Teratogen Information System Quantity/Quality of Evidence ratings for the most frequently used medications during pregnancy that have a baseline quantity/quality rating of fair or lower ¹ (Output)	FY 2012: 20 (Baseline)	21	NA	N/A
5.1.10 Increase the proportion of Hispanic women of reproductive age who have an optimal blood folate concentration for neural tube defect prevention. (Outcome)	FY 2013: 75.5% (Baseline)	N/A	76%	N/A
5.C: Number of fetal alcohol syndrome training centers and fetal alcohol syndrome surveillance programs (Output)	FY 2013: 8.0 (Target Met)	5.0	4.0	-1

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
5.D: Number of states funded to monitor autism and other developmental disabilities as part of the Autism and Developmental Disabilities Monitoring Network (Output)	FY 2012: 12.0 (Target Met)	12.0	12.0	Maintain
5.K: Number of countries conducting surveillance of neural tube defects and/or monitoring blood folates among countries with a CDC presence ² (Output)	FY2013: 15 (Target Met)	16	18	+2

¹Targets and results are set and reported biennially.

² FY 2012 results and baseline in FY 2014 President's Budget incurred a reporting error. Targets have been adjusted accordingly

Performance Trends: CDC has modeled existing evidence to establish a blood folate concentration that will optimize the reduction in risk for neural tube defects. Blood folate concentrations offer a reliable measure to accurately assess a population's risk of neural tube defects. Because Hispanic women have higher rates of neural tube defects than other race/ethnicities, CDC will track red blood cell folate concentrations among Hispanic women of reproductive age. This information will help CDC develop appropriate prevention interventions directed to Hispanic women. CDC has set a target of 76% for FY 2015, a 0.5% increase over the FY 2013 baseline of 75.5%. CDC may update the FY 2015 target for the FY 2016 Presidents Budget.

Recognizing the need for enhanced surveillance and epidemiology to support international neural tube defect prevention efforts, CDC will continue to monitor the number of countries with a CDC presence that conduct surveillance of neural tube defects and/or monitor blood folates. Due to a reporting error, FY 2012 baseline has been adjusted to 15. Material inadequacies in reporting have been identified and additional data sources will be applied in future reporting years. Based on the updated baseline, targets for FY 2013 and later have been adjusted. Results from FY 2013 indicate that the target (adjusted) has been met (Measure 5.K): 15 countries with a CDC-presence conducted surveillance of neural tube defects and/or monitoring blood folates.

CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network sites monitor the prevalence of Autism Spectrum Disorder (ASD) and other developmental disabilities in various geographic regions throughout the United States. ADDM has traditionally focused on eight-year-old children but has begun conducting surveillance on four-year-old children at some sites. The most recent ASD prevalence data from ADDM estimated that 1 in 88 children living in ADDM Network communities during 2008 have autism. This is a 78% increase in the identified prevalence of ASD between 2002 and 2008. In part, this increase is due to improved identification, diagnosis, and treatment of children in local communities. The next ASD prevalence report on ADDM data will be published in 2014.

CDC plays a critical role in addressing autism by monitoring and tracking rates, investigating risk factors, and educating families and providers about the importance of monitoring developmental milestones to identify and seek medical advice as soon as possible. Since early screening and diagnosis improve access to services during a child's most critical developmental period, CDC targets a reduction in disparities by focusing on children of low socioeconomic status and minorities (Measures 5.1.5a-d, 5.D). Results from the 2011 reporting period show improvements in the proportion of children with ASD who receive a first evaluation by 36 months of age, with targets met in two of the four measures. Results for the 2013 reporting period are available for two of the measures (5.1.5a and 5.1.5c) and show a slight decline for all children who receive a first evaluation by 36 months of age; however, there was an improvement in the proportion of children of minority race/ethnicity who receive a first evaluation by 36 months of age. Results for the 2013 reporting period for measures 5.1.5b and 5.1.5d will be available in June of 2014.

CDC supports activities to prevent fetal alcohol syndrome (FAS) and other fetal alcohol spectrum disorders (FASDs) with focused efforts to increase alcohol screening and evidence-based interventions in healthcare settings serving women of reproductive age and American-Indian communities. In addition, there are currently three model state-based FAS surveillance programs and five FASD Regional Training Centers (RTCs) (Measure 5.C). CDC's FY 2014 target reflects reductions in FAS surveillance sites, and the Regional Training Centers are reduced from five sites to four in 2015 as a result of budget constraints. Through the RTCs, CDC implements training programs to enhance knowledge and skills among medical and allied health students and practitioners in the prevention, identification, and treatment of FASDs. Reductions will drastically affect national efforts to train medical and allied health practitioners to provide evidence-based practices to reduce alcohol misuse and alcohol-exposed pregnancies. In FY 2013, three RTCs continued implementing alcohol screening and brief intervention within primary care systems in their regions.

Increasing primary care provider screening for alcohol misuse among women of reproductive age and the provision of evidence-based interventions are essential to improving maternal and child health and preventing FASDs. The FY 2013 target of 37.5% (1.5 percentage points over the FY 2012 baseline) for provider-based alcohol screening of women of reproductive age was not met (FY 2013 actual: 36.2%); the percentage remains about the same as the baseline percentage. However, it should be noted that there were variations in screening rates across specific provider types. The FY 2013 target of 33.5% (1.5 percentage points over the FY 2012 baseline) for provision of evidence-based interventions has been met (FY 2013 result: 34.9%) and increased among all provider types. CDC has slightly increased targets for the percentage of primary care providers who screen women of reproductive age for alcohol misuse, and for primary care providers who provide appropriate, evidence-based interventions (five percentage points above the FY 2012 baseline; Measure 5.1.8).

CDC helps to support birth defects tracking and data utilization in 14 states and territories in the United States. The birth defects programs ascertain all babies born with major birth defects who live in their geographic area to understand the impact of these conditions in the population. These birth defects can sometimes be diagnosed immediately at birth but some conditions might not be diagnosed until later in life. Ascertaining birth defects requires program staff to continually review medical records at multiple health care facilities as well as administrative datasets to ensure adequate information is captured. The proportion of CDC-funded birth defects programs that report quality data in a timely manner has increased to 64%, which meets the target set for Measure 5.1.7. State programs continue to improve timeliness in data collection through remote access and multiple data sources, efficiency in electronic data management, and having dedicated staff for data analysis and dissemination.

For FY 2015, CDC has replaced measure 5.1.6 (Among the medications most frequently used during pregnancy, increase the number with sufficient evidence to determine the fetal risk) with measure 5.1.9 (Teratogen Information System Quantity/Quality of Evidence ratings) because this measure defines the indicators using the quality/quantity rating rather than the risk rating. The risk rating is in large part determined by the pharmaceutical properties of medications whereas the quality/quantity rating is determined by the amount and quality of scientific evidence produced about a medication. The latter is more modifiable and provides a more useful indicator of performance for CDC's "Treating for Two" initiative.

Health and Development for People with Disabilities

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
5.2.5: Increase the percentage of jurisdictions that collect, report, and use individually identifiable data in order to reduce the number of infants not passing hearing screening that are lost to follow-up (Outcome)	FY 2011: 50% (Target Exceeded)	59%	63%	+4

Performance Trends: CDC’s support for the development, maintenance, and enhancement of state- and territorial-based Early Hearing Detection and Intervention (EHDI) Information Systems helps ensure recommended follow-up diagnostic and intervention services for infants who do not pass the hearing screening. Early diagnosis is essential for ensuring that infants with a hearing loss develop communication skills commensurate with their cognitive abilities, allowing for age-appropriate academic and social advancement. Furthermore, early identification and intervention programs demonstrate cost effectiveness for people with disabilities and their families. Estimates show early hearing diagnosis and intervention can save approximately \$200 million in additional education costs each year.

In FY 2011, 50% of jurisdictions collected, reported and utilized EHDI data, compared with 43% in 2010 (Measure 5.2.5). CDC has already documented screenings for hearing loss for more than 97% of children born in the United States. By increasing the percentage of jurisdictions able to collect and use individually identifiable data with the support of CDC funded EHDI Information Systems, the number of infants not receiving recommended follow-up and being late identified will continue to decrease.

Public Health Approach to Blood Disorders

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

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2014 +/- 2012 Target
5.3.1: Increase the percentage of hemophilia patients enrolled in the Universal Data Collection (UDC) system who are routinely screened for inhibitors (Outcome)	FY 2011: 37.4% (Baseline)	41.1%	N/A ¹	N/A

¹CDC replaced the UDC in FY 2013 and will replace this measure when baseline data from the new system become available in 2014

Performance Trends: Approximately 15-20% of people with hemophilia develop an inhibitor (antibody) to the products used to prevent bleeding, making the treatments less effective. Medical providers typically treat patients with higher and more frequent doses of the treatment products, which can exacerbate the inhibitor. Inhibitors can cause hemophilia treatment costs to exceed \$1,000,000 a year, increase hospitalizations, and compromise physical functioning.

Discovering an inhibitor as soon as possible helps improve outcomes and reduce costs. Although it’s widely accepted by hemophilia care providers that development of an inhibitor is a serious complication of treatment, routine screening for inhibitors is not the current standard of care. In FY 2013, CDC replaced the Universal Data Collection system with the Public Health Surveillance Project on Bleeding Disorders (PHSPBD). The PHSPBD increases the scope of data previously collected by the UDC system, providing information that better informs research for identifying risk factors and evidence-based prevention practices for effective treatments. CDC will revise Measure 5.3.1 to include data from the PHSPBD to measure the percentage of patients treated at hemophilia centers who are routinely screened for inhibitors. CDC will report on the revised measure once baseline data are available in June 2014.

ENVIRONMENTAL HEALTH

PERFORMANCE

Performance Measures for Program: Environmental Health Laboratory

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
6.1.1: Number of environmental chemicals, including nutritional indicators that are assessed for exposure of the U.S. population. (Output)	FY 2013: 316 (Target Not Met)	340	340	Maintain
6.1.3: Number of laboratories participating in DLS Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements ¹ (Output)	FY 2013: 1,295 (Target Exceeded)	1050	1100	+50
<u>6.A</u> : Number of environmental chemicals for which methods were developed or improved (Output)	FY 2013: 89 (Target Exceeded)	15	20	+5
<u>6.B</u> : Number of laboratory studies conducted to measure levels of environmental chemicals in exposed populations (Output)	FY 2013: 95 (Target Exceeded)	60	65	+5
<u>6.F</u> : Number of states assisted with screening newborns for preventable diseases (Output)	FY 2013: 50 (Target Met)	50	50	Maintain

(i.e., newborn screening, chronic diseases [diabetes, cholesterol], environmental health [blood lead, cadmium and mercury], and nutritional indicators).

Performance Trends: CDC’s biomonitoring measurements (in blood and urine) identify the level of chemicals and nutritional indicators in the U.S. population. The measurements provide national reference information for scientists, physicians, and health officials. In FY 2013, CDC measured 316 environmental chemicals and nutritional indicators in the U.S. population, slightly lower than the target because of routine, cycle-to-cycle variation in the indicators and chemicals assessed in NHANES participants (Measure 6.1.1). However, CDC expects to meet the FY 2015 target for this measure. In FY 2012 and FY 2013, CDC developed several new methods that measure multiple environmental chemicals in a single test, greatly exceeding its target to develop or improve methods (Measure 6.A). CDC adjusted FY 2014 and FY 2015 targets for this measure to reflect trends from previous years while accounting for the considerable time and scientific rigor required to develop methods that detect more than one chemical. CDC also exceeded its target of conducting 52 laboratory studies to identify populations with harmful exposures to chemicals (Measure 6.B). CDC adjusted FY 2014 and FY 2015 targets to address higher than anticipated results in both FY 2012 and FY 2013. New targets reflect variations dependent on opportunities with collaborators and the alignment of study proposals with the Environmental Health Laboratory’s mission and budgetary goals.

CDC’s Environmental Health Laboratory provides quality assurance and standardization programs for testing chronic diseases, newborn screening disorders, nutritional status, and environmental exposures. CDC has met or exceeded its targets for recruiting laboratories to voluntarily participate in these programs since 2007 (Measure 6.1.3). In FY 2012 CDC increased its FY 2014 and FY 2015 targets based on this trend, accounting for voluntary participation in CDC’s quality assurance and standardization programs and will reevaluate based on FY 2013 results. CDC provides newborn screening quality assurance to all states and met its FY 2013 target to provide quality assurance materials and technical expertise to 50 states for newborn screening of several preventable diseases (e.g. Severe Combined Immunodeficiency, Amino acid disorders, Endocrinopathies) (Measure 6.F).

Performance Measures for Program: Environmental Health Activities

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
<u>6.1.2</u> : Number of completed studies to determine the harmful health effects from environmental hazards. (Output)	FY 2013: 44 (Target Exceeded)	27	27	Maintain
<u>6.C</u> : Number of public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures (Output)	FY 2013: 32 (Target Exceeded) ¹	24	20	-4
<u>6.H</u> : Number of emergency radiation preparedness toolkits provided to clinicians/public health workers (Output)	FY 2013: 1,020 (Target Exceeded)	1,000	750	-250

¹Results reflect ACA/PPHF funding.

Performance Trends: Since 2006, CDC has met or exceeded its target for completing studies to examine the human health effects of exposure to water and air pollutants, radiation, and hazards related to natural and other disasters (Measure 6.1.2). These study results help CDC develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their health consequences. In FY 2013, CDC investigated the first documented outbreak of acetyl fentanyl overdose deaths in the United States. CDC has also worked with federal and state partners to investigate contaminated nutritional supplements that have caused adverse health effects, resulting in removal of the supplements from the market. Since FY 2005, state and local public health officials have used the Environmental Health Tracking Network to implement more than 200 data-driven public health actions (an average of approximately 24 per year) to prevent adverse health effects from environmental exposures, including 32 public health actions in FY 2013 (Measure 6.C). These actions include helping answer concerns about neighborhood air quality, preventing exposures to nitrates in drinking water, and assisting in preparing for extreme heat events. The Tracking Network also serves as a source of information on environmental hazards, exposure, population data and health outcomes. Targets have been revised to better reflect recent results, though reduced funding levels in FY 2015 will make it difficult for state and local governments to maintain such a high number of new public health actions. CDC will continue to monitor the program and will adjust targets accordingly.

Providing expertise in radiation health and exposure, CDC exceeded its target in FY 2013 for Measure 6.H by distributing 1,020 radiation toolkits. Due to the ongoing effects of Fukushima’s radiation disaster in March 2011, CDC experienced a spike in toolkit requests from Western states and international partners in FYs 2011 and 2012. However, the number of requests leveled off in FY 2013, and CDC anticipates distributing a more typical number of kits in FY 2014 and beyond. Since the creation of the toolkits in 2005, CDC has provided more than 27,000 kits to professionals across the nation and internationally to assist clinicians in developing plans and response capacity for radiation emergencies.

Performance Measure for Program: Asthma

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
<u>6.2.4</u> : Increase the proportion of those with current asthma who report they have received self –management training for asthma in populations served by CDC funded state asthma control programs. (Output)	FY 2011: 46% (Target Exceeded)	50%	50%	Maintain

Performance Trends: CDC measures the proportion of individuals with current asthma who report receiving asthma self-management training from a doctor or other health care provider (Measure 6.2.4). Implementing asthma action plans and effective asthma self-management (per the National Institutes of Health’s *Guidelines for the Diagnosis and Management of Asthma*) are vital to helping people stay out of the hospital and manage their asthma. Studies show asthma self-management education can lead to a 54 percent reduction in hospital readmissions and a 34 percent reduction in emergency department visits— ultimately saving \$35 for every one dollar spent in avoided health care costs and lost productivity. Asthma attack prevalence among persons with current asthma decreased from 55.8 percent in 2001 to 49.1percent in 2011. This decrease represents progress in asthma management.

CDC exceeded the FY 2011 target for delivering self-management training through its funded grantees with 46 percent reporting receiving training (Measure 6.2.4). The data for this measure comes from the Asthma Call-back Survey (ACBS), which is methodically linked to the Behavioral Risk Factor Surveillance System (BRFSS). Due to changes to the BRFSS sample for calendar year 2011 data, which includes the addition of a cell phone sample and revised weighting methodology, results for this measure from 2010 and earlier should not be compared or combined with data from 2011 and later. Funded states are implementing comprehensive, evidence-based programs that target health care providers and asthma educators in multiple settings (doctor’s offices, hospitals, schools, daycare centers, community organizations) to ensure they are aligning their efforts with the National Institute of Health’s *Guidelines for the Diagnosis and Management of Asthma*. CDC will release a new Funding Opportunity Announcement in FY 2014 and anticipates presenting a new supporting asthma measure accordingly.

Performance Measures for Program: Healthy Homes/Childhood Lead Poisoning Prevention¹

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
<u>6.2.5</u> : Reduce health disparities associated with blood lead levels in children aged 1-5 in the U.S. such that: a. The gap in blood lead levels between black children and children of other races is reduced (Contextual Indicator)	FY 2010: 0.52 (Baseline)	N/A	0.45	N/A
<u>6.2.5b</u> : The gap in blood lead levels between children living above the federal poverty level and those living below the poverty level is reduced (Contextual Indicator)	FY 2010: 0.54 (Baseline)	N/A	0.47	N/A
<u>6.K</u> : Number of states in which the Healthy Housing/Lead Poisoning Surveillance System (HHLPSS) has been deployed. (Output)	FY 2012: 18 (Baseline)	18	18	Maintain

¹Targets are set and reported biennially

Performance Trends: These measures (6.2.5a and 6.2.5b) serve as valuable indicators of the success of lead interventions nationwide. Both focus on the stark health disparity gaps that exist between children based on both race and household income. For example, African-American children are three times more likely than white children to have blood lead levels greater than five micrograms per cubic deciliter (the current blood lead level of concern). While overall U.S. child lead levels have fallen significantly in the last decade, reducing disparities is critical to decreasing the mean blood lead levels among all young children in the U.S. Since CDC is not currently funding interventions directly or through cooperative agreements, CDC cannot directly affect the achievement of the current measures. Therefore, CDC has not set FY 2014 or FY 2015 targets. CDC began retaining these measures in FY 2013 only as contextual indicators of the overall success of lead poisoning interventions nationwide. The FY 2011 data for these contextual indicators will be available by April 30, 2014.

CDC provides national expertise on lead poisoning prevention and a national surveillance system for blood lead and other housing related health hazards. The Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPPS) helps state and local health departments target case management, home remediation, education, and prevention activities to protect children from lead and other unhealthy exposures in the home. In FY 2012, 18 states used HHLPPS to inform lead prevention activities (Measure 6.K). CDC will maintain this level of performance in FY 2015.

INJURY PREVENTION AND CONTROL

PERFORMANCE

Program: Intentional Injury Prevention

Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from intentional injuries for people at all life stages.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
7.1.3: Increase the difference in teen dating violence prevalence between the control group and Dating Matters group. (Intermediate Outcome)	FY 2012: 0.0% (Baseline)	5%	10%	+5
7.2.5: Increase the percent of Core VIPP funded states that assess outcomes and impact of injury and violence prevention strategies using surveillance data. (Intermediate Outcome) ¹	CY 2013: 85.0% (Target Not Met)	95.0%	100.0%	+5

¹The Core VIPP program is cross-cutting and is supported by both the Intentional and Unintentional Injury Prevention budget lines.

Performance Trends: Violence-related injuries and deaths, including interpersonal and self-directed, cost approximately \$107 billion a year in medical and other costs.³²⁵ Teen dating violence is one area of growing concern in violence prevention. Teen victims of dating violence are more likely to be depressed and do poorly in school. They may engage in unhealthy behaviors, like using drugs and alcohol, and are more likely to have eating disorders. In extreme cases, some teens even think about or attempt suicide. Current science demonstrates it is most effective to begin working with teens at a younger age to stop dating violence before it starts.

CDC’s Dating Matters™ initiative is a combination of evidence-based and evidence-informed strategies that promote respectful, nonviolent dating relationships among youth ages 11–14 years in high-risk urban communities. CDC is examining the cost, feasibility, sustainability, and effectiveness of a comprehensive approach to teen dating violence in four high-risk urban communities during the first phase of a five-year demonstration project of Dating Matters™ (FY 2011 - FY 2015). Elements of this prevention initiative are being delivered in over 40 middle schools across four cities (Baltimore, Maryland; Chicago, Illinois; Ft. Lauderdale; Florida and Oakland, California) and include a rigorous evaluation as well as cost analysis. The evaluation will continue to follow youth through high school to monitor the long-term program effectiveness. CDC estimates that up to 100,000 students and adults will have participated in Dating Matters™ in the four demonstration sites when implementation is complete in FY 2015. In addition, CDC will continue planning for the dissemination of Dating Matters™ strategies to other urban communities beginning in FY 2016 through seed funding and/or partnerships with other CDC programs and federal agency partners. CDC grantees will adapt and utilize the following evidence-based programs as part of the Dating Matters™ initiative: 1) Safe Dates, which can decrease levels of dating violence among eighth graders; 2) Families for Safe Dates, which encourages families to talk about healthy dating relationships and dating abuse and can decrease levels of dating violence victimization among youth whose parents completed the program (for parents of eighth graders); and 3) Parents Matter, a community-level, family prevention program that enhances protective parenting practices for parents of 6th graders.

³²⁵ <http://www.cdc.gov/injury/wisqars/cost/cost-learn-more.html>

Additional CDC efforts for violence prevention include the Core Violence and Injury Prevention Program (Core VIPP), which is a cross cutting program that supports both intentional and unintentional injury prevention activities (Measure 7.2.5). The program is discussed in further detail in the Unintentional Injury Prevention section.

Program: Unintentional Injury Prevention

Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from unintentional injuries for people at all life stages.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
7.2.4: Reduce motor vehicle deaths per 100M miles traveled. (Outcome)	CY 2012: 1.14 (Target Not Met)	0.97	0.97	Maintain
7.2.5: Increase the percent of Core VIPP funded states that assess outcomes and impact of injury and violence prevention strategies using surveillance data. (Intermediate Outcome) ¹	FY 2013: 85.0% ² (Target Not Met)	95.0%	100.0%	+5

¹The Core VIPP program is cross-cutting and is supported by both the Intentional and Unintentional Injury Prevention budget lines.

²Due to budget constraints, the number of Core VIPP states was reduced to 20 starting in FY 2012. The baseline and FY 2012 target were computed using 28 states while the FY 2013 target, FY 2014 target and FY 2012 result were computed using the 20 states currently funded.

Performance Trends: Unintentional injuries are the leading cause of death for individuals ages 1–44 in the United States and cost more than \$81 billion in medical costs per year. CDC works in multiple areas across unintentional injury, including transportation safety and older adult falls prevention. CDC also works to strengthen states’ capabilities to address both intentional and unintentional injuries, especially through the Core Violence and Injury Prevention Program (Core VIPP).

Although CDC did not meet its target of 1.03 fatalities per 100 million vehicle miles traveled (VMT), the rate of traffic fatalities per 100 million VMT has seen an overall decline since 2005 (Measure 7.2.4). These declines are likely attributable to prevention strategies that increase seat belt usage, graduated driver licensing systems, creation of safer motor vehicles, and improvement in safe driving behaviors. Although reductions in traffic fatalities indicate motor vehicle safety efforts have been effective, the rate of decline experienced between 2005 and 2009 (21% reduction) slowed from 2010 to 2011 (one percent reduction) and then slightly increased in 2012. However, this is consistent with historical trends that show repeated instances of large declines followed by a multi-year leveling off period. CDC will continue to implement effective prevention strategies, including:

- CDC’s “Parents Are the Key” communications campaign toolkit, which provides resources to support graduated driver licensing systems and parental involvement in teen driving.
- CDC’s Tribal Motor Vehicle Injury Prevention Program (TMVIPP), which significantly impacted communities through culturally appropriate, effective interventions implemented in eight tribal communities across the United States. For example, through TMVIPP and a cooperative agreement between the California Rural Indian Health Board’s Injury Prevention program and the Yurok Tribal Police Department, the Yurok Tribe of Klamath, California observed an increase in seatbelt use from 75.2% (n=499) to 81.0% (n=604) in one year. Additionally, child safety seat use increased from 53.0% (n=45) to 60.4% (n=48).

CDC’s Core VIPP program provides support to state health departments to increase state capacity to effectively disseminate, implement, and evaluate best practices and science-based strategies for injury and violence prevention programs. The Core VIPP grantees use surveillance data to inform injury and violence prevention

activities. In 2013, grantees engaged in their second full year of program planning and implementation. As a result, 85% of grantees reported using data to assess outcomes and impact of injury and violence prevention strategies, an increase of 25% over the previous year and on target with the performance goal (Measure 7.2.5).

CDC will continue to monitor data collected from states, focusing on how they use their surveillance. Data monitoring throughout the project will identify intermediate and long-term outcomes and/or impacts. For example, through support of CDC's Core VIPP program, the Tennessee Department of Health added Neonatal Abstinence Syndrome (NAS) to the list of reportable diseases. NAS is a condition in which infants born to drug-addicted mothers experience withdrawal symptoms. Currently, these rates are obtained from hospital discharge data and may take up to 12-18 months for health departments to receive the data. By adding NAS as a reportable condition, health departments can more readily determine current incidence rates. This, in turn, will allow for rapid determination of successful policy activities related to reducing prescription drug misuse in Tennessee.

PUBLIC HEALTH SCIENTIFIC SERVICES

PERFORMANCE

Program: Health Statistics

Performance Measures for Long Term Objective: Monitor trends in the nation’s health through high-quality data systems and deliver timely data to the nation’s health decision-makers.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.A.E.1: Reduce the number of months from the end of data collection to data release on the internet (Outcome; Efficiency)	FY 2010: 7.6 (Target Exceeded) ¹	7.5	7.2	-0.3
8.A.1.1a: Sustain the percentage of NCHS website users that are satisfied with data quality and relevance (Outcome)	FY 2013: 77.1% (Target Exceeded)	77.4%	77.4%	Maintain
8.A.1.1b: Sustain the percentage of Federal Power Users (key federal officials involved in health and health care policy or programs) that indicate that data quality is good or excellent (Outcome)	FY 2013: 100% Good or Excellent (Target Met)	100% Good or Excellent	100% Good or Excellent	Maintain
8.A.1.3: Increase the number of web visits as a proxy for use of NCHS data ² (Output)	FY 2013: 12 Million (Target Exceeded)	12 Million	12 Million	Maintain
8.F: Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey (Output)	FY 2013: 15 (Target Met)	15	15	Maintain
8.G: Number of households interviewed in the National Health Interview Survey ^{3,4} (Output)	FY 2012: 42,366 (Target Not Met but Improved) ⁵	40,000	35,000	-5,000
8.H.1: Number of physicians surveyed in the National Ambulatory Medical Care Survey ^{3,4} (Output)	FY 2012: 18,741 (Target Exceeded)	14,500	3,300	-11,200
8.H.2: Number of patient visit records surveyed in the National Ambulatory Medical Care Survey ^{3,4} (Output)	FY 2012: 170,543 (Target Exceeded)	132,000	30,500	-101,500

¹Most recent result. Data from 2011 have not been released for all surveys and data collection systems at the time of submission.

²For FY 2013 onward, targets and results reflect an improved method for calculating web visits.

³Targets and results reflect ACA/PPHF funding received in FY 2012 and FY 2013. FY 2014 targets reflect FY 2013 PPHF funds.

⁴The increase in NHIS and NAMCS sample size will vary depending on when funds are received.

⁵The result published in the FY 2014 President’s Budget was preliminary. This is the final figure.

Performance Trends: CDC uses several indicators to measure its ability to provide useful, timely, and high quality data. CDC released FY 2010 data within 7.6 months of completing its data collection, exceeding the target for the third year in a row and improving efficiency while maintaining data quality (Measure 8.A.E.1). To drive program improvements, CDC also assesses user satisfaction. The percentage of National Center for Health Statistics’ (NCHS’) website users who are satisfied with data quality and relevance has increased by nearly six percentage points since 2010 to 77.1% in 2013 (Measure 8.A.1.1a). Similarly, CDC interviews Federal Power Users (key federal officials involved in health and health care policy or programs) to assess their satisfaction with CDC products and services including data quality, ease of data accessibility and use, professionalism of staff,

relevance of data to major health issues, and relevance of data to user needs. CDC met the target of 100% Good or Excellent ratings for the sixth consecutive year in FY 2013 (Measure 8.A.1.1b).

Finally, CDC tracks the number of web visits as a proxy for the use of NCHS data. Web visits to NCHS webpages within <http://www.cdc.gov> and texting subscribers increased by 3 million to 12 million in FY 2013 compared to FY 2010 (Measure 8.A.1.3). CDC began using a more accurate system for verifying web visits in FY 2013. This presents challenges for comparing future data with data prior to FY 2013 as the new system captures additional visits that were not previously accounted for by the old method. Therefore, CDC anticipates more modest gains in the future. CDC has also increased the number of releases on the NCHS Facebook page and has pursued cross promotion of NCHS content with other CDC social media channels.

In addition to data quality, CDC also monitors the implementation of its national surveys. The National Health and Nutrition Examination Survey mobile examination centers visited the planned 15 communities in FY 2013 (Measure 8.F). Since 2011, CDC has increased the number of interviews for two of its surveys designed to monitor health reform efforts, largely through support from the Prevention and Public Health Fund. Expanded samples will lead to more precise data on access to care, prevention, management of chronic conditions, and health outcomes as well as a greater number of estimates for some measures at the state level. The sample size of the National Health Interview Survey (NHIS) increased by approximately seven percent in FY 2012 to 42,366 households compared to 2011 (Measure 8.G). For the National Ambulatory Medical Care Survey (NAMCS), the number of physicians interviewed increased by 367% to 18,741, and patient records surveyed rose by 414% to 170,543 between FY 2011 and FY 2012 (Measures 8.H.1 and 8.H.2). Sample size is based on calendar years rather than fiscal years, and because of the timing of receipt of funds, CDC used funds from multiple years to support initial increases in the NAMCS sample size in FY 2012. CDC expects the NAMCS sample sizes will stabilize at a lower level in future survey years. Prevention and Public Health Funds received in FY 2013 supported increased survey sample sizes in the 2014 calendar year. CDC did not receive Prevention and Public Health Funds for NCHS in FY 2014, which is reflected in reduced FY 2015 targets for NHIS and NAMCS sample sizes.

Program: Surveillance, Epidemiology, and Laboratory Services (OSELs)

Performance Measures for Long Term Objective: Lower barriers to data exchange across jurisdictions as part of an integrated strategy for public health surveillance and response.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.B.1.3a: Increase the percentage of public health agencies that can receive production Electronic Laboratory Reporting (ELR) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology used by eligible hospitals ^{1,2} (Output)	FY 2013: 46% (Target Exceeded)	54%	54%	Maintain
8.B.1.3b: Increase the percentage of public health agencies (or their designee) that can receive Immunization Information System (IIS) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology ^{1,3} (Output)	FY 2013: 64% (Preliminary)	65%	65%	Maintain
8.B.1.3c: Increase the percentage of public health agencies that can receive production Syndromic Surveillance (SS) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology ^{1,4} (Output)	FY 2013: 50% (Preliminary)	63%	63%	Maintain

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.K: Sustain the number of states developing or deploying National Electronic Disease Surveillance System (NEDSS)-compatible systems or using the NEDSS Base System, to improve case identification, investigation and response (Output)	FY 2013: 50 (Target Met)	50	50	Maintain
8.L: Increase the average percentage of completed cell phone interviews to maintain population coverage in the Behavioral Risk Factor Surveillance (BRFSS) ⁵ (Output)	FY 2012: 21% (Baseline)	25%	27%	+2

¹ CDC is currently unable to track the percentage of agencies that can send EHR Meaningful Use compliant messages, but this may be possible starting in FY 2016, pending the final Meaningful Use Stage 3 criteria issued by the Office of the National Coordinator for Health Information Technology.

² ELR: The work of state public health agencies reflected in this measure is funded by the National Center for Emerging and Zoonotic Diseases through the Epidemiology and Laboratory Capacity Cooperative Agreement.

³ IIS: The work of state public health agencies reflected in this measure is funded by the National Center for Immunization and Respiratory Diseases through the Section 317 program.

⁴ SS: The work of state public health agencies reflected in this measure is funded through the Office of Public Health Preparedness and Response.

⁵ Targets and results reflect PPHF/ACA funding.

Performance Measures for Long Term Objective: Improve access to and reach of scientific public health information among key audiences to maximize health impact

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.B.2.1: Increase the reach of the Morbidity and Mortality Weekly Report (MMWR), as measured by the number of electronic and print subscribers (Output)	FY 2013: 206,174 (Target Exceeded)	206,174	216,482	+10,308
8.B.2.2: Increase the electronic media reach of CDC Vital Signs through use of mechanisms such as the CDC website and social media outlets, as measured by page views, social media followers, and texting and email subscribers (Output)	FY 2013: 2,924,842 (Target Exceeded)	2,924,842	3,071,084	+146,242
8.B.2.5: Increase access to and awareness of the Guide to Community Preventive Services, and Task Force findings and recommendations, using page views as proxy for use ¹ (Outcome)	FY 2013: 1,359,772 (Target Exceeded)	1,400,000	1,400,000	0

¹ Targets and results reflect ACA/PPHF funding.

Performance Measures for Long Term Objective: Improve the efficiency and accuracy of public health and clinical laboratory testing

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.B.3.2: Increase the percentage of public health and clinical laboratory professionals who improve laboratory policies and practices as a result of participating in CDC laboratory training workshops (Outcome)	FY 2013: 64.2% (Baseline)	70.0%	75.0%	+5

Public Health Informatics Performance Trends: CDC tracks the contribution of the informatics program and CDC program partners to the Electronic Health Records – Meaningful Use (EHR-MU) initiative. CDC is working to assess and ensure readiness of three key systems in each state: Electronic Laboratory Reporting, Immunization Information Systems, and Syndromic Surveillance. Public health agencies will assess their capability to receive data in a Meaningful Use-compliant format (i.e., Health Level 7 (HL7) 2.5.1 and 2.3.1 standards) from eligible hospitals, meaning those hospitals with certified EHRs participating in the Centers for Medicare and Medicaid Services' Meaningful Use program. In FY 2014, Meaningful Use stage two required all Immunization Information System providers to use only the latest format (HL7 version 2.5.1). While providers currently using the older format are likely to be grandfathered in, CDC anticipates a drop in capability during the transition to the newer format. This change in the definition of meaningful use compliant data affected the results for FY 2013, so CDC is re-assessing the results for verification. This may result in changes to FY 2014 and FY 2015 targets (Measure 8.B.1.3b). As demonstrated by FY 2013 preliminary results, CDC expects significant capability gains for Electronic Laboratory Reporting and Syndromic Surveillance as healthcare and public health agencies strive to meet Meaningful Use stage one and two requirements (Measures 8.B.1.3a and 8.B.1.3c). Per changes to MU compliant messages, CDC is re-assessing these results as well.

Public health agencies are not currently required to develop the ability to send messages to eligible providers and hospitals. The Office of the National Coordinator for Health Information Technology is considering a stage three measure to track public health agencies' submissions to EHRs for FY 2016. However, it is expected to be applicable to Immunization Information Systems only.

Surveillance Performance Trends: All 50 states have a National Electronic Disease Surveillance System (NEDSS)-compatible system for notifiable diseases reporting (Measure 8.K). "NEDSS-compatible" means a state's information system meets an established set of requirements, enabling states to share information efficiently with CDC and other health agencies. Currently, 19 jurisdictions use the NEDSS Base System, a software product developed by CDC for state and local health department use in detection and reporting of notifiable diseases and conditions. NEDSS Base System also provides electronic laboratory reporting capabilities, which allows timelier and more accurate disease reporting. Because NEDSS reporting allows for flexibility in systems, remaining jurisdictions use a variety of means. For example, Massachusetts uses the Massachusetts Virtual Epidemiologic Network, a NEDSS-compatible system. As a result, jurisdictions are able to implement integrated surveillance systems to manage investigation and response activities, and enable data analyses for public health action. Alabama found the NEDSS Base System improved information sharing between local offices and the state health department. This facilitated faster follow-up on cases and earlier detection of cross-jurisdictional outbreaks.

CDC established the Behavioral Risk Factor Surveillance System (BRFSS) as a landline telephone-based health survey system conducted by states and territories to monitor population risk factors for chronic disease and other leading causes of death and disability. However, advances in telecommunications, most notably the development of cell phones, have negatively impacted the ability to collect representative data from only landline telephone respondents. The number of cell phone-only households has grown rapidly and data indicate that cell phone-only adults tend to have different demographics and risk behaviors than those with a landline telephone. CDC introduced a new output measure for FY 2014 to track progress in increasing the percentage of cell phone interviews. To maintain the validity of the BRFSS, CDC increased the average percentage of cell phone interviews conducted across states from 4.5 percent in FY 2009 to 21% in FY 2012 (Measure 8.L). The 2011 BRFSS public use data set is the first to include data from both cell phone and landline respondents. Including cell phone data has affected some 2011 prevalence estimates—such as smoking and heavy drinking—which are more common among younger respondents who were under-represented in the landline-only survey.

Epidemiology Performance Trends: In FY 2013, CDC delivered critical epidemiological data and recommendations for solving public health problems to over 190,000 clinicians, epidemiologists, laboratorians, and other public health professionals through electronic and print communications published in the Morbidity

and Mortality Weekly Report (MMWR). The number of MMWR subscribers has increased by approximately 58% since 2010, and has exceeded the target for five consecutive years (Measure 8.B.2.1). Similarly, CDC Vital Signs is a monthly communication program that targets the public, health care professionals, and policymakers through fact sheets, social media, a website (<http://www.cdc.gov/vitalsigns>), and a linked issue of the MMWR. Its electronic media reach grew from 250,000 communication channels (page views, social media followers, and texting and email subscribers) in FY 2010 to over 2.9 million communications channels in FY 2013 due to print, broadcast and cable media interest (Measure 8.B.2.2). CDC Vital Signs exceeded FY 2012 and FY 2013 targets, but CDC anticipates slower growth in the future, as media saturation is likely.

The Community Guide website (<http://www.thecommunityguide.org>) is the primary dissemination tool for the independent, non-federal Community Preventive Services Task Force (Task Force) recommendations. Task Force recommendations provide evidence-based options for program, services, and policies that protect and improve population health. Decision makers, practitioners, and researchers can choose from among those options that best meet the needs, preferences, available resources, and constraints of their constituents. In FY 2013, CDC received 1,359,772 page views on the Community Guide website, exceeding the FY 2013 target by 31% (Measure 8.B.2.5). This is a 47% increase over FY 2011 baseline. However, CDC expects slower growth in page views in FY 2014 and FY 2015

Laboratory Standards and Services Performance Trends: CDC developed a new, expanded measure for FY 2013 that tracks improvements to laboratory practices and policies resulting from CDC hands-on trainings (Measure 8.B.3.2). Targeted improvements include more accurate and timely test results for improved community and patient health, less costly clinical testing procedures, more accurate and timely public health laboratory response to foodborne illness outbreaks, expanded public health laboratory testing capability, as well as safer and more secure laboratories, protecting both laboratory professionals and the community at large. The positive training outcomes quantified in this measure relate directly to improvements in laboratory testing efficiency and laboratory sustainability by capturing improvements such as testing accuracy, improved proficiency testing results, reduced test times, and laboratory cost savings.

FY 2013 results indicate that over 64% of public health and clinical laboratory workshop participants improved laboratory policies and practices and implemented new or modified testing protocols, a six percentage point increase from FY 2012 baseline. Noted improvements include enhanced laboratory biosafety and biosecurity as well as more accurate and timely test results for improved community and patient health.

Program: Public Health Workforce and Career Development¹

Performance Measures for Long Term Objective: Develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet 21st century health challenges.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in state, local, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management ² (Output)	FY 2013: 236 (Target Exceeded)	N/A (Measure Retired)	N/A (Measure Retired)	N/A (Measure Retired)
8.B.4.2: Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies ³ (Output)	FY 2013: 401 (Target Exceeded)	298	298	Maintain

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
8.B.4.3: Increase the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies ⁴ (Output)	FY 2012: 266 (Target Exceeded)	212	212	Maintain

¹Targets and results for 8.B.4.2 and 8.B.4.3 reflect some ACA/PPHF funding.

²8.B.4.1 includes ALL (new and continuing) CDC-funded trainees in the Epidemic Intelligence Service (EIS), Public Health Prevention Service (PHPS), and Preventive Medicine Residency/Fellowship (PMR/F).

³8.B.4.2 includes ALL (new and continuing) CDC-funded trainees in EIS, PHPS, PMR/F, Public Health Associate Program (PHAP), Emerging Infectious Diseases (EID) Laboratory Fellowship, CDC/CSTE Applied Epidemiology Fellowship, Health Systems Integration Program (HSIP), and Applied Public Health Informatics Fellowship (APHIF).

⁴8.B.4.3 includes NEW CDC-funded trainees in EIS, PHPS, PMR/F, PHIFP, PHAP, Prevention Effectiveness Fellowship (PEF), and Presidential Management Fellows (PMF) program.

Performance Trends: CDC’s experiential fellowship programs contribute to the public health workforce pipeline and help to fill a critical need, as the public health workforce has decreased by at least 50,000 jobs since 2008. In 2013, 83% of CDC’s fellowship program graduates pursued careers in public health practice or obtained additional public health education. In FY 2014, CDC retired measure 8.B.4.1 due to changes in CDC workforce program strategy and focus, including blending the Public Health Prevention Service (PHPS) program into the Public Health Associate Program and pausing the Preventive Medicine Residency Fellowship (PMR/F) program to reassess program goals. From 2008 to 2013, CDC met or exceeded its target for this now retired measure; the final result was 235 Epidemiology Intelligence Service, PHPS, and PMR/F fellows supported, more than a 30% increase over the FY 2013 target. Over the past three years, CDC exceeded the targets for its measures focused on training the next generation of the public health workforce (Measures 8.B.4.2 and 8.B.4.3). CDC sets the targets based on the typical, annual class size for each of the fellowship programs included in these measures.

Since FY 2010, CDC has leveraged resources from other CDC programs and the Prevention and Public Health Fund (PPHF) to support an increased number of trainees. CDC did not receive PPHF funds in FY 2014, which is reflected in the changes in the workforce program strategy and FY 2014 and FY 2015 performance goals.

CDC’s fellowship programs promote service while learning—fellows fill critical workforce needs at CDC and in state, tribal, local, and territorial (STLT) public health agencies while training for careers in public health. By FY 2013, CDC increased the number of trainees in STLT public health agencies from 119 trainees in 2009 to 401 (Measure 8.B.4.2) by targeting funding to fellowship programs that place fellows in STLT public health agencies rather than at CDC headquarters. This strengthened workforce capacity in several critical disciplines, such as applied epidemiology, public health management, and informatics. As of September 30, 2013, CDC supported 614 fellows, 401 (65%) of whom were placed in state, tribal, local and territorial field assignments in 46 states, Washington D.C., American Samoa, Guam, Puerto Rico, and six tribal locations using a combination of FY 2012 and FY 2013 funds. In FY 2013, PPHF supported the placement of 251 (63%) of CDC’s 401 fellows in STLT public health agencies. CDC has a target of 298 fellows in STLT public health agencies in FY 2015 and may adjust targets for the FY 2016 President’s Budget.

OCCUPATIONAL SAFETY AND HEALTH

PERFORMANCE

Program: National Occupational Research Agenda (NORA)

Performance Measures for Long Term Objective: Conduct research to reduce work-related illnesses and injuries.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
9.1.1: Increase the effectiveness of the implementation of the recommendations from the National Academies reviews (Outcome)	FY 2012: 50% of the [8] evaluated CDC NIOSH programs received a score of 4 out of 5 or better based on an external review of their progress implementing recommendations from their National Academies reviews (Target Met)	100% of the [7] evaluated CDC NIOSH programs will receive a score of 4 out of 5 or better based on an external review of their progress implementing recommendations from their National Academies reviews ²	N/A ¹	N/A
9.2.3b: Reduce the number of construction workers killed in roadway construction work zones due to being struck by construction vehicles or equipment ³ (Outcome)	FY 2011: 22 (Historical Actual)	9	9	Maintain

Targets and results are set and reported biennially.

²The number of evaluated programs was reduced to 7 because the Agriculture, Forestry, and Fishing sector was eliminated in FY 2013.

³This is a long term outcome measure, and final data will be collected in 2015.

Performance Measures for Long Term Objective: Reduce workplace illness, injury, and mortality in targeted sectors

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
9.2.2a: Reduce rate of non-fatal workplace injuries among youth ages 15-17 (Outcome)	FY 2013: 3.8 (Target Exceeded)	3.7	3.7	Maintain
9.2.2c: Maintain ≥ 95% of active underground coal mines in the U.S. that possesses NIOSH-approved plans to perform x-ray surveillance for pneumoconiosis (Outcome)	FY 2013: 96% (Target Exceeded)	90%	90%	Maintain
9.2.3a: Percent reduction in respirable coal dust overexposure ¹ (Outcome)	FY 2009: 30% (Historical Actual)	50%	55%	+5
9.2.3c: Ensure the quality of NIOSH certified respirators by increasing the number of audit activities completed (Outcome)	FY 2013: 242 (Target Exceeded)	171	175	+4
9.A: Number of safety and health patent filings (Output)	FY 2013: 3 (Target Not Met)	5	5	Maintain
9.B: Number of certification decisions issued for personal protective equipment (Output)	FY 2013: 462 (Target Exceeded)	300	300	Maintain

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
9.E: Number of research articles published in peer-review publications (Output)	FY 2013: 343 (Target Exceeded)	350	350	Maintain
9.J: Number of Health Hazard Evaluations (Output)	FY 2013: 229 (Historical Actual)	200	200	Maintain

¹Annual trend data will be available by FY 2014.

Performance Trends: CDC continues to meet its performance targets by using surveillance information to develop and evaluate projects. The number of research and intervention projects based on surveillance information declined in FY 2011 but rebounded to 129 projects in FY 2012 (Measure 9.1.2a). Additionally, 55 intervention programs used surveillance information to demonstrate the effectiveness of the program’s strategies in FY 2012, which is consistent with historical performance in FY 2010 and FY 2011 (Measure 9.1.2b).

CDC reduces workplace illness, injury, and mortality across occupational sectors. The rate of non-fatal workplace injuries among youth ages 15–17 rose slightly to 3.8 per 100 FTE in FY 2013, although still down from 4.2 per 100 FTE in 2009 (Measure 9.2.2a). CDC will continue to focus on reducing young worker injuries through increased awareness and basic knowledge of workplace safety and health. For example, CDC will continue to promote the use of a high school curriculum, "[Youth@Work: Talking Safety](#)"³²⁶, designed especially for young workers. The curriculum is available free of charge, and is customized for each State, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Exposure to coal mine dust causes various pulmonary diseases, including coal workers’ pneumoconiosis and chronic obstructive pulmonary disease. CDC works with underground coal mines in the United States to develop plans to perform x-ray surveillance for pneumoconiosis. Since 2008, at least 96% of active U.S. mines in the Coal Workers Health Surveillance Program have possessed a CDC-approved plan, well exceeding the 90% target (Measure 9.2.2c). A new regulation adopted in FY 2012 permitting digital chest imaging may bring additional mines into the program that do not have a CDC-approved plan, which may reduce the proportion of those with a plan. The FYs 2014 and 2015 target remains level as CDC works with these new mines to develop plans. By 2015, CDC expects Mining Sector interventions to achieve a 55% reduction in occupational illnesses due to respirable coal dust overexposure. Recent data from 2009 indicate a 30% reduction in coal dust exposure, more than double the initial 13.7% reduction achieved in 2003 (Measure 9.2.3a).

An estimated 20 million workers use Personal Protective Equipment to protect themselves from death, disability, and illnesses. CDC’s Personal Protective Technology program focuses expertise from many scientific disciplines to advance federal research on respirators and other personal protective technologies for workers. Audit activities ensure that CDC certified respirators achieve their approved level of performance. CDC completed 242 respirator audit activities in 2013, exceeding expectations for the second year in a row (Measure 9.2.3c). CDC set the FY 2015 target at 175 to remain ambitious in light of projections that manufacturing sites will grow and the type of respirator audited will take longer to test, allowing fewer audits to be completed each year. Additionally, FY 2013 data demonstrate improvements in the inventory and quality of respiratory protection for workers in all industry sectors through 462 certified respirator decisions, exceeding the target and showing an increase from FY 2012 (Measure 9.B). The FY 2015 target remains level due to the impact of consensus standards, advances in technology, and personnel resources available to respond to increased demand for respirator decisions.

CDC promotes the transfer of knowledge and technology for the development of products through patent filings and disseminates occupational safety and health information through publications. In FY 2013, CDC filed three

³²⁶ www.cdc.gov/niosh/talkingsafety/

safety and health patents, a slight decrease from FY 2012. However, the United States Patent and Trademark Office granted CDC a new patent for the Portable Aerosol Mobility Spectrometer, which measures nanoparticle/aerosol exposures, and is commercially available for safety and health professionals' use (Measure 9.A). The FY 2015 target remains level as CDC explores less expensive options such as licensing without patenting, private/government cost share options, etc. CDC also makes surveillance data available to researchers and the public, providing needed information for planning and decision-making. CDC steadily increased the number of research articles published annually in peer-reviewed publications from 325 in 2010 to 343 in 2013 (Measure 9.E). These publications represent a substantial contribution to the scientific literature regarding occupational health and safety. For example, in 2013, CDC published [*Criteria for a Recommended Standard: Occupational Exposure to Hexavalent Chromium*](#)³²⁷. In this criteria document, CDC reviewed the critical health effects studies of hexavalent chromium (Cr[VI]) compounds in order to update its assessment of the potential health effects of occupational exposure to Cr(VI) compounds and its recommendations to prevent and control these workplace exposures.

CDC responds to employer, employee, and state and local requests for worker Health Hazard Evaluations (HHEs). 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. In FY 2013, CDC conducted 229 HHEs but does not expect to maintain this level of performance due to constrained resources and fewer requests (Measure 9.J). The FY 2015 target is set at 200 as CDC works to increase the awareness of the program. For example, CDC plans to conduct outreach activities to small businesses and underserved communities to increase participation in HHEs. CDC also plans to increase outreach to local health departments using brochures and webinars.

³²⁷ www.cdc.gov/niosh/docs/2013-128/

GLOBAL HEALTH

PERFORMANCE

Program: Global HIV/AIDS

Performance measures for Long Term Objective: Partner with ministries of health (MOHs), international and local partners and other United States Government (USG) agencies to achieve the PEPFAR goals of reducing the worldwide rate of new HIV infections and saving lives by focusing on three highly effective, evidence-based prevention interventions: (1) antiretroviral treatment as prevention, (2) prevention of mother-to-child transmission; and (3) voluntary medical male circumcision.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
<u>10.A.1.5</u> : Increase the number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (Output)	FY 2013: 3,623,255 (Target Exceeded)	3,310,618	3,895,317	+584,699
<u>10.A.1.6</u> : Increase the number of HIV+ pregnant women receiving antiretroviral medications, to reduce mother-to-child HIV transmission (Output)	FY 2013: 432,241 (Target Exceeded)	467,599	496,505	+28,906
<u>10.A.1.7</u> : Increase the number of males age 15 and over circumcised as part of the minimum package of male circumcision for HIV prevention services (Output)	FY 2013: 1,037,065 (Target Exceeded)	941,521	950,000	+8,479

Performance Trends: Global HIV/AIDS funding supports CDC's essential role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Creating an AIDS-free generation is a policy priority for the United States. Preventing new HIV infections is achievable and critical to stem the global HIV/AIDS epidemic, even in the absence of an HIV vaccine. To accomplish this goal, CDC focuses on scaling up three pivotal evidence-based interventions: antiretroviral therapy (ART), preventing mother-to-child transmission (PMTCT), and voluntary medical male circumcision (VMMC). ART reduces an HIV positive person's viral load, reducing the risk of sexual transmission to a partner by up to 96%. The use of appropriate antiretroviral medication during pregnancy and breastfeeding can reduce the risk of mother-to-child transmission to less than five percent. Conclusive scientific evidence shows that circumcision reduces men's risk of HIV acquisition from heterosexual exposure by at least 60%, with numerous additional benefits for themselves and their partners. When scaled-up and used in combination, these three interventions offer a historic opportunity to drive down the worldwide rate of new HIV infections and advance towards achieving an AIDS-free generation.

Beginning with the FY 2014 President's Budget, CDC began reporting measures that represent CDC-specific contributions for achieving PEPFAR targets rather than aggregate efforts encompassing all USG agencies. As PEPFAR transitions from an emergency response program to a sustainable initiative, partner countries are quickly gaining the capacity to increase ownership of direct service delivery. This will allow CDC to emphasize technical assistance and systems strengthening, such as quality improvement, supportive supervision, and sustainable management of a country-led response to the HIV epidemic. To reflect the program's shift toward greater country ownership, capture changing models of USG support, and ensure consistency with upcoming changes to the PEPFAR indicators, CDC will refine the definition of direct service delivery and introduce a new definition of technical assistance. These changes will affect CDC's performance measures during FY 2014. Consequently, CDC has maintained current targets and will revise them for the FY 2016 President's Budget.

In FY 2013, CDC-supported partners in 22 PEPFAR countries (including the Asia Regional Office) provided 3,623,255 adults and children with advanced HIV with ART, a 38% increase compared to FY 2012 and an 87% increase compared to FY 2011 (10.A.1.5). CDC provides leadership, guidance, and supportive supervision to

priority countries to foster the rapid scale-up of ART. For example, CDC worked closely with the Ministry of Health in Mozambique to develop a national HIV/AIDS acceleration plan (2013-2015) with the goal of providing universal access to ART for eligible HIV-infected adults and children (80% coverage) and all infected pregnant women (90% coverage). The strategy to quickly increase the number of people on ART will enhance the health, longevity, and quality of life for people living with HIV and reduce transmission. The number of people on ART supported by CDC in Mozambique increased by 45%, from 174,306 in FY 2012 to 252,085 in FY 2013.

In FY 2013, CDC-supported partners in 19 PEPFAR countries provided 432,241 HIV positive pregnant women with antiretroviral drugs (ARVs), a 17% increase from FY 2012 and a 48% increase from FY 2011 (10.A.1.6). CDC provides leadership and technical assistance to priority countries to plan, implement, monitor and evaluate PMTCT activities. CDC supported the implementation of a new approach to eliminating mother-to-child HIV transmission and improving maternal health, called Option B+. This approach expands treatment eligibility criteria by offering lifelong treatment to all pregnant and breastfeeding women and streamlines patient management, enabling decentralization of service delivery and increasing access. Since September 2013, CDC supported national Ministries of Health to implement Option B+ in more than 12 PEPFAR-supported countries. Malawi’s national implementation of Option B+ resulted in an upsurge of pregnant and breastfeeding women initiated on ART, from a baseline of 1,257 in the quarter prior to Option B+ implementation to approximately 9,500 pregnant and breastfeeding women initiated per quarter in FY 2013. To further increase access and coverage, PMTCT and treatment colleagues work collaboratively to synergize PMTCT and ART scale-up efforts, including the provision of expert advice to ensure an ongoing adequate supply of HIV test kits and antiretroviral drugs, and supporting implementation of integrated service delivery models.

In FY 2013, CDC-supported partners in 10 high priority PEPFAR countries performed 1,037,065 voluntary medical circumcisions of males aged 15 and older by a qualified clinician, a 92% increase compared to FY 2012 and a 255% increase compared to FY 2011 (Measure 10.A.1.7). CDC collaborates with country programs to scale up VMMC by expanding training, increasing the number of dedicated VMMC teams, supporting mobile services and conducting outreach to mobilize eligible males. CDC supports introductory studies in six countries, using a new non-surgical device, PrePex®, which will further support the rapid scale up of VMMC. PrePex® has the potential to address several VMMC program challenges by making circumcision safer, faster, able to be performed by nurses, and more acceptable to men. As of September 2013, more than 1,600 men were circumcised using this device.

Program: Global Immunization

Contextual Indicator for Long Term Objective: Help domestic and international partners achieve World Health Organization's goal of global polio eradication.

Contextual Indicator	Most Recent Result	FY 2015 Target
10.B.1.3: Reduce the number of countries in the world with endemic wild polio virus (Outcome)	FY 2012: 3 (Target Not Met)	0

Performance measure for Long Term Objective: Help domestic and international partners achieve World Health Organization's goal of global polio eradication.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
10.B.1.2: Increase the number of children vaccinated with Oral Polio Vaccine (OPV) as a result of non-vaccine operational support funding to implement OPV mass immunization campaigns in Asia, Africa, and Europe (Output)	FY 2012: 18,741,507 (Target Not Met)	55,000,000	55,000,000	Maintain

Contextual Indicator for Long Term Objective: Work with global partners to reduce the cumulative global measles-related mortality by 95 percent compared with CY 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.

Contextual Indicator	Most Recent Result	FY 2015 Target
10.B.2.1: Reduce the number of global measles-related deaths ¹ (Outcome)	FY 2011: 158,000 (Target Not Met)	38,850

¹ The Global Measles Initiative formulated an improved method for calculating global measles mortality in late 2010 following measles outbreaks in Africa in 2009 and 2010. The actual results from 2009 onward reflect the improved measurement. Targets before 2012 are not based upon the revised formula.

Performance measures for Long Term Objective: Work with global partners to reduce the cumulative global measles-related mortality by 95 percent compared with CY 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
10.B.2.2: Maintain number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission (Outcome)	FY 2011: 0 (Target Met)	0	0	Maintain
10.B.2.3: Increase the number of countries that achieve at least 90% immunization coverage in children under 1 year of age for DTP3 (three shot series of vaccines covering diphtheria, tetanus, and pertussis). (Outcome)	FY 2011: 133 (Target Met)	141	143	+2

Efficiency measure for Global Immunization

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
10.B.E.1: Increase the percentage of the annual budget that directly supports the program purpose in the field. (Efficiency)	FY 2012: 85% (Target Not Met)	≥90%	≥90%	Maintain

Performance Trends: Global immunization funding supports polio eradication and measles mortality reduction efforts. CDC is the lead technical monitoring agency for the Independent Monitoring Board of the Global Polio Eradication Initiative (GPEI). The number of countries reporting endemic wild poliovirus (WPV) remained stable at four from FY 2008-2010 and then declined to three countries —Pakistan, Afghanistan and Nigeria— from FY 2010 to present (Measure 10.B.1.3). Since January 2011, India has not reported any WPV cases, in part due to CDC’s strategic support to India’s Ministry of Health and Family Welfare and GPEI partners. The recurrent circulation of WPV from northern Nigeria into previously polio-free areas, as well as continued circulation along the Afghanistan-Pakistan border, hindered the achievement of the FY 2012 target and compounds the challenge of interrupting residual WPV transmission.

Eradicating WPV cases in the three remaining countries is vital to preventing re-infection among polio-free countries and requires intensive operational efforts and more dedicated resources per child to reach children in isolated areas. Starting in 2012, CDC implemented emergency measures in the remaining endemic countries to recapture previous gains. In response to an increased availability of donor funds, CDC intensified its efforts by

enhancing operations and increasing social mobilization. The enhancements resulted in an emphasis on targeted field consultations, scaling up successful innovations for polio eradication activities, and capacity building through training in accordance with the Global Polio Emergency Action Plan. Together, these activities resulted in a nearly two-thirds decrease in the number of global polio cases between 2011 (650 cases) and 2012 (223 cases). However, CDC purchased approximately 60 million fewer OPV doses than in 2011, resulting in the vaccination of approximately 19 million children—a 40 percent decline from 2011 (10.B.1.2). Increasing child polio vaccinations will further reduce global polio cases.

Most polio re-infected countries encounter substantial and recurrent outbreaks due to low routine immunization coverage levels (less than 80 percent), suboptimal outbreak response, and weak health systems—constituting a “WPV importation belt” that stretches from West Africa to Central Africa to the Horn of Africa. As a result, in May 2010 the World Health Assembly adopted the 2010–2012 Global Polio Eradication Initiative Strategy, which sets a goal of WPV interruption by December 2012. In light of concerns that the goal would not be achieved, the Executive Board of the World Health Organization (WHO) declared polio eradication a “programmatic emergency for global public health.” As a result, CDC activated its Emergency Operations Center (EOC) for polio eradication in December of 2011 to scale up its activities and rapidly expand technical expertise. This includes outbreak prevention and control, disease surveillance reviews; and immunization campaign planning, implementation and monitoring. CDC consults weekly with WHO and the United Nations Children’s Fund (UNICEF) to identify needs and determine optimal resource allocation. Resulting activities have led to a nearly two-thirds reduction in the number of polio cases between CY 2011 and CY 2012. CDC collaborations have resulted in the absence of Type 3 poliovirus in Asia since April 2012 and Africa since November 2012. Wild poliovirus is currently restricted to the fewest number of districts in the fewest countries in the recorded history of the disease.

Reducing cumulative global measles-related mortality by 95 percent compared with CY 2000 estimates presents unique challenges. Global measles mortality data released in late CY 2011 revealed outbreaks from CY 2009 through CY 2011 in Africa reversed some of the consistent gains in measles mortality reduction. Though CDC and its partners did not meet the target for reducing measles related deaths, mortality has decreased 78 percent since CY 2002 (10.B.2.1). In CY 2012, WHO documented 25,693 measles cases in Europe, posing a severe public health challenge to the Western Hemisphere. Since CY 2008, CDC’s collaboration with the Pan American Health Organization has helped ensure that these cases do not spur a resurgence of measles (Measure 10.B.2.2).

To maintain the gains made by polio eradication and measles mortality reduction, CDC partners with ministries of health (MOHs), WHO, and UNICEF to strengthen national immunization systems. The number of countries that achieve at least 90 percent immunization coverage in children under one year of age for DTP3 (third dose diphtheria, tetanus, pertussis vaccine) is the globally accepted performance indicator for national immunization programs. An increase in the number of countries achieving this target reflects progress in the global effort to strengthen immunization systems, resulting in an expected decline in the number of vaccine preventable diseases. The number of countries achieving 90 percent immunization coverage for DTP3 has steadily increased from 125 in FY 2008 to 133 in FY 2011 (Measure 10.B.2.3).

Increased staffing costs associated with activating CDC’s Emergency Operations Center for polio eradication and rising administrative and travel costs reduced the percentage of the annual budget directly supporting program operations (Measure 10.B.E.1). CDC continues to review cost reduction options on a monthly basis to minimize administrative overhead while maximizing direct spending for field related activities. Continued plans to achieve the 90 percent threshold in FY 2015 include temporarily assigning a higher percentage of staff to the field and increasing the number of days spent in the field. Once achieved, CDC will return to normal EOC activation staffing levels and begin polio elimination activities.

Program: Parasitic Diseases and Malaria

CDC Contextual Indicators for Long Term Objective: Decrease the rate of deaths from all causes in children under five in the President’s Malaria Initiative (PMI) target countries.

Contextual Indicators	Most Recent Result	FY 2015 Target
<u>10.C.1</u> : Increase the percentage of children under five years old who slept under an insecticide-treated bednet the previous night in PMI target countries (Outcome)	FY 2012: 60.0% (Target Not Met but Improved)	85%
<u>10.C.3</u> : Increase the percentage of women who have received two or more doses of intermittent preventive treatment during pregnancy (IPTp) among women that have completed a pregnancy in the last two years (Outcome)	FY 2012: 39% (Target Not Met but Improved)	85%

Budget Output Measure for Long Term Objective: Decrease the rate of deaths from all cause sin children under five in the President’s Malaria Initiative (PMI) target countries.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
10.C.A: The number of CDC authored publications that inform the global evidence for malaria control and prevention programs (Output)	FY 2012: 27 (Baseline)	57	57	Maintain

CDC Performance Measure for Long Term Objective: To deliver timely and accurate reference diagnostic laboratory services for the detection of parasites in specimens submitted by domestic and international public health partners to CDC

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
<u>10.C.4</u> : The percentage of laboratory test results reported within the expected turn-around time (two weeks) upon receipt by CDC labs (Outcome)	FY 2012: 91% (Target Exceeded)	90%	90%	Maintain

Performance Trends: Malaria prevention and treatment tools are among the most cost-effective interventions available to improve global maternal and child health and survival. CDC’s research enhances the development of new tools to manage and mitigate threats from drug and insecticide resistance, informs future program and policy decisions, and builds the capacity of host country governments through strategic partnerships, such as the Ifakara Health Institute in Tanzania. Findings from collaborative research conducted with colleagues from Ifakara were shared with district health officials and the national malaria control team, helping them to improve training, supervision, and supply chains for health workers.

Based on evidence from CDC research over the last two decades, global malaria prevention and control programs continue to promote cost-effective interventions and scale-up efforts. These interventions include (1) intermittent preventive treatment in pregnancy (IPTp), (2) insecticide-treated bed nets (ITNs) and indoor residual spraying (IRS) to protect individuals and communities from infected mosquitoes, and (3) artemisinin combination therapy (ACT) to treat individuals diagnosed with malaria.

While CDC and its partners did not meet FY 2012 President’s Malaria Initiative (PMI) performance targets for Measures 10.C.1 and 10.C.3, PMI countries expanded the use of malaria prevention and treatment tools compared to the FY 2006 baseline. The percentage of children under five years old who slept under an insecticide-treated bednet the night before nearly quadrupled from 16% to 60% (Measure 10.C.1). Additionally, the percentage of women who received at least two doses of IPTp increased from 18% to 39% (Measure 10.C.3). The shortfalls in meeting targets largely reflect inefficiencies in procurement and distribution systems in host countries. Through PMI, CDC and its partners are working to mitigate procurement delays to ensure timely

programmatic scale-up. CDC is also monitoring the effectiveness of IPTp among pregnant women to inform future policy decisions for utilization. To date, scale-up of these interventions through PMI and other program efforts have contributed to the reduction of deaths from all causes in children under five years of age by 16%-50% in surveyed PMI countries. Country results vary widely as unique contextual factors heavily influence outcomes. These efforts have also contributed to saving more than 3.3 million lives since 2000 (World Malaria Report, 2013).

In FY 2012, CDC developed a new measure for the number of authored publications that contribute to the global evidence base for malaria control and prevention programs. For example, in January 2012, CDC published positive results from a study evaluating the combined use of IRS and ITNs in low malaria transmission areas. Prior to PMI implementation, CDC's modeling of the impact of bednet coverage of older children and adults informed WHO and PMI policy on universal coverage for ITNs. CDC also confirmed that the use of ACTs for the treatment of malaria (as recommended by WHO and now used by most African countries) slowed the development of drug resistant malaria parasites and helped reduce malaria prevalence.

Through FY 2009-2011, CDC published an annual average of 45 peer-reviewed papers (Measure 10.C.A). The time between research initiation and publication of results typically exceeds a 12-month period, and as a result, the number of publications varies from year to year. The number of papers published in FY 2011-2012 decreased to 27. However, CDC continued to develop global policy documents and guidelines during that time. In addition to the Seventh Annual PMI Report to Congress, from FY 2012-2013, CDC co-authored several technical reports including the WHO World Malaria Report (2012), the Malaria Rapid Diagnostic Test Performance (Round 4), and the Roll Back Malaria Progress and Impact Series reports for Malawi and Madagascar. Each of these reports summarizes critical surveillance and monitoring and evaluation data that will inform global policy and programming.

Current research includes strengthening the role and use of rapid diagnostic tests, exploring the potential use of insecticide-treated wall linings, and conducting a Phase III vaccine trial of the RTS,S malaria vaccine in Kenya. RTS,S is the most clinically advanced malaria vaccine candidate in the world. Preliminary results from the ongoing clinical trial showed that the vaccine cut by nearly half the number of malaria cases in children and cut by 1/3 the number of malaria cases in young infants. The vaccine averted 941 cases per 1000 vaccinated children and 444 in vaccinated young infants. CDC, in collaboration with the Kenya Medical Research Institute, oversees one of 11 study sites in this multisite trial. The FY 2015 target for the number of authored publications that contribute to the global evidence base for malaria control and prevention programs remains fixed at the FY 2014 level.

While malaria and other parasitic diseases have a tremendous impact on global morbidity and mortality, they are a significant health concern in the U.S. due to increased international travel, importations, and domestically acquired infections. CDC's parasitic disease labs are global and national resources for ensuring efficient and high-quality analyses essential to timely and accurate diagnosis and treatment. In FY 2012, CDC analyzed and reported results for 91% of specimens in a timely manner, approximately two weeks from the time of receipt by CDC labs, exceeding the 87% target (Measure 10.C.4). The FY 2015 target holds performance steady near the FY 2012 result level.

Program: Global Health Protection

With the launch of the Global Health Security Agenda in FY 2014, CDC continues to work closely with USG partners to improve disease prevention, detection, and response over time. Following full implementation of GHS beginning in FY 2015 as proposed, CDC will articulate performance trends tied specifically to GHS resources

Performance measure for Long Term Objective: Build outbreak detection and response public health capacity in support of the International Health Regulations (2005).

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
10.E.1: Increase the percentage of outbreak and possible Public Health Emergencies of International Concern assistance requests that are handled in a timely manner (Outcome)	FY 2012: 72% (Target Not Met)	80%	83%	+3

Performance Trends: The Global Disease Detection (GDD) monitoring and evaluation program captures quarterly data to monitor progress and assess the impact of GDD Centers. CDC increased the proportion of outbreak and possible Public Health Emergencies of International Concern assistance requests handled in a timely manner from a baseline of 70 percent in FY 2009 to 79 percent in FY 2011, however, timely handling of requests dropped to 72 percent in FY 2012 (Measure 10.E.1). Performance for this measure is affected by the volume of requests received, type of assistance requested, location of the outbreak, and maturity of the GDD Center providing the response. As a result of these dynamics, the trend reflects peaks and valleys instead of steady continuous improvement, but overall progression reveals improved in-country capacity to rapidly respond to outbreaks from baseline to FY 2012. For example, four new GDD Centers (India, South Africa, Bangladesh, and Georgia) began reporting monitoring and evaluation data into the system in FY 2012 and FY 2013. Initial results for these less mature centers reflect slower response rates. However, as these centers become more established, their capacity to respond to outbreaks should increase, improving the average response time for all centers.

Recent outbreak responses included: human H5N1 influenza in Bangladesh and Egypt; novel corona virus in Kenya and Saudi Arabia; Ebola in Uganda; Crimean-Congo hemorrhagic fever in South Africa and Tajikistan; anthrax in Bangladesh, Georgia, and Kenya; dengue in Bangladesh, Guatemala, Haiti and South Africa; and cholera in China, Haiti, Kenya, and South Africa.

Performance measures for Long Term Objective: To increase the number of skilled Epidemiologists providing sustained public health capacity in low and middle-income countries.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
10.F.1a: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology Training Program (FETP). New Residents (Outcome)	FY 2012: 280 (Target Exceeded)	430	430	Maintain
10.F.1b: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology and Laboratory Training Program (FELTP). Total Graduates (Outcome)	FY 2012: 2,881 (Target Exceeded)	3,101	3,256	+155

Performance Trends: Since 1980, CDC has developed 50 international Field Epidemiology Training Programs (FETPs) serving 94 countries that have graduated over 2,800 epidemiologists. In FY 2012, CDC exceeded targets for new residents and total graduates (Measures 10.F.1a and 10.F.1b). On average, 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions—some examples include the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic, the Secretary General of the National Health Security Office and Director General of the Department of Disease Control in Thailand, and the Deputy Director of the National Malaria

Control Program in Ghana. FETP graduates strengthen sustainable public health capacity in their countries, which is critical in transitioning U.S.-led global health investments to long-term host country ownership. In FY 2012, FETP graduates and residents conducted more than 400 outbreak investigations, over 190 planned investigations, and approximately 440 surveillance system evaluations. CDC is planning for a slight increase in graduates in FY 2015 based on current participation, yet remains conservative regarding the number of new residents expected to enroll in FY 2015. CDC will also work with the countries' ministries of health to implement basic and intermediate level FETPs, which will help accelerate progress. CDC is working closely with TEPHINET (<http://www.tephinet.org/>) to implement the accreditation process for the FETPs, which will help maintain the quality of FETPs globally.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

PERFORMANCE

Program Buildings and Facilities

Performance Measures Long Term Objective: Improve efficiency and sustainability of CDC Facilities¹

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
12.E.2: Increase the percent of CDC facilities (5,000 square feet and above) that meet the Guiding Principles for High Performance and Sustainable Federal Buildings (Efficiency) ²	FY 2013: 23.6% (Target Exceeded)	13.0%	15.0%	+2
12.E.1: Reduce energy (E) and water (W) consumption per square foot (Efficiency)	FY 2013: 27.1%(E) (Target Exceeded); +28.6% (W) (Target Not Met)	27.0% (E); 14.0% (W)	30.0% (E); 16.0% (W)	+3(E); +2(W)

¹Targets are set by HHS and align to Executive Order 13514 and the Energy Independence and Security Act of 2007.

Performance Measures Long Term Objective: Improve CDC's Buildings and Facilities Office's processes and performance¹

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
12.1.1: Maintain Earned Value Management (EVM) index values of one for capital and repair/improvement projects based on scope, schedule, and cost (Output)	FY 2013: 1.02 (Target Exceeded)	1.00±0.08	1.00±0.08	Maintain
12.2.1a: Improve work order closure rates (Output)	FY 2013: 93% (Target Exceeded)	91%	91%	Maintain
12.2.1c: Improve Condition Index, as measured by the ratio of the functional replacement value (FRV) of an asset with its backlog of maintenance and repair (BMAR) needs (Output)	FY 2013: 91.53 CI (Target Exceeded)	90.0 CI	90.0 CI	Maintain
12.2.1d: Reduce non-mission dependency, as measured by the percentage of real property assets that are not deemed directly necessary to support the Agency's mission (Output)	FY 2013: 3.91% (Target Not Met)	2%	2%	Maintain
12.2.1e: Improve building utilization ² (Output)	FY 2013: 13.73% (U) (Target Not Met)	5.00% (U)	5.00% (U)	Maintain

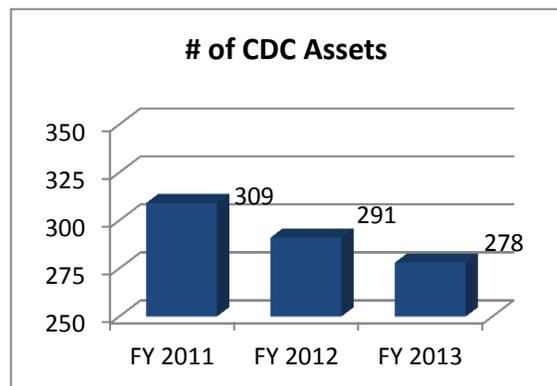
Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
12.2.1f: Improve buildings and facilities operating costs (Output)	FY 2013: \$13.13/sq. ft. (Target Not Met)	\$10.29 /sq. ft.	\$10.29 /sq. ft.	Maintain

¹Targets are set by HHS and align to Executive Order 13327; the Federal Real Property Council defines the metrics

²Under-utilized (U); The Federal Real Property Council has removed the metric Over-utilization (O) for FY 2013 and forward.

Performance Trends: CDC's Buildings and Facilities Office equips CDC to carry out its mission in safe, sustainable, and efficient operating facilities. Since 2010, CDC has:

- Exceeded energy performance targets. CDC did not meet its FY 2013 water consumption target owing to usage on the Roybal Campus (Measure 12.E.1). In FY 2014 through FY 2015 CDC will conduct a water usage study for the Roybal campus to address water usage and give guidance for future projects. Water meters have been added at individual buildings to capture data for nearly all Roybal Campus facilities, with plans to expand metering at other locations in the near future as well.
- Increased the percentage of sustainable facilities far beyond HHS targets (Measure 12.E.2). This includes recently completed Building 107, which added 269,139 new square feet, causing a short term reduced Guiding Principle compliant percentage. Guiding Principle status for B107 is yet to be determined, and will not be available until FY 2014. For a detailed overview of "Guiding Principles", please visit the GSA website on sustainable design: <http://www.gsa.gov/portal/category/21083>
- Although CDC continues to exceed CI target metrics (Measure 12.2.1c), overall CI dropped slightly from 92.62 to 91.53. This was due to an increase in the Backlog of Maintenance and Repair (BMAR) of about \$20 Million over an asset portfolio of over \$3.4 Billion. CDC recently shifted reporting for the Backlog of Maintenance and Repair (BMAR) to an Asset Business Plan system (ABP). The previous system for tracking BMAR was a manual estimate, only. CDC's ABP system now tracks BMAR directly with executed, completed projects. The result is that variances will occur from year-to-year, depending on the projects executed and the funding available.
- Continued to compress office space to meet the new utilization rate (UR) standard of 170 usable square feet per occupant (Measure 12.2.1e), but did not meet the target for under-utilization (U). The Federal Real Property Council removed the measure for over-utilization (O) in FY 2013. Several assets were marked for future demolition in FY13, which also resulted in a not-utilized status for those assets. CDC was not able to demolish these assets in FY13 (as also mentioned below).
- Exceeded HHS targets for customer service by reducing work order transaction times (Measure 12.2.1a), and strengthened project management through Earned Value Management (EVM) (Measure 12.1.1).



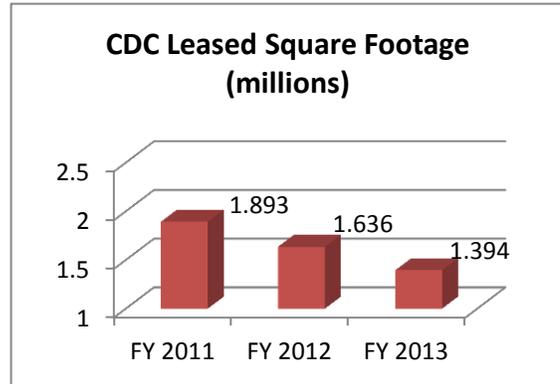
CDC did not meet its Mission Dependency target (Measure 12.2.1d). CDC continually re-evaluates its assets for mission-dependency, and for FY 2013, CDC identified several small assets (less than 100 square feet each) at the Pittsburgh Research Center as potential targets for demolition. After designating these assets as "inactive" in our asset data, their classification changed to non-mission dependent and not utilized. Since the Federal Real

Property Council mission dependency metric is not weighted based on square footage, these small assets result in as much impact on our mission dependency performance result as our large laboratory buildings. Because of unusually high demolition costs for the Pittsburgh Research Center assets, CDC did not follow through on its FY 2013 plans. The contractor proposal even exceeded the value of one of the assets. CDC will obtain new proposals for demolition in FY 2014.

Regardless, CDC continues to demolish and terminate non-mission dependent assets or assets with low Condition Indices. Forty assets have been demolished or terminated since FY 2010:

CDC’s operating costs fluctuated between FY 2010 and FY 2012. Because CDC’s laboratories comprise approximately 44% of its total asset square footage, the inherently high laboratory operating costs disproportionately increase CDC's overall operating cost

CDC continues to compress its office space (i.e., better floor layouts and smaller cubicles) to meet the new UR standards. Overall, CDC has reduced leased square footage of buildings and structures by approximately 500,000 gross square feet from FY 2011 through FY 2013. This includes eight leases in Atlanta and Fort Collins in FY 2013, saving over \$1,000,000 in recurring annual costs.



CDC began developing a new FY 2015-FY 2025 Master Plan and Environmental Impact Statement (EIS). CDC developed a preferred alternative for the Master Plan in FY 2013. Final completion of the 2025 Master Plan should occur in FY 2014. CDC also completed an office compression and carrying capacity study in early FY 2013 assessing how best to compress existing office buildings, both owned and leased, to meet or exceed the new 170 UR standard. CDC will incorporate these results into the Master Planning for future buildings, growth, and mission. CDC is also using the study as a baseline for reducing all of its office buildings to the new 170 UR standard.

Program: Communications

Performance Measure for Long Term Objective: Improve access to and reach of CDC's scientific health information among key audiences to maximize health impact

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 Planning +/- FY 2014 Target
11.B.1.1c: Increase health behavior impact of CDC.gov (Outcome)	FY 2013: 88% (Target Exceeded)	89%	90%	+1

Performance Trends: The Pew Research Center’s Internet & American Life Project estimates that 85 percent of adults used the internet in 2013, and that 59 percent of those adults used the internet to find health information. However, not all health information meets the needs of consumers or changes behavior. CDC.gov consistently ranks among the top major federal websites by demonstrating high user satisfaction scores measured by American Customer Satisfaction Index (ACSI). CDC uses the satisfaction scores to improve its overall web site and ensure that its audiences are satisfied with the usability of the site, credibility of the information, and functionality of the web tools (such as content syndication). In particular, this measure helps CDC’s web and health communication specialists understand the impact of materials placed on CDC.gov and assess how audiences use the content provided (e.g., washing their hands more or attempting to quit smoking).

From FY 2010 to FY 2013, visitors indicating positive health impact and behavior change after visiting CDC.gov increased from 68% to 88%. CDC has exceeded its targets since FY 2011. However, a significant increase occurred from FY 2011 to FY 2012 because CDC refined the ACSI survey questions for FY 2012, which eliminated users for whom the behavior change is not applicable. This provides greater accuracy for this measure, and higher satisfaction among users seeking information for their own health needs or those of their families. CDC will slightly improve its performance level in FY 2014 and FY 2015.

Program: State, Tribal, Local and Territorial Support

Performance Measures for Long Term Objective: Improve the capacity of State, Tribal, local and territorial public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public’s health

Measure	Most Recent Result	FY 2014 Target ⁴	FY 2015 Target ⁴	FY 2015 +/- FY 2014
11.B.4.1a (State): Increase the percentage of nationally PHAB ¹ accredited state and local public health agencies (Intermediate Outcome)	FY 2013: 4% (Target Not Met)	N/A%	N/A	NA
11.B.4.1b (Local): Increase the percentage of nationally PHAB ¹ accredited State and local public health agencies (Intermediate Outcome)	FY 2013: 0.84% (Baseline)	N/A%	N/A	NA
11.B.4.2: Percentage of NPHII ² awardees that demonstrate increased efficiencies or improved program effectiveness through the implementation of performance or quality improvement projects ³ (Intermediate Outcome)	FY 2012: 38% (Target Exceeded)	N/A%	N/A	NA

¹Public Health Accreditation Board

²National Public Health Improvement Initiative

³The measure language used in the FY 2014 President's Budget reverted to a version prior to a revision made in May 2012. This edit corrects that error. CDC updated targets and results to reflect revised language

⁴ Congress did not appropriate funding for NPHII within PPHF in FY 2014; the program and its related measures (11.B.4.1 a and b, and 11.B.4.2) are being eliminated.

Performance Trends: Through FY 2013, CDC built the capacity of state, tribal, local, and territorial (STLT) health agencies to: 1) achieve national accreditation and better manage and deliver high-quality services to their communities (11.B.4.1) and 2) utilize performance improvement practices that lead to more efficient and effective public health services, systems, and organizations (11.B.4.2). Progress in these two areas improved the health of the public with relatively low cost while increasing public health agency transparency and accountability to policymakers and the public. However, Congress did not appropriate funding for NPHII within PPHF in FY 2014. Therefore, CDC did not set targets as the program will be eliminated. Below are highlights and significant achievements of the program from FY 2012-FY 2013.

The Public Health Accreditation Board (PHAB) launched the nation’s very first public health department accreditation program in September 2011 and accredited the first health departments in February 2013. PHAB and health departments developed their respective capacities to assess accreditation readiness throughout FY 2012, although no health departments achieved accreditation. The number of accreditation applicants to PHAB increased from 15 states, 112 local health agencies, and one tribal health agency in FY 2012 to 22 states, 219 local health departments, and two tribal health departments in FY 2013. This represents an increase from 30% of state health departments and 5% of local health departments in FY 2012 to 44% of state health departments and 10% of local health departments in FY 2013.

During this time, CDC developed new accreditation tools and trainings, and expanded CDC's health department accreditation support initiatives. As of February 2014, a total of 269 health departments have applied to PHAB for accreditation. In general, most health departments are taking more time than previously anticipated to develop the capacity and documentation necessary to meet the accreditation requirements, which represent “stretch” standards in many cases. The process also takes a considerable number of months from application to accreditation. While this speaks to the meaningful nature of the national accreditation program, initial estimated targets did not adequately account for these factors.

NPHII grantees in the PHAB system as of February 2014:

- 47% (23/49) of state grantees (24 states/DC are currently in the PHAB system)
- 78% (7/9) local grantees (241 local HDs are currently in the PHAB system)
- 14% (1/7) tribes/tribal organizations (2 Tribal HDs are currently in the PHAB system)
- 4% have already achieved national accreditation.

In FY 2012, 38 percent of NPHII awardees demonstrated increased efficiencies or improved program effectiveness through the implementation of performance or quality improvement projects (11.B.4.2). This is a 13 percentage-point increase over FY 2011 and the second consecutive year CDC exceeded its target. CDC will continue to collect and utilize this data to 1) demonstrate return on investment, 2) identify grantees requiring additional consultation and capacity building assistance, 3) develop peer-to-peer networks, and 4) identify practices for adoption, adaptation, and implementation.

National Public Health Improvement Initiative – Impact Examples

Grantee	Achievement	Efficiency	Effectiveness
Oklahoma	Decreased the percentage of early elective deliveries (births) by 66%	Costs saved	Increased preventive behaviors
North Carolina	Is increasing newborns screened for hearing loss by 1 month of age and those that complete diagnostic hearing evaluation by 3 months (projected savings: \$4,170,000 based on 2 years of birth cohorts)	Costs saved	Increased preventive behaviors
Alabama	Decreased family planning clinic wait times by an average of 34% in 28 counties	Time saved	Increased preventive behaviors
Virginia	Increased enrollment in its Plan First program by 600%	Costs avoided	Increased preventive behaviors
Chicago	Achieved PHAB accreditation and attributes their success to NPHII funding.		Quality enhancement of services, programs, or data systems
New Jersey	Decreased healthcare delivery costs by 10% for participating agencies in Trenton as a result of the new health information exchange system	Costs saved	Quality enhancement of services, programs, or data systems
North Carolina	Increased productivity for call handling in vital statistics by 97%	Costs avoided	Quality enhancement of services, programs, or data systems
Wisconsin	Merged two city health departments with an estimated annual cost savings of \$300,000	Costs saved	Organizational design improvements

Grantee	Achievement	Efficiency	Effectiveness
Louisiana	Improved productivity in environmental health sanitarian services by 95%, with a 41% increase in the number of inspections per day, and a 29% decrease in the cost per inspection	Costs saved	Quality enhancement of services, programs, or data systems
Virginia	Reduced average processing time for procurement and human resources by 43%. And reduced # staff involved from 20 to 3.	Costs saved	Quality enhancement of services, programs, or data systems
South Carolina	Realized an annual savings of \$140,000 in prompt payment discounts by improving its invoice payment system	Costs saved	Quality enhancement of services, programs, or data systems
Washington	Reduced the average time to license a pharmacist by 24% and decreased days to complete scheduling and post-survey processes of hospital inspections by over 500%	Time saved	Increased customer / staff satisfaction
Minnesota	Streamlined processes in their drinking water unit and project a 96% reduction in task time, 74% reduction in wait time, 64% reduction in number of tasks, and 73% reduction in number of handoffs.	Time saved	Quality enhancement of services, programs, or data systems
Texas	Reduced the steps in its process for awarding contracts by 65%	Reduced number of steps	Quality enhancement of services, programs, or data systems

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

PERFORMANCE

Program: State and Local Preparedness and Response Capability

Performance Measures for Long Term Objective: Enhance and sustain preparedness and response capability across state, local, and territorial health departments.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
<u>13.5.2</u> : Increase the percentage of state public health laboratories that directly receive CDC Public Health Emergency Preparedness funding that can correctly subtype E. Coli O157:H7 and submit the results into a national reporting system within four working days for 90% of the samples received (Output)	FY 2012:76% (Target Exceeded)	74%	80%	+6
<u>13.5.3</u> : Increase the percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners (Outcome)	FY 2012:89% (Target Not Met)	95%	95%	Maintain

Performance Trends: CDC utilizes Public Health Emergency Preparedness (PHEP) awardee-reported data to aid jurisdictions in identifying preparedness gaps and develop targeted strategies to improve performance across operations.

In FY 2012, 76 percent of PHEP-funded public health laboratories correctly subtyped *E. coli* and submitted results within four working days (Measure 13.5.2). CDC exceeded the FY 2012 target by two percentage points, due in part to an improved data quality assurance process. This result continues a trend of exceeding annual targets for accurate *E. coli* subtyping and reporting since FY 2010. The FY 2015 target is conservative because CDC transitioned to an enhanced data collection system in FY 2013, which will require a new baseline for this measure beginning in FY 2014. Measure 13.5.2 reflects states’ and select localities’ ability to detect and determine the extent and scope of potential outbreaks to minimize their impact. Rapid diagnostic testing and timely lab reporting allows for the swift removal of harmful products, decreasing cases of illness and duration of exposure to consumers. *E. coli* remains a serious public health concern in the United States. In November 2013, 33 cases of an outbreak strain of STEC O157:H7 were detected in Arizona, California, Texas, and Washington. The outbreak ended in December 2013, with no fatalities, however seven of the identified cases required hospitalization. CDC and state and local public health partners utilized CDC’s PulseNet laboratory surveillance system to identify cases and conducted interviews with ill persons to determine exposure. Rapid laboratory testing and national food safety reporting enabled timely and coordinated action on the part of state and federal agencies.

The ability to assemble key staff for timely decision-making and the establishment of effective incident management structures are essential components of a public health emergency response. Awardees must demonstrate the ability to rapidly assemble key incident management leadership empowered to make response decisions. In FY 2012, CDC increased to 89 percent of PHEP-funded public health agencies convening trained staff within 60 minutes of notification to make decisions regarding partner engagement and incident response

(Measure 13.5.3). Although this represents an increase of two percentage points over the FY 2011 results CDC did not meet its target. CDC will continue to work with grantees to improve results and achieve future targets. CDC's Public Health Emergency Preparedness investments contributed to the rapid response of personnel to the April 15, 2013 Boston Marathon Bombings. Within 10 minutes of the explosion and continuing throughout the emergency, the Health and Homeland Alert Network provided emergent information quickly and consistently to all hospitals in the state. Massachusetts activated its Emergency Operations Center, enacted fatality and volunteer management procedures, and executed its crisis management system to help manage and track the response.

Program: CDC Preparedness and Response Capability

Performance Measures for Long Term Objective: Integrate and enhance existing surveillance systems at the local, state, national, and international levels to detect, monitor, report, and evaluate public health threats.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
13.1.3: Increase the number of Laboratory Response Network (LRN) member laboratories able to use their current Laboratory Information Management System (LIMS) for LRN-specific electronic data exchange (Output)	FY 2013: 28 (Target Exceeded)	30	40	+10
13.1.1a: Increase the proportion of jurisdictions contributing data into BioSense 2.0 to improve the national picture of population health. (Output)	FY 2013: 65% (Target Exceeded)	71%	84%	+13

Performance Trends: Since FY 2009, CDC has steadily increased Laboratory Response Network (LRN)-specific electronic data exchange capacity of member labs, growing from 16 labs in FY 2012 to 28 labs in FY 2013, exceeding the target by 40% (Measure 13.1.3). While almost 100 percent of the approximately 150 LRN labs are capable of exchanging data through the LRN Results Messenger, CDC encourages labs to transition to the enhanced Laboratory Information Management System Integration (LIMSi). LIMSi allows labs to quickly respond to public health threats by providing an integrated solution that builds on existing systems and workflow, rather than utilizing additional CDC software. CDC incorporated feedback from participating laboratories to further enhance the LIMSi implementation process. Additionally, CDC worked with LIMS vendors to repackage the LRN configurations at lower cost and provided more timely implementations. CDC estimates total LRN LIMSi implementations will expand to include at least 40 labs by the end of FY 2015.

BioSense 2.0 allows for the sharing of near real-time data to facilitate integration and interpretation across jurisdictions and federal agencies for faster detection and response. CDC recruits jurisdictions to participate in the program by establishing Data Use Agreements (DUA) which allow hospital emergency departments to share patient symptom data from their geographic area. As of November 2013, 65 percent (41 of 63) of Epidemiology and Laboratory Capacity (ELC) jurisdictions have signed DUAs, and eight additional ELC jurisdictions are pending. The number of signed agreements illustrates significant strides in state and local engagement and acceptance, exceeding expectations for this measure (13.1.1a).

Performance Measures for Long Term Objective: Enhance and sustain nationwide and international laboratory capacity to gather, ship, and screen and test samples for public health threats and to conduct research and development that lead to interventions for such threats.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
<u>13.3.1</u> : Sustain the percentage of Laboratory Response Network (LRN) laboratories that have demonstrated ability to rapidly detect select biological threat agents	FY 2013:89% (Target Not Met)	92%	92%	Maintain

Performance Trends: Laboratory Response Network (LRN) proficiency testing ensures laboratories within the network have the ability to rapidly identify biological threat agents. This includes performing LRN assays using agent-specific testing algorithms and available electronic resources to submit results. For the first time since FY 2007, CDC did not meet the target for the percentage of LRN labs that pass proficiency testing. Laboratories experienced low scores for the orthopoxviruses organism proficiency assessment. An increase in staff turnover resulted in a limited offering of Rash Illness algorithm trainings. The Rash Illness algorithm is used by epidemiologist to direct laboratory testing when infections with orthopoxviruses (including smallpox) are suspected. In FY 2014, CDC will intensify state level training efforts to improve interpretation of the algorithm and further enhance LRN laboratory practices (Measure 13.3.1). Future targets remain fixed at 92 percent due to the increased complexity of proficiency testing protocols and the release of new assays, both of which are expected to challenge future passing rates.

Performance Measures for Long-Term Objective: Assure an integrated, sustainable, nationwide response and recover capacity to limit morbidity and mortality from public health threats.

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014 Target
<u>13.4.2</u> : Sustain the percentage of state public health agencies that are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC (Outcome)	FY 2013:100% (Target Met)	100%	100%	Maintain
<u>13.4.5</u> : Number of trained and ready preparedness and response teams available for response to multiple events (Output)	FY 2013:18 (Target Exceeded)	15	15	Maintain
<u>13.4.6</u> : Percentage of inventory accuracies attained by using quality inventory management systems(Outcome)	FY 2013: 98.10% (Target Exceeded)	97%	97%	Maintain

Performance Trends: CDC manages and distributes Strategic National Stockpile (SNS) materiel utilizing proven practices and innovative solutions. These improvements are driven by various initiatives across the spectrum of SNS funded activities and result in reduced management costs for stockpiled medical countermeasures and increased operational efficiency.

Mitigating morbidity and mortality in a public health emergency requires skilled and prepared state and local partners to effectively utilize stockpiled Medical Counter Measures (MCM). CDC trains and supports partners to receive, distribute, and dispense MCMs through a broad range of technical assistance activities funded through SNS appropriations. These activities include:

- development and delivery of program guidance, informational documents, and operational/planning tools and IT systems;
- federally funded training offerings for MCM response activities through a catalog of on-site, invitational travel, online, or mixed medium opportunities for the efficient and effective development of federal, state, and local responders;
- on-site planning and program reviews by SNS SMEs;
- and support for federal, state and local emergency response exercises with subject matter expert assistance for advance planning, on-site exercise and evaluation staff, and simulated SNS containers and product for realistic hands-on implementation receiving, distribution and dispensing plans

To evaluate the effectiveness of these activities, CDC conducts targeted technical assistance reviews (TARs) which assess preparedness planning criteria for each PHEP awardee. Technical assistance reviews include the assessment of 13 core planning domains necessary to successfully execute an effective MCM response. In FY 2012 and FY 2013, CDC met its target to sustain local-level medical countermeasure dispensing capability (Measure 13.4.2).

CDC improved operational efficiency in FY 2013 by developing a new operational structure allowing for increased flexibility to rapidly organize and deploy subject matter experts to respond to multiple and concurrent public health threats. This “responder pool approach” promotes the cross training of deployable staff to support various response types while reducing individual staff commitments and the number of teams required to adequately respond to a public health emergency. CDC decreased the FY 2014 target to 15 responder teams to align with the new approach, and will maintain this target in FY 2015. In FY 2013, concurrent efforts to better define response roles for all DSNS staff members led to an increase in volunteers and training of deployable staff, resulting in a responder pool capable of scaling up to 18 fully staffed response teams, trained and ready to be deployed to multiple events. (Measure 13.4.5) The overall increase of deployable staff allows for a reduction in on-call time for each individual deployable team member.

WORKING CAPITAL FUND

PERFORMANCE

Performance Measures for Working Capital Fund

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
15.2.2: Maintain the percent of invoices paid on time (Efficiency)	FY 2013: 99.6% (Target Exceeded)	98%	98%	Maintain
15.4.2: Reduce the percentage of high-risk contract types awarded (Efficiency) ¹	FY 2012: -1.81% (Target Not Met but Improved)	-10%	-10%	Maintain

¹Noncompetitive, competitive one-bid, cost reimbursement, time and material, or labor hour.

Performance Trends: CDC's Office of the Chief Financial Officer (OCFO) actively supports CDC's goals and customers through fiscal stewardship and financial strategy by providing financial services, budgetary and legislative guidance, and quality assurance. CDC has secured an unqualified audit opinion on the agency's financial statements each year since FY 1999.

Moreover, CDC has maintained a 98 percent prompt payment level since FY 2008 (Measure 15.2.2), which is pursuant to the U.S. Treasury Department's Prompt Payment rule requiring federal agencies to pay vendors in a timely manner. The Prompt Payment rule assesses late interest penalties against agencies that pay vendors after a payment due date. By paying 98 percent of invoices on time, CDC successfully limited interest payments to \$12.51 per \$1,000,000 in total payments in FY 2013, a 22% reduction over FY 2012, and a 59% reduction from FY 2011.

CDC's Procurement and Grants Office (PGO) is accountable to agency leadership, the Administration, Congress, partners, and the public for effective and efficient procurement of CDC grants and contracts. CDC accomplishes this in part by reducing and limiting high-risk awards and efficient contracts closeout. While CDC met HHS's target of reducing awards in high risk categories in FY 2010, it did not meet its targets for FY 2011, FY 2012, or FY 2013 (Measure 15.4.2). The FY 2011 and FY 2012 percentage increased primarily due to a change in the denominator of total eligible dollars and does not reflect an actual increase in the number of high risk contracts being awarded. In FY 2012, CDC performed extremely well in two of the four sub-categories, reducing non-competitive awards by 36% and cost reimbursements by 20%. In FY 2013, CDC made significant improvements in three of the four sub-categories, reducing non-competitive awards by an additional 7.2%, reducing one-bid awards by 7.6%, and reducing cost-type contracts by 3.8%. CDC's time and material contracts and labor hour contracts increased by 16.8%, however, offsetting most of the reductions in the other three sub-categories.

CDC's portfolio of high-risk contracts is already low. Over 86% of our contract dollars are awarded competitively, less than five percent of our contract dollars represent a competitive contract that received only one offer, and 87% of our contracts are fixed-price contracts (rather than cost reimbursement, time and materials, or labor hour contracts). HHS maintains a targeted reduction of an additional 10% annually. CDC will work diligently to meet or exceed this target; however, the agency realizes this may be difficult given that our portfolio of high-risk contracts is already low and that the HHS target calls for additional reductions each year.

In FY 2014, CDC began implementation of the Working Capital Fund (WCF), which aims to achieve greater efficiency and transparency in the provision of Agency-wide business support services. The selected measures that CDC has chosen to focus on initially are 1) Variance between WCF annual revenues and WCF annual costs, 2) Percent variance between service orders and actual consumption and 3) Number of bills that require correction as a percentage of total bills. Baseline data for these select measures will become available in FY 2015. It is anticipated that data systems will continue to be refined as implementation moves forward and as a result, it is likely that the measures will similarly evolve.

CDC CONTRIBUTIONS TO HHS PERFORMANCE

The FY 2015 HHS Performance Plan includes a total of 22 CDC-associated measures. CDC contributes measures to three FY 2014–2015 federal Agency Priority Goals, leveraging its expertise in surveillance and promotion of evidence-based practices. CDC leads key activities for 19 measures in the FY 2014-FY 2018 HHS Strategic Plan.

CDC contributions to Agency Priority Goals, FY 2014- 2015¹

CDC Component	Program	Measure	HHS SP
National Center for Emerging and Zoonotic Infectious Diseases	Food Safety	By December 31, 2015, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 1.9 cases per 100,000.	3.E
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	By December 31, 2015, reduce the annual adult combustible tobacco consumption in the United States from 1,342 cigarette equivalents per capita to 1,174 cigarette equivalents per capita, which will represent an approximate 12% decrease from the 2012 baseline.	3.D
National Center for Emerging and Zoonotic Infectious Diseases	Healthcare Associated Infections/National Healthcare Safety Network	To reduce the national rate of healthcare-associated infections (HAIs) by September 30, 2015 by demonstrating a 10% reduction in national hospital-acquired catheter-associated urinary tract infections (CAUTI) from the current SIR of 1.02 to a target SIR of 0.92	1.B

¹ CDC contributes to these shared goals but does not lead them

CDC contributions to the FY 2015 HHS Performance Plan

CDC Component	Program	Measure	HHS SP
National Center for Emerging and Zoonotic Infectious Diseases	National Health Care Safety Network and Healthcare-Associated Infections	Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (3.3.3)	1.B
National Center for Emerging and Zoonotic Infectious Diseases	National Health Care Safety Network and Healthcare-Associated Infections	Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (3.3.4)	1.B
National Center for Chronic Disease Prevention and Health Promotion	Coordinated Chronic Disease Grant	Increase the proportion of adults who engage in leisure time physical activity (4.11.9)	1.C
Office of Surveillance, Epidemiology, and Laboratory Services	Laboratory	Increase the percentage of public health agencies that can receive production Electronic Laboratory Reporting (ELR) Meaningful Use-compliant messages from certified Electronic Health Record (EHR) technology used by eligible hospitals (8.B.1.3a)	1.F
Office of Surveillance, Epidemiology, and Laboratory Services	Epidemiology	Increase monitoring of awareness and use of the Guide to Community Preventive Services, and Task Force findings and recommendations (8.B.2.5)	2.D
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Domestic HIV/AIDS prevention and research	Increase the number of states that report all CD4 and HIV viral load values for surveillance purposes (2.2.4)	2.E

CDC Component	Program	Measure	HHS SP
Office of Surveillance, Epidemiology, and Laboratory Services	Public Health Workforce and Career Development	Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies (8.B.4.2)	2.E
Center for Global Health	Field Epidemiology and Laboratory Training and sustainable Management Development	Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP) (10.F.1a-b)	2.E
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	Reduce the proportion of adolescents (grades 9-12) who are current cigarette smokers (4.6.5)	3.D
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers (4.6.3)	3.D
National Center for Immunization and Respiratory Diseases	Immunization (Section 317)	Sustain immunization coverage of at least 90% in children 19 to 35 months of age for one dose of MMR vaccine (1.2.1c)	3.E
National Center for Immunization and Respiratory Diseases	Immunization (Section 317)	Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (1.3.3a)	3.E
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Domestic HIV/AIDS prevention and research	Reduce the proportion of persons with an HIV diagnosis at later stages of disease within three months of diagnosis (2.1.8)	3.E
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Tuberculosis	Decrease the rate of cases of TB among U.S.-born persons (per 100,000 population) (2.8.1)	3.E
National Center for Emerging and Zoonotic Infectious Diseases	National Health Care Safety Network and Healthcare-Associated Infections	Reduce the incidence (per 100,000 population) of healthcare associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections. (3.3.2a)	3.E
Center for Global Health	Global HIV/AIDS	Increase the number of adults and children with advanced HIV infection receiving antiretroviral therapy (10.A.1.5)	3.E
Office of Public Health Preparedness and Response	Division of State and Local Readiness	Increase the percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners (13.5.3)	3.F
Office of Surveillance, Epidemiology, and Laboratory Services	Epidemiology	Increase the electronic media reach of CDC Vital Signs through use of mechanisms such as the CDC website and social media outlets, as measured by page views, social media followers, and texting and email subscribers (8.B.2.2)	4.B

FY 2015 DISCONTINUED MEASURES TABLE

Measure ID 1.6.3: Percentage of countries achieving an increase of five percent over last year's indicator score on CDC's National Inventory of Core Capacities for Pandemic Influenza Preparedness and Response. (Output)

FY	Target	Result
2012	75%	42.5% (Target Not Met)
2010	50%	94% (Target Exceeded)

Between May and October of 2008, 40 countries completed baseline self-assessments, facilitated by CDC staff. A further 12 countries participated in late 2009 and early 2010 to establish baselines. As of November 2010, 36 countries of the initial 40 countries which participated had repeated the tool after an approximate two year interval, allowing for comparing baseline and subsequent scores. The percentage of countries achieving an increase of five percent over last year's indicator score actually increased steadily over baseline at biannual capacity reviews, and exceeded targets, with almost all bilateral partner countries meeting this goal. However, the construction of the measure actually tracked the aggregate change, which made it appear performance declined after 2010, although it did not. These partners' capacity for influenza preparedness and response became so high the program's focus is on maintaining these gains in a sustainable manner rather than improving upon the already very high achievement.

Measure 2.2.5: Increase the number of states with mature, name-based HIV surveillance systems (Output)

FY	Target	Result
2012	50	50 (Target Exceeded)
2011	48	50 (Target Exceeded)
2010	46	46 (Target Met)
2009	37	39 (Target Exceeded)

All 50 states now have mature, name-based surveillance

Measure ID 3.2.1: Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (Outcome)

FY	Target	Result
2014	48	Dec 31, 2016
2013	49	Dec 31, 2015
2012	48	Dec 31, 2014
2011	49	Mar 31, 2014

FY	Target	Result
2010	50	55.8 (Target Not Met but Improved)
2009	55	59.2 (Target Not Met)
2008	57	58.5 (Target Exceeded)

This measure is being retired because it is only a small representation of antibiotic prescribing patterns and may not accurately reflect all changes in prescribing behavior.

Measure 3.2.2: Decrease the proportion of hospitals with carbapenem-resistant (CRE) *Klebsiella* spp. or *Escherichia coli* (E.coli) healthcare-associated infections (Outcome)

FY	Target	Result
2014	3%	Jul 31, 2015
2013	4%	Jul 31, 2014
2012	N/A	8.02
2011	Set Baseline	6.54% (Baseline)

CDC has replaced this measure with a CRE measure (3.2.3) that provides more useful data, depicting a more accurate, focused, and interpretable measure of the spread of CRE in hospitals. While the measure being replaced measure only included acute care facilities reporting a healthcare-associated infection (HAI) to NHSN, the new measure will include all acute care facilities reporting any surveillance data to NHSN. The number of HAIs reported to NHSN increased in 2012 due to implementation of 2012 Center for Medicare and Medicaid Services, Inpatient Prospective Payment System, Hospital Inpatient Quality Reporting requirements for CAUTI and SSI. As anticipated, CDC’s target was not met in FY 2012.

Measure 3.4.3: Increase the likelihood of travelers seeking pre-travel medical advice for travel to Africa and Asia. (Outcome)

FY	Target	Result
2012	10	May 31, 2014
2011	9.5	7.2
2010	9	8.7
2009	8.5	4.4 (Target Not Met)

The data used to report on this measure (3.4.3) are not owned by the CDC, rather the CDC procures these data from elsewhere. Not owning the data presents many challenges and difficulties in consistently reporting out on this measure.

Measure 3.5.1: Increase the percentage of laboratories (large commercial/independent and hospital) using Electronic Laboratory Reporting (ELR) in Grantee Jurisdictions¹ (Intermediate Outcome)¹

FY	Target	Result
2013	47%	Dec 31, 2014
2012	37%	29% (Target Not Met but Improved)
2011	27%	23% (Target Not Met but Improved)
2010	Set Baseline	17% (Baseline)

Targets reflect ACA/PPHF funding

This measure focused on increasing the quantity of laboratories reporting ELR as an indicator for ELR implementation. However, CDC has discovered that a better indicator of ELR implementation is to measure ELR among laboratories that handle high volumes of total lab reports (paper and ELR). Therefore, CDC replaced this measure with measure 3.5.2, which tracks increasing meaningful volumes of ELR among targeted laboratories that already handle large volumes of total lab reports. This will substantially improve public health surveillance through increased use of ELR among the nation’s labs that handle the most volume of lab reporting.

Measure 4.8.1: Reduce birth rates among adolescent females aged 15 to 19 years in targeted communities (per 1,000 births). (Intermediate Outcome)

FY	Target	Result
2014	58.5	Sep 30, 2016
2013	61.6	Sep 30, 2015
2012	64.8	Sep 30, 2014
2011	Set Baseline	68.3 (Baseline)
2010	N/A	70.1 (Historical Actual)
2009	N/A	71.8 (Historical Actual)

Funding for this initiative in targeted communities ended in FY 2014 (although final data will not be available until FY 2015). Teen pregnancy prevention is a CDC Winnable Battle and activities to reduce this health outcome will continue on a national scale in FY 2015. This health outcome will be measured with vital statistics data via measure 4.8.5.

Measure 4.8.2: Increase the number of reporting areas (states) that provide optimal data for assessing preconception health practices, gaps, and barriers related to maternal and infant health using the Pregnancy Risk Assessment Monitoring System. (Intermediate Outcome)

FY	Target	Result
2013	41	41 (Target Met)
2012	41	41 (Target Met)
2011	6	6 (Target Met)
2010	N/A	6 (Historical Actual)

FY	Target	Result
2009	N/A	5 (Historical Actual)

The target of 41 was met in FY 2012 and will be maintained as there are no immediate plans to increase the number of reporting areas. The preconception health practices, gaps, and barriers are now part of the core questionnaire for PRAMS and collected by all 41 sites. Even if new PRAMS reporting areas were added, it is now part of the core questionnaire. However, this is not the case for sudden infant death syndrome (SUID). Therefore, CDC has replaced this measure with measure 4.8.4, which tracks CDC’s efforts to increase reporting areas related to SUID

Measures 4.9.3: Increase the number of central cancer registries that provide targeted reports on incidence and late-stage diagnosis of screening-amenable cancers (Output)

FY	Target	Result
2014	45	Jan 31, 2015
2013	42	Mar 31, 2014
2012	38	41 (Target Exceeded)
2011	35	41 (Target Exceeded)
2010	Set Baseline	34 (Baseline)

CDC has replaced this measure with measure 4.9.4, which tracks the number of CDC-funded state cancer registries that receive physician cancer reports from Electronic Health Records. By the end of FY 2014, the majority of CDC-funded cancer registries will be providing reports on incidence and late-stage diagnosis of screening-amenable cancers.

Measure 4.12.3: Increase the percent of high school students who attend physical education classes on 1 or more days in an average week when they were in school. (Intermediate Outcome)

FY	Target	Result
2013	56.4 %	Jun 30, 2014
2011	58.6 %	51.8 % (Target Not Met)
2009	Set Baseline	56.4 % (Baseline)
2007	N/A	53.6 % (Historical Actual)

¹The FY 2013 target was revised based on results from 2011.

This measure has been replaced with measure 4.12.5 to align with the strategies and outcomes of the new FOA to states (CDC RFA DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health). Additionally, measure 4.12.3 does not meet the standards in CDC’s School Health Guidelines to Promote Healthy Eating and Physical Activity.

Measure 4.13.1: Increase the number of people with access to smoke-free or tobacco-free environments in settings such as workplaces, restaurants and bars; multi-unit housing, schools, campuses, and outdoor places (e.g., parks, beaches). (Output)

FY	Target	Result
2015	Discontinued	Dec 31, 2016
2014	16,697,875	Dec 31, 2015
2013	8,348,937	Dec 31, 2014
2012	3,339,575	10,934,888 (Target Exceeded)
2011	Set Baseline	1,684,006 (Baseline)
2010	Set Baseline	0 (Baseline)

CDC is retiring this measure because the Community Transformation Grants program was eliminated.

Measure 4.13.2: Increase the number of people with access to environments with healthy food or beverage options in schools, afterschool programs, early childcare settings, workplaces, and other community settings. (Output)

FY	Target	Result
2015	Discontinued	Dec 31, 2016
2014	15,846,548	Dec 31, 2015
2013	7,923,274	Dec 31, 2014
2012	3,169,310	22,362,079 (Target Exceeded)
2011	Set Baseline	214,551 (Baseline)
2010	Set Baseline	0 (Baseline)

CDC is retiring this measure because the Community Transformation Grants program was eliminated.

Measure 4.13.3: Increase the number of people with access to physical activity opportunities in schools, afterschool programs, early childcare settings, workplaces, and other community settings. (Output)

FY	Target	Result
2015	Discontinued	Dec 31, 2016
2014	12,494,676	Dec 31, 2015
2013	6,247,338	Dec 31, 2014
2012	2,498,935	9,715,167 (Target Exceeded)
2011	Set Baseline	81,822

FY	Target	Result
		(Baseline)
2010	Set Baseline	0 (Baseline)

CDC is retiring this measure because the Community Transformation Grants program was eliminated.

Measure 4.13.4: Increase the number of people with access to systems or opportunities that support control of high blood pressure and of high cholesterol in health care and other community settings. (Output)

FY	Target	Result
2015	Discontinued	Dec 31, 2016
2014	5,989,374	Dec 31, 2015
2013	2,994,687	Dec 31, 2014
2012	1,197,875	5,596,522 (Target Exceeded)
2011	Set Baseline	161,461 (Baseline)
2010	Set Baseline	0 (Baseline)

CDC is retiring this measure because the Community Transformation Grants program was eliminated.

Measure 5.1.2: Reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of these conditions among Hispanics. (Outcome)

FY	Target	Result
2012	4.4	Feb 28, 2016
2011	4.5	Feb 28, 2015
2010	4.6	Feb 28, 2014
2009	4.7	Feb 28, 2013
2008	4.8	Feb 28, 2012
2007	4.9	5.7/10,000 (Target Not Met)
2006	5.0	5.5/10,000 (Target Not Met but Improved)

CDC has replaced this measure with measure 5.1.10, focusing on monitoring blood folate concentrations and identifying at-risk and/or vulnerable populations. The new measure builds on current programmatic efforts to identify a blood folate concentration associated with a reduced risk of neural tube defects, and ongoing efforts to monitor folic acid intake and blood folate status on a national level. These efforts enable CDC to identify populations of women of reproductive age who have low folic acid intakes and/or low blood folate status, both of which can indicate an increased risk for having a pregnancy affected by a neural tube defect.

Measure 5.1.6: Among the medications most frequently used during pregnancy, increase the number with sufficient evidence to determine the fetal risk (Replaced with measure 5.1.9) (Output)

FY	Target	Result
2014	3	Dec 31, 2014
2012	Baseline	2

CDC will replace this measure with a measure based on the Teratogen Information System Quantity/Quality of Evidence ratings. The risk rating for Measure 5.1.6 is in large part determined by the pharmaceutical properties of medications whereas the quality/quantity rating is determined by the amount and quality of scientific evidence produced about a medication. The latter is more modifiable and provides a more useful performance measure.

Measure 7.1.2b: Reduce victimization of youth enrolled in grades 9-12 as measured by the 12-month incidence of dating violence. (Outcome)

FY	Target	Result
2013	9.2%	July 1, 2014
2011	9.5%	9.4% (Target Met) ¹
2009	8.1%	9.8% (Target Not Met)

CDC incorrectly recorded the FY 2011 target. It should have been set at 9.5% of youth reporting incidences of dating violence within 12 months.

Measure 7.1.2b is a national measure of youth violence. CDC’s youth violence efforts contribute to achieving this measure, but the measure does not track performance of CDC’s youth violence efforts. CDC has replaced this measure with measure 7.1.3, which tracks rates of teen dating violence. This provides more transparency and accountability of CDC-funded activities.

Measure 8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management (Output)¹

FY	Target	Result
2013	175 ²	231 (Target Exceeded)
2012	200	230 (Target Exceeded)
2011	200	218 (Target Exceeded)
2010	200	200 (Target Met)
2009	200	198 (Target Not Met)

8.B.4.1 includes ALL (new and continuing) CDC-funded trainees in the Epidemic Intelligence Service (EIS), Public Health Prevention Service (PHPS), and Preventive Medicine Residency/Fellowship (PMR/F).

²CDC did not select a 2013 class of PHPS trainees in order to complete an improvement assessment. Accordingly, the FY 2013 target has been lowered from 200 to 175

CDC is retiring this measure due to a change in workforce program strategy and focus for two of the three fellowship, including blending the Public Health Prevention Service (PHPS) program into the Public Health Associate Program and pausing the Preventive Medicine Residency Fellowship (PMR/F) program to reassess program goals. The remaining fellowship program, the Epidemiology Intelligence Service (EIS) will continue to be tracked in measure 8.B.4.3, which tracks the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies.

Measure 9.1.2c: Reduce the prevalence rate of elevated blood lead levels in adults (per 100,000) due to work exposure (Output)

FY	Target	Result
2013	6.39	Jun 30, 2014
2012	Reduce the prevalence rate of elevated blood lead levels in adults by 3% (from the previous year value)	5.5 (Target Exceeded)
2011	Heighten use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%	6.40 (Target Exceeded)
2010	Heighten use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%	7.0 adults per 100,000 with elevated blood lead levels (Target Not Met)
2009	Heighten use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%	6.3 adults per 100,000 with elevated blood lead levels (Target Met)

The Adult Blood Lead Level Epidemiology and Surveillance (ABLES) program was eliminated to meet spending reductions required by the Sequester.

SUPPORTING INFORMATION

OBJECT CLASS TABLE – DIRECT

Object Class	FY 2013 Enacted	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 PB +/- FY 2014
Personnel Compensation:				
Full-Time Permanent(11.1)	\$677,666	\$684,965	\$691,741	\$6,776
Other than Full-Time Permanent (11.3)	\$93,949	\$94,960	\$95,910	\$950
Other Personnel Comp. (11.5)	\$23,003	\$23,251	\$23,484	\$233
Military Personnel (11.7)	\$62,191	\$62,860	\$63,536	\$676
Special Personal Service Comp. (11.8)	\$721	\$729	\$731	\$2
Total Personnel Compensation	\$857,530	\$866,765	\$875,400	\$8,635
Civilian personnel Benefits (12.1)	\$240,596	\$243,187	\$245,619	\$2,432
Military Personnel Benefits (12.2)	\$41,834	\$42,284	\$42,739	\$455
Benefits to Former Personnel (13.0)	\$2,072	\$2,095	\$2,118	\$23
SubTotal Pay Costs	\$1,142,032	\$1,154,331	\$1,165,875	\$11,544
Travel (21.0)	\$29,531	\$31,580	\$38,180	\$6,600
Transportation of Things (22.0)	\$8,019	\$8,575	\$8,738	\$163
Rental Payments to GSA (23.1)	\$30,902	\$33,046	\$33,575	\$529
Rental Payments to Others (23.2)	\$1,224	\$1,309	\$1,334	\$25
Communications, Utilities, and Misc. Charges (23.3)	\$31,310	\$33,482	\$34,118	\$636
NTWK Use Data TRANSM SVC (23.8)	\$443	\$474	\$483	\$9
Printing and Reproduction (24.0)	\$2,561	\$2,739	\$2,791	\$52
Other Contractual Services (25)	\$1,032,041	\$1,133,636	\$901,994	(\$231,642)
Advisory and Assistance Services (25.1)	\$515,616	\$581,386	\$474,280	(\$107,106)
Other Services (25.2)	\$157,657	\$168,594	\$130,575	(\$38,019)
Purchases from Government Accounts (25.3)	\$218,135	\$233,268	\$180,665	(\$52,603)
Operation and Maintenance of Facilities (25.4)	\$44,603	\$47,697	\$36,941	(\$10,756)
Research and Development Contracts (25.5)	\$37,932	\$40,563	\$31,416	(\$9,147)
Medical Services (25.6)	\$4,806	\$5,139	\$3,980	(\$1,159)
Operation and Maintenance of Equipment (25.7)	\$29,471	\$31,515	\$24,408	(\$7,107)
Subsistence and Support of Persons (25.8)	\$470	\$503	\$390	(\$113)
Consultants, other and misc (25.9)	\$23,351	\$24,971	\$19,340	(\$5,631)
Supplies and Materials (26.0)	\$200,755	\$214,682	\$214,597	(\$85)
Equipment (31.0)	\$48,690	\$52,068	\$49,413	(\$2,655)
Land and Structures (32.0)	\$10,215	\$10,924	\$10,924	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$2,892,308	\$3,129,879	\$2,937,287	(\$192,592)
Insurance Claims and Indemnities (42.0)	\$298	\$319	\$319	\$0
Interest and Dividends (43.0)	\$73	\$78	\$78	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$4,288,370	\$4,652,791	\$4,233,831	(\$418,960)
Total Budget Authority	\$5,430,402	\$5,807,120	\$5,399,706	(\$407,414)
Average Cost per FTE				
Civilian FTEs	8,782	8,782	8,782	0
Civilian Average Salary and Benefits	\$119	\$120	\$121	\$1
Percent change	N/A	1%	1%	0%
Military FTEs	807	807	807	0
Military Average Salary and Benefits	\$129	\$130	\$132	\$3
Percent change	N/A	1%	1%	N/A
Total FTEs	9,589	9,589	9,589	0
Average Salary and Benefits	\$120	\$121	\$122	\$1
Percent change	N/A	1%	1%	0%

OBJECT CLASS TABLE – REIMBURSABLE

Object Class	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
Personnel Compensation:			
Full-Time Permanent(11.1)	\$113,754	\$113,754	\$113,754
Other than Full-Time Permanent (11.3)	\$23,965	\$23,965	\$23,965
Other Personnel Comp. (11.5)	\$5,919	\$5,919	\$5,919
Military Personnel (11.7)	\$10,281	\$10,281	\$10,281
Special Personal Service Comp. (11.8)	\$274	\$274	\$274
Total Personnel Compensation	\$154,193	\$154,193	\$154,193
Civilian Personnel Benefits (12.1)	\$38,644	\$38,644	\$38,644
Military Personnel Benefits (12.2)	\$6,915	\$6,915	\$6,915
Benefits to Former Personnel (13.0)	\$0	\$0	\$0
SubTotal Pay Costs	\$199,751	\$199,751	\$199,751
Travel (21.0)	\$14,170	\$14,170	\$14,170
Transportation of Things (22.0)	\$708	\$708	\$708
Rental Payments to GSA (23.1)	\$963	\$963	\$963
Rental Payments to Others (23.2)	\$313	\$313	\$313
Communications, Utilities, and Misc. Charges (23.3)	\$1,678	\$1,678	\$1,678
Printing and Reproduction (24.0)	\$1,194	\$1,194	\$1,194
Other Contractual Services:			
Advisory and Assistance Services (25.1)	\$97,718	\$97,718	\$97,718
Other Services (25.2)	\$95,466	\$95,466	\$95,466
Purchases from Government Accounts (25.3)	\$74,477	\$74,477	\$74,477
Operation and Maintenance of Facilities (25.4)	\$3,330	\$3,330	\$3,330
Research and Development Contracts (25.5)	\$33,824	\$33,824	\$33,824
Medical Services (25.6)	\$31,896	\$31,896	\$31,896
Operation and Maintenance of Equipment (25.7)	\$2,852	\$2,852	\$2,852
Subsistence and Support of Persons (25.8)	\$3	\$3	\$3
Consultants, other and misc (25.9)	\$2,548	\$2,548	\$2,548
Subtotal Other Contractual Services	\$342,114	\$342,114	\$342,114
Supplies and Materials (26.0)	\$48,082	\$48,082	\$48,082
Equipment (31.0)	\$13,128	\$13,128	\$13,128
Land and Structures (32.0)	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$188,426	\$188,426	\$188,426
Insurance Claims and Indemnities (42.0)	\$84	\$84	\$84
Interest and Dividends (43.0)	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$610,860	\$610,860	\$610,860
Total Budget Authority	\$810,611	\$810,611	\$810,611
Average Cost per FTE			
Reimbursable FTEs	1,159	1,159	1,159
Average Salary and Benefits	\$162,897	\$162,897	\$162,897
Percent change	N/A	0.0%	0.0%
Military FTEs	98	98	98
Military Average Salary and Benefits	\$193,207	\$193,207	\$193,207
Percent change	N/A	0.0%	0.0%
Total FTEs	1257	1,257	1,257
Total Average Salary and Benefits	\$165,357	\$165,357	\$165,357
Percent change	N/A	0.00%	0.00%

OBJECT CLASS TABLE - AFFORDABLE CARE ACT

(dollars in thousands)	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Request	FY 2015 +/-FY 2014 Enacted
Personnel Compensation:				
Full-Time Permanent(11.1)	\$9,656	\$17,340	\$16,885	(\$455)
Other than Full-Time Permanent (11.3)	\$3,715	\$6,672	\$6,497	(\$175)
Other Personnel Comp. (11.5)	\$208	\$374	\$364	(\$10)
Military Personnel (11.7)	\$1,077	\$1,934	\$1,884	(\$51)
Special Personal Service Comp. (11.8)	\$10	\$19	\$18	(\$0)
Total Personnel Compensation	\$14,667	\$26,338	\$25,648	(\$690)
Civilian personnel Benefits (12.1)	\$4,236	\$7,607	\$7,408	(\$199)
Military Personnel Benefits (12.2)	\$933	\$1,675	\$1,631	(\$44)
Benefits to Former Personnel (13.0)	\$0	\$0	\$0	\$0
SubTotal Pay Costs	\$19,836	\$35,620	\$34,687	(\$934)
Travel (21.0)	\$806	\$1,447	\$1,409	(\$38)
Transportation of Things (22.0)	\$291	\$523	\$510	(\$14)
Rental Payments to GSA (23.1)	\$14,634	\$26,280	\$26,518	\$238
Rental Payments to Others (23.2)	\$1	\$2	\$2	(\$0)
Communications, Utilities, and Misc.Charges (23.3)	\$1	\$2	\$2	(\$0)
NTWK Use Data TRANSM SVC (23.8)	\$0	\$0	\$0	\$0
Printing and Reproduction (24.0)	\$2	\$4	\$4	(\$0)
Other Contractual Services:				
Advisory and Assistance Services (25.1)	\$98,352	\$176,619	\$171,062	(\$5,557)
Other Services (25.2)	\$95	\$171	\$166	(\$4)
Purchases from Government Accounts (25.3)	\$30,936	\$55,554	\$54,098	(\$1,456)
Operation and Maintenance of Facilities (25.4)	\$0	\$0	\$0	\$0
Research and Development Contracts (25.5)	\$0	\$0	\$0	\$0
Medical Services (25.6)	\$1,244	\$2,235	\$2,176	(\$59)
Operation and Maintenance of Equipment (25.7)	\$330	\$592	\$576	(\$16)
Subsistence and Support of Persons (25.8)	\$0	\$0	\$0	\$0
Consultants, other and misc (25.9)	\$3	\$5	\$5	(\$0)
Subtotal Other Contractual Services	\$130,959	\$235,176	\$228,084	(\$7,091)
Supplies and Materials (26.0)	\$47,112	\$84,603	\$82,386	(\$2,218)
Equipment (31.0)	\$1,326	\$2,380	\$2,318	(\$62)
Land and Structures (32.0)	\$0	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$247,947	\$445,261	\$433,590	(\$11,671)
Insurance Claims and Indemnities (42.0)	\$0	\$0	\$0	\$0
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$443,080	\$795,680	\$774,823	(\$20,856)
Total Budget Authority	\$462,916	\$831,300	\$809,510	(\$21,790)
Average Cost per FTE¹				
Civilian FTEs	230	230	230	0
Civilian Average Salary and Benefits	N/A	\$139,179	\$135,531	(\$4)
Percent change	N/A	N/A	NA	NA
Military FTEs	20	20	20	0
Military Average Salary and Benefits	N/A	\$180	\$176	(\$5)
Percent change	N/A	N/A	NA	NA
Total FTEs	N/A	250	250	0
Total Average Salary²	N/A	\$142	\$139	-\$4
Percent change	N/A	N/A	NA	NA

¹ PPHF FTEs based on direct hire estimates

² PPHF Civilian Avg. Salary only includes partial compensation

SALARIES AND EXPENSES

	FY 2013 Enacted	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 PB +/- FY 2014
Personnel Compensation:				
Full-Time Permanent(11.1)	\$677,666	\$684,965	\$691,741	\$6,776
Other than Full-Time Permanent (11.3)	\$93,949	\$94,960	\$95,910	\$950
Other Personnel Comp. (11.5)	\$23,003	\$23,251	\$23,484	\$233
Military Personnel (11.7)	\$62,191	\$62,860	\$63,536	\$676
Special Personal Service Comp. (11.8)	\$721	\$729	\$731	\$2
Total Personnel Compensation	\$857,530	\$866,765	\$875,400	\$8,635
Civilian personnel Benefits (12.1)	\$240,596	\$243,187	\$245,619	\$2,432
Military Personnel Benefits (12.2)	\$41,834	\$42,284	\$42,739	\$455
Benefits to Former Personnel (13.0)	\$2,072	\$2,095	\$2,118	\$23
SubTotal Pay Costs	\$1,142,032	\$1,154,331	\$1,165,875	\$11,544
Travel (21.0)	\$29,531	\$31,580	\$38,180	\$6,600
Transportation of Things (22.0)	\$8,019	\$8,575	\$8,738	\$163
Communications, Utilities, and Misc. Charges (23.3)	\$31,310	\$33,482	\$34,118	\$636
Printing and Reproduction (24.0)	\$2,561	\$2,739	\$2,791	\$52
Other Contractual Services:				
	\$1,032,041	\$1,133,636	\$901,994	(\$231,642)
Advisory and Assistance Services (25.1)	\$515,616	\$581,386	\$474,280	(\$107,106)
Other Services (25.2)	\$157,657	\$168,594	\$130,575	(\$38,019)
Purchases from Government Accounts (25.3)	\$218,135	\$233,268	\$180,665	(\$52,603)
Operation and Maintenance of Facilities (25.4)	\$44,603	\$47,697	\$36,941	(\$10,756)
Research and Development Contracts (25.5)	\$37,932	\$40,563	\$31,416	(\$9,147)
Medical Services (25.6)	\$4,806	\$5,139	\$3,980	(\$1,159)
Operation and Maintenance of Equipment (25.7)	\$29,471	\$31,515	\$24,408	(\$7,107)
Subsistence and Support of Persons (25.8)	\$470	\$503	\$390	(\$113)
Supplies and Materials (26.0)	\$200,755	\$214,682	\$214,597	(\$85)
Subtotal Non-Pay Costs	\$1,304,217	\$1,424,694	\$1,200,419	(\$224,275)
Rental Payments to Others (23.2)	\$1,224	\$1,309	\$1,334	\$25
Total, Salaries & Expenses and Rent	\$2,447,473	\$2,580,334	\$2,367,628	(\$212,731)
Direct FTE	10,846	10,846	10,846	0

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE) – CDC

	FY 2013		FY 2014		FY 2015	
	Civilian	Comm Corp	Civilian	Comm Corp	Civilian	Comm Corp
Direct FTE						
Immunization and Respiratory Diseases	562	62	562	62	562	62
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	1,090	108	1,090	108	1,090	108
Emerging and Zoonotic Infectious Diseases	948	123	948	123	948	123
Chronic Disease Prevention and Health Promotion	823	83	823	83	823	83
Birth Defects, Developmental Disabilities, Disability and Health	221	10	221	10	221	10
Environmental Health	373	31	373	31	373	31
Injury Prevention and Control	204	13	204	13	204	13
Public Health Scientific Services	372	95	372	95	372	95
Occupational Safety and Health	782	55	782	55	782	55
Global Health	810	121	810	121	810	121
CDC-wide Cross-cutting Activities	2,082	43	2,082	43	2,082	43
Public Health Leadership and Support	576	15	576	15	576	15
Business Services Support	1,506	28	1,506	28	1,506	28
Public Health Preparedness and Response	515	63	515	63	515	63
Subtotal, Direct FTE	8,782	807	8,782	807	8,782	807
Reimbursable FTE						
Immunization and Respiratory Diseases	2	0	2	0	2	0
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	3	3	3	3	3	3
Emerging and Zoonotic Infectious Diseases	43	3	43	3	43	3
Chronic Disease Prevention and Health Promotion	13	2	13	2	13	2
Birth Defects, Developmental Disabilities, Disability and Health	0	0	0	0	0	0
Environmental Health	41	11	41	11	41	11
Injury Prevention and Control	0	0	0	0	0	0
Public Health Scientific Services	607	24	607	24	607	24
Occupational Safety and Health	261	33	261	33	261	33
Global Health	54	20	54	20	54	20
CDC-wide Cross-cutting Activities	134	1	134	1	134	1
Public Health Leadership and Support	131	1	131	1	131	1
Business Services Support	3	0	3	0	3	0
Public Health Preparedness and Response	1	1	1	1	1	1
Subtotal, Reimbursable FTE	1,159	98	1,159	98	1,159	98
TOTAL, CDC FTE	9,941	905	9,941	905	9,941	905

DETAIL OF POSITIONS

(dollars in millions)	FY 2013 Actual	FY 2014 Base	FY 2015 Budget
Executive Level	-	-	-
Executive level I	-	-	-
Executive level II	-	-	-
Executive level III	-	-	-
Executive level IV	-	-	-
Executive level V	-	-	-
Subtotal	-	-	-
Total-Executive Level Salary	-	-	-
ES-6			
ES-5			
ES-4			
ES-3			
ES-2			
ES-1			
Total - SES	32	28	27
Total - SES Salary	\$4,704,421.52	\$4,343,346.533	\$4,632,587.86
GS-15	664	645	616
GS-14	1,874	1,822	1,767
GS-13	2,728	2,626	2,564
GS-12	1,568	1,528	1,487
GS-11	846	835	826
GS-10	64	59	60
GS-9	463	404	409
GS-8	81	78	75
GS-7	330	291	278
GS-6	73	55	57
GS-5	204	182	178
GS-4	58	29	24
GS-3	22	12	10
GS-2	7	3	2
GS-1	3	0	0
Subtotal	8,985	8,569	8,353
Total - GS Salary	\$789,476,640	\$857,540,825	\$828,686,844
Average ES level			
Average ES salary			
Average GS grade	12.0	12.0	12.0
Average GS salary	\$87,866	\$100,075	\$99,208
Average Special Pay Categories			
Average Comm. Corps Salary ³	\$86,752	\$91,054	\$96,864
Average Wage Grade Salary	\$55,842	\$58,112	\$58,945

¹ Includes special pays and allowances

² Totals do not include reimbursable FTEs

³ This table reflects "positions" not full-time equivalent(s) (FTEs)

PROGRAMS PROPOSED FOR ELIMINATION

The following table shows the programs proposed for elimination in the President's FY 2015 Budget request. The Budget prioritizes health programs that have a demonstrated record of success or that hold significant promise for increasing accountability and improving health outcomes. Following the table is a brief summary of each program and the rationale for its elimination.

Program	FY 2014 Enacted Level (in millions)
Preventive Public Health and Health Services Block Grant (PPHF)	\$160.000
Racial and Ethnic Approach to Community Health (REACH) (BA, PPHF)	\$51.005
Occupational Safety and Health – Education and Research Centers (BA)	\$27.519
National Occupational Research Agenda –Agricultural, Forestry and Fishing sector (PHS Eval)	\$24.000
Workplace Wellness (PPHF)	\$10.000
Academic Centers for Preparedness (BA)	\$8.100
High Obesity Rate Counties	\$5.000
Total Reduction Amount	\$285.624

Preventive Public Health and Health Services Block Grant (-\$160.0 million)

The FY 2015 budget request continues the elimination of the Preventive Health and Health Services Block Grant (PHHSBG) program, which was proposed in FY 2014. These activities may be more effectively and efficiently implemented through the State [Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health](http://www.cdc.gov/chronicdisease/about/statepubhealthactions-prevcd.htm)³²⁸ program, which provides resources to states to coordinate activities across categorical funding streams. When the PHHSBG was first authorized in 1981, there were minimal resources within CDC’s budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity, and many states did not receive funding from CDC to support prevention of chronic disease. However, since 1981, categorical programs at CDC have grown and can better address these public health threats. Elimination of this program provides an opportunity to find savings, while expanding core public health activities and for other CDC priorities such as food safety and the reduction of healthcare-acquired infections.

Racial and Ethnic Approach to Community Health (-\$51.0 million)

The FY 2015 budget request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program. The newly funded Partnerships to Improve Community Health, funded at \$80 million, will build on past program successes and lessons learned from CDC’s community-based programs. This effort will also adopt best practices and lessons learned from the REACH program into its strategy in program planning and implementation.

Occupational Safety and Health – Education and Research Centers (-\$27.5 million)

The FY 2015 budget request eliminates the Education Research Centers (ERCs). Originally created almost 40 years ago, the ERC program has addressed the limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. The ERCs’ reach and

³²⁸ <http://www.cdc.gov/chronicdisease/about/statepubhealthactions-prevcd.htm>

impact have grown substantially across the nation since the program's inception, increasing awareness of the importance of coursework specializing in these areas. Although the budget does not include funding for the federal portion of these grants, CDC will continue to provide scientific and programmatic expertise to the ERCs as requested.

National Occupational Research Agenda –Agricultural, Forestry and Fishing sector (-\$24.0 million)

The FY 2015 budget request reflects elimination of the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupational Research Agenda (NORA). Although this program has made positive contributions, it has been proposed for elimination in a limited-resource environment.

Workplace Wellness (-\$10.0 million)

The FY 2015 budget request eliminates the Workplace Wellness program. These programs were of limited duration and will have completed their work in FY 2014. CDC will integrate lessons learned from these projects into on-going chronic disease prevention programs.

Academic Centers for Preparedness (-\$8.1 million)

The FY 2015 budget request reflects the elimination of the Academic Centers for Public Health Preparedness. CDC recognizes the impactful scientific research and workforce development work conducted by these Centers in support of preparedness and response. CDC will continue to support research and training for public health preparedness through the research agenda of the OPHPR Science Office. Eliminating funding for these centers allows CDC to prioritize funding for state and local health departments through the Public Health Emergency Preparedness (PHEP) cooperative agreement and puts boots-on-the-ground to respond to every day and catastrophic health emergencies.

High Obesity Rate Counties (-\$5.0 million)

The FY 2015 budget request eliminates the High Obesity Rate Counties program. This program was of limited duration and will complete their work in FY 2014. CDC will integrate lessons learned from these projects into on-going chronic disease prevention programs. These funds will be redirected to other obesity-related activities.

CDC FULL TIME EQUIVALENTS FUNDED BY THE AFFORDABLE CARE ACT

Discretionary Program ^{1,2}	(dollars in millions)	ACA Sec.	2011 Total	2011 FTEs	2012 Total	2012 FTEs	2013 Total	2013 FTEs	2014 Total	2014 FTEs	2015 Total	2015 FTEs
Cancer Prevention & Control		4002	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$104.0	5.0	\$179.2	5.0
Community Guide / Community Preventive Services Task Force		4002	\$7.0	3.1	\$10.0	16.0	\$7.4	16.0	\$0.0	0.0	\$8.0	0.0
Community Transformation Grants (CTG)		4002	\$145.0	39.5	\$226.0	55.6	\$146.3	39.3	\$0.0	0.0	\$0.0	0.0
Diabetes Prevention		4002	\$0.0	0.0	\$10.0	0.0	\$0.0	0.0	\$73.0	2.0	\$73.0	2.0
Environmental Public Health Tracking		4002	\$35.0	14.6	\$35.0	15.0	\$20.7	12.4	\$0.0	0.0	\$24.0	0.0
Healthcare-associated Infections (HAI)		4002	\$11.8	1.2	\$11.8	5.0	\$11.8	0.0	\$12.0	0.0	\$11.8	0.0
Heart Disease & Stroke Prevention Program		4002	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$73.0	2.0	\$73.0	2.0
Lead Poisoning Prevention		4002	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$13.0	2.0	\$13.0	2.0
Million Hearts		4002	\$0.0	0.0	\$0.0	2.2	\$4.6	0.3	\$4.0	0.3	\$4.0	0.3
National Early Care Collaboratives		4002	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$4.0	2.0	\$4.0	2.0
National Prevention Strategy		4002	\$1.0	1.1	\$1.0	1.4	\$0.9	1.4	\$0.0	0.0	\$0.0	0.0
Public Health Workforce		4002	\$25.0	51.8	\$25.0	176.3	\$15.6	155.6	\$0.0	0.0	\$15.0	0.0
Racial & Ethnic Approaches to Community Health (REACH)		4002	\$25.0	3.1	\$40.0	0.0	\$0.0	0.0	\$30.0	39.3	\$0.0	0.0
Workplace Wellness		4303	\$10.0	0.1	\$10.0	0.0	\$0.0	0.0	\$10.0	0.0	\$0.0	0.0
Preventive Health and Health Services Block Grants		4201	\$0.0	0.0	\$0.0	0.0	\$0.0	0.0	\$160	7.0	\$0.0	0.0
Total			\$259.8	114.5	\$368.8	271.5	\$207.3	225.0	\$323.0	59.6	\$405.0	13.3

¹Excludes employees or contractors who: Are supported through appropriations enacted in laws other than PPACA and work on programs that existed prior to the passage of PPACA; Spend less than 50% of their time on activities funded by or newly authorized in ACA; or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed price contracts.

²CDC tracks total contract costs for ACA activities in the Affordable Care Act Object Class Table but does not track individual contract staff.

Mandatory Program ^{1,2}	(dollars in millions)	ACA Sec.	2011 Total	2011 FTEs	2012 Total	2012 FTEs	2013 Total	2013 FTEs	2014 Total	2014 FTEs	2015 Total	2015 FTEs
Childhood Obesity		4306	\$0.0	1.8	\$0.0	2.0	\$0.0	1.1	\$0.0	1.1	\$0.0	0.0
Total			\$0.0	1.8	\$0.0	2.0	\$0.0	1.1	\$0.0	1.1	\$0.0	0.0

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA) WORKSHEET

	PY 2014 Actual	FY 2015 Estimates	FY 2016* Estimates
1) Number of Physicians Receiving PCAs	2	2	2
2) Number of Physicians with One-Year PCA Agreements	0	0	0
3) Number of Physicians with Multi-Year PCA Agreements	2	2	2
4) Average Annual PCA Physician Pay (without PCA payment)	\$179,700	\$179,700	\$179,700
5) Average Annual PCA Payment	\$28,000	\$28,000	\$28,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position		
	Category II Research Position	2	2
	Category III Occupational Health		
	Category IV-A Disability Evaluation		
	Category IV-B Health and Medical Admin.		

*FY 2015 data will be approved during the FY 2014 Budget cycle.

- 1) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not Applicable.

- 2) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

\$30,000. All of CDC's physicians who are eligible for PCA funds are in Category II, Research. CDC employs two SES physicians for whom this PCA amount is appropriate and necessary.

- 3) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)

CDC has found that SES salaries do not meet the threshold to attract top level senior officials for critical science-focused positions who are appointed under SES and PCA is needed to continue to attract and retain those top level physicians.

- 4) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)

The use of PCA has enabled successful recruitment of physicians to key positions at CDC. It is anticipated that failure to offer PCA funds to CDC physicians could result in an increase in turnover.

- 5) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

It is expected that PCA will continue through 2014 for the three SES members currently receiving PCA. The need will remain to pay PCA to any new physicians appointed under SES. Market pay will be utilized for all new accessions of physicians appointed under Title 5.

FY 2013 INTRAMURAL AND EXTRAMURAL OBLIGATIONS

Major CDC Program	(dollars in thousands) ¹	Extramural ²	Intramural	Grand Total
Agency for Toxic Substances and Disease Registry (ATSDR)		\$28,832	\$43,133	\$71,965
Birth Defects, Developmental Disabilities, Disability and Health		\$96,850	\$32,854	\$129,704
CDC-Wide Activities and Program Support		\$327,216	\$290,627	\$617,843
Chronic Disease Prevention and Health Promotion		\$620,854	\$118,406	\$739,261
Emerging and Zoonotic Infectious Diseases		\$121,271	\$125,022	\$246,293
Energy Employees Occupational Illness Compensation Program Act		\$44,082	\$5,722	\$49,804
Environmental Health		\$55,875	\$46,586	\$102,460
Global Health		\$182,153	\$148,969	\$331,122
Health Reform - Prevention and Public Health Fund (PPHF)		\$424,638	\$37,462	\$462,100
HIV/AIDS, Viral Hepatitis, STI and TB Prevention		\$890,106	\$157,440	\$1,047,546
Immunization and Respiratory Diseases		\$490,213	\$85,230	\$575,443
Injury Prevention and Control		\$101,607	\$28,748	\$130,355
National Institute for Occupational Safety and Health		\$137,995	\$145,829	\$283,824
Public Health Preparedness and Response		\$772,415	\$482,823	\$1,255,238
Public Health Scientific Services (PHSS)		\$199,983	\$191,285	\$391,267
Vaccines for Children		\$3,590,423	\$16,488	\$3,606,912
World Trade Center Health Programs (WTC) ³		\$253,182	\$3,128	\$256,310
Grand Total		\$8,337,694	\$1,959,751	\$10,297,446

¹ Obligations include sequestration reductions and may vary from appropriated amounts due to multi year funding.

² All contracts are classified extramural in the analysis supporting this table. This varies slightly from prior reports.

³ WTC amount reflects total program obligations and does not include NYC reimbursement.

USER FEES

Activity	FY13 Actual	FY 14 Estimate¹
Emerging & Zoonotic Infectious User Fees	\$121,180.09	\$121,180.09
Global Health DPD User Fees	\$ 10,000.00	\$10,000.00
Health Statistics User Fees	\$1,575,560.00	\$1,575,560.00
NIOSH Respirator Certification Program	\$435,829.00	\$ 435,829.00
Vessel Sanitation Program	\$2,485,457.00	\$2,485,457.00
Cooperative Research and Development Agreement (CRADA)	\$901,997.00	\$901,997.00
Grand Total	\$5,530,023.09	\$5,530,023.09

¹ FY 2014 Estimate amount based on FY 2013 Actual Obligations.

CDC FY 2014 WORKING CAPITAL FUND EXHIBITS

The Joint Explanatory Statement accompanying the Consolidated Appropriations Act, 2014 (P.L. 113-76) included requirements for CDC to provide breakouts of select Working Capital Fund details. Center specific data will be presented to congress during a joint briefing to the House and Senate Appropriations Committees.

Projected FY 2014 Working Capital Fund: Summary by Object Class

OC	Description	Total
11/12	Personnel Compensation/Benefits	\$205,675,967
21	Travel	\$1,782,700
22	Transportation of Things	\$435,073
23	Rent, Communication & Utilities	\$74,493,757
24	Printing and Reproduction	\$59,972
25	Other Contractual Services	\$209,957,226
26	Supplies & Materials	\$1,755,941
31	Equipment	\$6,273,311
-	Other	\$11,769,233
Grand Total		\$512,203,180

Projected FY 2014 Working Capital Fund: FTEs and Contract Full Time Equivalents

Service Provider	Number of FTEs	Number of Contractors
Safety, Security, and Asset Management	378	1429
IT Services, Support, and Infrastructure	340	691
Management Analysis and Support Services	27	2
Procurement and Grants	252	79
Human Resources	243	32
Financial Management	332	156
Grand Total	1572	2389

Projected FY 2014 Working Capital Fund: Individual Service Line and Forecasted Consumption

Service Line (SL)	Billing Basis	SL Budget	Forecasted Consumption
Centralized Administrative Services		\$38,799,116	
Service and Supply Fund	*Total Obligations	\$35,971,613	\$11,624,852,783
Clearing/Expense Accounts	*Total Obligations	\$781,834	\$11,624,852,783
Joint Funding Agreements	*Total Obligations	\$2,045,669	\$11,624,852,783
Office of the Chief Financial Officer		\$52,873,786	
Budget Execution	# of Budget Analysts	\$25,789,008	\$132
Payment Services	# of Accts Payable and Purchase Order Transactions	\$6,567,318	\$2,442,451
Accounting	*Total Obligations	\$5,966,807	\$11,624,852,783
<i>Travel-related Audit and Payment Services</i>		<i>\$4,266,783</i>	
Dom. - Travel-related Audit and Payment Services	# of Completed Travel Orders (Dom.)	\$3,215,507	\$19,190
Int. - Travel-related Audit and Payment Services	# of Completed Travel Orders (Int.)	\$1,051,276	\$3,779
Financial Systems	*Total Obligations	\$6,629,601	\$11,624,852,783
Debt Management - Interagency Agreements	# of IAA Transactions	\$1,922,259	\$5,184
Debt Management - Accounts	# of Accounts Receivable Transactions	\$956,748	\$2,469

Service Line (SL)	Billing Basis	SL Budget	Forecasted Consumption
Receivable			
Int. Financial Oversight and Support	*Post Held Funds Obligations	\$775,261	\$113,654,044
Human Resources		\$36,403,591	
Staff Management and Recruitment	# of HR Analysts	\$9,484,234	\$51
Education and Training	# of On-board Employees	\$8,382,575	\$10,064
Human Capital Advisory Services	# of On-board Employees	\$5,001,351	\$10,064
Workforce Relations	# of On-Board Employees (excluding CC)	\$5,535,805	\$9,117
Executive and Scientific Resources Support	# of Employees in SES SL/ST SBRS or Title 42 Positions	\$993,447	\$1,483
Immigration Services	# of Cases	\$1,830,212	\$1,078
Commissioned Corps	# of Commissioned Corps Officers	\$1,559,212	\$947
Ethics	# of On-board Employees	\$1,814,064	\$10,064
Int. HR Services	# of CGH Emp. (All) and non-CGH Emp. (Int.)	\$1,802,691	\$1,065
IT Services, Support, and Infrastructure¹		\$152,917,924	
E-mail	# of E-mail Accounts	\$5,100,947	\$20,756
Remote Access	# of IT Users (US and overseas)	\$3,900,297	\$15,594
Enterprise File and Data Center Services	# of IT Users (US and overseas)	\$17,597,114	\$15,594
Personal Computing Hardware and Software	# of Devices (laptop/desktop/tablet)	\$29,382,947	\$25,810
Networking	# of U.S. based IT Users	\$17,410,428	\$14,127
Telecommunications	# of U.S. based IT Users	\$13,380,258	\$14,127
Meeting Management Technology	# of U.S. based IT Users	\$6,866,276	\$14,127
Int. IT Services	# of Staff Based at CDC Int. Sites	\$9,212,091	\$1,216
Microsoft Licensing Services	# of IT Users (US and overseas)	\$9,943,067	\$15,594
Enterprise Business Systems Services	# of IT Users (US and overseas)	\$23,667,384	\$15,594
Information Resources Management	# of IT Users (US and overseas)	\$7,245,394	\$15,594
Information Security Services	# of IT Users (US and overseas)	\$6,372,014	\$15,594
Int. Information Security Services	# of Staff Based at CDC Int. Sites	\$133,147	\$1,216
<i>Information Systems Cert. and Accreditation (C&A)</i>		\$2,706,560	
C&A - Full High System	# of Full High Systems	\$212,106	\$5
C&A - Full Moderate System	# of Full Moderate Systems	\$543,671	\$18
C&A - Full Low System	# of Full Low Systems	\$361,174	\$33
C&A - EMSSP Moderate External System	# of EMSSP Mod Ext Systems	\$344,121	\$52
C&A - EMSSP Moderate Internal System	# of EMSSP Mod Int Systems	\$617,229	\$97
C&A - EMSSP Low External System	# of EMSSP Low Ext Systems	\$380,094	\$160
C&A - EMSSP Low Internal System	# of EMSSP Low Int Systems	\$248,164	\$117
Management Analysis & Support Services		\$5,590,417	
Management Analysis Support Services	# of Staff	\$5,590,417	\$14,947
Procurement and Grants Office		\$40,441,286	
Grants Management	*Total Grant Obligations	\$18,827,132	\$4,921,899,005
Purchase Card Management	# of Credit Card Transactions	\$436,724	\$122,609
Contracting Officer Representative (COR) Training	# of Certifications	\$184,226	\$1,332
<i>Procurement/ Acquisition Management</i>		\$20,993,204	
New Contracts (Dom.)	# of New Contracts (Dom.)	\$2,874,084	\$184
New Non-Competitive Task Orders (Dom.)	# of New Non-Competitive Task Orders (Dom.)	\$588,354	\$339
SAP Services (Dom.)	# of SAP Services (Dom.)	\$2,366,433	\$909
Task Order Mods (Dom.)	# of Task Order Mods (Dom.)	\$4,567,988	\$2,632

Service Line (SL)	Billing Basis	SL Budget	Forecasted Consumption
SAP Mods (Dom.)	# of SAP Mods (Dom.)	\$3,682,854	\$4,244
Contract Mods (Dom.)	# of Contract Mods (Dom.)	\$2,398,541	\$1,382
New Competitive Task Orders (Dom.)	# of New Competitive Task Orders (Dom.)	\$1,181,915	\$227
SAP Supplies (Dom.)	# of SAP Supplies (Dom.)	\$2,735,239	\$1,576
IAA Transactions (Dom.)	# of IAA Transactions (Dom.)	\$0	\$0
New Contracts (Int.)	# of New Contracts (Int.)	\$119,181	\$7
New Non-Competitive Task Orders (Int.)	# of New Non-Competitive Task Orders (Int.)	\$11,351	\$6
SAP Services (Int.)	# of SAP Services (Int.)	\$73,779	\$26
Task Order Mods (Int.)	# of Task Order Mods (Int.)	\$141,882	\$75
SAP Mods (Int.)	# of SAP Mods (Int.)	\$24,593	\$26
Contract Mods (Int.)	# of Contract Mods (Int.)	\$58,645	\$31
New Competitive Task Orders (Int.)	# of New Competitive Task Orders (Int.)	\$68,103	\$12
SAP Supplies (Int.)	# of SAP Supplies (Int.)	\$100,263	\$53
IAA Transactions (Int.)	# of IAA Transactions (Int.)	\$0	\$0
Safety, Security, and Asset Management¹		\$185,177,061	
Corporate Real Estate Services	Total Square Footage	\$23,973,337	\$5,673,283
Rent, Utilities, and Operations and Maintenance	RUOM Square Footage	\$84,798,818	\$4,506,062
Int. Corporate Real Estate Services	# of Staff at CDC Int Sites excl LES	\$381,893	\$265
Physical Security	Physical Security Square Footage	\$38,162,075	\$5,699,595
Personnel Security	# of Staff	\$7,338,303	\$14,947
Public Health and Medical Intelligence	*Total Obligations	\$1,561,000	\$11,624,852,783
Global Travel Security	# of Travel Orders (Int.)	\$791,890	\$5,328
Secure Communication and Intelligence	# of Staff with Security Clearances	\$1,329,215	\$1,317
Int. Security Services	# of Staff Based Outside the U.S.	\$273,399	\$1,519
Clinic Services	# of on-board Employees (excluding off-site locations)	\$4,356,464	\$7,140
Worklife Wellness Services	# of On-site Staff(Wellness)	\$3,474,307	\$11,370
Lab - Environment, Health and Safety Services	Lab Space Square Footage	\$4,386,095	\$2,162,335
Universal - Environment, Health, and Safety Services	# of On-site Staff(EHS)	\$3,307,811	\$11,829
Int. Site - Environment, Health, and Safety Services	# of Staff Based at CDC Int. Sites	\$137,803	\$265
Property Management	# of Accountable Assets	\$4,492,055	\$44,666
Fleet Management	# of GSA Vehicle Dispatches	\$1,433,510	\$1,213
Shipping	# of Shipping Transactions	\$4,979,086	\$14,315
Service Lines Total		\$512,203,180	

¹The planned budget does not fully fund the service line in FY 2014. The Board may decide to use the reserve to cover this gap or carry forward the balance into the future fiscal year.

SIGNIFICANT ITEMS

SIGNIFICANT ITEMS IN FY 2014 APPROPRIATIONS REPORTS - SENATE

Significant items for inclusion in the FY 2015 Centers for Disease Control and Prevention Congressional Justification from the Senate Appropriations Committee, LHHS Subcommittee, S.Rept. 113-71.

Exemption Rates

The Committee urges CDC to continue working with State and local governments to ensure that the universal immunization recommendations, as defined by the Advisory Committee on Immunization Practices, are implemented. The Committee encourages CDC to work with States to track exemption rates and assess the impact that exemptions may have on vaccine preventable disease rates. CDC should provide to State and local health officials, the provider community, and the public, scientifically accurate information on vaccines and vaccine-preventable diseases that is presented in culturally and linguistically appropriate manners.

Action taken or to be taken

CDC recognizes the role state and local legislation can have on immunization coverage rates. CDC currently tracks state and local legislation regarding vaccine requirements, such as for school entry, as well as exemption rates. CDC annually assesses, analyzes, and publishes vaccination coverage rates in the Morbidity and Mortality Weekly Report (MMWR). This information is also shared with state immunization programs to assist them with their program planning. CDC also supports state and local public awareness campaigns and provider education through its cooperative agreement to 64 state, local, and territorial immunization awardees. In addition, CDC conducts formative research to inform the development of communication materials and campaigns in support of delivering effective, relevant, and scientifically accurate information on vaccines and the prevention of vaccine-preventable diseases.

Public Health Role

The Committee has combined the funding amounts for section 317 vaccine purchases with funding for program implementation and accountability to allow CDC maximum flexibility to increase quality and safety activities as insurance coverage rates change over time. The Committee urges CDC to use this flexibility to shift resources to better reflect the changing public health role. Specifically, the Committee recommends that CDC increase resources to: (1) modernize immunization information systems; (2) prepare public health departments for changes in the healthcare delivery system, including new billing procedures related to privately insured patients; (3) strengthen the evidence base to inform immunization policy; and (4) improve program monitoring, including vaccine-preventable disease surveillance, vaccine coverage assessment, adverse event reporting, and laboratory training.

Action taken or to be taken

CDC appreciates the Committee's recognition of the important public health role CDC's immunization program plays in ensuring high vaccination rates and low rates of vaccine-preventable diseases. The flexibility of the budget line consolidation will allow CDC to continue to strategically invest resources to support its three priorities for the Immunization Program which are to: 1) preserve core public health immunization infrastructure at the local, state, and federal levels; 2) make strategic investments to enhance the immunization infrastructure and evidence base and improve efficiency; and 3) maintain an adequate amount of vaccine purchase to provide a vaccination safety net for uninsured adults, and for response to vaccine-preventable disease outbreaks and other vaccine urgent needs.

Anticipating the evolving role of public health, CDC has strategically directed immunization resources to prepare for the new healthcare environment. CDC has made investments in Immunization Information Systems (IIS) that inform and support clinical decision-making and allow interfacing with electronic health records (EHRs) and vaccine ordering systems—allowing more than 95% of 56 awardees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions. Since 2009, CDC has also invested funding

to expand immunization infrastructure to assist public health clinics that serve fully-insured patients with billing for immunization services in order to preserve access to life-saving immunizations for fully-insured populations. In some communities, such as rural areas, health departments serve as a critical access point. To date, CDC has funded 38 immunization awardees for billing planning and/or implementation efforts. The Budget includes up to \$ 8 million to expand the capacity of public health departments to bill for immunizations....CDC is also supporting efforts to strengthen the evidence base for national immunization policies and programs through support of important evaluations of the effectiveness and impact on disease for recent vaccine recommendations, including rotavirus vaccine, the meningococcal conjugate vaccine (MCV), tetanus-diphtheria-cellular pertussis-containing vaccines, and the 13-valent pneumococcal conjugate vaccine (PCV-13).

Vaccine Purchase Formula Change

The Committee supports CDC’s policy decision to limit the conditions under which fully insured individuals may receive vaccines purchased through section 317 funds. The Committee believes that section 317 should be the payer of last resort for vaccination. However, the Committee has some concerns about the administration’s plan to change from a vaccine purchase allocation formula that is based strictly on each State’s total population to a formula based on Census estimates of each State’s uninsured population. The Committee notes that this change would inadvertently penalize uninsured and underinsured individuals in States that are using all available tools to insure their populace. The Committee urges CDC to develop a component in the formula that would provide an incentive to States to administer section 317-funded vaccines in a way that addresses coverage gaps, which cannot be filled with other available Federal programs.

Action taken or to be taken

As the Committee has recognized, CDC has made policy changes that ensure Section 317-purchased vaccine is used only for uninsured populations and for outbreak response. This is particularly important as more tools are available to improve access to vaccination through public and private insurance. The proposed formula change in the FY 2014 President’s Budget was another effort to support the use of Section 317 vaccine as a payer of last resort. CDC understands the concerns raised by the Committee and will continue to explore options to ensure that states using all options to insure their populations will not be penalized. At this time, because CDC and its awardees have already taken steps to assure that Section 317 vaccine resources are used for critical public health gaps and not to supplant coverage for routine vaccination by an appropriate public or private payer, the impact of the proposed formula is negligible. Currently, all awardees receive a minimum amount of vaccine to reach uninsured populations and respond to outbreaks of vaccine-preventable disease.

HIV Prevention

The Committee accepts the administration proposal to realign and consolidate the various funding streams that are awarded to State health departments for the surveillance and prevention of HIV. The Committee believes this consolidation will allow needed flexibility while the public health system adapts to the expansion of preventive services brought about by the implementation of the ACA. The Committee requests that CDC provide an accurate picture of how States are using this additional flexibility in future budget justifications.

Action taken or to be taken

Consolidation of the HIV budget line will allow the agency to respond more efficiently to changing HIV prevention needs, including changes resulting from implementation of the Affordable Care Act. The agency level flexibility afforded by the consolidation will allow CDC to continue steps to lessen administrative burden on states and to allow its grantees flexibility in directing HIV prevention resources.

Liver Disease

Liver diseases of all kinds have a significant impact on the health and well-being of Americans. The Committee notes that liver diseases are addressed by several Centers of CDC. For example, public health efforts around

hepatitis are housed in this Center, but fatty liver disease is associated with obesity, the prevention of which is led by the Center on Chronic Diseases. The Committee encourages CDC to consider ways to coordinate public health efforts on liver diseases across Centers.

Action taken or to be taken

CDC works in a number of areas associated with the prevention of liver disease, and is committed to ensuring that these areas are complementary. CDC's recommendations on viral hepatitis encourage healthcare providers and infected persons to minimize other possible risks to the health of their livers. For example, CDC's recommendations for the prevention and control of hepatitis C include recommendations to counsel infected persons to reduce other risks to their liver health by reducing injection drug use and alcohol use, and getting vaccinated for hepatitis B, and, if appropriate, hepatitis A. More recent recommendations to screen persons born between 1945 and 1965 for hepatitis C also recommend that already-infected persons reduce or eliminate alcohol consumption, and avoid over the counter and herbal medicines without first checking with a healthcare provider. They also recommend that persons who are infected and are obese consider weight management or losing weight, following a healthy diet and staying physically active. Healthcare providers are advised to provide a brief alcohol use screening and brief intervention for persons with hepatitis C infection.

Complementing hepatitis program efforts, more than twenty of CDC's Comprehensive Cancer Control grantees have a Cancer Control Plan that addresses chronic hepatitis B and/or hepatitis C infections as risk factors for liver cancer or recommend interventions for liver cancer prevention. Overall, the states that have larger Asian/Pacific Island populations are more involved in strategies and interventions aimed at liver cancer prevention since the incidence in these populations is higher than others. Additionally, CDC captures nationwide data about liver cancer in the National Program of Cancer Registries. CDC also funds the 50 states and the District of Columbia to implement evidence-based obesity and chronic disease prevention programs. As the Committee noted, obesity is a risk factor for fatty liver disease. CDC provides national leadership to reduce obesity, increase physical activity, and improve dietary quality.

Viral Hepatitis Screening

The Committee urges CDC to prioritize testing activities and initiatives to identify people infected with asymptomatic forms of hepatitis. The Committee further encourages CDC to conduct prevention research to identify and disseminate best practices for implementing viral hepatitis screening, including new tests and testing procedures, standards of preventive care, and prompt linkage of persons testing positive for viral hepatitis to needed medical management and treatment. CDC should investigate opportunities to make purchasing options for hepatitis testing supplies more streamlined and efficient.

Action taken or to be taken

In FY 2012, CDC received Prevention and Public Health Funds to support demonstration sites for hepatitis B and hepatitis C testing of asymptomatic people, and for linkages to care when appropriate. Nine sites were selected to do hepatitis B testing, and 24 sites to do hepatitis C testing. Evaluation of these sites is ongoing, but preliminary data indicate that over 45,000 tests were completed in the first year of the initiative. While this number is somewhat lower than the one-year goal, it still is a significant achievement in view of the fact that most sites were unable to begin testing until well after halfway through the year. CDC was able to provide continuation funding to almost all of the sites in FY 2013, and substantial gains in the total number of completed tests are expected in the second year.

CDC has explored opportunities for making the purchasing of hepatitis testing supplies more streamlined and efficient. While CDC has found bulk purchasing is likely to be difficult and inefficient, the agency is exploring other avenues to make purchasing more efficient for our grantees. These include establishing bulk or discounted

pricing with the companies where grantees could be assured of lowered pricing and would work directly with the company to buy what they needed.

Advanced Molecular Detection

The Committee recommends that CDC use the first year of funding to begin building the science base of this initiative before funding the coordination of States. In starting this initiative, the Committee notes that this is a focused, time-limited effort on a particular genetic sequencing capability that has implications across many of CDC's program areas. To the extent that this capability reveals a potential advance that is limited to an issue area covered by other programs and Centers of CDC, the Committee expects CDC to transition the research and implementation of that new technique to the relevant condition-specific and laboratory support programs of CDC. The Committee strongly supports ongoing innovation in all programs of CDC and intends this initiative to strengthen that commitment across the agency.

Action taken or to be taken

CDC appreciates the Committee's support to begin building this important initiative. CDC has formed an Advanced Molecular Detection (AMD) planning team and a steering committee consisting of scientific leadership staff from across the agency to develop the 5-year AMD program implementation plan. The implementation plan will address leadership, governance and coordination, CDC IT and laboratory infrastructure needs, bioinformatics staffing capacity, training, innovation, and policies for data management.

Food Safety

The Committee recommendation includes additional funding to maintain appropriate staffing levels and enhance laboratory capacity in States to identify food-borne illnesses and effectively confine outbreaks. Further, the Committee continues to support the integrated Food Safety Centers of Excellence. These Centers, housed within State health departments, serve a critical role in developing and disseminating best practices and tools in food safety surveillance and outbreak response.

Action taken or to be taken

Large foodborne disease outbreaks continue to threaten public health, and CDC has prioritized efforts to detect and stop outbreaks faster, including providing funding and guidance to five Integrated Food Safety Centers of Excellence (Colorado, Florida, Minnesota, Oregon, and Tennessee) as they establish their priority activities. CDC will work with the Centers and other programs like FoodCORE to strengthen foodborne illness surveillance and outbreak investigations nationally.

Antimicrobial Resistance

The Committee urges CDC to work with State health departments to expand the work of prevention collaboratives, which seek to interrupt and prevent the transmission of significant antibiotic-resistant pathogens across healthcare settings. CDC, with the collaboratives, should evaluate the impact of possible interventions on hospital readmissions, healthcare-associated infection rates, or other measures relevant to health or economic activity. CDC and the Prevention Epicenters are encouraged to continue evaluating interventions to prevent or limit the development of antimicrobial resistance, facilitating public health research on the prevention and control of resistant organisms, and assessing the appropriateness of current surveillance and prevention programs in healthcare and institutional settings.

Action taken or to be taken

In FY 2013, CDC funded 15 state health departments to expand their healthcare-associated infections (HAI) prevention collaboratives in both hospitals and other healthcare settings. These collaboratives use CDC's National Healthcare Safety Network (NHSN) data and CDC's best practices to prevent or eliminate HAI, including

Clostridium difficile infections (CDI) and infections caused by multi-drug resistant organisms (MDRO). CDC also works with states to enhance detection and prevention of antimicrobial resistant pathogens, like Carbapenem resistant Enterobacteriaceae (CRE), in healthcare settings and to monitor and improve antimicrobial use. In FY 2014, CDC funded states to implement “detect and protect” interventions for *Clostridium difficile*, CRE and other MDROs using NHSN data on infections and antibiotic use to identify gaps for improvements. CDC is working with health departments and healthcare facilities to prevent transmissions of infections between facilities, including improvement of inter-facility communication related to patient transfers (transitions of care) and increasing adherence to infection control recommendations across facilities. CDC funds the Prevention Epicenters (IL, MA, OH, UT, NC) to address gaps and pilot innovative ways to prevent HAIs and antimicrobial resistance. In 2013, CDC’s Epicenters led the *REDUCE MRSA* trial that showed an important reduction (44%) of MRSA infections using decolonization with a germ-killing product on all intensive-care unit (ICU) patients.

Unsafe Injection Practices

The Committee remains troubled by outbreaks of and ongoing public exposure to life-threatening infections and bacteria caused by unsafe injection practices in healthcare facilities, including the misuse of vials and syringes. Outbreaks are entirely preventable when evidence-based infection control practices are followed. CDC is encouraged to continue its injection safety activities, including provider education and awareness, detection, tracking, and response. The Committee encourages broader outreach to healthcare providers and State and local health departments to disseminate the standards-based resources and toolkits that were created through previous investments of this Committee and through the PPH Fund. The Committee is aware that CMS is collecting additional data on infection control procedures of ambulatory surgical centers, beginning in fiscal year 2013, and encourages CDC to collaborate with CMS to analyze this data and use it to target prevention resources more effectively.

Action taken or to be taken

Between 2001 and 2013, over 50 outbreaks of viral hepatitis or bacterial infections occurred in various healthcare settings from unsafe injection practices requiring the notification and testing of over 150,000 patients. Safe injection and infection control practices are critical for patient safety. CDC and the Safe Injection Practices Coalition (SIPC) collaborate on the *One and Only Campaign*, a public health education campaign that provides educational materials, media messages, and toolkits to raise awareness among healthcare providers and the public about safe injection practices. CDC currently funds four states (CO, NC, NJ, and NY) to disseminate *Campaign* materials and conduct healthcare provider education. CDC also develops guidelines and tools to improve injection practices and prevent transmission of bloodborne pathogens and provides technical assistance and laboratory support to state and local health departments to detect infections and respond to outbreaks. CDC and CMS are joining efforts to analyze and interpret data from ambulatory surgical center (ASC) surveys, improve data collection, and use these data to target prevention and oversight activities.

Lyme Disease

The agreement encourages CDC to consider expanding activities related to developing sensitive and more accurate diagnostic tools and tests for Lyme disease, including the evaluation of emerging diagnostic methods and improving utilization of adequate (validated) diagnostic testing to account for the multiple clinical manifestations of Lyme disease. CDC is further encouraged to expand its epidemiological research activities on tick-borne diseases to include an objective to determine the frequency and nature of the possible long-term complications of Lyme disease and to improve surveillance and reporting of Lyme and other tick-borne diseases in order to produce more accurate data on their incidence. Finally, the agreement suggests that CDC evaluate the feasibility of developing a national reporting system on Lyme disease, including laboratory reporting and to expand prevention of Lyme and tick-borne diseases through increased community-based public education as well as physician and healthcare provider programs based on the latest scientific research on the diseases.

Action taken or to be taken

CDC appreciates the Committee’s support of CDC’s Lyme disease program. CDC has been working in all of the general areas highlighted in the conference report and will continue to work diligently to expand these activities. To address the conferees encouragement of CDC to expand its activities related to developing sensitive and more accurate diagnostic tools and tests for Lyme disease, CDC maintains and distributes upon request a comprehensive serum panel for the purpose of developing and evaluating new diagnostics tests for Lyme disease. CDC will continue efforts aimed at identifying unique diagnostic biomarkers of active infection and will work with the National Institutes of Health and the Food and Drug Administration to facilitate development and approval of improved Lyme diagnostic tests. Additionally, CDC is in the process of launching a tick-borne disease acute febrile illness study to detect and identify novel tick-borne pathogens that may be responsible for Lyme disease-like illness in the U.S. and that are not diagnosed by current Lyme disease tests.

To address the conference language that CDC expand epidemiological research activities on tick-borne diseases, to include an objective to determine the long-term course of illness for Lyme disease and to improve surveillance and reporting of Lyme and other tick-borne diseases in order to produce more accurate data on their prevalence, CDC continues to support a 5-year research study aimed at identifying and characterizing long-term and potentially chronic complications associated with Lyme disease infection.

Lyme disease has been a nationally notifiable disease since 1991, and cases are reported to CDC each year through the National Notifiable Diseases Surveillance System or NNDSS. Thus, the principal challenge for surveillance is not the lack of a reporting system but rather assuring that cases are captured and entered into the system. To this end, CDC is funding health departments in over a dozen high incidence states to improve surveillance and reporting for Lyme and other tick-borne illnesses. This funding supports improved reporting by both physicians and laboratories. In addition, through our Emerging Infections Program, CDC is funding research studies in three states to better determine why and to what degree Lyme disease cases are under-reported. This work is designed to yield better estimates of the national burden of Lyme disease and to identify fundamental ways in which reporting can be made more complete and accurate (e.g., through use of electronic medical records). CDC continues to fund and conduct research to validate the most effective prevention methods and approaches for use by individuals and communities, to distribute newly-developed prevention resources and toolkits for prevention education, and to develop a healthcare provider education program based on validated, scientifically-proven research.

Colorectal Cancer

The Committee requests a report detailing CDC’s activities in each State regarding colorectal cancer.

Action taken or to be taken

The CDC’s Division of Cancer Prevention and Control will develop and submit a report to Congress on CDC activities with grantees in the colorectal cancer program.

Diabetes

The Committee remains impressed by the implementation of the evidence-based National Diabetes Prevention Program [DPP] and includes \$10,000,000 to expand the use of this model. The Committee notes that approximately one-third of people with diabetes do not know that they have it, while another 57 million have pre-diabetes and are at high risk for developing this deadly disease. The Committee directs CDC to ensure that diabetes prevention activities are conducted by all States within the coordinated chronic disease efforts.

Action taken or to be taken

The State Public Health Action to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health program (SPA) coordinates state programming for diabetes, obesity, heart

disease and stroke, and school health through a single five-year cooperative agreement. This coordination permits states to continue their diabetes prevention and control efforts while leveraging the momentum and resources of other chronic disease prevention programs. CDC funds all 50 states and Washington, D.C. at a basic level to work on evidence-based strategies and support core public health functions such as partnership engagement, workforce development, surveillance, and epidemiology. Thirty-two of these states received enhanced funding to expand the reach of these evidence-based interventions and to conduct more comprehensive evaluation.

Through this cooperative agreement, CDC will continue expansion of the National DPP and support efforts to evaluate the program and ensure organizations delivering the lifestyle intervention are meeting program standards for CDC recognition. CDC recognition is a way to ensure that organizations delivering the intervention maintain fidelity to the science around diabetes prevention. Recognition increases the opportunity that employers will offer the lifestyle change program as a covered health benefit for employees and that insurance companies will reimburse organizations that deliver the lifestyle intervention; and is critical for long-term expansion and sustainability of the program nationally.

CDC's National DPP will continue to fund existing grantees to increase availability of the program in more cities and states throughout the country. Additionally, CDC expects to work with one or two companies or national organizations with extensive and existing partnerships with employers to design benefits packages offering the lifestyle intervention as a covered health benefit. To increase enrollment, referral and participation in the National DPP, CDC will test methods to increase engagement and utilization of lifestyle interventions, which may include a telephone or internet referral system to provide information about the health consequences of prediabetes and register persons at high-risk for type 2 diabetes into a lifestyle intervention program in their local community.

During this funding cycle, CDC expects grantees and contractors to achieve an increased number of participants in the National DPP, an increased number of employers who offer the lifestyle intervention as a covered health benefit for employees, and an increased number of private and public payers reimbursing organizations that deliver the lifestyle intervention. CDC estimates the National Diabetes Prevention Program could save the U.S. healthcare system approximately \$5.7 billion.³²⁹

Diet and Nutrition

The Committee believes that attention to the flavor of food is critical to inspiring the consumption of healthy and nutritious food. For that reason, the Committee continues to strongly support CDC's initiatives to develop training resources for foodservice professionals and employees on the preparation of foods that are healthful, flavorful, and delivered in the most cost-effective manner. In particular, CDC is encouraged to produce and disseminate digital media instruction on best practices for delivering healthy meals in large volume settings.

Action taken or to be taken

CDC will continue to provide technical assistance and training on meal preparation and menu development to improve the food environment in schools and early care and education facilities. This includes teaching providers how to procure, store, prepare, and serve healthy and nutritious foods.

³²⁹ A Nationwide Community-based Lifestyle Program Could Delay or Prevent Type 2 Diabetes Cases and Save \$5.7 Billion in 25 years. *Health Affairs* 2012;31(1):50-60. Xiaohui Zhuo, Ping Zhang, Edward W. Gregg, Lawrence Barker, Thomas J. Hoerger, Tony Pearson-Clarke, and Ann Albright.

<http://content.healthaffairs.org/content/31/1/50.full>

CDC entered into a Memorandum of Understanding (MOU) with the Culinary Institute of America to educate volume food service leaders on strategies to increase the number of healthy and tasty menu options for children and adults, as well as accelerating research and innovation on culinary strategies such as sodium and trans fat reduction and increasing fruit and vegetable servings. CDC will use this existing relationship to evaluate opportunities to communicate best practices using digital media.

Epilepsy

The Committee applauds the CDC epilepsy program for the progress it has made in advancing a public health agenda that seeks to improve the lives of people living with this disease. The Committee encourages CDC to continue expanding collaborations and addressing the recommendations of the 2012 IOM report “Epilepsy Across the Spectrum: Promoting Health and Understanding.”

Action taken or to be taken

CDC will continue to fund national partners to develop and implement programs to enhance epilepsy public awareness and promote partnerships, education, and communication about epilepsy at local and national levels (IOM Report Recommendations 10 and 11). CDC will continue support for the Managing Epilepsy Well (MEW) Network, composed of six Prevention Research Centers, which has been effective at advancing the science related to epilepsy self-management and making evidence-based programs that overcome transportation and stigma barriers available to people with epilepsy (IOM RR 9). For example, the first evidence-based on-line epilepsy self-management program (WebEASE) is now available at no cost on the Epilepsy Foundation web site. Two other evidence-based programs designed to treat depression in people with epilepsy are available, and CDC supports professional training opportunities for providers interested in implementing these programs locally (IOM RR 7 and 8).

CDC supports population studies and epidemiological studies to define epilepsy incidence and prevalence in various populations (IOM RR 2). Other epidemiologic studies underway in states are examining the burden of epilepsy incidence and prognosis in older adults, and comorbidity and early mortality associated with epilepsy in adults and children with epilepsy (IOM RR 4). Using data from the National Center for Health Statistics, [CDC published a 2013 report³³⁰](#) highlighting the burden of multiple chronic conditions in U.S. adults with epilepsy.

CDC supports the development of standardized laboratory tests on blood samples to identify people with cysticercosis and taeniasis that can be easily and economically employed throughout the world (IOM RR 3). Detecting these infections (caused by a tapeworm) is important to prevent a common cause of epilepsy in some U.S. immigrant population and in many developing countries.

In collaboration with NIH, CDC has also implemented activities for the development of a state-based registry to examine the burden of early mortality in young adults with epilepsy, in up to 15 states or metropolitan areas (IOM RR 3).

Heart Disease and Stroke

The Committee continues to support strongly the Paul Coverdell National Acute Stroke Registry. In addition, the Committee eagerly anticipates the upcoming release of data from the NCHS heart attack follow-up study, funded with PPH funding beginning in fiscal year 2011. Through this study, CDC is reviewing past medical records of individuals who are treated for heart attack in emergency rooms, to determine if patterns exist for earlier intervention. CDC is directed to move expeditiously to incorporate any lessons learned into the State programs

³³⁰ http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6243a2.htm?s_cid=mm6243a2_w

Action taken or to be taken

Heart disease and stroke are the leading causes of death and disability in the United States. CDC concurs with the Senate regarding the need to incorporate any lessons learned from past medical records of individuals who are treated for heart attack in emergency rooms into the State programs. CDC anticipates receiving the initial results of data from the "Lookback Module" of the NCHS ambulatory care surveys, which will assess the management of risk factors for cardiovascular disease, in July 2014. The chances of surviving a heart attack are greater when emergency treatment (e.g., cardiopulmonary resuscitation (CPR) or electrical shock (defibrillation) begins quickly.

CDC continues to support projects and research designed to improve quick and early treatment of cardiovascular related events. For example, with the same level of funding, in July 2012, CDC expanded the Paul Coverdell National Acute Stroke Registry portfolio from six states to 11 states to develop and improve stroke care that covers the continuum of care. CDC will continue to incorporate lessons learned into State programs to ensure ongoing improvement in the quality of care for heart attack and stroke patients.

Inflammatory Bowel Disease

Inflammatory Bowel Disease- The Committee continues to prioritize CDC’s inflammatory bowel disease epidemiology study, and requests a report on the ongoing activities in this important area.

Action taken or to be taken

CDC continues to support ongoing epidemiological research conducted by the Crohn’s & Colitis Foundation of America (CCFA) through the “Prevalence and Incidence of Inflammatory Bowel Disease” cooperative agreement. The goals of this project are to estimate IBD prevalence and incidence, define the demographic and clinical characteristics of IBD, assess the impact of various clinical practices in the management of IBD, and understand the impact of the disease on the health of affected persons. CCFA is currently completing baseline data abstraction, radiology, and pathology for study enrollees and conducting sub study data analyses. This project continues and augments previous epidemiological studies in IBD. CDC also supports a systematic review of current research to include recommendations on research gaps and ongoing and future research opportunities.

The CDC’s Division of Population Health will develop and submit a report to Congress on activities related to the “Prevalence and Incidence of Inflammatory Bowel Disease” epidemiological research study.

Interstitial Cystitis

The Committee commends CDC’s work to raise awareness of interstitial cystitis, particularly as emerging epidemiology data indicates that this condition is underdiagnosed in the male population. The Committee continues to prioritize the Interstitial Cystitis Education and Awareness Program and encourages CDC to partner with the advocacy community on this issue.

Action taken or to be taken

CDC supports the Interstitial Cystitis Association (ICA), a voluntary patient organization, through a cooperative agreement to educate providers on IC symptomatology, identification, diagnosis, and referral to familial and health care provider support services. ICA also educates specific populations affected with IC to improve care opportunities. CDC will issue a new, competitive funding opportunity in FY 2015 to develop, implement, and evaluate a national campaign to increase public awareness and educate providers through media and health provider toolkits

Lupus Patient Registry

The Committee applauds the efforts of the National Lupus Patient Registry. The Committee recommendation includes funding to conduct cohort and burden of illness studies to help study long-term outcomes, socioeconomic burdens, and mortality associated with lupus. Given the complexity of and difficulty in diagnosing the disease, the Committee is concerned that individuals with lupus could be missing from the registries. To address this concern, the Committee urges CDC to develop a national campaign focused on healthcare provider education and improved public understanding of lupus. The Committee directs CDC to work with the Office of Minority Health to ensure that all provider education efforts are coordinated and not duplicative.

Action taken or to be taken

Lupus registries were developed for epidemiologic purposes. Results from [Georgia](#)³³¹ and [Michigan](#)³³² were published in a recent issue of Arthritis and Rheumatism. The studies describe these collaborative scientific efforts (with CDC and their respective state health departments), offer long-awaited updates on the epidemiology of lupus in the U.S., and update lupus epidemiology with improved precision, highlighting the magnitude of disease burden including important health disparities for individuals with lupus. Additional CDC-sponsored investigations are underway in Manhattan, San Francisco, and with the Indian Health Service to examine U.S. populations with larger representations of Hispanic, Asian, and Native American individuals, which will complement the recently published data.

CDC will coordinate efforts with the Office of Minority Health by:

- Sharing CDC data related to healthcare providers' knowledge, attitudes, beliefs and behaviors related to prevention and treatment of chronic diseases.
- Convening CDC subject matter experts and others to identify effective healthcare provider education practices and programs.
- Coordinating relevant efforts related to lupus patient registries, follow-up studies, and campaign outreach efforts to healthcare providers and the public.
- Partnering with HHS OMH to leverage the materials created and posted on the Lupus Initiative website. <http://thelupusinitiative.org/teachinglearning/>

In addition, CDC plans to conduct audience research to better understand the characteristics and attributes of public messages to promote improved understanding of lupus, and the most effective mechanisms to deliver messages for the public. This research will commence in FY 2014 with preliminary results expected in mid to late FY 2015.

Maternal Mortality Reviews

The Committee continues to support CDC's work to standardize core data sets for State-based maternal mortality reviews, which identify deaths, review associated factors, and take action to institute changes to decrease pregnancy-related and pregnancy-associated mortality. The Committee looks forward to the dissemination of the final case abstraction form in the coming year.

Action taken or to be taken

CDC, in collaboration with the Association of Maternal and Child Health Programs, is working with six states (Colorado, Delaware, Georgia, New York, North Carolina, and Ohio) to prevent maternal death and improve maternal health outcomes. In October 2013, these states received the beta version of the CDC developed Maternal Mortality Review Data System (MMRDS); five states are planning to actively beta test the MMRDS with three already in the process. The remaining state will not beta test but is looking for opportunities to bring their existing system into alignment. Beta testing is expected to be completed by May 2014. Along with beta testing,

³³¹ <http://onlinelibrary.wiley.com/doi/10.1002/art.38239/pdf>

³³² <http://onlinelibrary.wiley.com/doi/10.1002/art.38238/pdf>

CDC is working with these six states to 1) identify core variables in the MMRDS for case summaries and analytic files, and 2) develop consensus on the content of the committee determination/recommendation page(s) that records a Maternal Mortality Review Committee's determination of cause of death, preventability of death, and recommendations for preventing future deaths.

National Early Care and Education Collaboratives

According to statistics published in the Journal of American Medical Association, over a quarter of children aged 2 to 5 are overweight or obese. An estimated 12 million children spend time in early care and education [ECE] settings on a regular basis. The Committee recommendation includes \$4,000,000 to continue the highly successful collaboratives, which assist ECE providers in six States adopt policies and practices related to nutrition, breastfeeding support, physical activity, and screen time.

Action taken or to be taken

CDC is partnering with the Administration for Children and Families, the Child and Adult Care Food Program Sponsors Association, the United States Department of Agriculture and the First Lady's "Let's Move!" program to assist early care and education (ECE) providers with establishing improved physical activity and nutrition environments, including limiting screen time and supporting breastfeeding. CDC funds Nemours, a non-profit organization serving children and their families, to engage early care and education providers in initiatives designed to reduce obesity among children 0 to 5 years of age. Among the various activities conducted by Nemours are a thorough assessment of participating ECE Center policies and practices related to obesity prevention which serves as a basis for creating year-long action plans for improvement; training on improving the nutritional quality of foods and beverages procured and served in their facilities; purchasing and preparing healthy food options for children in their care; and conducting training designed to improve age appropriate physical activity to meet the National Guidelines. Nemours also disseminates educational resources, activity guides and tip sheets to states and ECE providers to educate them on best practices. Additionally, Nemours maintains the "Let's Move! Childcare" website. CDC plans to continue to work to expand the number of state collaboratives that assist early care and education providers with implementing national obesity prevention standards.

Office on Smoking and Health (OSH)

The Committee expects OSH to transfer at least the same amount it did in fiscal year 2013 to the Environmental Health Laboratory. The Committee notes that this transfer is to be provided to the lab in a manner that supplements and in no way replaces existing funding for tobacco-related activities. The Committee is pleased with the reported results of the OSH media campaign, "Tips from Former Smokers." In its first year, the Tips campaign generated more than 207,000 additional calls to State quitlines and more than 510,000 hits to www.smokefree.gov, the Government's Web site offering quit assistance. Research has shown that at least five to six smokers try to quit on their own for every one person who calls a quitline. The Committee expects OSH to commit at least the same amount in fiscal year 2014 for a media campaign and quitlines as it did in fiscal year 2013.

Action taken or to be taken

Environmental Health Laboratory: CDC will continue to conduct and disseminate state-of-the-art tobacco prevention research, including research through CDC's Tobacco Laboratory. CDC will allocate approximately \$3.5 million from the appropriation for tobacco to the Environmental Health Laboratory in FY 2014, the same amount as FY 2013. This will enable the laboratory to continue to conduct critical research on toxic and addictive substances present in tobacco products, tobacco smoke, and in people who use tobacco products or who are exposed to secondhand smoke. The transfer will also allow the lab to continue to support and provide technical assistance to the Food and Drug Administration as it implements components of the Family Smoking Prevention and Tobacco Control Act that require testing of tobacco products and constituents.

Media Campaign: On February 3, 2014, CDC launched the third phase of its national tobacco education campaign, *Tips from Former Smokers*. The campaign aims to increase awareness of the harms of tobacco use, especially the challenges of living with tobacco-related disease and disability, and to promote smokers to quit. CDC anticipates this third phase will follow in the strong tradition of the *Tips from Former Smokers* campaign, which first launched in 2012. At least 1.6 million smokers tried to quit because of the campaign, at least 220,000 quit smoking during the campaign, of which at least 100,000 likely quit for good. CDC estimates that the growth in smokers who quit could have added between a third to almost half a million years of life to the U.S. population. In addition, an estimated 4.7 million additional non-smokers recommended cessation services to their family and friends, and over 6 million Americans talked to friends and family about the dangers of smoking due to the campaign.

CDC launched the second phase of the *Tips from Former Smokers* campaign in 2013. This phase expanded upon the 2012 effort by featuring additional smoking-related health conditions, including people with chronic obstructive pulmonary disease, diabetes complications exacerbated by smoking, and asthma, and included a diverse set of participants representing the following communities: Lesbian, Gay, Bisexual, and Transgender (LGBT), African American, and American Indian/Alaska Native. Preliminary results indicate success similar to the 2012 campaign. The 2013 campaign produced more than 150,000 additional calls to 1-800-QUIT NOW, a number that links callers to their state quitlines. The campaign also generated almost 2.8 million additional visitors to the campaign website, www.cdc.gov/tips. CDC is in the process of evaluating the impact of this second phase of the campaign and anticipates comprehensive evaluation results in mid-2014.

CDC anticipates that the third phase of the campaign will continue to encourage smokers to quit and raise awareness among smokers and nonsmokers of the harms of tobacco use. Additional new ads are anticipated to air in August 2014.

Ovarian Cancer

Within the funds provided for Johanna's Law, up to \$1,000,000 shall be used for a review of the state of the science on ovarian cancer. To conduct this review, CDC should engage all relevant operating divisions of HHS, as well as stakeholders and experts from the private and nonprofit sectors. The review should include: an evaluation and summary of the existing state of the science; an assessment of existing government initiatives; and identification of and recommendations for other public and private sector efforts that would help the Nation make progress in reducing the incidence and mortality of ovarian cancer. In addition, the Committee requests an update in the fiscal year 2015 budget justification on CDC's effort to integrate ovarian cancer into other related programs at the CDC.

Action taken or to be taken

With FY 2014 funding, CDC expects to engage appropriate experts and relevant stakeholders to facilitate a review of the state of the science on ovarian cancer.

CDC's ovarian cancer funding is used to support a variety of activities, including research, surveillance, and health communication and education development, along with programmatic efforts related to ovarian cancer prevention and control. CDC's National Program of Cancer Registries collects surveillance data for all cancers, including ovarian cancer, which is used by states to guide cancer program planning, outreach, and education efforts. The National Comprehensive Cancer Control Program (NCCCP) funds states, territories, and tribal organizations to convene and support coalitions of key public and private partners to develop and implement cancer plans and prioritize efforts to reduce the highest burden cancers within their jurisdiction. Within these cancer plans certain grantees are implementing ovarian cancer initiatives such as exploring how ovarian cancer risk assessment can be translated into clinical settings; conducting provider education; and, increasing public awareness of ovarian cancer symptoms. NCCCP grantees are also actively disseminating ovarian cancer-related

materials and messages from CDC’s gynecologic cancer awareness media campaign, Inside Knowledge, to women and health providers in their states.

To help address women at higher risk for breast and ovarian cancer, specifically those with BRCA1 and BRCA2 genetic mutations, CDC funds 3 states to promote cancer genomics best practices through surveillance, education, and policy approaches. Grantees are conducting activities such as:

- Integrating a Breast/Ovarian Cancer Genetics Referral Screening Tool (B-RST) in several sites, including existing public health programs, to help identify women at high risk and refer them to appropriate genetic services;
- Providing targeted BRCA educational materials to the physicians of patients with early breast and/or ovarian cancer reported to their respective state cancer registries; and
- Improving health insurance access to recommended services among private and public payers. These states have also integrated genomics objectives into their state cancer control plans.

Psoriasis

The Committee commends CDC on the release of the report “Developing and Addressing the Public Health Agenda for Psoriasis and Psoriatic Arthritis,” funded under the jurisdiction of this Committee in fiscal year 2010 and released in February 2013. The Committee encourages the Center on Chronic Disease Prevention and Health Promotion to collaborate with the National Center for Health Statistics to identify survey instruments that could be used to implement this agenda.

Action taken or to be taken

Since FY 2010, the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has collaborated with the National Center for Health Statistics (NCHS) on the following activities:

- NCHS staff have worked with the expert scientific panel on the CDC Psoriasis Surveillance Project, providing background information on NHANES and other NCHS data on psoriasis. As part of this effort, NCHS staff have supported activities to analyze and publish psoriasis surveillance data available from previously collected datasets.
- NCHS has obtained data on psoriasis from a variety of its data systems.
- NHANES obtained data on psoriasis from 2003-06 for survey participants ages 20-59 and again since 2009 data on participants 16 and older. These data collection activities have been and continue to be conducted without funding from the specific psoriasis funding provided to CDC in FY 2010.
- Data on psoriasis are also available from routinely conducted surveys of providers, including the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey, which obtain data on all health care encounters.

NCCDPHP and NCHS will continue to collaborate on ways to address the priorities of the recent report.

School-Based Food Allergy Guidelines

Deaths from anaphylactic reactions to food allergens are entirely preventable. Nevertheless, these tragedies continue to occur when epinephrine is not readily accessible for prompt administration or bystanders are not adequately prepared to respond. Many State legislatures have passed or are considering legislation to require or allow schools to stock epinephrine. The Committee recommendation includes funding to support the dissemination and implementation of the food allergy school guidelines, which CDC is expected to issue this fall. CDC is encouraged to consider making epinephrine purchase an allowable use of School Health funds, subject to terms and conditions related to storage and appropriate use.

Action taken or to be taken

In October 2013, CDC released the [Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Centers](#)³³³ to support implementation of food allergy management and prevention plans and practices for children and youth in these settings. CDC is partnering with Food Allergy Research and Education, the American Academy of Pediatrics, and the National Association of School Nurses to disseminate and provide training to education and medical professionals on the *Guidelines*. In addition, CDC is funding state health departments for the first time to build the capacity of schools and school districts to help students manage chronic conditions, including food allergies.

The Guidelines include information about the proper storage and use of epinephrine including the designation and training of non-health personnel to administer epinephrine when health staffs are not available. The current funding mechanism for CDC’s food allergy portfolio is *National Programs to Improve the Health and Educational Outcomes of Young People (CDC RFA DP11-1101)*, which includes the following restrictions on recipient use of funds: Recipients may not use funds for research; recipients may not use funds for the provision of clinical care, school health services, or school nurses; recipients may not use funds for the purchase or provision of drugs for the treatment of asthma or food allergies.

Cardiomyopathy

The Committee continues to support CDC's efforts to track the rates of sudden cardiac arrest [SCA], develop evidence-based prevention strategies for SCA deaths in youth, and disseminate information to schools, coaches, and parents.

Action taken or to be taken

CDC supports efforts to track the rates of sudden cardiac arrest [SCA], develop evidence-based prevention strategies for SCA deaths in youth, and disseminate information to schools, coaches, and parents. From 2004-2012, CDC supported the Cardiac Arrest Registry to Enhance Survival (CARES) project. CARES is a registry of cardiac arrest events that allows participating sites to enter out-of-hospital cardiac arrest (OHCA)-related data, generate summary reports, and compare local data with similar emergency medical services (EMS) systems elsewhere.

In 2012 CARES secured funding from the American Heart Association, American Red Cross, Emory University, Medtronic Foundation, and Zoll Corporation and ensured non-government sustainability for the registry.

Coordinated Chronic Disease Funding

The Committee commends CDC on the release of the February 2013 funding opportunity announcement [FOA] ‘State Public Health Actions to Prevention and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.’ This announcement implements an approach requested by the Committee for the past 3 years

Action taken or to be taken

In February 2013, CDC released funding opportunity announcement [FOA] ‘State Public Health Actions to Prevention and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.’ This new FOA provides CDC school health funding to all 50 states for the first time. Thirty-two states receive enhanced funding for additional school health activities to implement effective strategies to promote healthy eating and physical activity and improve physical education. In addition, seventeen states are funded for a growth area for CDC, managing chronic conditions in schools. The new FOA also creates synergies and efficiencies by addressing obesity prevention and related health outcomes through the combined funding and

³³³ <http://www.cdc.gov/healthyyouth/foodallergies/index.htm>

efforts of four CDC Divisions: the Division of Population Health, the Division of Nutrition, Physical Activity and Obesity Prevention, the Division of Heart Disease and Stroke and the Division of Diabetes Translation. In support of the program's launch through state health departments, CDC has developed a training plan to increase states' capacity to implement effective strategies and created an evaluation plan to ensure optimal results. This approach will lead to improved health outcomes and is in response to congressional language and recommendations from State Health Departments.

Obesity Outreach

While some indicators show slight drops in obesity rates recently, the Committee remains concerned that there has been little change in the areas where the problem is worst, particularly in rural areas. The Committee recommendation includes \$5,000,000 in PPH Fund competitive funding to conduct pilot programs that focus on the use of existing extension and outreach services in the counties with the highest prevalence of obesity. All counties with an obesity prevalence of over 40 percent, as determined by CDC's latest county level data in the Behavioral Risk Factor Surveillance System, shall be eligible to participate in this extension and outreach program.

Action taken or to be taken

CDC recognizes the issue of high obesity rates in many rural areas and the unique challenges faced in these communities. To address this issue, CDC will adapt its Childhood Obesity Research Demonstration Project (CORD) model for use in rural communities. CORD integrates primary care and public health approaches, including extension services in the community, to support healthy behaviors that impact child and family obesity. The CORD model, including its package of common interventions and evaluation measures, will be initiated in 3-5 pilot programs in local rural health agencies with extension and outreach services in the counties with the highest prevalence of obesity.

Oral Health

The Committee recommendation includes funding for States to strengthen their capacities to assess the prevalence of oral diseases and to target resources and interventions, such as community prevention and school-linked sealant programs, to the underserved. The Committee is pleased with CDC's work on the new communications plan related to prevention initiatives, and includes additional funding to implement the plan. The Committee continues to support the development of an oral health literacy program in response to recommendations from the IOM.

Action taken or to be taken

In 2013, CDC funded 21 states to assist state health departments to build and/or maintain effective public health capacity for implementation, evaluation, and dissemination of best practices associated with oral disease prevention and improvement of oral health. Depending on available appropriations, this cooperative agreement should last until 2018. During this time, States will increase access to preventive dental services through school-based dental sealant programs and increase awareness regarding the importance of oral health and the benefits of community water fluoridation as a strategy to prevent tooth decay. CDC's Fluoride Communication Plan works with states and national partners to increase education supporting the benefits of community water fluoridation.

Congenital Heart Defects [CHDs]

CHDs continue to be the most common birth defect and leading cause of infant mortality in the United States. Even those who receive successful intervention will need lifelong, costly, specialized cardiac care. Estimates suggest there are over 2 million people alive today with CHDs. The Committee commends CDC for its increasing efforts to address the lifelong needs of this growing population, particularly in collaboration with other Federal agencies and private organizations. However, the Committee is concerned that there continues to be a lack of

rigorous epidemiological and longitudinal data on individuals of all ages with CHDs and includes funding to continue initial efforts to compile this information. The Committee provides \$3,000,000 to collect and analyze nationally representative, population-based epidemiological and longitudinal data on infants, children, and adults, with the goal of improving estimates of CHD incidence, prevalence, and disease burden, which can be used to better assess the public health impact of this condition.

Action taken or to be taken

In 2012, CDC issued a competitive Funding Opportunity Announcement and is now working on this pilot project with three funded sites: the New York State Department of Health, Emory University in Atlanta, Georgia, and the Massachusetts Department of Public Health to develop population-based surveillance of adolescents and adults with congenital heart defects by linking existing epidemiological data sources. The objectives of these new tracking activities are to better understand the survival, healthcare utilization, and longer term outcomes of adolescents and adults affected by congenital heart defects.

CDC continues to expand work on congenital heart defects through cooperative agreements designed to better understand the survival, healthcare utilization, and longer term outcomes of adolescents and adults affected by congenital heart defects.

A small amount of funding has been used to leverage expanded partnerships in a non-duplicative manner to identify and achieve common priorities by working with the Congenital Heart Public Health Consortium (CHPHC). The CHPHC is a group of organizations uniting resources and efforts in public health activities. The mission of the CHPHC is to prevent congenital heart defects and improve outcomes for affected children and adults.

In FY 2015, CDC will continue to support improved surveillance of congenital heart defects across the lifespan. Understanding health issues and needs across the lifespan is vital to improving the lives of individuals born with these conditions. Additionally, an external guidance committee has been established to provide expert input and consultation on project activities.

Duchenne Care Considerations

The Committee recognizes the value the Duchenne “Care Considerations” guidelines have had in improving the standardization of care and quality of life for patients with Duchenne muscular dystrophy and in extending the lifespan of Duchenne patients. The Committee encourages CDC, in collaboration with other Federal health agencies, to issue updated care recommendations and to develop new adult care recommendations expeditiously. Further, the Committee encourages CDC to evaluate whether outcomes are improved by care that is consistent with the existing guidelines.

Action taken or to be taken

Before publication of the Duchenne Muscular Dystrophy (DMD) Care considerations, muscular dystrophy partner organizations and clinicians recognized disparities in the level of clinical care received by individuals with DMD. CDC funded a multiple year project to produce the first set of comprehensive DMD Care Considerations that were published in 2010. Since their publication, the guidelines have been well-received by families of patients with DMD and healthcare providers. It has been widely disseminated by partner groups and the DMD community and a family friendly version was produced and translated into over 20 different languages. CDC recognizes that the Care Considerations must be updated periodically to keep abreast of the latest in treatment practices for the condition and therefore, in FY 2014, CDC is funding a project to begin planning for the update. An updated literature review of the original care considerations topics (neuromuscular, cardiac, respiratory, rehabilitation, psychosocial, gastrointestinal/nutrition, diagnostic, and orthopedic/surgical) and a new literature review for additional topics (adult, emergency, and primary care; endocrinology) is currently underway. A steering committee composed of clinical experts, advocates, and federal agency representatives will then review this literature and make suggestions for updating, disseminating, and evaluating the DMD care considerations.

These activities must occur before bringing together expert committees to complete the update of the care considerations.

Although, the DMD Care Considerations have been well-received by the DMD community, it is unknown whether clinicians caring for patients with DMD are recommending the treatments and services outlined in the care document. To address this need, CDC is funding a project beginning in FY 2014 to evaluate agreement between treatments and services actually provided to people who have DMD and current treatment recommendations as documented in the DMD Care Considerations. This research will identify gaps between the recommended standards of care and actual care received. Additionally, healthcare providers will be surveyed to identify barriers and challenges involved in the delivery of treatments and services.

Fragile X and Fragile X-Associated Disorders [FXD]

The Committee continues to support CDC's efforts to identify and define the population impacted by FXD, with the goal of understanding the public health impact of these conditions. Given the connection between fragile X syndrome and autism, the prospect of targeted treatments for both conditions, and current budgetary constraints, the Committee urges CDC to explore ways to create greater efficiency and synergy between programs addressing each condition.

Action taken or to be taken

CDC works to understand the public health impact of Fragile X and Fragile X-Associated Disorders and recognizes the importance of creating greater efficiencies during all budgetary cycles.

Currently, CDC supports the Fragile X Clinical and Research Consortium -- a group of more than twenty five Fragile X clinics across the United States that manage a national Fragile X registry and the database, designed to work together to increase scientific and clinical understanding of Fragile X Disorders. The registry and database, or Fragile X Online Registry with Accessible Research Database (FORWARD), bridges information across programs as it includes clinical report form questions for enrollees about Autism Spectrum Disorders (ASD) diagnoses.

CDC's autism surveillance system, the Autism and Developmental Disabilities Monitoring (ADDM) Network, incorporates information about Fragile X Syndrome in both its case-finding methods and in coding conditions that co-occur with ASD. Findings indicate Fragile X co-occurs in less than 1% of children with ASD (as identified by ADDM).

CDC also funded the project "Enhancing Current Capacity for Surveillance of ASD and Other Developmental Disabilities from a Public Health Perspective" which aims to better implement services and understand the scope of ASDs. Within the program, synergistic efforts were taken to examine the feasibility of determining population prevalence estimates of Fragile X and other single-gene disorders among children with ASD. This pilot study revealed that genetic test results and interpretive reports are rarely available in the health and education records of children with ASD or intellectual disability; these are the types of records used in ADDM. As such, the ADDM methodology is not likely to be a feasible approach for studying Fragile X and alternative methods are needed to investigate these conditions in a scientifically meaningful way.

One alternative method is the use of state-based linked administrative data to study rare conditions. CDC, in partnership with The University of South Carolina, has submitted a paper on the Co-morbid Conditions Associated with Adolescents and Young Adults with Fragile X Syndrome, which includes ASD.

CDC will continue to strengthen synergies between its work on these two important conditions.

Hemophilia Treatment Centers

The Committee is disappointed that funds appropriated specifically to address hemophilia have been used to develop public health approaches to other blood disorders. The Committee recommendation for hemophilia more closely aligns to a true accounting of funds spent on hemophilia and the Committee expects no further diversion of funds. The Committee includes sufficient funding to maintain and expand the surveillance and research activities of the national network of hemophilia treatment centers and CDC's national outreach and prevention programs on hemophilia. The CDC hemophilia programs provide critical information to better understand risk factors for complications and identify high-risk populations for prevention measures.

Action taken or to be taken

In response to the issues raised in this report language, CDC is revising its allocation of hemophilia funding in 2014 to align with the Committee's current expectations.

Limb Loss Resource Center

The Committee is disappointed to learn that \$1,000,000 appropriated for outreach and education on limb loss has been diverted to support broad activities that may not be of benefit to individuals who have lost a limb. The Committee directs that CDC allocate the full \$2,600,000 provided herein for a limb loss resource center to that activity in fiscal year 2014.

Action taken or to be taken

As a result of this Congressional direction, CDC will fully allocate the limb loss appropriation to the current limb loss resource center including the provision of technical assistance for that Center. CDC will also maintain support for mobility limitations activities through the disability and health budget line. We believe that this approach will adhere to the Committee's intent for these appropriated funds and allow for the maintenance of important public health synergies between the limb loss program and the disability and health program.

Paralysis Resource Center

The Committee has transferred for the Paralysis Resource Center program to ACL, as requested by the administration. The Committee expects CDC to work with ACL to ensure a smooth transition for grantees and those served by this program.

Action taken or to be taken

CDC commends the Paralysis Resource Center for its work over the years in providing public health resources to individuals, families, providers, and caretakers on spinal cord injury, paralysis, and mobility-related disabilities and looks forward to a continued partnership. CDC will work closely with ACL to ensure that the grantees and those served by the Paralysis Resource Center program have a smooth transition in the transfer of activities. CDC will continue to offer scientific guidance to the Resource Center's national survey on the prevalence of paralysis until the survey's completion in FY 2014.

Tourette Syndrome

The Committee commends CDC for its national public health education and research program on Tourette syndrome. The Committee intends that funds be used to continue to educate physicians, educators, clinicians, allied professionals, and the general public about the disorder and to improve scientific knowledge on prevalence, risk factors and co-morbidities of Tourette syndrome.

Action taken or to be taken

As three of every 1,000 children 6 through 17 years of age living in the US have been diagnosed with Tourette Syndrome (TS) based on parent-reported data, CDC recognizes the importance of continuing to improve

scientific knowledge on the prevalence, risk factors, and co-morbidities as well as working with public health and allied professions to better understand TS.

In FY 2013, CDC used prevalence data from the 2007 National Survey of Children’s Health (NSCH) to describe health care needs of children with TS, in a publication in the *Journal of Child Neurology*, and the impact of TS on parenting aggravation in a publication in the *Disability and Health Journal*. CDC also presented new prevalence and impact data from the 2011-2012 NSCH at the American Academy of Child and Adolescent Psychiatry annual meeting. CDC is continuing to work with grantees at the University of Rochester and University of South Florida where analyses and publications are underway to describe the impact of TS on social relationships, health care use, health risk behaviors, school outcomes, along with the cost of TS.

CDC is also using data from the NSCH to document the impact of TS including the prevalence of TS, and indicators of school functioning and social competence. CDC is planning a follow-back study to reach out to families who participated in the 2011-2012 NSCH and indicated their child had TS. This activity is intended to learn more about co-occurring conditions, diagnosis and treatment of TS. CDC is also including TS in the CDC-funded Project to Learn about Youth Mental Health (PLAY-MH) in order to estimate the prevalence of TS within a community sample where PLAY-MH is implemented.

CDC values its partnership with the Tourette Syndrome Association (TSA) – in the nine years of collaboration, the association has provided over 800 intensive medical, allied, school-based and public education programs nationwide in every state, reaching over 36,000 professionals and individuals through programs and exhibits. In evaluating the effectiveness of the education, data show that over 95% of educators reported that their skills in working with students who have TS have been improved as a result of the TSA program.

We look forward to continuing to build on the progress we’ve made thus far to work in collaboration with our partners to extend outreach activities, educate health care professionals, further the public health research agenda on TS, and better understand various disparities in the prevalence and diagnosis of TS.

Tuberous Sclerosis Complex (TSC)

Because TSC is a leading genetic cause of more prevalent neurological disorders such as autism and epilepsy, the Committee encourages CDC to incorporate information about TSC in CDC’s surveillance systems for those conditions.

Action taken or to be taken

CDC’s autism surveillance system, the Autism and Developmental Disabilities Monitoring (ADDM) Network incorporates information about TSC in both its case-finding methods and in coding conditions that co-occur with autism spectrum disorder (ASD). However, TSC is quite uncommon and co-occurs in less than 1% of children with ASD as identified by ADDM. A pilot study conducted in Maryland and South Carolina during the ADDM 2008 surveillance year revealed that genetic test results and interpretive reports are rarely available in the health and education records of children with ASD or intellectual disability; these are the data sources used for ADDM. Therefore, the ADDM methodology is not likely to be a feasible approach for studying this condition. Alternative methods are needed to investigate these conditions in a scientifically meaningful way, which might include screening with biomarkers or gene sequencing, although neither of these modalities are yet feasible at a population level.

Vital Statistics

The Committee recommendation includes sufficient funding to collect 12 months of vital statistics data within the calendar year. In addition, the Committee notes that standard certificates of births and deaths were finalized 10 years ago, yet 10 States have not fully adopted the 2003 modifications. The Committee urges CDC to survey States about their reasons for and against adoption, prior to engaging in any process to update the

certificates again. The Committee remains committed to expansions in the quality and timeliness of vital statistics data, which can help prevent identity theft and the fraudulent use of Federal and State benefits.

Action taken or to be taken

The National Vital Statistics System (NVSS) provides continuous and essential data to assess and track overall population health; to plan, implement, and evaluate health and social services for children, families, and adults; and to set health policy at the national, state, and local levels. Efforts to improve the quality and timeliness of these data are ongoing and involve the continuing implementation of both the 2003 certificates and electronic registration systems. In FY 2013, CDC's National Center for Health Statistics (NCHS) contracted with another two states to implement electronic birth systems using the 2003 U.S. Standard Birth Certificate. These are the last of the 10 states still needing to fully phase-in to new electronic birth registration systems. NCHS is providing technical assistance to these states as they plan, build, and implement their new electronic systems. These state systems are expected to be operational in either FY 2014 or FY 2015. The FY 2015 Budget includes \$5 million within the Prevention and Public Health Fund to support the expansion of vital statistics including phasing in and expanding electronic death registration systems in up to eight jurisdictions and developing systems that support vital records collection, analysis, and dissemination.

Twelve of the 57 vital registration jurisdictions are currently not using the 2003 U.S. Standard Certificate for deaths. As with births, NCHS is working with the states to implement the 2003 revision of the U. S. Standard Death Certificate. NCHS has also entered into contracts with seven states to enhance the timeliness, coverage, and quality of their electronic death registration systems. NCHS has contracted with the National Association of Public Health Statistics and Information Systems to evaluate the barriers states encountered in moving forward to improve the timeliness of their death records through electronic death registration systems. NCHS is also piloting the electronic transfer of death information between electronic medical records and an electronic death registration system in Utah.

To facilitate analysis and dissemination of these important data in a timely manner, NCHS continues to provide enhanced technical assistance to states and territories, including onsite and targeted assistance based on recommendations for improving registration procedures and coding of state mortality data. During FY 2013, these efforts improved the ability of states and territories to provide 12 months of high quality vital statistics data to NCHS in a timelier manner— contributing to quicker production of national data.

There are currently no plans to update the standard certificates, and efforts now underway will contribute to CDC's ability to continue to improve national vital statistics data while acknowledging the practical challenges that such improvements involve.

Chronic Diseases Biomarkers

Biomarkers are a uniquely powerful tool to identify high-risk individuals, diagnose disease conditions promptly and accurately, and effectively track prevention and treatment efforts. However, biomarkers can only be effective if the measurement tool can be standardized and the quality of the testing assured. For example, the Committee is aware of methods to screen for cholesterol that examine not just the type of lipid particles but the size. Researchers have demonstrated that this information can be used to better determine the risk for heart disease; however, there exists no standard to help clinicians interpret the data. As a result, patients who receive advanced cholesterol tests can receive dramatically disparate results. CDC's Environmental Health Laboratory is one of the premier institutions for the development of standards and the quality assurance of measuring for biomarkers. The Committee recommendation includes funding to begin the development of reference methods and materials for several cardiovascular disease biomarkers, including small low-density lipoprotein, apolipoprotein D, high-sensitivity C-reactive protein, and troponin. In addition, CDC is encouraged to begin development of a reference method and reference materials for measurement of estrogen. The Committee

recognizes both the need for reference methods for these biomarkers and the potential return on investment in the form of cost savings for Federal healthcare programs including Medicare and Medicaid.

Action taken or to be taken

The Environmental Health Laboratory is developing reference methods and materials to assure the quality of tests for cholesterol, small low-density lipoprotein (small LDL), apolipoprotein B, high-sensitivity C-reactive protein, troponin, and estrogen (estradiol) in academic, research, and clinical laboratories. In FY 2014, CDC will ensure the accuracy of more than 300 million cholesterol tests in the United States. CDC will maintain highly accurate reference methods for measuring total cholesterol, high-density lipoprotein (HDL), LDL, and triglycerides; monitor and train laboratories and manufacturers; and provide reference materials to more than 80 labs. CDC will also complete 50% of the development of new, reference-quality tests for measuring size fractions of LDL and HDL cholesterol (including small LDL), which are promising, better diagnostic markers for cardiovascular disease. In addition, CDC will standardize estradiol measurements in six major research and clinical laboratories, improving the diagnosis and treatment of breast cancer.

National Environmental Public Health Tracking

The Committee recommendation is sufficient to continue to support the 23 States and one city that were funded through this program in fiscal year 2012. This investment allows State, local, and tribal governments to evaluate potential linkages between disease and environmental exposures in their areas. The Committee encourages CDC to explore the feasibility of creating interoperability between the tracking network and major electronic health record systems to facilitate a more robust collection of de-identified data from which to compare health outcomes with environmental exposures.

Action taken or to be taken

CDC provided funding for 24 state and local health departments in FY 2013 and FY 2014. In August 2014, CDC will begin piloting use of electronic health records in the tracking network. A few states are expected to participate. The pilot project will determine the technical requirements and challenges of integrating electronic health records in tracking systems. CDC expects to release the findings of the pilot project in 2015.

Falls Prevention Interventions

The Committee includes \$3,000,000 from the PPH Fund to expand older adult falls prevention activities at CDC, in coordination with ACL. The Committee intends that CDC use the funding to conduct research to evaluate and disseminate the most effective fall prevention interventions and that ACL use the funding provided that agency to conduct outreach and demonstration programs to expand the implementation of effective interventions.

Action taken or to be taken

CDC uses the best available scientific data to identify effective fall interventions and to determine the optimal strategies to promote widespread adoption of proven programs. CDC supports state health departments and other key partners in implementing and disseminating evidence-based community fall prevention programs and links clinical practice with community programs. CDC will continue to develop and promote evidence-based programs, supporting state-level implementation, and promoting changes in clinical practice. For example, CDC developed and will disseminate *Stopping Elderly Accidents, Deaths and Injuries (STEADI)*, a multifaceted resource for healthcare providers to address falls through risk assessment, treatment, and referrals. [Home & Recreational Safety](http://www.cdc.gov/homeandrecreationsafety)³³⁴ CDC will also create tools to support the use of effective programs, including a website to support implementation of Tai Chi: Moving for Better Balance. Training materials will be developed for both instructors

³³⁴ <http://www.cdc.gov/homeandrecreationsafety/Falls/steady/index.html>

and master trainers. This resource will expand the number of trained instructors and lead to more widespread dissemination of this Tai Chi program.

National Violent Death Reporting System

The Committee recommendation includes \$18,465,000 to allow CDC to expand the NVDRS beyond the current 18 States. NVDRS is a surveillance system that pools information from State and local medical examiners, coroners, law enforcement, crime labs, and vital statistics into a single incident record, which presents a more complete picture of the circumstances surrounding a violent death. An enhanced NVDRS will provide States, communities, and researchers the ability to identify the preventable characteristics of violent deaths, including both homicides and suicides, at a more localized level. The Committee encourages CDC to plan how best to disseminate the new data on the magnitude, trends, and characteristics of violent deaths to prevention researchers, practitioners, and policymakers. The Committee intends this expansion to aid in the development, implementation, and evaluation of violence prevention strategies at the national, State, and local levels.

Action taken or to be taken

The FY 2014 Omnibus Conference Report includes \$11,200,000 in funding (\$11,333,000 comparably adjusted) for BSS realignment. Expanding NVDRS will provide national standardized and integrated incident-based data from a variety of law enforcement and public health sources, across multiple jurisdictions to enable comparisons of violent deaths within and across states; provide communities with vital information to better understand the preventable characteristics of violent deaths; support violence prevention efforts by providing nationwide data on violent death occurrences; support system enhancements such as improved data collection and increased system responsiveness; and allow CDC to better identify and report on national trends on different types of homicides. In FY 2014, CDC will complete the update of NVDRS to a web-based data collection system, which will make the system more reliable and accessible and improve the efficiency and timeliness of the system. The FY 2015 President's Budget includes a request for an increase of \$12,237,000 over the FY 2014 Enacted Budget to expand NVDRS to all 50 states and to Washington, D.C.

Sports-Related Injuries

The Committee is concerned about the number and severity of injuries related to sports activities at every age and experience level, from professional sports to sports programs for children. While physical activity is an important part of a healthy lifestyle and should be promoted as a national public health goal, the number of injuries, particularly those related to head injury and concussion, is a matter of grave concern. The Committee believes that new developments in sports safety equipment can reduce the number of injuries to participants in sports activities. In addition, safer technologies that have already been implemented in one sport can be applied to safety equipment in other sports, yielding widespread improvements in safety and injury reduction. For example, the Committee is aware of new designs for football helmets aimed at reducing or eliminating the injuries that contribute to concussions and traumatic brain injuries. The Committee encourages CDC to test and improve these new helmet designs in cooperation with academic centers, sports sanctioning organizations, and equipment manufacturers.

Action taken or to be taken

The scope of CDC's contribution in addressing sports-related injuries is to provide guidance on how best to identify and manage individuals who have endured a concussion and on how to prevent sports-related injuries altogether. For instance, CDC has been working with partners to launch a Heads Up to Parents website and app ([Heads-Up-APP³³⁵](http://www.cdcfoundation.org/heads-up-app)). These new resources provide an important tool for parents and coaches who play a key role in helping to keep kids and teens safe from concussion and other serious brain injuries. The new app assists parents in selecting a helmet and also provides important safety information and tips on spotting a concussion.

³³⁵ <http://www.cdcfoundation.org/heads-up-app>

The website offers a variety of materials, including videos, fact sheets, and training for sports coaches. CDC also supports the implementation of concussion in sports policies in 40 states through *Heads Up* online training modules for coaches and healthcare professionals. To date, over 1 million coaches have been trained.

Traumatic Brain Injury (TBI)

The Committee encourages CDC to consider supporting multidisciplinary approaches to early identification and treatment of TBI cases.

Action taken or to be taken

CDC investigates and reports the epidemiology of Traumatic Brain Injury (TBI) in the overall civilian population of the United States, and examines TBI among special populations. CDC also identifies and supports evidence-based approaches to the primary prevention of injuries—including the major causes of TBI, like falls, motor vehicle crashes, and child injury. CDC is leading a Pediatric mild TBI (“mTBI,” which is sometimes described as a concussion) Guidelines Workgroup that has collaborated with leading experts to develop clinical guidelines and tools for diagnosis and management of mTBI among the pediatric population. CDC has also worked with state health departments, state athletic associations, athletic directors, and schools to assess the implementation of “Return to Play” policies. The product from this collaboration is a state guide to disseminate best practices for implementation, effects of Return to Play Laws, and unintended consequences of sports related injuries other states have experienced.

Facilities

The Committee is proud of the decade of investments made to implement the CDC Master Facilities Plan, which recently concluded with the opening of Building 107. One of the strategic goals of that plan was to move CDC from leased facilities into federally owned property to reduce facility-related costs to the agency. In furtherance of that goal, the Committee directs NIOSH to maximize the use of existing federally owned research facilities and property to conduct its work. In particular, the Committee is concerned that NIOSH has expanded its leasing activities while there remains unused space it owns.

Action taken or to be taken

NIOSH has no plans to expand leased space for research activities.

Mining Research Regional Approaches

The Committee strongly supports mine research done to prevent injury and improve conditions in metal/non-metal mines located predominantly in the western half of the country, including mines in the newly revitalized Silver Valley of Idaho, the gold mining areas of Nevada, the platinum area in Montana, the trona mines in Wyoming, and the mines of various types in Alaska. In particular, the Committee strongly supports the Catastrophic Failure Detection and Prevention, Mining Injury and Disease Prevention, and Mining and Surveillance and Statistical programs. The Committee urges NIOSH to coordinate research goals with mine operators and unions in the various regions of the country.

Action taken or to be taken

CDC’s Mining Program continues to work closely with labor and industry associations throughout the United States, and uses their input to develop research goals. Importantly, these organizations, as well as individual mines, often become partners or collaborators in the ensuing research.

Individual mines are selected for inclusion in research projects based on the alignment with the project needs, geographic location, and the willingness of the mine to participate, among other factors. CDC’s Mining Program has a long history of collaboration with the gold mines in Nevada, the platinum area in Montana, the mines in the Silver Valley of Idaho, and the trona mines in Wyoming. Mines in Alaska have also been included in research

studies, when they have offered unique opportunities that could not be studied elsewhere. Mines in Nevada, Idaho, and Montana are currently participating in research projects to prevent catastrophic failure, injury, and occupational disease. The amount of research in the revitalized Silver Valley region is being significantly expanded. It is anticipated that the level of research to improve metal/nonmetal mining safety and health will continue to increase.

Skin Cancer

The Committee directs NIOSH to conduct research to on the incidence of skin cancers among occupational workers who spend a majority of their work hours in vehicles or equipment operated outdoors. Such vehicles or equipment includes trucks, transit vehicles, tractors and related farm equipment, and construction equipment. The Committee encourages NIOSH to identify technologies to mitigate incidences of skin cancers among this group of occupational workers by reducing worker exposure to UVA and UVB radiation.

Action taken or to be taken

NIOSH is reviewing data from the National Health Interview Survey (NHIS) for melanoma, non-melanoma, and unspecified skin cancer among occupational workers who spend a majority of their time outdoors (this includes operators of equipment such as tractors, trucks, and other agricultural and construction equipment). In the fall of 2014, a report of findings concerning the prevalence of these cancers among these workers will be prepared, along with recommendations for reducing exposure where necessary.

National Public Health Institute

The Committee is aware that the International Association of National Public Health Institutes has begun to transfer its technical assistance functions to CDC, making CDC the global leader on building NPHI capacity around the world. The Committee includes a new initiative to support the creation of NPHIs in developing countries. The Committee provides \$10,000,000 to be available over a 2-year period for CDC to work in at least five countries. The Committee expects CDC's engagement to be time-limited, extending from 3 to 5 years. The Committee further expects this initiative to engage countries in all regions of the world; however, the Committee understands that any participating country must show a high level of commitment to reorganize its ministry of health in this manner.

Action taken or to be taken

Consolidating and organizing public health expertise and systems within a national public health institute (NPHI) is a proven way for countries to carry out essential public health functions, improve accountability, and increase efficiency. Through direct engagement with Ministries of Health, CDC efforts focus on establishing and strengthening NPHIs for a long-term, sustainable solution to develop global public health capacity, achieve global health security, and increase public health impact. These efforts build upon the expertise and experiences of the International Association of National Public Health Institutes (IANPHI). CDC works closely with IANPHI in-country on developing and strengthening NPHIs. CDC's NPHI program is also partnering with the President's Emergency Plan for AIDS Relief in countries where an NPHI can serve as a sustainable legacy of U.S. Government investment. With the increase of \$7.5 million in FY2014 omnibus funding over FY 2013 level, CDC will help up to five countries to assist other nations in setting up and strengthening National Public Health Institutes. This is an organizational effort, and in no way limits capacity-building work in other programs of CDC. CDC will design and test assessment tools and a monitoring and evaluation framework that can be used to support and track the NPHI development. CDC will explore partnerships with the Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, and others that allow information exchange between U.S. state public health experts and in-country NPHI staff. CDC also will engage other well-established NPHIs to provide technical expertise and to support fundraising with their national aid organizations to leverage CDC investments in NPHI development among in-country bi-lateral partners.

Coordination

The Committee encourages CDC to continue efforts to align its preparedness grant programs with programs of the Departments of Homeland Security and Transportation that have complementary goals. As those efforts progress, the Committee encourages CDC to seek greater efficiencies in applications, reporting, and data collection for State and local grantees.

Action taken or to be taken

A Memorandum of Understanding (MOU) for emergency preparedness grant coordination was signed by HHS' office of the Assistant Secretary for Preparedness and Response (ASPR), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), National Highway Traffic Safety Administration (NHTSA) and Federal Emergency Management Agency (FEMA). Achievements are as follows:

- Produced a Joint Hospital Preparedness Program/Public Health Emergency Preparedness (HPP-PHEP) Funding Opportunity Announcement within an aligned grant cycle
- Implemented an HPP-PHEP joint assessment tool that assists state, local, and territorial public health and healthcare system preparedness programs identify planning gaps and prioritize subsequent preparedness investments
- Included common language within the FEMA Homeland Security Grant Program (HSGP) Funding Opportunity Announcement and the Joint HPP-PHEP FY 2013 continuation guidance to promote effective state, local, and territorial preparedness planning between emergency management, public health and the healthcare system
 - Approximately 70% of PHEP awardees report a significantly less burdensome application process (up from 39% last year)
 - Majority of state, local, and territorial HPP-PHEP programs report that CDC is moving public health preparedness planning and response in the right direction

SIGNIFICANT ITEMS IN FY 2014 CONSOLIDATED APPROPRIATIONS ACT

Significant items for inclusion in the FY 2015 Centers for Disease Control and Prevention Congressional Justification from the Joint Explanatory Statement accompanying the Consolidated Appropriations Act, 2014 (P.L. 113-76).

Public Health Emergency Preparedness index

The CDC should continue to coordinate with other federal agencies on the index and provide an update in the fiscal year 2015 budget request on the index, time line to implement, and how the tool will be used for future budget requests to identify needs for public health emergency preparedness and the strategic national stockpile.

Action taken or to be taken

The National Health Security Preparedness Index™ (NHSPI™; the Index) is a comprehensive annual measure of health security and preparedness at national and state levels. The Index is designed to inform states and all others responsible for health security preparedness in the United States. The Association of State and Territorial Health Officials (ASTHO), through a cooperative agreement from CDC's Office of Public Health Preparedness and Response, coordinated the development of the NHSPI™, along with more than 75 experts representing states, counties, cities, partner federal agencies (including HHS, DoD, and DHS) academia, private sector, and other organizations. The NHSPI™ was built in the context of Presidential Policy Directive (PPD)-8 with the goal of capturing the "whole of community" that influences the health security preparedness of our nation (as defined in the National Health Security Strategy). Through the "whole of community" lens, the Index relates to many national capabilities.

The NHSPI™ is broader in scope than the Public Health Emergency Preparedness (PHEP) cooperative agreement performance measures. Index results are not linked to a state's level of PHEP funding. The NHSPI™ is intended to strengthen the nation's health security-by identifying national and state strengths as well as gap areas, and it can serve as a resource to facilitate quality improvement. In addition, the Index will inform the effective use of health security related funds at the national, state, and local levels and help policymakers, practitioners, communicators, and academia set priorities. In subsequent years, the Index will provide a mechanism to evaluate the effectiveness of policy decisions by evaluating measures over time. The Strategic National Stockpile priorities are driven by the Public Health Emergency Medical Countermeasure Enterprise (PHEMCE), led by the Assistant Secretary for Preparedness and Response. In 2014, the NHSPI™ Project Team will continue to coordinate with additional federal and non-federal partners to enhance the Index.