



DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2014

**Centers for Disease Control
and Prevention**

***Justification of
Estimates for
Appropriation Committees***

MESSAGE FROM THE DIRECTOR

As Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Agency for Toxic Substances and Disease Registry, I am pleased to present the agency's budget request for Fiscal Year (FY) 2014. This budget request reflects the Administration's priorities in support of key Department of Health and Human Services goals that will help people live healthy, safe, and productive lives.

For 66 years, CDC has served as a public health leader throughout the United States and the world. CDC is dedicated to protecting health and promoting quality of life by preventing and controlling disease, injury, and disability, as well as reducing the health and economic burden of the leading causes of disease, disability, and death.

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

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

The FY 2014 budget request prioritizes essential investments. The request also streamlines our approach, as we continue our commitment to be efficient, effective stewards of the American people's resources. Maintaining critical agency investments in FY 2014 will allow CDC to continue its important work and build public health capacity at the local, state, and international levels to protect and promote health.

I am confident this justification 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
Administrator, Agency for Toxic Substances and Disease Registry

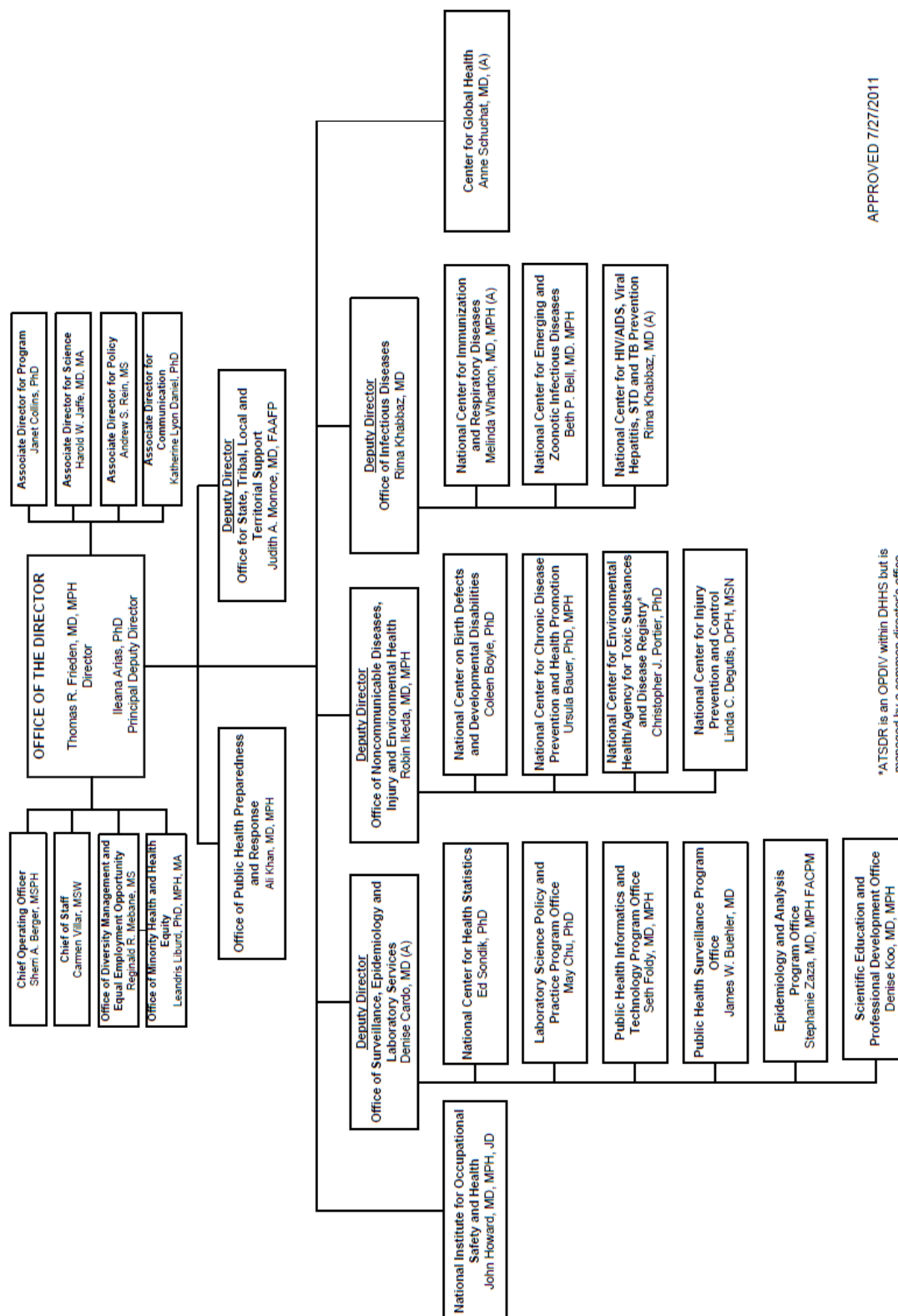
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CDC ORGANIZATIONAL CHART

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.

APPROVED 7/27/2011

Names Updated 1/10/2013

PERFORMANCE BUDGET OVERVIEW

INTRODUCTION AND MISSION

The Centers for Disease Control and Prevention (CDC) is an operating division of the Department of Health and Human Services (HHS). Since 1946, CDC has worked to keep America safe 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 is the nation's health protection agency — saving lives, protecting people from health threats, and saving money through prevention.

CDC's mission, simply put, is to keep Americans safe and healthy where they work, live and play. Our scientists and disease detectives work around the world to put proven prevention strategies to work, track diseases, research outbreaks, and respond to emergencies of all kinds. CDC works with partners around the country and world to:

- Protecting Americans from infectious diseases
- Preventing the leading causes of disease, disability, and death
- Keeping Americans safe from environmental and work-related hazards
- Protecting Americans from natural and bioterrorism threats
- Monitoring health and ensuring laboratory excellence
- Ensuring global disease protection

**CDC works 24-7
to save lives and
protect people
from health
threats**

These aims form the foundation of CDC's mission and each CDC program contributes through comprehensive public health activities. CDC programs provide partners and Americans with the essential health information and tools they need to make protect and advance their health. CDC's highly trained staff provide critical national leadership to increase the health security of our nation.

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



For more information, please visit
www.cdc.gov/budget, or, using a QR reader on your
smartphone, scan this QR code for quick access to
CDC's budget materials.

OVERVIEW OF THE BUDGET REQUEST

The fiscal year (FY) 2014 President's Budget request includes a total overall funding level of \$11.257 billion in discretionary budget authority, mandatory funding, Public Health Service (PHS) Evaluation funds, and the Affordable Care Act Prevention and Public Health Fund (PPHF) for CDC and ATSDR. This is an overall increase of \$70.838 million above the FY 2012 level. CDC's program level funding, excluding mandatory funding except PPHF, is proposed at \$6.665 billion, a decrease of \$270.044 million below the FY 2012 level. Additionally, the following programs are no longer proposed for consolidation: Chronic Disease, Environmental Health, and Birth Defects.

The FY 2014 budget request includes:

- A decrease of \$432.461 million in budget authority
- A net decrease of \$53.890 million from PPHF, specific changes are also outlined in the sections below
- An increase of \$246.307 million from PHS Evaluation Fund
- A decrease of \$30.000 million from Public Health and Social Services Emergency Fund (PHSSEF)
- An increase of \$287.442 million for Vaccines for Children
- An increase of \$53.440 million for the World Trade Center Health Program

CDC remains committed to maximizing the impact of every dollar entrusted to the agency. The FY 2014 budget request maintains investments in key programs, while identifying strategic reductions that will allow CDC to advance our core public health mission in the most cost-effective way in this challenging fiscal environment.

INCREASED PROGRAM INVESTMENTS

This budget requests increases to support essential CDC goals:

- Protecting Americans from infectious diseases
- Ensuring global disease protection
- Preventing the leading causes of disease, disability and death
- Monitoring health
- Keeping Americans safe from environmental and work hazards

Increases described in this section represent overall program level increases for CDC, as compared to the FY 2012 level, including budget authority, PHS Evaluation funds, and resources from the PHSSEF and PPHF. Proposed funding levels also incorporate a pay raise of 1% for civilian and 1.2% for commissioned corps personnel, for a total pay increase of \$11.570 million.

Protecting Americans from Infectious Diseases

Vaccines for Children - Mandatory Funding (+\$287.442 million)

The FY 2014 budget request includes an increase of \$287.442 million above the FY 2012 level for the Vaccines for Children (VFC) Program. The FY 2014 estimate includes an increase for vaccine purchase which is based on price and forecast changes for vaccines. 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.

Advanced Molecular Detection and Response to Infectious Disease Outbreaks (+\$40.000 million)

The FY 2014 budget request includes an increase of \$40.000 million for a new crosscutting Advanced Molecular Detection and Response to Infectious Disease Outbreaks initiative, a fundamental change and modernization in public health microbiology and bioinformatics capabilities at CDC. In 2011, a panel of external consultants reviewed bioinformatics capabilities in CDC's infectious disease programs. The panel found that CDC's ability to meet its basic public health mission is threatened by not keeping pace with major technologic advances in the diagnosis and characterization of infectious agents. With this initiative, CDC will adopt new technological approaches to reduce the burden of infectious diseases. Modernizing public health microbiology capacities will improve biosurveillance data monitoring and enable the analysis and timely dissemination of critical public health information to partners, the media, and the public. Without the bioinformatics capacity to effectively manage, analyze, and interpret the huge amounts of data generated by these new technologies, CDC's ability to effectively respond to infectious disease outbreaks is at risk.

Food Safety (+\$16.605 million)

The FY 2014 budget request includes an increase of \$16.605 million for improvements to Food Safety. This increase will enable CDC to move toward implementation of CDC's provisions of the Food Safety Modernization Act (FSMA). Activities include enhancing and integrating surveillance systems, upgrading the PulseNet system, improving timeliness of outbreak detection and response by state and local partners through the FoodCORE program, attributing illnesses to specific food commodity groups to aid in prevention efforts, monitoring the effectiveness of food safety prevention measures, and supporting FSMA's Integrated Food Safety Centers of Excellence. These investments will help restore and improve state and local capacity to monitor foodborne illness and respond to outbreaks.

Domestic HIV/AIDS Prevention and Research (+\$13.491 million)

The FY 2014 budget request includes an increase of \$13.491 million for domestic HIV prevention, including \$10 million to improve timeliness of HIV surveillance as well as an increase of \$3 million in PHS Evaluation transfers to assess and improve CDC's HIV school health programs. The budget also proposes to reallocate \$40 million from less efficient activities to support Community High-Impact Prevention (CHIP), a new initiative that will maximize HIV prevention through capacity-building and community-based organizations to improve systems that link persons recently diagnosed with HIV to care. This initiative focuses CDC resources on implementing sustainable, high-impact HIV testing and screening programs, delivering comprehensive prevention for HIV-positive individuals including linkage to and engagement in care and prevention services, using data to improve viral load suppression rates and other services, scalable and effective behavioral interventions, and public health strategies for at-risk populations.

With new resources proposed, CDC will upgrade the quality and efficiency of HIV surveillance data by developing and promoting the use of standard formats for electronic reporting of laboratory results. These improvements are expected to help jurisdictions gather more information about HIV in their communities, and this information can be used to further improve prevention and care efforts. To assess and refine its core HIV school health activities, CDC will examine the extent to which schools have revised HIV prevention policies, practices, and services to align with their self-assessments; school adoption of effective instructional strategies and curricula; and new approaches to teacher training. CDC will also conduct case studies and program evaluation of activities designed to enhance HIV risk reduction efforts. CDC will also dedicate \$10 million of total HIV resources to build the infrastructure

and capacity that state public health departments and community-based organizations will need to bill private insurers for infectious disease testing. Overall, the HIV/AIDS prevention investments will continue to align activities with the *National HIV/AIDS Strategy*.

National Healthcare Safety Network (+\$12.491million)

The FY 2014 budget request includes an increase of \$12.491 million for improvements to the National Healthcare Safety Network (NHSN). This increase allows CDC to target healthcare-associated infections (HAI) prevention in two critical areas. CDC will focus on NHSN's multi-drug, ward-specific, and facility-wide data on highly antibiotic resistant infections that will trigger the "Detect and Protect" strategy. The strategy identifies pathogens and transmission within and between facilities in a region. CDC also will target HAI prevention to reduce healthcare-associated infections in more than 1,800 additional facilities, using NHSN data, to find problem areas in high-use Medicaid facilities that are outliers with high rates of HAIs and will use NHSN's Antimicrobial Use Resistance Module to generate ward-specific and facility-wide data on antimicrobial resistance using electronic data sources.

Ensuring Global Disease Protection

Polio Eradication (+\$15.149 million)

The FY 2014 budget request includes an increase of \$15.149 million 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 the end of 2014. Lessons learned from the successes in India will be the focus of the increased efforts, which include maintaining sensitive surveillance, improving the quality of supplemental immunization activities, intensifying immunization programs in high-risk areas and populations, and introducing the use of bivalent oral polio vaccine. CDC and GPEI partner efforts will align with the Polio Eradication and Endgame Strategy from 2013–2018.

Preventing the Leading Causes of Disease, Disability, and Death

National Violent Death Reporting System (+\$20.000 million)

The FY 2014 budget request includes an increase of \$20.000 million for National Violent Death Reporting System (NVDRS) to allow CDC to expand the system to all 50 states and DC. NVDRS is a state-based surveillance system that pools information from state and local medical examiners, coroners, law enforcement, crime labs, and vital statistics into a single incident record in order to form a more complete picture of the circumstances surrounding violent deaths. An enhanced nationwide NVDRS will provide states and communities with vital information to better understand the preventable characteristics of violent deaths, including both homicides and suicides. The President's newly released plan to reduce gun violence, *Now is the Time*, states that we need better data to help Americans better 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 to inform the development, implementation, and evaluation of violence prevention strategies in order to save lives.

Tobacco (+\$13.837 million)

The FY 2014 budget request includes an increase of \$12.000 million in PPHF funding and an increase of \$1.837 million in budget authority for tobacco use prevention and control. CDC will use this increase to expand the first-ever paid national campaign against smoking, "Tips from Former Smokers." Last year the campaign prompted more than 200,000 additional calls to the 800-QUIT-Now quitline and more than 500,000 visits to a cessation support website when the campaign was aired. As a result, thousands of lives and millions of health care dollars will be saved. Because medical care of smokers costs, on average, \$2,000 more than non-smokers and about \$1,000 more than ex-smokers, the campaign will more than pay for itself. The request also supports expanded state quitline operations, a crucial adjunct to the media campaign. Quitlines increase quit rates by 50% and reach tobacco users in populations that historically

have had the most limited access to and use of evidence-based tobacco cessation treatments. As a result, in 2012 alone, nearly 900,000 calls were handled by state quitlines, which can be projected to result in more than 100,000 successful quits, saving lives and healthcare costs.

Gun Violence Prevention Research (+\$10.000 million)

The FY 2014 budget request includes an increase of \$10.000 million to prevent gun violence by supporting research into the causes and prevention of gun violence. The President's plan, *Now is the Time*, calls for this critical public health research to give all Americans information they need. Topics will follow the research agenda currently being developed with external partners and will address questions aimed at understanding the characteristics of gun violence, the risk and protective factors associated with firearm violence, and the role of violent video and violent media content on behavior. CDC will make funds available to strengthen available data systems for gun research and otherwise support research into the causes and prevention of gun violence through a competitive, peer-review process, funding approximately 10 to 15 three- to five-year competitive grants and cooperative agreements.

Million Hearts™ (+\$5.000 million)

The FY 2014 budget request includes an increase of \$5.000 million in PPHF funding for Million Hearts™, a national public-private initiative developed to prevent one million heart attacks and strokes by 2017. These investments will support selected heart disease and stroke prevention activities within the Million Hearts™ initiative that directly complement Community Transformation Grant cardiovascular disease prevention activities. With these resources The Million Hearts™ initiative will initiate grants to promote medication management through counseling and pharmacy support in selected communities.

Rape Prevention and Education (+\$5.000 million)

The FY 2014 budget request includes an increase of \$5.000 million in PHS Evaluation transfers for the Rape Prevention and Education (RPE) program. This increase will be used to evaluate interventions and strategies designed to prevent sexual violence. In FY 2014, CDC will competitively fund approximately five to seven academic or research institutions for this work. Funded institutions will partner with existing RPE grantees and conduct systematic data collection and evaluation efforts with the goal of generating findings to improve sexual violence prevention nationwide. Evaluations will build the evidence base in sexual violence prevention and lead to the scaling up of evidence-based efforts throughout the RPE program.

Monitoring Health

Health Statistics (+\$22.413million)

The FY 2014 budget request includes an increase of \$22.413 million in PHS Evaluation transfers for the Vital Statistics System. This increase allows CDC to expand vital registration by purchasing 12 months of birth and death data from the vital registration jurisdictions and to fully implement electronic birth records in the two remaining jurisdictions. This budget request prioritizes and supports the expansion of vital statistics to gradually phase in electronic death records in the 21 remaining jurisdictions over four years. The increase will also support development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods. This investment will expand CDC's capability to monitor key health indicators at the national, state, and community level.

Keeping Americans Safe from Environmental and Work-related Hazards

World Trade Center Health Program - Mandatory Funding (+\$53.440 million)

The FY 2014 budget request includes an increase of \$53.440 million to provide additional funding for:

- monitoring and treatment services in the World Trade Center Health Program, including costs associated with the addition of certain cancers to the list of WTC-related health conditions;
- program inclusion—as required by the James Zadroga Act—of responders from the Shanksville, Pennsylvania and Pentagon sites, who will be eligible to enroll in the program in 2013; and
- an increase in infrastructure costs for the Clinical Centers of Excellence and the Nationwide Provider Network to support those clinical activities.

Healthy Homes/Lead Poisoning Prevention (+\$2.468 million)

The FY 2014 budget request includes an increase of \$2.468 million for CDC to remain a resource to federal, state, and local agencies on primary prevention and clinical interventions to prevent lead poisoning and other housing related diseases. With increased funding in FY 2014, CDC will provide scientific and software expertise to state and local health departments using the Healthy Homes and Lead Poisoning Surveillance System (HHL PSS). This system facilitates data collection on lead poisoning and other health hazards in homes, initiating actions by federal, state, and local agencies to protect children from lead exposure. HHL PSS ensures that limited resources are targeted to the highest-risk children. CDC will also use increased funding to train public health workers on reliable, low-cost methods for reducing lead and other risks through its National Healthy Homes Training Center and Network. CDC, however, will not be able to fund extramural activities at the requested level, consistent with the FY 2012 Appropriations level.

PROGRAM DECREASES AND ELIMINATIONS

Decreases and eliminations described in this section represent overall program level decreases for CDC, as compared to the FY 2012 level, including budget authority, PHS Evaluation funds, and resources from the PHSSEF and PPHF.

Community Transformation Grants (-\$79.660 million)

The FY 2014 budget request includes a decrease of \$79.660 million for Community Transformation Grants (CTG). These resources were associated with the small communities component of the CTG program, which was fully funded in FY 2012, thus continuation of these resources are not needed in FY 2014. CTG activities in these small communities may request to continue activities into FY 2015 if their funding allows. In FY 2014, the CTG program will continue to amplify efforts to promote healthy behaviors that control healthcare costs.

Preventive Health and Health Services Block Grant (-\$79.545 million)

The FY 2014 budget request reflects the elimination of the Preventive Health and Health Services Block Grant program. These activities may be more effectively and efficiently implemented through the Chronic Disease Prevention and Health Promotion Program's combined Funding Opportunity Announcement, which provides the ability for to states to coordinate activities across several related categorical funding streams. Resources to state health departments from PPHF investments may also help meet these needs. 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.

Immunization (-\$60.842 million)

The FY 2014 budget request includes a decrease of \$60.842 million for the Section 317 immunization program. Health insurance expansion will further increase access to immunizations and 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 Advisory Committee on Immunization Practices recommended vaccines without charging a deductible, copayment,

or coinsurance when administered by an in-network provider. This reduction aligns with CDC's new policy implemented in 2012 to only fund vaccine purchased for routine vaccination of uninsured individuals and for response to outbreaks and other urgent public health vaccine needs.

The FY 2014 budget request will continue to provide for critical immunization program operations, including \$25 million for implementing billing systems for immunization services at public health clinics to sustain high levels of vaccine coverage, and support for the scientific evidence base informing immunization policies, and critical vaccine purchase for uninsured individuals and outbreak response.

Occupational Safety and Health (-\$54.456 million)

The FY 2014 budget request includes a decrease of \$54.456 million for Occupational Safety and Health, which reflects elimination of the Education and Research Centers, and the Agriculture, Forestry, and Fishing sector of the National Occupational Research Agenda. While these programs have made positive accomplishments in advancing workplace safety and health, they have been proposed for elimination in a limited-resource environment.

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

The FY2014 budget request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program. The Community Transformation Grants (CTG) program, which builds on past program successes and lessons learned, marks the next stage of CDC's community-based programs. The CTG program integrates best practices and lessons learned from the REACH program into its approach, amplifying the dissemination of these best practices and lessons learned to communities across the nation.

Strategic National Stockpile (-\$38.190 million)

The FY 2014 budget request includes a decrease of \$38.190 million for the Strategic National Stockpile, including elimination of \$30 million in one-time PHSSEF funding for pandemic influenza. The reduction will be implemented by not replacing expiring items that rank lower on formulary priorities, based on an annual review of the SNS. Reduction could result in fewer people receiving treatment during an influenza pandemic and fewer people receiving post-exposure prophylaxis following exposure to anthrax.

Breast and Cervical Cancer and Colorectal Screening (-\$41.884 million)

The FY 2014 budget request includes a decrease of \$41.884 million for the National Breast and Cervical Cancer, Early Detection Program, and Colorectal Cancer Screening Program, including elimination of one-time PPHF investment of \$10 million in FY 2012. As the Affordable Care Act (ACA) increases access to cancer screening services beginning in 2014, the public health need to provide these clinical services will be diminished. 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 reducing tobacco use, healthcare-associated infections and food safety and reduces funding for direct screenings such as breast, cervical and colorectal screening that are already covered by insurance.

Buildings and Facilities (-\$10.355 million)

The FY 2014 budget request includes a decrease of \$10.355 million, which will support all critical repairs and improvements through a combination of proposed budget authority and carryover balances. The FY 2014 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. R&I projects funded in existing owned facilities will be sufficient to maintain CDC's portfolio Condition Index at 90 or

higher for laboratory, laboratory support, and critical infrastructure assets, and fund additional critical program-requested R&I projects.

Workplace Wellness (-\$10.000 million)

The FY 2014 budget eliminates the Workplace Wellness program, which received \$10.000 million in PPHF funding in FY 2012. 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.

State and Local Preparedness and Response Capability (-\$8.219 million)

The FY 2014 budget request includes a decrease of \$8.219 million for State and Local Preparedness and Response Capability. The decrease would reduce the amount of funding awarded to state and local health departments through the Public Health Emergency Preparedness and Cities Readiness Initiative programs. Specifically, reductions in funding may reduce exercising of capability-based plans that are essential for ensuring operational readiness and ongoing program development. Reductions may slow the development of risk reduction strategies for vulnerable and at-risk populations that align with overarching state and local emergency management response plans. State and local partners' capabilities in information sharing, disease surveillance and detection, public health workforce and other core infrastructure could decrease, which may affect the duration and severity of outbreaks.

Environmental Health Tracking Network (-\$6.000 million)

The FY 2014 budget request includes a decrease of \$6.000 million for the National Environmental Health Tracking Network. At the requested level, CDC will reduce the amount of funding to states and eliminate technical assistance to other health agencies. The number of public health actions undertaken using Tracking Network data will increase from 15 to 16 with CDC's focus on capacity building for existing grants, but CDC expects health departments to use Tracking Network data for less public health actions than in FY 2012.

Hospitals Promoting Breastfeeding (-\$4.550 million)

The FY 2014 budget request includes a decrease of \$4.550 million for the hospitals promoting breastfeeding program. The three-year, \$6 million Hospital Collaboratives grant will come to an end in 2013. With \$2.5 million proposed in FY 2014, 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 locale. 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 Combined FOA and CTG grants.

Prevention Research Centers (-\$3.871 million)

The FY 2014 budget request includes a decrease of \$3.871 million for the prevention research centers. CDC will implement this decrease by streamlining prevention research efforts through the Prevention Research Center program's Comprehensive Centers.

TRANSFERS

The Paralysis Resource Center (Christopher Reeve) (-\$6.700 million)

The FY 2014 budget request proposes to transfer the Paralysis Resource Center (Christopher Reeve) to the Administration for Community Living (ACL). In FY 2012, this activity was funded at \$6.700 million.

KEY PROGRAMMATIC CHANGES

Working Capital Fund Implementation

In FY 2014, CDC will implement the Working Capital Fund (WCF), as authorized in the FY 2012 appropriation bill, to achieve greater efficiency and transparency of business services support. The WCF is a revolving fund that serves as the sole funding mechanism to finance centralized business services support across CDC. CDC's working capital fund will encompass a portfolio of business services support in the following major categories: Buildings, Facilities, and Logistics Management Services, Financial Management and Oversight Services, IT Services, Support, and Infrastructure Services, Security and Safety Services, Procurement Services, Human Resources, Compliance Services, General Administrative Support Services. The services rendered under the WCF are performed at pre-established rates that are used to cover the full cost of operations and future investments (i.e., capital expenses). The WCF operates on revenues collected for services, rather than Congressional appropriations, thereby creating market-like incentives for both customers and service providers to maximize efficiency. Like most WCFs, CDC's WCF will have reserves (unobligated balances) that are not constrained by the fiscal year cycle. Restricted reserves include amounts that will be used for capital IT infrastructure investment financing and accrued annual leave, while unrestricted reserves include amounts that will be used to offset any unforeseen, one-time costs that the Fund may incur during the fiscal year. The WCF Governance Board will determine a target between 2 to 4 percent of WCF annual operating revenue to cover unrestricted reserves on an annual basis.

Realignment of the BSS Budget

CDC's WCF replaces the Business Services Support (BSS) direct appropriation, which was used in previous fiscal years to provide funding for all of CDC's Business Service Offices (BSOs) such as the Procurement and Grants Office, Financial Management Office, and Information Technology Services Office. To support WCF, the 2014 request distributes BSS funding into each programmatic budget line. The distribution amounts were calculated using FY 2011 consumption data to provide an estimate. FY 2012 consumption data will be available when the FY 2014 appropriation cycle begins and may result in minor adjustments to the distribution. Each major budget line will receive an amount of the BSS direct appropriation that is proportionate to the historical share of business service costs attributable to each CIO (Centers, Institutes, and Offices). In FY 2014, programs will receive bills for services consumed, based on pre-established rates that encompass the full cost of service provision.

Human resources, equal employment opportunity, and some safety and health services will also be included in the working capital fund service portfolio. These services were historically funded by Public Health Leadership and Support (PHLS). As a result, funding will be distributed from PHLS to program lines, as part of the overall BSS realignment, to provide continued support for these services, and programs will be billed the same way they are billed for other business services (e.g., IT, Financial Services, Procurement and Grants, etc.).

The table below reflects the realignment of budget authority funding that supports business services to the program budget lines. The amounts in this table were calculated using FY 2011 consumption data. FY 2012 consumption data will be available when the FY 2014 appropriation cycle begins and may result in minor adjustments to the distribution presented.

Working Capital Fund All Purpose Table

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ Working Capital Fund (WCF) All Purpose Table (Dollars in Thousands)					
Budget Activity/Description	FY 2012			2014	
	Enacted	BSS Realignment ¹	Enacted ² (Comparably Adjusted)	President's Budget	President's Budget +/- FY 2012 Enacted CA
Immunization and Respiratory Diseases	<u>\$778,947</u>	<u>\$35,915</u>	<u>\$814,862</u>	<u>\$754,020</u>	<u>-\$60,842</u>
Immunization and Respiratory Diseases - BA	\$576,083	\$35,915	\$611,998	\$668,696	\$56,698
Immunization and Respiratory Diseases - PHS Evaluation Transfer	\$12,864	\$0	\$12,864	\$12,864	\$0
Immunization and Respiratory Diseases - PPHF	\$190,000	\$0	\$190,000	\$72,460	-\$117,540
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	<u>\$1,109,934</u>	<u>\$53,030</u>	<u>\$1,162,964</u>	<u>\$1,176,942</u>	<u>\$13,978</u>
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	\$1,099,934	\$53,030	\$1,152,964	\$1,173,942	\$20,978
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PHS Eval	\$0	\$0	\$0	\$3,000	\$3,000
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PPHF	\$10,000	\$0	\$10,000	\$0	-\$10,000
Emerging and Zoonotic Infectious Diseases	<u>\$304,226</u>	<u>\$57,917</u>	<u>\$362,143</u>	<u>\$432,414</u>	<u>\$70,271</u>
Emerging and Zoonotic Infectious Diseases - BA	\$252,476	\$57,917	\$310,393	\$380,664	\$70,271
Emerging and Zoonotic Infectious Diseases - PPHF	\$51,750	\$0	\$51,750	\$51,750	\$0
Chronic Disease Prevention and Health Promotion	<u>\$1,167,427</u>	<u>\$43,939</u>	<u>\$1,211,366</u>	<u>\$1,036,093</u>	<u>-\$175,273</u>
Chronic Disease Prevention and Health Promotion - BA	\$756,377	\$43,939	\$800,316	\$620,189	-\$180,127
Chronic Disease Prevention and Health Promotion - PPHF	\$411,050	\$0	\$411,050	\$415,904	\$4,854
Birth Defects, Developmental Disabilities, Disability and Health	<u>\$130,587</u>	<u>\$11,205</u>	<u>\$141,792</u>	<u>\$141,944</u>	<u>\$152</u>
Birth Defects, Developmental Disabilities, Disability and Health-BA	\$130,587	\$11,205	\$141,792	\$67,148	-\$74,644
Birth Defects, Developmental Disabilities, Disability and Health-PPHF	\$0	\$0	\$0	\$74,796	\$74,796
Environmental Health	<u>\$139,998</u>	<u>\$18,235</u>	<u>\$158,233</u>	<u>\$155,126</u>	<u>-\$3,107</u>
Environmental Health - BA	\$104,998	\$18,235	\$123,233	\$126,126	\$2,893
Environmental Health - PPHF	\$35,000	\$0	\$35,000	\$29,000	-\$6,000
Injury Prevention and Control	<u>\$137,693</u>	<u>\$8,611</u>	<u>\$146,304</u>	<u>\$181,585</u>	<u>\$35,281</u>
Injury Prevention and Control - BA	\$137,693	\$8,611	\$146,304	\$176,585	\$30,281
Injury Prevention and Control - PHS Evaluation Transfer	\$0	\$0	\$0	\$5,000	\$5,000
Public Health Scientific Services	<u>\$461,741</u>	<u>\$55,721</u>	<u>\$517,462</u>	<u>\$539,305</u>	<u>\$21,843</u>
Public Health Scientific Services - BA	\$143,972	\$55,721	\$199,693	\$144,416	-\$55,277
Public Health Scientific Services - PHS Evaluation Transfer	\$247,769	\$0	\$247,769	\$324,889	\$77,120
Public Health Scientific Services - PPHF	\$70,000	\$0	\$70,000	\$70,000	\$0
Occupational Safety and Health	<u>\$292,588</u>	<u>\$32,693</u>	<u>\$325,281</u>	<u>\$271,911</u>	<u>-\$53,370</u>
Occupational Safety and Health - BA	\$181,864	\$32,693	\$214,557	\$0	-\$214,557
Occupational Safety and Health - PHS Evaluation Transfer	\$110,724	\$0	\$110,724	\$271,911	\$161,187
Global Health	<u>\$347,594</u>	<u>\$29,014</u>	<u>\$376,608</u>	<u>\$393,024</u>	<u>\$16,416</u>
Public Health Preparedness and Response	<u>\$1,329,479</u>	<u>\$52,338</u>	<u>\$1,381,817</u>	<u>\$1,334,316</u>	<u>-\$47,501</u>
Public Health Preparedness and Response - BA	\$1,299,479	\$52,338	\$1,351,817	\$1,334,316	-\$17,501
Public Health Preparedness and Response - PHSSEF	\$30,000	\$0	\$30,000	\$0	-\$30,000
Cross-Cutting Activities and Program Support	<u>\$659,113</u>	<u>-\$398,618</u>	<u>\$260,495</u>	<u>\$172,603</u>	<u>-\$87,892</u>
Cross-Cutting Activities and Program Support - BA	\$617,913	-\$398,618	\$219,295	\$131,403	-\$87,892
Cross-Cutting Activities and Program Support - PPHF	\$41,200	\$0	\$41,200	\$41,200	\$0
Total CDC, BA (adjusted for proposed ACL transfer)	<u>\$5,648,970</u>	<u>\$0</u>	<u>\$5,648,970</u>	<u>\$5,216,509</u>	<u>-\$432,461</u>
Total CDC, Budget Authority -	<u>\$5,655,670</u>	<u>\$0</u>	<u>\$5,655,670</u>	<u>\$5,216,509</u>	<u>-\$439,161</u>
Total CDC, (adjusted for proposed ACL transfer)	<u>\$6,020,327</u>	<u>\$0</u>	<u>\$6,020,327</u>	<u>\$5,834,173</u>	<u>-\$186,154</u>
Total CDC, (Budget Authority & PHS Evaluation Transfers) -	<u>\$6,027,027</u>	<u>\$0</u>	<u>\$6,027,027</u>	<u>\$5,834,173</u>	<u>-\$192,854</u>
Program Level, (adjusted for proposed ACL transfer)	<u>\$6,859,327</u>	<u>\$0</u>	<u>\$6,859,327</u>	<u>\$6,589,283</u>	<u>-\$270,044</u>
Program Level (includes BA, PHS Eval, PHSSEF & PPHF) -	<u>\$6,866,027</u>	<u>\$0</u>	<u>\$6,866,027</u>	<u>\$6,589,283</u>	<u>-\$276,744</u>

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ Working Capital Fund (WCF) All Purpose Table (continued) (Dollars in Thousands)					
Budget Activity/Description	FY 2012			2014	
	Enacted	BSS Realignment ¹	Enacted ² (Comparably Adjusted)	President's Budget	President's Budget +/- FY 2012 Enacted CA
<i>Agency for Toxic Substances and Disease Registry</i>	\$76,215	\$0	\$76,215	\$76,215	\$0
<i>Public Health and Social Services Emergency Fund (Transfer) (non-add)</i>	\$30,000	\$0	\$30,000	\$0	-\$30,000
<i>Affordable Care Act- Prevention and Public Health Fund Transfer (non-add)</i>	\$809,000	\$0	\$809,000	\$755,110	-\$53,890
<i>Vaccines for Children⁷</i>	\$4,005,941	\$0	\$4,005,941	\$4,293,383	\$287,442
<i>Energy Employees Occupational Illness Compensation Program Act (EEOICPA)</i>	\$55,358	\$0	\$55,358	\$55,358	\$0
<i>World Trade Center (Mandatory)⁸</i>	\$187,560	\$0	\$187,560	\$241,000	\$53,440
<i>PHS Evaluation Transfers (non-add)</i>	\$371,357	\$0	\$371,357	\$617,664	\$246,307
<i>Other User Fees</i>	\$2,226	\$0	\$2,226	\$2,226	\$0
<i>(Total CDC/ATSDR adjusted for proposed ACL transfer)</i>	<i>\$11,186,627</i>	<i>\$0</i>	<i>\$11,186,627</i>	<i>\$11,257,465</i>	<i>\$70,838</i>
<i>Total, CDC/ATSDR Program Level -</i>	<i>\$11,193,327</i>	<i>\$0</i>	<i>\$11,193,327</i>	<i>\$11,257,465</i>	<i>\$64,138</i>

¹ The BSS Realignment estimates were calculated using FY 2011 consumption data. FY 2012 Consumption data will be available when the FY 2014 appropriations cycle begins and may result in minor changes.

² The FY 2012 and 2013 amounts have been made comparable to FY 2014 to reflect proposed BSS realignment.

³ FY 2012 Domestic HIV lines have been made comparable to FY 2013 PB to reflect the FY 2013 PB proposed structure.

⁴ The Core Infectious Disease line was proposed in FY 2013 PB. This consolidates multiple budget lines under the Emerging and Zoonotic Infectious Diseases budget line. The 2012 Core Infectious Disease amount has been comparably adjusted.

⁵ FY 2012 and 2013 Disabilities and Health line has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

⁶ A portion of Healthcare Surveillance/Statistics funding supports NCHS activities.

⁷ The FY 2012 level reflects an estimated funding level. The FY 2013 level represents the anticipated transfer from Medicaid, and does not include \$0.656 million in prior year recoveries and refunds, for a total program level of \$3,607.256 million. The FY 2014 level represents the anticipated transfer from Medicaid.

⁸ The FY 2012 through FY 2014 amounts reflect the Federal government's estimated obligations.

PREVENTION AND PUBLIC HEALTH FUND SPEND PLAN

CDC's FY 2014 request from the Affordable Care Act Prevention and Public Health Fund is a total of \$755,110,000 of the \$1,000,000,000 available. This request is an overall decrease of \$53,890,000 below CDC's FY 2012 level for the Prevention and Public Health Fund, which had \$1,000,000,000 in available resources. These investments in prevention and public health programs will improve individual and population health and can help restrain the rate of growth in public and private sector healthcare costs.

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

CDC's approach to the Prevention Fund is to ensure that every dollar spent has the greatest possible impact. To achieve this end, some Prevention Fund program dollars will be used to jointly fund activities also supported through CDC's regular appropriation to provide the greatest possible return on this investment in our Nation's health. Many of these activities are described in greater detail in the program narratives found within the Narrative by Activity section of this FY 2014 budget submission.

PREVENTING THE LEADING CAUSES OF DEATH

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Preventing Leading Causes of Death	\$602.050	N/A	\$564.160
Cancer Prevention and Control	\$10.000	N/A	\$173.064
Community Transformation Grants (CTGs)	\$226.000	N/A	\$136.340
Tobacco	\$83.000	N/A	\$95.000
Birth Defects	\$0.000	N/A	\$74.796
Immunization	\$190.000	N/A	\$72.460
Million Hearts™	\$0.000	N/A	\$5.000
Let's Move!! Healthy Weight Task Force	\$5.000	N/A	\$4.000
Hospitals Promoting Breastfeeding	\$7.050	N/A	\$2.500
National Prevention Strategy	\$1.000	N/A	\$1.000
Racial Ethnic Approaches to Community Health Grant Program (REACH)	\$40.000	N/A	\$0.000
Workplace Wellness	\$10.000	N/A	\$0.000
Diabetes	\$10.000	N/A	\$0.000
Viral Hepatitis	\$10.000	N/A	\$0.000

¹ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CDC is requesting \$564,160,000 from the Prevention Fund to support Community Transformation Grants, cancer prevention and control, tobacco prevention, immunization, and other activities to address the leading causes of death and disability. CDC's largest Prevention and Public Health Fund investment to date is to prevent the leading causes of death by targeting their risk factors. The leading causes of death account for nearly two-thirds of all preventable deaths in the United States. To prevent heart attacks, strokes, cancers, and other chronic diseases, we must address risk factors such as tobacco use, nutrition, and physical activity and ensure people have access to community and clinical preventive services such as behavioral interventions, disease screening, and treatment. The Prevention Fund will enable communities and health departments to maximize prevention by supporting changes to the way services are provided, reducing redundancies across the healthcare and public health systems, and bridging successful programs from clinic to community. The Prevention Fund will enable communities and workplaces to target their priorities and invest in interventions proven to improve health outcomes.

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

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

Preventing tobacco use, which accounts for over 440,000 deaths each year, not only saves lives but also reduces direct healthcare costs and improves productivity. In FY 2014, CDC will continue to implement strategic, comprehensive counter-marketing efforts that will result in significant reductions in initiation and prevalence of tobacco use.

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

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

IMPROVING PUBLIC HEALTH DETECTION AND RESPONSE

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Improving Public Health Detection and Response	\$151.950	N/A	\$145.950
National Public Health Improvement Initiative	\$40.200	N/A	\$40.200
Epidemiology and Laboratory Capacity (ELC) / Emerging Infections Program (EIP)	\$40.000	N/A	\$40.000
Environmental Public Health Tracking	\$35.000	N/A	\$29.000
Public Health Workforce	\$25.000	N/A	\$25.000
Healthcare-Associated Infections	\$11.750	N/A	\$11.750

¹ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CDC is requesting \$145,950,000 from the Prevention Fund to support select investments to strengthen federal, state, local, tribal, and territorial public health detection and response capacity, our nation's first line of defense against health threats. The Prevention Fund will improve health agencies' capacity to manage scarce resources and continue to detect and respond rapidly to outbreaks, natural disasters, and man-made harms. Investments will improve efficiencies and performance in federal, state, and local public health laboratories; support surveillance and health tracking systems; and fund training that increases state and local public health capacity and develops the next generation of public health leaders. CDC will use Prevention Funds to invest in core programs, such as the Epidemiology and Laboratory Capacity program and the Emerging Infections Program, that bolster state and local capacity to detect and respond to infectious diseases, including those caused by pertussis, influenza, rotovirus, healthcare-

associated infections, and foodborne pathogens. This will increase the percentage of laboratories (commercial and hospital) sharing information via electronic laboratory reporting, allowing for faster detection and analysis of disease-causing agents.

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

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

USING INFORMATION FOR ACTION

(dollars in millions)	FY 2012 Enacted	FY 2013 CR¹	FY 2014 President's Budget
Information for Action	\$55.000	N/A	\$45.000
Healthcare Statistics/ Healthcare Surveillance	\$35.000	N/A	\$30.000
Community Guide	\$10.000	N/A	\$10.000
Prevention Research Centers	\$10.000	N/A	\$0.000
Public Health Research	\$0.000	N/A	\$5.000

¹ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

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

CDC will use Prevention Fund resources to collect and analyze health data and produce accurate and timely information for action on health outcomes, risk factors for poor health, and best practices that improve health. We will conduct systematic reviews of public health interventions to prevent disability, disease, and death, and disseminate the results to the public, clinicians, health officials, and community leaders. Resources from the Prevention Fund will support a number of Community Guide systematic reviews in 2014, leading to increased implementation of evidence-based practices and policies and an increase in the availability of relevant information to assist decision makers and practitioners in prioritizing interventions for implementation. We will continue to make investments in surveys designed and executed by the National Center for Health Statistics and provide local-level data to aid in decision making about clinical and community changes to increase opportunities to prevent disease and injury.

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.

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.

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

HIGHLIGHTS OF AGENCY ACCOMPLISHMENTS

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 2012, approximately 10,000 healthcare facilities, including nearly all U.S. hospitals, participate in NHSN for local quality improvement. The combination of CDC data systems, guidelines, and programs has contributed to significant reductions of HAIs in healthcare settings, including:
 - 32 percent reduction in central line-associated bloodstream infections
 - 18 percent reduction in healthcare-associated invasive *methicillin-resistant Staphylococcus aureus* (MRSA) infections
 - 25 percent decrease in hospital-acquired *Clostridium difficile* infection in participating hospitals in Massachusetts
- CDC's Laboratory Response Network (LRN), which has increased to over 160 laboratories, enables the public health laboratory system to respond to public health threats and emergencies by providing rapid and reliable diagnostic detection capability for numerous threat agents. An estimated 90 percent of the U.S. population (a five percent increase over the last two years) lives within 100 miles of an LRN member laboratory, ensuring broad access to testing during public health emergencies.

- Health departments are receiving laboratory reports faster and at lower cost through the use of electronic laboratory reporting (ELR). As of early 2012, ELR consisted of approximately 49 percent of all laboratory reports received by state health departments. One state tracked the spread and extent of H1N1 with just a one day lag time because of the timeliness of the ELR and the absence of a need to manually enter the lab reports.
- CDC is better able to track and diagnose diseases caused by mosquitos and other vectors using nationwide surveillance systems like CDC's ArboNet. For example, ArboNet equipped CDC to effectively respond to the 2012 West Nile virus outbreak with increased outreach, surveillance and support for state and local health departments.
- CDC's Tobacco Lab improved detection of chemical alterations to cigarettes by tobacco companies by developing a screening method for known carcinogens in cigarette smoke and for chemical groups that enhance delivery of nicotine to smokers. CDC reported relevant data to the Food and Drug Administration as a baseline for regulating tobacco products.
- CDC's Public Health Associate Program is improving today's public health infrastructure at state and local levels, while training tomorrow's public health leaders. CDC has increased trainees from 87 in 2010 to 159 in 2012, enabling greater numbers of associates to serve on the frontlines of public health and provide critical services.
- CDC's National Public Health Improvement Initiative supports state, tribal, local, and territorial public health agencies to improve the efficiency and effectiveness of their public health efforts. For example, New Jersey cut the time for reporting influenza results from 2-3 weeks down to 2-3 days, enabling earlier detection and response to protect the public's health. Virginia created an online system to replace time-consuming procurement processes and identified more than \$1.2 million in annual information technology savings.

Improve health security at home and around the world

- CDC launched the BioSense 2.0 surveillance system, using highly secure Internet "cloud" technology to cut information storage costs – a savings of approximately \$8 million. CDC redirected these savings to state and local jurisdictions to enhance their capacities to monitor emergent disease trends.
- Since FY 2011, CDC implemented Strategic National Stockpile cost savings initiatives, such as
 - discontinuing the Shelf-life Extension Program relabeling and eliminating bifurcated needles from the formulary (projected savings of \$37,000,000 in relabeling and procurement costs in FY 2012);
 - combining three warehouses into one, saving approximately \$1,000,000 per year; reducing \$8,000,000 from the operation support contract over a two-year period; reducing annual travel and personnel requirements by \$791,000;
 - allowing the dedicated aircraft contract to expire (projected savings of \$1,800,000 in FY 2012); and
 - negotiating a \$408,000,000 price reduction for anthrax vaccine replacement over five years.
- CDC developed the most rapid, sensitive and selective method to diagnose anthrax in its early stages and throughout the course of the disease. CDC can now analyze more than 1,000 anthrax samples per day which greatly enhances the agency's response capabilities for one of the world's oldest and most deadly diseases.

- CDC provides city and county data for more than 170 locations through its Selected Metropolitan/Micropolitan Area Risk Trends (SMART) data based on the Behavioral Risk Factor Surveillance System. Localities are using SMART data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs.
- CDC's Field Epidemiology Training Program (FETP) has strengthened health systems in more than 60 countries by graduating more than 2,600 highly trained disease detectives, approximately 80 percent of whom remain in their countries in a leadership role detecting and responding to threats to health. In the last three years, CDC-supported FETPs have responded to 709 outbreaks and strengthened 1,293 surveillance systems, resulting in increased capacity to detect disease and prevent its spread around the world.
- As part of the President's Emergency Plan for AIDS Relief, CDC's Global AIDS Program has contributed to getting 4.5 million people on treatment for HIV and protecting 600,000 babies from HIV who otherwise would have been infected.
- CDC has assisted the President's Malaria Initiative with the distribution of 78 million insecticide-treated mosquito bed nets, 92 million lifesaving antimalarial treatments, and 12 million preventive treatment courses for pregnant women. These efforts have resulted in a 50 percent reduction in all-cause mortality among children age five and younger.
- As a co-founder of the Measles Initiative, CDC has contributed to the vaccination of one billion children worldwide through supplementary immunization activities (SIAs). Of the 10 million deaths prevented through measles vaccination in the past decade, SIAs prevented 4 million deaths.
- CDC released Epi Info™ 7 in 2011, a suite of software tools for essential epidemiologic services such as rapid assessment and control of disease outbreaks, development of public health surveillance and disease monitoring systems, and education of public health professionals. More than 1 million Epi Info™ users are benefiting from this system to detect health threats and help protect the health of residents in 180 countries worldwide.
- CDC has contributed significantly to the more than 99 percent decline in global polio cases. In just the past year, the number of countries reporting polio cases has declined from 15 with 467 cases and eight outbreaks in 2011 to just four countries reporting 171 cases and zero outbreaks in 2012. India, one of the four remaining endemic countries in 2010, achieved a major milestone in January 2012 by going two years with no polio transmission.
- Following Haiti's devastating earthquake in January 2010, CDC helped reestablish and strengthen the country's public health system. In 2012, CDC helped identify and treat more than 5,700 HIV positive pregnant women, bringing the total of HIV positive pregnant women on antiretroviral drug treatment to more than 41,000. CDC also has supported national immunization campaigns for measles, rubella, and polio, which achieved 82 percent overall coverage among Haitian children nine years of age and younger.
- CDC works in more than 60 countries to help vaccinate children against contagious and life-threatening vaccine-preventable diseases. CDC is supporting the first mass vaccination campaigns to eliminate epidemic meningococcal meningitis in sub Saharan Africa, which launched in Burkina Faso in 2010 and in Cameroon, Chad, Mali, Niger, and Nigeria in 2011.

Better prevent the leading causes of illness, injury, disability, and death

- Through screening and clinical preventive service efforts, between 2008 and 2011, CDC's WISEWOMAN program identified thousands of persons with previously undiagnosed high blood pressure (6,422 cases), high cholesterol (5,295 cases), and diabetes (1,945 cases).
- Since 2010, grantees of CDC's Sodium Reduction in Communities program demonstrated reductions in sodium content of meals served in specific locations. For example, one community reduced sodium in senior meal sites by almost 10 percent, and by up to 14 percent of menu items in some restaurants. Another community worked with schools to reduce sodium in school lunches by 20 percent.
- Supported in part through scientific and programmatic youth violence prevention guidance provided by CDC's UNITY program, the City of Minneapolis saw significant reductions in crime and violent incidents involving juveniles (ages 8-24) between 2006-2011, including:
 - 43.7 percent reduction in juvenile arrests for violent crime (violent crime is the same as FBI defined as: homicide, rape, robbery and aggravated assault)
 - 65.7 percent reduction in incidents involving guns and juveniles
 - 39.7 percent reduction in firearm related injuries in Minneapolis youth and young adults
- In FY 2012, CDC Vital Signs greatly expanded dissemination of new data and critical information about the leading causes of death and disability. CDC utilized more than 1.9 million communication channels, including <http://www.cdc.gov/vitalsigns>, social media outlets, and CDC information services, to educate and inform healthcare professionals, policymakers, and the public.
- CDC completed 50 systematic reviews on community preventive services that were used by the Community Preventive Services Task Force to produce findings and recommendations for prevention programs, services, and policies. Task Force findings and recommendations empower decision makers to optimize resources to protect and improve population health; reduce future demand for healthcare spending that is driven by preventable disease and disability; and increase the productivity and competitiveness of the U.S. workforce.
- CDC has expanded its analyses and resources showing the impact of prevention on the U.S. economy and business. Increased dissemination of data, fact sheets, presentations, and scientific publications expand the understanding of prevention's return on investment, reduction of excess healthcare costs, and benefits to productivity. These include savings and return on investment for immunizations, diabetes lifestyle interventions, trans fat elimination, cigarette pack warning labels, as well as excess healthcare costs due to tobacco, diabetes, and obesity.
- More than 50 million people – or one in six Americans – live in communities that are improving nutrition and physical activity and reducing tobacco use and secondhand smoke, thanks to the Communities Putting Prevention to Work (CPPW) initiative. For example: Since March 19, 2010, approximately 9.7 million Americans in 17 communities have greater access to healthier foods sold in vending machines across multiple settings, and approximately 10.8 million Americans in 19 communities live in a neighborhood that provides enhanced support for walking and biking. In addition, through expansion of smoke-free workplaces, restaurants, bars, multi-unit housing complexes, campuses, parks, and beaches, more than 26 million Americans are less likely to be exposed to cancer- and heart disease-causing chemicals in tobacco smoke.

- CDC launched the first-ever national, paid anti-tobacco media campaign, *Tips from Former Smokers*, which generated almost 200,000 additional calls to 1-800-QUIT-NOW and more than 400,000 additional unique visitors to www.smokefree.gov. As a result of the campaign, CDC estimates more than 50,000 smokers will quit smoking, which will save nearly \$70 million in annual medical costs and productivity losses.
- Per capita cigarette consumption among adults in the United States declined from 1,507 to 1,232 between 2008 and 2011, indicating that current smokers are smoking fewer cigarettes.
- Deaths from motor vehicle crashes are near their all-time low, and CDC's research and prevention efforts have helped save lives. For example, CDC data have helped states implement evidence-based programs and policies such as "Parents are the Key" and safer licensing laws for young drivers. Graduated driver licensing laws have contributed to a 36 percent decline in the annual number of 16- and 17-year-old drivers involved in fatal crashes.
- Recommended childhood vaccines through age six currently save 42,000 lives, prevent 20 million cases of disease, and save \$70 billion each year. For example, prior to the introduction of rotavirus vaccine for U.S. infants in 2006, the disease was responsible for 55,000 to 70,000 hospitalizations. In 2009, hospitalizations due to rotavirus had decreased by 55 percent to 28,125.
- The U.S. Olympic Medical Director used CDC's Heads Up training for clinicians to train 2012 Olympic medical staff on the recognition and response to concussions.
- Identified as a CDC priority in 2010, teen pregnancy prevention efforts are working, and the teen birth rate has reached an all-time low. Fewer teens are initiating sex and more sexually active teens are using effective contraceptive methods. CDC released the first-ever U.S. recommendations on medical eligibility for contraceptive use to help physicians and patients make sound decisions about effective contraceptive options.

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 goals, strategy, and progress. Three primary questions frame the QPR process: Are programs focused on the most important health outcomes? How will programs accomplish their goals? How does CDC know that adequate progress is being made?

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 in the FY 2014 budget. 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 research and 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 campaign to combat the childhood obesity epidemic and the President's Task Force on Childhood Obesity, CDC funds school health programs to improve food and beverage options and increase physical activity.

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

CDC is a 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; and
- The Motor Vehicle Injury Tribal Initiative, 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.

Many of these areas of alignment are captured in the HHS Strategic Plan and the inaugural FY 2013 HHS Performance Plan as well as three Agency Priority Goals (APG) in which CDC is a significant partner.

CDC leads 12 measures in the 2010-2015 HHS Strategic Plan and eight measures in the FY 2014 HHS Performance Plan, which include: 1) improving healthcare quality and patient safety; 2) strengthening public health surveillance and epidemiology; 3) enhancing support of the public health infrastructure at the state, tribal, local, and territorial levels; 4) addressing obesity through childhood nutrition, food labeling, and physical fitness; 5) protecting Americans in public health emergencies; 6) increasing impact in global health; 7) preventing and controlling use of tobacco; 8) enhancing food safety; and 9) mitigating and preventing infectious and chronic diseases.

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

ALL PURPOSE TABLE

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ All Purpose Table (APT) (Dollars in Thousands)				
Budget Activity/Description	FY 2012 Enacted ¹ (Comparably Adjusted)	FY 2013 CR ^{1,2} (Comparably Adjusted)	2014	
			President's Budget	President's Budget +/- FY 2012 Enacted
Immunization and Respiratory Diseases	<u>\$814,862</u>	<u>\$628,851</u>	<u>\$754,020</u>	<u>-\$60,842</u>
Immunization and Respiratory Diseases - BA	\$611,998	\$615,908	\$668,696	\$56,698
<i>Immunization and Respiratory Diseases - PHS Eval</i>	<i>\$12,864</i>	<i>\$12,943</i>	<i>\$12,864</i>	<i>\$0</i>
Immunization and Respiratory Diseases - PPHF	\$190,000	N/A	\$72,460	-\$117,540
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	<u>\$1,162,964</u>	<u>\$1,160,108</u>	<u>\$1,176,942</u>	<u>\$13,978</u>
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	\$1,152,964	\$1,160,108	\$1,173,942	\$20,978
<i>HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PHS Eval</i>	<i>\$0</i>	<i>\$0</i>	<i>\$3,000</i>	<i>\$3,000</i>
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PPHF	\$10,000	N/A	\$0	-\$10,000
Emerging and Zoonotic Infectious Diseases	<u>\$362,143</u>	<u>\$312,366</u>	<u>\$432,414</u>	<u>\$70,271</u>
Emerging and Zoonotic Infectious Diseases - BA	\$310,393	\$312,366	\$380,664	\$70,271
Emerging and Zoonotic Infectious Diseases - PPHF	\$51,750	N/A	\$51,750	\$0
Chronic Disease Prevention and Health Promotion	<u>\$1,211,366</u>	<u>\$805,432</u>	<u>\$1,036,093</u>	<u>-\$175,273</u>
Chronic Disease Prevention and Health Promotion - BA	\$800,316	\$805,432	\$620,189	-\$180,127
Chronic Disease Prevention and Health Promotion - PPHF	\$411,050	N/A	\$415,904	\$4,854
Birth Defects, Developmental Disabilities, Disability and Health	<u>\$141,792</u>	<u>\$142,696</u>	<u>\$141,944</u>	<u>\$152</u>
Birth Defects, Developmental Disabilities, Disability and Health – BA ³	\$141,792	\$142,696	\$67,148	-\$74,644
Birth Defects, Developmental Disabilities, Disability and Health-PPHF	\$0	N/A	\$74,796	\$74,796
Environmental Health	<u>\$158,233</u>	<u>\$124,018</u>	<u>\$155,126</u>	<u>-\$3,107</u>
Environmental Health - BA	\$123,233	\$124,018	\$126,126	\$2,893
Environmental Health - PPHF	\$35,000	N/A	\$29,000	-\$6,000
Injury Prevention and Control	<u>\$146,304</u>	<u>\$147,238</u>	<u>\$181,585</u>	<u>\$35,281</u>
Injury Prevention and Control - BA	\$146,304	\$147,238	\$176,585	\$30,281
Injury Prevention and Control - PHS Evaluation Transfer	\$0	\$0	\$5,000	\$5,000
Public Health Scientific Services	<u>\$517,462</u>	<u>\$450,232</u>	<u>\$539,305</u>	<u>\$21,843</u>
Public Health Scientific Services - BA	\$199,693	\$200,946	\$144,416	-\$55,277
<i>Public Health Scientific Services - PHS Evaluation Transfer</i>	<i>\$247,769</i>	<i>\$249,286</i>	<i>\$324,889</i>	<i>\$77,120</i>
Public Health Scientific Services - PPHF	\$70,000	N/A	\$70,000	\$0
Occupational Safety and Health	<u>\$325,281</u>	<u>\$327,327</u>	<u>\$271,911</u>	<u>-\$53,370</u>
Occupational Safety and Health - BA	\$214,557	\$215,925	\$0	-\$214,557
<i>Occupational Safety and Health - PHS Evaluation Transfer</i>	<i>\$110,724</i>	<i>\$111,402</i>	<i>\$271,911</i>	<i>\$161,187</i>
Global Health	<u>\$376,608</u>	<u>\$378,979</u>	<u>\$393,024</u>	<u>\$16,416</u>
Public Health Preparedness and Response	<u>\$1,381,817</u>	<u>\$1,360,463</u>	<u>\$1,334,316</u>	<u>-\$47,501</u>
Public Health Preparedness and Response - BA	\$1,351,817	\$1,360,463	\$1,334,316	-\$17,501
Public Health Preparedness and Response - PHSSEF	\$30,000	\$0	\$0	-\$30,000
Cross-Cutting Activities and Program Support	<u>\$260,495</u>	<u>\$220,822</u>	<u>\$172,603</u>	<u>-\$87,892</u>
Cross-Cutting Activities and Program Support - BA	\$219,295	\$220,822	\$131,403	-\$87,892
Cross-Cutting Activities and Program Support - PPHF	\$41,200	N/A	\$41,200	\$0
Total CDC, BA (adjusted for proposed ACL transfer)	<u>\$5,648,970</u>	<u>\$5,684,901</u>	<u>\$5,216,509</u>	<u>-\$432,461</u>
Total CDC, Budget Authority -	<u>\$5,655,670</u>	<u>\$5,691,644</u>	<u>\$5,216,509</u>	<u>-\$439,161</u>

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ All Purpose Table (APT) (Dollars in Thousands)				
Budget Activity/Description	FY 2012 Enacted ¹ (Comparably Adjusted)	FY 2013 CR ^{1,2} (Comparably Adjusted)	2014	
			President's Budget	President's Budget +/- FY 2012 Enacted
<i>Total CDC, (adjusted for proposed ACL transfer)</i>	\$6,020,327	\$6,058,532	\$5,834,173	-\$186,154
<i>Total CDC, (Budget Authority & PHS Evaluation Transfers) -</i>	\$6,027,027	\$6,065,275	\$5,834,173	-\$192,854
<i>Program Level, (adjusted for proposed ACL transfer)</i>	\$6,859,327	\$6,058,532	\$6,589,283	-\$270,044
<i>Program Level (includes BA, PHS Eval, PHSSEF & PPHF) -</i>	\$6,866,027	\$6,065,275	\$6,589,283	-\$276,744
<i>Agency for Toxic Substances and Disease Registry</i>	\$76,215	\$76,681	\$76,215	\$0
<i>Public Health and Social Services Emergency Fund (Transfer) (non-add)</i>	\$30,000	\$0	\$0	-\$30,000
<i>Affordable Care Act- Prevention and Public Health Fund Transfer (non-add)</i>	\$809,000	N/A	\$755,110	-\$53,890
<i>Vaccines for Children⁴</i>	\$4,005,941	\$3,607,256	\$4,293,383	\$287,442
<i>Energy Employees Occupational Illness Compensation Program Act (EEOICPA)</i>	\$55,358	\$55,358	\$55,358	\$0
<i>World Trade Center (Mandatory)⁵</i>	\$187,560	\$239,230	\$241,000	\$53,440
<i>PHS Evaluation Transfers (non-add)</i>	\$371,357	\$373,631	\$617,664	\$246,307
<i>Other User Fees</i>	\$2,226	\$2,226	\$2,226	\$0
<i>(Total CDC/ATSDR adjusted for proposed ACL transfer)</i>	\$11,186,627	\$10,039,283	\$11,257,465	\$70,838
<i>Total, CDC/ATSDR Program Level -</i>	\$11,193,327	\$10,046,026	\$11,257,465	\$64,138

¹ The FY 2012 and 2013 amounts have been made comparable to FY 2014 to reflect proposed BSS realignment.

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

³ FY 2012 and 2013 Disabilities and Health line has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

⁴ The FY 2012 level reflects an estimated funding level. The FY 2013 level represents the anticipated transfer from Medicaid, and does not include \$0.656 million in prior year recoveries and refunds, for a total program level of \$3,607.256 million. The FY 2014 level represents the anticipated transfer from Medicaid.

⁵ The FY 2012 through FY 2014 amounts reflect the Federal government's estimated obligations.

BUDGET EXHIBITS

APPROPRIATIONS LANGUAGE

CENTERS FOR DISEASE CONTROL AND PREVENTION

Immunization and Respiratory Diseases

For carrying out titles II, III, [VII,] XVII, and XXI, and section 2821 of the PHS Act, titles II and IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act, with respect to immunization and respiratory diseases, \$668,696,000[\$583,855,000]: *Provided*, That in addition to amounts provided herein, \$12,864,000[\$13,765,000] shall be available from amounts available under section 241 of the PHS Act to carry out the National Immunization Surveys.

Note.—A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under the Continuing Appropriations Resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

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

For carrying out titles II, III, [VII,] XVII, and XXIII [, and XXVI] of the PHS Act with respect to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis prevention, \$1,173,942,000[\$1,145,678,000: *Provided*, That Centers for Disease Control and Prevention and State grant recipients may transfer up to ten percent of funds appropriated for Centers for Disease Control and Prevention HIV/AIDS, sexually transmitted disease, hepatitis, and tuberculosis activities to address the overlapping epidemics of these diseases by improving program collaboration and providing integrated services in accordance with priorities identified by the Centers for Disease Control and Prevention: *Provided further*, That with respect to the previous proviso, grantees shall submit a plan in writing to the Centers for Disease Control and Prevention and obtain the approval of the Centers for Disease Control and Prevention to transfer such funds]: *Provided*, That in addition to the amounts provided herein, \$0,000,000 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, [VII,] and XVII, and section 2821 of the PHS Act, titles II and IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act, with respect to emerging and zoonotic infectious diseases, \$380,664,000[\$279,477,000], of which \$1,000,000 shall remain available until expended to pay for the transportation, medical care, treatment, and other related costs of persons quarantined or isolated under federal or state quarantine laws.

Chronic Disease Prevention and Health Promotion

For carrying out titles II, III, [VII,] XI, XV, and XVII [, and XIX] of the PHS Act and [section 4201 of the Patient Protection and Affordable Care Act,] *Public Law 111–148* with respect to chronic disease prevention and health promotion, \$620,189,000[\$608,019,000]: *Provided*, That [, in addition to amounts provided herein, \$25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the Prevention Research Centers:] *Centers for Disease Control and Prevention and State grant recipients may reallocate up to five percent of grant funds received for diabetes, heart disease and stroke, obesity, and school health activities to address cross-cutting chronic disease issues: Provided further*, That with respect to the previous proviso, grantees shall submit a plan in writing to the Centers for Disease Control and Prevention and obtain the approval of the Centers for Disease Control and Prevention to reallocate such funds: *Provided further*, That funds appropriated under this account may be available for making grants under section 1509 of the PHS Act for up to 21 States, tribes, or tribal

organizations: *Provided further, That the Secretary may grant up to ten waivers under section 1503(d) of the PHS Act.*

Birth Defects, Developmental Disabilities, Disabilities and Health

For carrying out titles II, III, [VII,] XI, and XVII of the PHS Act with respect to birth defects, developmental disabilities, disabilities and health, \$67,148,000[\$18,476,000].

Public Health Scientific Services

For carrying out titles II, [and] III, and XVII of the PHS Act and Public Law 111–148 with respect to health statistics, surveillance, health informatics, and workforce development, \$144,416,000[\$35,695,000]: *Provided, That in addition to amounts provided herein, \$324,889,000[\$379,374,000] shall be available from amounts available under section 241 of the PHS Act to carry out Public Health Scientific Services.*

Environmental Health

For carrying out titles II, III, [VII,] and XVII of the PHS Act with respect to environmental health, \$126,126,000[\$103,672,000].

Injury Prevention and Control

For carrying out titles II, III, [VII,] and XVII of the PHS Act with respect to injury prevention and control, \$176,585,000[\$137,754,000]: *Provided, that in addition to the amounts provided herein, \$5,000,000 shall be available from amounts under section 241 of the PHS Act to carry out the evaluation of Rape Prevention and Education programs authorized by the Violence Against Women Act. [Provided, That funds appropriated under this heading may be used to fund evaluation, research, and pilot programs for sexual violence prevention programs.]*

National Institute for Occupational Safety and Health

For carrying out titles II, III, [VII,] and XVII of the PHS Act, sections 101, 102, 103, 201, 202, 203, 301, 501, and 514 of the Federal Mine Safety and Health Act, section 13 of the Mine Improvement and New Emergency Response Act, and sections 20, 21, and 22 of the Occupational Safety and Health Act, with respect to occupational safety and health, \$271,911,000[\$249,364,000] shall be available from amounts available under section 241 of the PHS Act.

Energy Employees Occupational Illness Compensation Program

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

Global Health

For carrying out titles II, III, [VII] and XVII of the PHS Act with respect to global health, \$393,024,000 [\$362,889,000] of which \$131,942,000[\$117,156,000] for international HIV/AIDS shall remain available

through September 30, 2015[2014]: *Provided*, That funds may be used for purchase and insurance of official motor vehicles in foreign countries.

Public Health Preparedness and Response

For carrying out titles II, III, [VII,] and XVII of the PHS Act with respect to public health preparedness and response, and for expenses necessary to support activities related to countering potential biological, nuclear, radiological, and chemical threats to civilian populations, \$1,334,316,000[\$1,228,360,000], of which \$510,278,000[\$439,444,000] shall remain available until expended for the Strategic National Stockpile [under section 319F-2 of the PHS Act].

CDC-Wide Activities and Program Support

For carrying out titles II, III, [VII,] and 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 Act", "Global Health", "Public Health Preparedness and Response", and "Public Health Scientific Services", and for carrying out section 4001 of the Patient Protection and Affordable Care Act, \$131,403,000[\$487,648,000], of which \$14,591,000[\$368,529,000] shall be available until expended for equipment, construction, and renovation of facilities [until September 30, 2014, for business services: *Provided*, That paragraphs (1) through (3) of subsection (b) of section 2821 of the PHS Act shall not apply to funds appropriated under this heading and in all other accounts of the Centers for Disease Control and Prevention (referred to in this title as "CDC")]: *Provided*, That funds appropriated under this heading and in all other accounts of the Centers for Disease Control and Prevention (referred to in this title as "CDC") 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[2014]: *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 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.

Note.—A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under the Continuing Appropriations Resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

APPROPRIATIONS LANGUAGE ANALYSIS

Language Provision	Explanation
<i>Immunization and Respiratory Diseases</i>	
For carrying out titles II, III, [VII,] XVII, and XXI, and section 2821 of the PHS Act	Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.
<i>HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention</i>	
For carrying out titles II, III, [VII,] XVII, and XXIII[, and XXVI] of the PHS Act	Titles VII and XXVI of the PHS Act do not contain authorities for this CDC account.
[\$1,145,678,000: <i>Provided</i> , That Centers for Disease Control and Prevention and State grant recipients may transfer up to ten percent of funds appropriated for Centers for Disease Control and Prevention HIV/AIDS, sexually transmitted disease, hepatitis, and tuberculosis activities to address the overlapping epidemics of these diseases by improving program collaboration and providing integrated services in accordance with priorities identified by the Centers for Disease Control and Prevention: <i>Provided further</i> , That with respect to the previous proviso, grantees shall submit a plan in writing to the Centers for Disease Control and Prevention and obtain the approval of the Centers for Disease Control and Prevention to transfer such funds]	CDC is not requesting this language in FY 2014.
<i>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.</i>	Language added to reflect the transfer of PHS Evaluation funds (PHS Act 241) to support HIV school health.
<i>Emerging and Zoonotic Infectious Diseases</i>	
For carrying out titles II, III, [VII,] and XVII, and section 2821 of the PHS Act	Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.
<i>Chronic Disease Prevention and Health Promotion</i>	
For carrying out titles II, III, [VII,] XI, XV, and XVII[, and XIX] of the PHS Act and [section 4201 of the Patient Protection and Affordable Care Act,] <i>Public Law 111-148</i>	Titles VII and XIX of the PHS Act do not contain authorities for this CDC account.

Language Provision	Explanation
[That, in addition to amounts provided herein, \$25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the Prevention Research Centers:]	Language removed to reflect that CDC is not requesting in FY 2014 the transfer of PHS Evaluation funds (PHS Act 241) to support Prevention Research Centers.
<i>That Centers for Disease Control and Prevention and State grant recipients may reallocate up to five percent of grant funds received for diabetes, heart disease and stroke, obesity, and school health activities to address cross-cutting chronic disease issues: Provided further, That with respect to the previous proviso, grantees shall submit a plan in writing to the Centers for Disease Control and Prevention and obtain the approval of the Centers for Disease Control and Prevention to reallocate such funds:</i>	CDC requests authority to allow CDC and grant recipients to reallocate up to five percent of grant funds across the selected chronic disease prevention and health promotion activities to enhance coordination and strengthen collaborative work across activities. Because chronic diseases and their risk factors share many social, environmental, behavioral, and biological determinants and are often managed by the same or similar organizations, health promotion and prevention efforts require significant collaboration. This collaborative orientation allows grantees the flexibility needed to maximize resources and structure programs in a more comprehensive manner.
<i>Provided further, That the Secretary may grant up to ten waivers under section 1503(d) of the PHS Act.</i>	Currently, the National Breast and Cervical Cancer Early Detection Program authorization requires that States spend at least 60 percent of funds on direct services, but provides waiver authority for no more than five States. CDC requests increasing the cap on the number of waivers that the Secretary may grant so that additional States may tailor activities to meet the needs of their specific populations as the Affordable Care Act is implemented over time.
<i>Birth Defects, Developmental Disabilities, Disabilities and Health</i>	
For carrying out titles II, III, [VII,] XI, and XVII of the PHS Act	Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.
<i>Public Health Scientific Services</i>	
For carrying out titles II, [and] III and XVII of the PHS Act and Public Law 111-148	This account carries out Title XVII of the PHS Act and sections of P.L. 111-148.
<i>Environmental Health</i>	
For carrying out titles II, III, [VII,] and XVII of the PHS Act	Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.

Language Provision		Explanation	
<i>Injury Prevention and Control</i>			
For carrying out titles II, III, [VII,] and XVII of the PHS Act		Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.	
<i>Provided, That in addition to the amounts provided herein, \$5,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out the evaluation of Rape Prevention and Education programs authorized by the Violence Against Women Act.</i>		Language added to reflect the transfer of PHS Evaluation funds (PHS Act 241) to support the evaluation of the Rape Prevention and Education program.	
[<i>Provided, That funds appropriated under this heading may be used to fund evaluation, research, and pilot programs for sexual violence prevention programs.</i>]		This language is no longer needed with the addition of the prior language “to carry out the evaluation of Rape Prevention and Education programs.”	
<i>National Institute for Occupational Safety and Health</i>			
For carrying out titles II, III, [VII,] and XVII of the PHS Act		Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.	
<i>Global Health</i>			
For carrying out titles II, III, [VII] and XVII of the PHS Act		Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.	
<i>Public Health Preparedness and Response</i>			
For carrying out titles II, III, [VII,] and XVII of the PHS Act		Title VII (Health Professions Education) of the PHS Act does not contain authorities for this CDC account.	

Language Provision	Explanation
shall remain available until expended for the Strategic National Stockpile [under section 319F-2 of the PHS Act].	To help accomplish the Strategic National Stockpile's mission of providing the right resources at the right time to secure the nation's health, CDC intends to provide direct funding support to partner organizations by means of grants and cooperative agreements. However, Section 319F-2 does not clearly authorize the use of grants or cooperative agreements. By removing the reference to 319F-2 in the emergency preparedness and response appropriation account, CDC would be allowed to expend Strategic National Stockpile funds in accordance with the other listed PHS Act authorities, which do authorize grants and cooperative agreements.
<i>CDC-Wide Activities and Program Support</i>	
For carrying out titles II, III, [VII,] and XVII [and XIX], and section 2821 of the PHS Act	Titles VII and XIX of the PHS Act do not contain authorities for this CDC account.
of which \$14,591,000[\$368,529,000] shall be available until expended for equipment, construction, and renovation of facilities	CDC requests this funding for buildings and facilities. No-year funding optimizes facility repair and improvement planning efforts, and helps allow CDC to plan for long-term building and facilities capital projects.
[until September 30, 2014, for business services...]	CDC's Working Capital Fund will be in place by FY 2014, so there is no need to include separate language appropriating two-year funding for business services.
[... <i>Provided</i> , That paragraphs (1) through (3) of subsection (b) of section 2821 of the PHS Act shall not apply to funds appropriated under this heading and in all other accounts of the Centers for Disease Control and Prevention (referred to in this title as "CDC")]	The referenced subsections of section 2821 of the PHS Act refer to an authorization of appropriations which expires in FY 2013, so there is no need to include this language in FY 2014.
<i>Provided further</i> , 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	CDC requests this clarification to ensure that Individual Learning Accounts be made available across all CDC accounts.

AMOUNTS AVAILABLE FOR OBLIGATION

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DISEASE, CONTROL, RESEARCH AND TRAINING AMOUNTS AVAILABLE FOR OBLIGATION^{1, 2}			
	FY 2012 Enacted³	FY 2013 CR⁴	FY 2014 President's Budget³
Discretionary Appropriation:			
Annual ¹	\$5,657,023,000	\$5,684,901,000	\$5,216,509,000
HHS Secretary's Transfer	-\$1,353,000	-\$6,700,000	\$0
Subtotal, adjusted Appropriation	\$5,655,670,000	\$5,678,201,000	\$5,216,509,000
Mandatory and Other Appropriations:			
Transfers from Other Accounts ³	\$809,000,000	N/A	\$755,110,000
Receipts from CRADA	\$2,100,000	\$2,000,000	\$2,000,000
Receipts from Royalties	\$0	\$0	\$0
Appropriation (EEOICPA)	\$55,358,000	\$55,358,000	\$55,358,000
Subtotal, adjusted Mandatory and Other Appropriations	\$866,458,000	\$57,358,000	\$812,468,000
Recovery of prior year Obligations	\$0	\$0	\$0
Unobligated balance start of year	-\$193,193,284	-\$193,193,284	-\$193,193,284
Unobligated balance expiring	\$0	\$0	\$0
Unobligated balance end of year	\$193,193,284	\$193,193,284	\$193,193,284
Total Obligations	\$ 6,522,128,000	\$ 5,735,559,000	\$ 6,028,977,000

¹ Excludes Vaccine for Children.

² Excludes the following amounts for reimbursements: FY 2012 \$765,559,000; FY 2013 \$948,086,000 and FY 2014 \$948,086,000

³ Includes Health Reform

⁴ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

SUMMARY OF CHANGES

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF CHANGES (DOLLARS IN THOUSANDS)				
	Dollars		FTEs	
FY 2014 President's Budget (Program Level)	\$6,589,283		10,823	
FY 2012 Enacted (Program Level)	\$6,859,327		10,877	
Net Change	-\$270,044		-54	
	FTEs	FY 2012 Approp.	FTEs	Change from Base*
Increases:				
HIV/AIDS, Viral Hepatitis, STD, & TB Prevention				
Domestic HIV/AIDS Prevention and Research	---	\$822,633	---	\$13,491
Emerging and Zoonotic Infectious Diseases				
Food Safety	---	\$32,618	---	\$16,605
National Healthcare Safety Network	---	\$19,071	---	\$12,491
Advanced Molecular Detection	---	\$0	---	\$40,000
Chronic Disease Prevention, Health Promotion, & Genomics				
Tobacco Prevention and Control	---	\$198,523	---	\$13,837
Million Hearts™	---	\$0	---	\$5,000
Environmental Health				
Healthy Homes/Childhood Lead Poisoning	---	\$2,520	---	\$2,468
Injury Prevention and Control				
Rape Prevention	---	\$41,709	---	\$5,020
Gun Violence Prevention Research	---	\$3,027	---	\$10,000
NVDRS	---	\$3,570	---	\$20,000
Public Health Scientific Services				
Health Statistics	---	\$179,441	---	\$22,413
Global Health				
Polio Eradication	---	\$115,904	---	\$15,149
Cross-Cutting Activities and Program Support				
Public Health Leadership and Support	---	\$114,804	---	\$2,008
Pay Raise				
Pay Raise for All Other Lines (non-add)	---	---	---	\$6,929
Total Increases	N/A	\$1,533,820	N/A	\$185,411
Decreases:				
Immunization & Respiratory Diseases				
Section 317 Immunization Program/Program Implementation and Accountability	---	\$642,215	---	-\$60,842
Chronic Disease Prevention, Health Promotion, & Genomics				
Cancer Prevention and Control	---	\$371,544	---	-\$41,884
Racial and Ethnic Approaches to Community Health (REACH)	---	\$53,940	---	-\$53,940
Community Transformation Grants	---	\$226,000	---	-\$79,660
Prevention Research Centers	---	\$28,912	---	-\$3,871
Workplace Wellness	---	\$10,000	---	-\$10,000
Hospitals Promoting Breastfeeding	---	\$7,050	---	-\$4,550
Environmental Health				
Environmental and Health Outcome Tracking Network	---	\$35,000	---	-\$6,000
Occupational Safety & Health				
NORA - Ag. Sector	---	\$124,346	---	-\$25,681
Education and Research Centers	---	\$28,775	---	-\$28,775

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF CHANGES (Cont.) (DOLLARS IN THOUSANDS)				
	FTEs	FY 2012 Approp.	FTEs	Change from Base*
Public Health Preparedness & Response				
State and Local Preparedness and Response Capability	---	\$666,245	---	-\$8,219
Strategic National Stockpile	---	\$548,468	---	-\$38,190
Cross-Cutting Activities and Program Support	---		---	
Preventive Health and Health Services Block Grants	---	\$79,545	---	-\$79,545
Building and Facilities	---	\$24,946	---	-\$10,355
All Other Decreases	---		---	
All Other Decreases	---		---	-\$3,943
Total Decreases	N/A	\$2,846,986	N/A	-\$455,455
Transfers				
Birth Defects, Developmental Disabilities, Disability and Health				
Paralysis Resource Center	---	\$6,700	---	-\$6,700
Built-In:				
1. Annualization of Jan - 2013 Pay Raise	---	---	---	\$1,228
2. FY 2014 Pay Increases	---	---	---	\$0
3. Changes in Day of Pay	---	---	---	\$4,857
4. Rental Payments to GSA and Others	---	---	---	\$168
Total Built-In	10,877	\$6,862,027	-54	\$6,253
1. Absorption of Current Services	---	---	---	-\$6,253
Total	---	---	---	-\$6,253
Total Increases (Program Level)	N/A	\$1,533,820	0	\$185,411
Total Decreases (Program Level)	N/A	\$2,846,986	-54	-\$455,455
NET CHANGE - L/HHS/ED Program Level	10,877	\$6,866,027	-54	-\$270,044
Other Program Level Changes				
1. Vaccines for Children	---	\$4,005,941	---	\$287,442
2. World Trade Center Health Program	---	\$187,560	---	\$53,440
Total - Program Level Net Increase	10,877	\$4,005,941	-54	\$340,882
NET CHANGE: BUDGET AUTHORITY & PROGRAM LEVEL	10,877	\$10,867,968	-54	\$70,838

* Program increases and decreases are displayed without proposed pay raise . The overall proposed pay raise amount for CDC is displayed separately under the Pay raise line.

BUDGET AUTHORITY BY ACTIVITY

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 BUDGET AUTHORITY BY ACTIVITY (Dollars in Thousands)				
Budget Activity/Description	FY 2012 Enacted ¹ (Comparably Adjusted)	FY 2013 CR ¹ (Comparably Adjusted)	2014	
			President's Budget	President's Budget +/- FY 2012 Enacted
Immunization and Respiratory Diseases - BA	\$611,998	\$615,908	\$668,696	\$56,698
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	\$1,152,964	\$1,160,108	\$1,173,942	\$20,978
Emerging and Zoonotic Infectious Diseases - BA	\$310,393	\$312,366	\$380,664	\$70,271
Chronic Disease Prevention and Health Promotion - BA	\$800,316	\$805,432	\$620,189	-\$180,127
Birth Defects, Developmental Disabilities, Disability and Health-BA ²	\$141,792	\$142,696	\$67,148	-\$74,644
Environmental Health - BA	\$123,233	\$124,018	\$126,126	\$2,893
Environmental Health - PPHF	\$35,000	N/A	\$29,000	-\$6,000
Injury Prevention and Control - BA	\$146,304	\$147,238	\$176,585	\$30,281
Public Health Scientific Services - BA	\$199,693	\$200,946	\$144,416	-\$55,277
Occupational Safety and Health - BA	\$214,557	\$215,925	\$0	-\$214,557
Global Health	\$376,608	\$378,979	\$393,024	\$16,416
Public Health Preparedness and Response - BA	\$1,351,817	\$1,360,463	\$1,334,316	-\$17,501
Cross-Cutting Activities and Program Support - BA	\$219,295	\$220,822	\$131,403	-\$87,892
Total CDC, Budget Authority³ -	\$5,648,970	\$5,684,901	\$5,216,509	-\$432,461

¹ The FY 2012 and 2013 amounts have been made comparable to FY 2014 to reflect proposed BSS realignment.

² FY 2012 and 2013 Disabilities and Health line has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

AUTHORIZING LEGISLATION

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2014 Amount Authorized	FY 2014 Presidents Budget
Immunization and Respiratory Diseases	Indefinite	\$814.862	Indefinite	\$754.020
PHSA Title II §§ 301, 307, 310, 311, 317, 317N, 317S, 319, 319C, 319E, 319F, 322, 325, 327, 340C, 352, 2102(a)(6), Title XVII*, 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)				
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	Indefinite	\$1,162.964	Indefinite	\$1,176.942
PHSA Title II §§ 301, 306*, 307, 308(d), 310, 311, 317, 317E*, 317N*, 317P, 318*, 318B*, 322, 325, 327, 352, Title XVII*, 2315, 2320, 2341 Title II of P.L. 103-333 Section 212 of the Consolidated Appropriations Act, 2012 (P.L. 112-74, Division F)				
Emerging Zoonotic Infectious Diseases	Indefinite	\$362.143	Indefinite	\$432.414
PHSA Title II §§ 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)				
Chronic Disease Prevention, Health Promotion	Indefinite	\$1,211.366	Indefinite	\$1,036.093
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) The Patient Protection and Affordable Care Act of 2010, § 4201* (P.L. 111-148) Comprehensive Smoking Education Act of 1984, P.L. 98-474 (15 U.S.C. 1335(a) and 15 U.S.C. 1341) Comprehensive Smokeless Tobacco Health Education Act of 1986 (P.L. 99-252)				
Birth Defects, Developmental Disabilities, Disabilities & Health	Indefinite	\$141.792	Indefinite	\$141.944
PHSA Title II §§ 301, 304, 307, 308(d), 310, 311, 317, 317C*, 317J*, 317K*, 317L*, 317Q, 327, 352, , 399M, 399Q*, 399S, 399T, 399AA, 399BB, 399CC, 1102, 1110, 1112, 1114, Title				

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2014 Amount Authorized	FY 2014 Presidents Budget
XI, Title XVII*; The Prematurity Research Expansion And Education For Mothers Who Deliver Infants Early Act §§ 3,5 (42 U.S.C. 247b-4f* and 42 U.S.C. 247b-4g).				
Environmental Health	Indefinite	\$158.233	Indefinite	\$155.126
PHSA Title II §§ 301, 307, 310, 311, 317, 317A*, 317B*, 317I*, 327, 352, 361, 366, 1102, Title XVII*				
The Toxic Substances Control Act, § 405(c) (15 U.S.C. 2685)				
Injury Prevention and Control	Indefinite	\$146.304	Indefinite	\$181.585
PHSA Title II §§ 214, 215, 301, 304, 307, 308(d), 310, 311, 317, 319, 319D*, 327, 352, 391*, 392*, 393*, 393A*, 393B*, 393C*, 393D*, 394*, 394A*, , 399P*, 1102, Title XVII*				
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)*				
Public Health Scientific Services	Indefinite	\$517.462	Indefinite	\$539.305
PHSA Title II §§ 241, 301, 304, 306, 307, 308(d), 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)				
Occupational Safety and Health	Indefinite	\$325.281	Indefinite	\$271.911
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 PL 107-188 and 109-236 (29 U.S.C. 669–671)				
Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164 and P.L. 109-236 (30 U.S.C. 811–813, 842, 843–846, 861, 951–952, 957, 962, 963, 964)				
Black Lung Benefits Reform Act of 1977 § 19, P.L. 95-239 (30 U.S.C. 902)				
Bureau of Mine Act, as amended by P.L. 104-208 (30 U.S.C. 1 note, 3, 5)				
Radiation Exposure Compensation Act, §§ 6 and 12 (42 U.S.C.				

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2014 Amount Authorized	FY 2014 Presidents Budget
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 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	Indefinite	\$376.608	Indefinite	\$393.024
PHSA Title II §§ 301, 304, 307, 310, 319*, 327, 340C, 361–369*, Title XVII*, 2315, 2341 Foreign Assistance Act of 1961 §§ 104, 627, 628 Federal Employee International Organization Service Act § 3 (5 USC 3343) International Health Research Act of 1960 § 5 Agriculture Trade Development and Assistance Act of 1954 § 104 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 (P.L.110-293) Section 212 of the Consolidated Appropriations Act, 2012 (P.L. 112-74, Division F)				
Public Health Preparedness and Response	Indefinite	\$1,381.817	Indefinite	\$1,334.316
PHSA Title II §§ 301, 307, 310, 311, 317, 319, 319C-1*, 319D*, 319F*, 319F-2*, 319G*, 351A*, 352, 361, Title XVII* 2801, 2812*				
CDC-Wide Activities and Program Support	Indefinite	\$260.495	Indefinite	\$172.603
PHSA Title II §§ 301, 304, 306*, 307, 308, 310, 311, 317, 317F*, 319, 319A, 319D*, 322, 325, 327, 352, 361–369, 391*, 1102, Title XVII*, 2821*				

*Expired/Expiring authorization of appropriations noted with *

APPROPRIATIONS HISTORY TABLE

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION¹ APPROPRIATION HISTORY TABLE DISEASE CONTROL, RESEARCH, AND TRAINING				
Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2005 ^{2,3}	4,213,553,000	4,228,778,000	4,538,592,000	4,533,911,000
2005 Labor/HHS Reduction	--	--	--	-1,944,000
2005 Rescission	--	--	--	-36,256,000
2005 Supplemental ³	--	--	--	15,000,000
2006 ^{2,4}	3,910,963,000	5,945,991,000	6,064,115,000	5,884,934,000
2006 Rescission	--	--	--	-58,848,000
2006 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	825,000,000
2013	4,991,523,000	--	5,713,698,000	--
2013 Public Health Prevention Fund	903,210,000	--	858,000,000	N/A
2014	5,216,509,000			
2014 Public Health Prevention Fund	755,110,000			

¹ Does not include funding for ATSDR, PHS evaluation transfers, user fees, and PHSSEF transfers.

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. Therefore, CDC did not request Prevention and Public Health (PPH) funds from Congress, but from HHS. The amounts here reflect CDC's request and final amount allotted from the PPH Fund to CDC from HHS.

APPROPRIATIONS NOT AUTHORIZED BY LAW

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

NARRATIVES BY ACTIVITY

IMMUNIZATION AND RESPIRATORY DISEASES

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$611.998	\$615.908	\$668.696	+\$56.698
PHS Evaluation Transfer	\$12.864	\$12.943	\$12.864	\$0.000
ACA/PPHF	\$190.000	N/A	\$72.460	-\$117.540
Total	\$814.862	\$628.851	\$754.020	-\$60.842
FTEs	673	669	669	-4

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: 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)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$754,020,000 for immunization and respiratory diseases, including \$72,460,000 from the Affordable Care Act Prevention and Public Health Fund and \$12,864,000 in PHS Evaluation funding, is a decrease of \$60,842,000 below the FY 2012 level because of increased coverage through healthcare expansion.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Section 317 Immunization	\$379.310	\$381.737	\$391.549	+\$12.239
Program Implementation and Accountability	\$72.905	\$73.365	\$116.950	+\$44.045
PHS Evaluation Transfer (non-add)	\$12.864	\$12.943	\$12.864	\$0.000
Influenza Planning and Response	\$172.647	\$173.749	\$173.061	+\$0.414
ACA/PPHF	\$190.000	N/A	\$72.460	-\$117.540
Total	\$814.862	\$628.851	\$754.020	-\$60.842

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CDC focuses on the prevention of disease, disability, and death of children, adolescents, and adults through immunization and by control of respiratory and related diseases. These activities contribute to CDC's goal of protecting Americans from infectious diseases. CDC administers the two primary federal programs that support immunization for underinsured and uninsured populations in the United States—the discretionary Section 317 Immunization Program and the mandatory Vaccines for Children (VFC) Program. Through these two programs, CDC improves access to immunization services for vulnerable populations 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.

FUNDING HISTORY

Section 317 Immunization¹	
Fiscal Year	Dollars (in millions)
2004	\$468.789
2005	\$493.032
2006	\$517.199
2007	\$512.804
2008	\$527.359
2009	\$557.359
2009 (ARRA)	\$300.000
2010	\$561.459
2011	\$488.576
2011 (ACA/PPHF)	\$100.000
2012	\$452.215
2012 (ACA/PPHF)	\$190.000
2013	\$455.102
2013 (ACA/PPHF) ³	N/A

Immunization and Respiratory Diseases¹	
Fiscal Year	Dollars (in millions)
2009 ²	\$716.048
2010	\$721.180
2011	\$648.257
2011 (ACA/PPHF)	\$100.000
2012	\$624.862
2012 (ACA/PPHF)	\$190.000
2013	\$628.851
2013 (ACA/PPHF) ³	N/A

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates.

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

³The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The table below reflects the sources of VFC funding and estimates of total VFC obligations. The FY 2014 estimate is a net increase of \$287,442,000 above the FY 2012 estimate. The FY 2014 estimate includes an increase for vaccine purchase which is based on price and forecast changes for vaccines.

VFC	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate
Unobligated Balances Brought Forward/Recoveries	\$3M ²	\$0.656M ²	N/A
Non-expenditure Transfer from CMS	\$4,006M	\$3,607M	\$4,293M
Total VFC Obligations ¹	\$4,009M	\$3,607M	\$4,293M

¹In FY 2012, total VFC actual obligations of \$4,000,453,162 did not equal total available resources. The FY 2014 estimate is an increase of \$287,442,000 above the FY 2012 estimate, exclusive of unobligated balances brought forward.

²Unobligated balances from 2011 and 2012 fund segments, which represented indefinite budgetary resource authority, were returned to the Centers for Medicare & Medicaid Services (CMS). Amount reflects prior year recoveries and refunds.

SECTION 317 IMMUNIZATION PROGRAM AND PROGRAM IMPLEMENTATION AND ACCOUNTABILITY BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$439.351	\$442.159	\$495.635	+\$56.284
PHS Evaluation Transfer	\$12.864	\$12.943	\$12.864	\$0.000
ACA/PPHF	\$190.000	N/A	\$72.460	-\$117.540
Total	\$642.215	\$455.102	\$580.959	-\$61.256

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: CDC's national immunization recommendations currently provide guidance for the prevention of 17 vaccine-preventable diseases (VPDs) across the lifespan. In the United States, most VPDs are at or near record lows, with a majority showing a 90 percent or greater decline in reported cases when compared with the pre-vaccine era.

Section 317 of the Public Health Service Act authorizes the implementation of immunization programs for children, adolescents, and adults. Enacted in 1962, the Section 317 Program plays a fundamental role in the achievement of national immunization goals. The Section 317 Immunization Program aims to achieve and sustain high vaccination coverage rates to prevent death and disability from VPDs. CDC provides direct assistance to implement the Section 317 Program through cooperative agreements to 64 awardees, including all 50 states, the District of Columbia, five large cities, five territories, and three Pacific Freely Associated States. CDC provides the 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, and program implementation.

The Section 317 Program provides the majority of federal support for essential public health functions 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 and low incidence of VPDs. Furthermore, the infrastructure aids in maintaining public health preparedness for a response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. Regardless of whether a vaccine is purchased with public or private funds, the highly trained public health workforce and the investments in VPD surveillance systems, as well as the vaccine effectiveness studies, vaccine safety systems, and coverage assessments provide for a safe and effective national immunization system.

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. A key strength of the Section 317 Program is its flexibility—allowing states to use their Section 317-purchased vaccine to meet their unique needs and priorities. This flexibility is also critical in responding to VPD outbreaks, such as the 2012 pertussis outbreaks. For example, Section 317 vaccine was a critical resource for the public health response to the 2012 pertussis outbreak in Washington State. Pertussis, or whooping cough, can transmit from unvaccinated adolescents and adults to infants too young to be vaccinated. Washington State was able to divert some of its Section 317 vaccine to targeted vaccination of pregnant women and adult caregivers of young infants—an important strategy to protect vulnerable infants from serious complications, and in some cases, death from a VPD.

Health reforms of the Affordable Care Act (ACA) will improve access to immunization services by requiring new private health plans and most public insurance to cover routinely recommended vaccines without co-payment. As a result, more Americans will have coverage for the costs of the vaccine itself and the clinical administration of the vaccine. However, these health insurance reforms do not address the

public health functions that must be in place to ensure safe and effective national immunization policies and programs. As more Americans have access to immunization services through public and private health insurance, the essential public health workforce and systems provided by the Section 317 Immunization infrastructure grants are just as critical in FY 2014 and beyond as they were before the health insurance reforms.

Budget Proposal: CDC's FY 2014 request of \$580,959,000 for the Section 317 Immunization Program and immunization program implementation and accountability, including \$72,460,000 from the Affordable Care Act Prevention and Public Health Fund and \$12,864,000 in PHS Evaluation funding, is a decrease of \$61,256,000 below the FY 2012 level. This request includes \$25,000,000 to expand the capacity of public health departments to bill health insurers for immunization services.

For FY 2014, 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; and
- Make strategic investments to enhance the immunization infrastructure and evidence base and improve efficiency.

Since September 2010, new health plans are required to cover Advisory Committee on Immunization Practices (ACIP) recommended vaccines without charging a deductible, copayment, or coinsurance when the vaccines are administered by an in-network provider. In FY 2014, expansion of immunization coverage through health reform will further decrease the number of uninsured and underinsured individuals served by the 317 Program. However, in FY 2014, the Section 317 Immunization Program will continue to be responsible for providing federally purchased vaccines to protect uninsured and underinsured Americans from preventable diseases and thus protecting communities from the dangers of low vaccination rates. CDC estimates that although it is expected that 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. This includes responding to VPD outbreaks such as the 2012 pertussis outbreaks, where vaccination of parents and other adult caregivers of infants was an important public health strategy in controlling these outbreaks; failure to vaccinate these adults because of health insurance status would have caused unacceptable delays in protecting vulnerable infants. Other recent public health urgent needs include responding to the 2012-2013 pediatric influenza vaccine supply issues, where it became necessary to use Section 317 vaccine to vaccinate some privately insured children because their pediatricians did not have an adequate supply of privately-purchased pediatric flu vaccines.

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. Consistent with CDC's new vaccine policy issued in 2012, awardees can no longer use 317-purchased vaccine to provide routine vaccination for fully insured individuals. In alignment with the vaccine use policy and to assure that public funds are not subsidizing insured benefits, the FY 2014 budget request revises the 317 vaccine allocation formula by allocating vaccine direct assistance based on the estimated number of uninsured adults within each awardee's jurisdiction. This budget request also addresses immunization program priorities to provide Section 317

vaccine for response to urgent vaccine needs, which will be allocated to awardees for responding to VPD outbreaks and other urgent public health needs as required.

- CDC determines the total amount of vaccine direct assistance to be allocated based on immunization program priorities. It is essential that CDC maintain core public health infrastructure and this is taken into consideration when determining the amount of Section 317 vaccine purchase.
 - In order to address immunization program priorities, in FY 2014 CDC allocates approximately 60 percent of the Section 317 Immunization resources towards sustaining critical immunization infrastructure, and approximately 40 percent for vaccine direct assistance.
 - Of the vaccine direct assistance, CDC will allocate approximately \$18.6 million for outbreak response and other urgent needs.
 - Beginning in FY 2014, the remaining vaccine direct assistance will be allocated to the 64 Section 317 Immunization Programs based on the percentage of uninsured adults, ages 19 to 64 years in their jurisdictions. The final allocation to awardees was then adjusted as necessary to minimize large fluctuations. This will support an orderly transition to the new vaccine allocation formula and limit disruption to the Section 317 Immunization Program.
- For 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 through 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.

In FY 2014, 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. Maintaining this public health infrastructure is an immunization program priority. Behind every vaccine given to a child, adolescent, or adult in the United States are the public health experts and systems that:

- Conduct the science that provides the evidence-base for national immunization policy, including burden of disease, vaccine effectiveness and safety, economic analyses, and program feasibility. CDC's vaccine effectiveness research provided critical scientific evidence of waning immunity that informed the ACIP's new recommendation for a booster dose of meningococcal conjugate vaccine at age 16 to assure protection through the high-risk college years.
- Collect, analyze, and report 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.
- Monitor immunization coverage rates to identify and reach populations at greater risk for VPDs. The National Immunization Survey (NIS) is essential to document programmatic achievements and to identify disparities in immunization coverage rates. The NIS documented increases in adolescent vaccination rates from 2009 to 2010 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.
- Communicate the benefits of vaccine to the public—through science-based communications campaigns and tools—to aid them in making informed vaccine decisions to protect themselves and their loved ones.

- 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 for conversations with parents about vaccination. These resources include evidence-based strategies, print materials, and web-based tools.
- 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.
- Respond to disease outbreaks by rapidly identifying and investigating cases, conducting surveillance and laboratory testing, and implementing targeted vaccination efforts and other measures to control the spread of disease and prevent future outbreaks.
- Manage vaccine supply disruptions and shortages to ensure the best public health outcomes until restoration of vaccine supply.

In FY 2014, 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.

In FY 2014, CDC will use Section 317 funds to support intramural and extramural immunization activities to promote access to high quality vaccination, and respond to urgent public health needs. CDC will invest in VPD surveillance, laboratory capacity, outbreak response, and scientific studies to evaluate vaccine effectiveness and program impact to strengthen the scientific evidence-base for immunization policy and practice decisions. CDC will also ensure a safe national immunization program through the implementation of CDC's vaccine safety priority studies by strengthening vaccine safety surveillance for rare vaccine adverse events; improving adverse-event reporting through electronic reporting; and developing vaccine safety profiles for each newly licensed vaccine in collaboration with other federal agencies. In FY 2014, CDC will increase national public awareness and provider knowledge about VPDs and immunization recommendations, using an array of media and culturally appropriate tools and resources to support informed decision-making about vaccination.

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 percent of 56 awardees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions. In FY 2014, 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.

Since 2009, CDC has 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. The purpose of billing is to expand access to fully insured individuals in areas where there is not adequate in-network provider coverage. Implementation grantees funded in 2011 and 2012 are working on developing contracts with payers and conducting

assessments and training to local health departments. In FY 2014, CDC will continue to support its awardees in this area. As of FY 2013, 35 awardees are developing and/or implementing billing systems in targeted areas of their jurisdictions. However, while expanded billing capacity in public health clinics 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.

Section 317 Immunization Budget Authority Summary Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Immunization Infrastructure Grants ²	\$223.418	\$221.759	\$235.211
Vaccine Purchase ²	\$74.793	\$76.700	\$72.540
Extramural Program Operations ²	\$42.599	\$44.436	\$44.070
Intramural Program Operations	\$27.060	\$27.332	\$28.120
Total	\$367.870	\$370.227	\$379.941

¹The FY 2012 and FY 2013 amounts have not been made comparable for the BSS realignment and FY 2014 does not include the BSS amount.

² See 317 Immunization Grant Table for more information.

In FY 2014, Section 317 funds will be used to advance public health immunization priorities through the following activities:

- Immunization infrastructure funding 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 vaccine-preventable disease outbreaks.
- Vaccine purchase direct assistance will be allocated 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 funds 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.
- Intramural program operations support 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.

Grant Table:

Section 317 Immunization Grant Table^{1,2}

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	64	64	64
Average Award	\$7.745	\$5.484	\$6.141
Range of Awards	\$0.417–\$55.710	\$0.362–\$38.817	\$0.506–\$45.817
Number of New Awards	0	0	0
Number of Continuing Awards	64	64	64
Total Grant Award	\$557.870	\$370.227	\$452.401

¹This table includes Section 317 budget authority and Prevention and Public Health Funds, except for FY 2013. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

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

In FY 2014, CDC will provide infrastructure funding to 64 awardees through a non-competitive, formula-based, discretionary cooperative agreement program that provides financial assistance for state and local immunization operations. Through these population-based awards and this collaboration, the Section 317 Program has established a comprehensive immunization system that provides 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, and management of vaccine shortages. In addition, CDC will provide its 64 awardees with direct assistance for vaccine purchased from the federal contracts. This vaccine direct assistance will be allocated using the new formula described in the budget proposal section above.

INFLUENZA PLANNING AND RESPONSE BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$172.647	\$173.749	\$173.061	+\$0.414

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program 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. Seasonal influenza remains a formidable public health challenge due to the substantial health and economic burden throughout the world. Influenza seasons are unpredictable in timing and severity. From 1976 to 2006, annual estimates of influenza-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people. A study published in 2007 estimated that seasonal influenza contributed an estimated \$10.4 billion annually in direct medical costs in the United States.¹

In 2011, CDC assessed the response to the 2009 H1N1 influenza pandemic and identified priorities to ensure the agency, state and local health departments, and the public are better prepared for subsequent influenza pandemics. The key drivers of the strategy are Prevention, Detection and Monitoring, and Response.

Prevention of seasonal influenza requires an annual reassessment of the virus strains contained in the vaccine; the assessment is based on data collected by CDC. The vaccine must be produced and administered annually. Since 2010, the Advisory Committee on Immunization Practices (ACIP) has

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

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.

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; identify viruses that are causing disease and may pose a pandemic threat; as well as 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 has trained workers in the same state laboratories that have similar responsibilities during foodborne outbreaks.

CDC trains to be able to respond quickly and effectively to an influenza pandemic. Within the United States, CDC provides scientific and programmatic expertise to state and territorial health departments to develop operational plans for an influenza pandemic through CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement with funding from the PHEP budget line. The health departments improve and update the plans based upon their response experiences. CDC works to coordinate emergency response plans between health departments, hospitals, and emergency responders to ensure a rapid, efficient, and effective response at the local level.

Budget Proposal: CDC's FY 2014 request of \$173,061,000 for influenza planning and response is an increase of \$414,000 above the FY 2012 level.

Influenza Prevention

In FY 2014, CDC will support efforts to prevent influenza through vaccination. CDC focuses on increasing demand 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 non-traditional providers as a means to extend the reach of influenza vaccination. Annual vaccination campaigns serve to assist with reaching the Healthy People 2020 influenza vaccination goals for minority and high-risk populations, and help to build capacity for vaccination campaigns 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

In FY 2014, CDC will serve as a World Health Organization (WHO) Collaborating Center to rapidly detect, identify, and characterize emerging influenza viruses so that vaccine-candidate viruses used to produce vaccines for seasonal and novel viruses are rapidly selected. A crucial ingredient of effective influenza control is to shorten the interval between the identification of novel influenza viruses and the delivery of effective vaccines.

CDC will 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. In 2012, to assist decision-makers in understanding the impact of a novel virus, CDC introduced the Influenza Risk Assessment Tool (IRAT). The IRAT is an evaluation tool developed by CDC and external influenza experts that measures the potential pandemic risk posed by influenza A viruses that currently circulate in animals but not in humans. The IRAT makes an assessment of potential pandemic risk based on calculations of 10 scientific criteria.

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 will provide this support through continuing cooperative agreement funding with 36 countries, with emphasis on countries that continue to experience animal outbreaks and human cases of H5N1 influenza. CDC's international support has resulted in twice as many countries reporting to WHO FluNet since 2005. Also, the number of countries sharing influenza isolates, a key term of reference to quickly detect novel viruses, has increased by over 75 percent since support began. CDC will work on expanding virus sample sharing among countries so that vaccines and diagnostic tests for viruses with pandemic potential can be produced.

CDC will support the capability of state and local health departments to conduct influenza laboratory testing by maintaining 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.

Grant Table:

Influenza Planning and Response ELC Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	\$0.117	\$0.107	\$0.107
Range of Awards	\$0.016–\$0.232	\$0.016–\$0.232	\$0.016–\$0.232
Number of New Awards	0	0	0
Number of Continuing Awards	56	56	56
Total Grant Award	\$6.526	\$6.000	\$6.000

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

The Epidemiology and Laboratory Capacity for Infectious Diseases Program (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 2014, public health departments will be funded to improve detection of novel human influenza virus infections, such as the H3N2v influenza virus. Rapid and thorough investigations determined that this virus caused 308 human cases 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 nine different systems. This network of systems provides data on influenza viruses, outpatient influenza-like illness, influenza-associated hospitalizations, influenza-associated deaths, and the 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 for scientific and programmatic expertise 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).

Response to Influenza Pandemics

In FY 2014, CDC will work to ensure the availability and effectiveness of medical countermeasures and equipment in the event of an influenza pandemic; such countermeasures include antiviral drugs, respirators, and ventilators. To complement these product-based interventions, CDC will develop and evaluate interventions to mitigate the impact of an influenza pandemic through strategies to reduce the likelihood that susceptible individuals have contact with contagious individuals. In addition, CDC is developing a nationwide system of nurse triage/call centers that would be activated during a pandemic to provide advice to ill individuals and thereby reduce the burden on hospitals, healthcare facilities, and public health facilities. 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, and by providing scientific and programmatic expertise to help CDC's 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. CDC will also support coordination efforts between health departments, hospitals, and emergency responders. Coordination 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. Outside the United States, CDC will support countries to provide laboratory confirmation of influenza—the key to protecting the United States through early detection of novel influenza viruses with pandemic potential. CDC will test its response capabilities in FY 2014 with a 3-day functional exercise that engages the incident management system to test improvements made in response to gaps identified in past responses and exercises.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
ACA/PPHF	\$190.000	N/A	\$72.460	-\$117.540

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The following activities are included:

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

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
1.2.1c: Achieve and sustain immunization coverage in children 19 to 35 months of age for one dose of measles, mumps, and rubella (MMR) vaccine (Intermediate Outcome)	FY 2011: 92% (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 pneumococcal conjugate vaccine (PCV) (Intermediate Outcome)	FY 2011: 84% (Target Not Met but Improved)	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 2011: 67% (Target Exceeded)	60%	68%	+8
1.2.2a: Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose Tdap (tetanus and diphtheria toxoids and cellular pertussis) (Intermediate Outcome)	FY 2011: 81% (Target Exceeded)	70%	83%	+13
1.2.2b: Achieve and sustain immunization coverage of at least 80% in adolescents 13 to 15 years of age for 1 dose meningococcal conjugate vaccine (MCV4) (Intermediate Outcome)	FY 2011: 72% (Target Exceeded)	70%	78%	+8
1.C: Number of states (including the District of Columbia) achieving 65% coverage for 1 birth dose hepatitis B vaccine (19-35 months of age) (Output)	FY 2011: 49 (Target Exceeded)	40	45	+5
1.D: Number of states (including the District of Columbia) achieving 30% coverage for influenza vaccine (6-23 months of age) (Output)	FY 2011: 36 (Target Exceeded)	29	36	+7
1.E: Number of states (including the District of Columbia) achieving 25% coverage for ≥ 3 doses human papillomavirus vaccine (13-17 years of age) (Output)	FY 2011: 46 (Target Exceeded)	40	51	+11
1.F: Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose Tdap vaccine (13-17 years of age) (Output)	FY 2011: 50 (Target Exceeded)	46	51	+5

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
1.G: Number of states (including the District of Columbia) achieving 45% coverage for ≥ 1 dose meningococcal conjugate vaccine (13-17 years of age) (Output)	FY 2011: 42 (Target Exceeded)	40	50	+10
1.N: Percent of grantees that have met current milestones required for successful implementation of immunization billing systems for third-party payors (Output)	N/A	N/A	85%	N/A

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
1.3.1b: Increase the percentage of adults aged 65 and older who are vaccinated against pneumococcal disease (Intermediate Outcome)	FY 2011: 62.3% (Target Not Met)	67%	73%	+6
1.3.2b: Increase the percentage of pneumococcal vaccination among non-institutionalized high-risk adults ages 18 to 64 (Intermediate Outcome)	FY 2011: 30.5% (Target Exceeded)	31%	36%	+5
1.3.3a: Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Intermediate Outcome)	FY 2012: 38.8% (Baseline)	44%	50%	+6

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 \$10.20 is saved in direct medical costs for every \$1 invested in vaccines for VPDs (Table 1).

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
Hepatitis B	saves \$2.40
Varicella	saves \$2.00
Inactivated Polio (IPV)	saves \$8.60
<i>Haemophilus influenzae</i> type b (Hib)	saves \$4.90

Vaccine:	Cost Savings: for every \$1 spent on an individual vaccine
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.

In FY 2011, CDC continued to improve and sustain immunization coverage for children 19-35 months of age. CDC achieved levels near or above national (Healthy People 2020) targets for most of the routinely recommended childhood vaccinations. Since 2008, measles, mumps, and rubella (MMR) vaccinations have met or exceeded 90 percent coverage rates and CDC will maintain this performance target in FY 2014. Rotavirus vaccine coverage increased by eight percentage points from 59 percent in FY 2010 to 67 percent in FY 2011. Coverage of pneumococcal conjugate vaccine (PCV) increased from 83 percent in FY 2010 to 84 percent in FY 2011 (Measures 1.2.1). Although CDC did not meet targeted coverage rates for PCV strategies to improve 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 and notification, immunization information systems, and regular assessment of coverage levels in the National Immunization Survey.

CDC exceeded targets for both adolescent performance measures in FY 2011. Tetanus, diphtheria and pertussis (Tdap) vaccine coverage increased from 74 percent in FY 2010 to 81 percent in FY 2011, and meningococcal conjugate vaccine (MCV4) coverage increased from 65 percent in FY 2010 to 72 percent in FY 2011 (Measures 1.2.2). CDC's efforts to promote awareness of adolescent immunization recommendations, by providing education and training to both public and private providers, have helped 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 2011. CDC exceeded all targets and is on track to meet or exceed FY 2014 targets (Measures 1.C, 1.E-1.G).

In some communities, public health clinics are an important access point to health services and provide vaccinations to the full spectrum of uninsured, under-insured, and fully insured patients. To ensure life-saving immunizations are available to those who are not fully insured, clinics that serve fully insured patients must be able to bill for immunization services and recoup some of their costs. In FY 2011, CDC funded 21 grantees to plan and/or implement third-party payer billing systems in public health clinics, and all met their milestones. In FY 2012, CDC increased its funded grantees to 35 with Prevention and Public Health Funding (PPHF).

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 increased FY 2010 targets based on HP 2010 goals; however, CDC did not meet the coverage targets for adult pneumococcal adult vaccination. Vaccinations for adults 65 and older decreased from 61 percent in FY 2009 to 60 percent in FY 2010 but increased in FY 2011 to 62.3 percent (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 of 21 percent in FY 2011 (Measure 1.3.2b). Measure 1.3.3a is a new measure CDC developed during FY 2012 to reflect the universal influenza vaccination recommendation. The new measure aligns with CDC's Advisory Committee on Immunization Practices (ACIP) updated recommendation (as of 2010) for the seasonal influenza vaccine.

Addressing barriers to adult immunization and increasing adult vaccination rates will require 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, and other specialists and pharmacists. CDC's efforts to improve adult vaccination coverage rates include: (1) increasing patient and provider education to improve demand; (2) implementing system changes in practitioner office settings to reduce missed opportunities for vaccinations; (3) enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations; (4) expanding provider outreach to the variety of healthcare service providers in which adults receive care; and (5) implementing vaccination programs in new venues such as pharmacies and other retail clinics.

CDC assesses vaccination coverage levels across the lifespan to identify groups at risk of vaccine-preventable diseases. This involves monitoring racial and ethnic disparities, evaluating the effectiveness of programs, monitoring uptake of new vaccines, assessing differential impact of vaccine shortages, measuring provider performance, and providing greater understanding of socio-demographic and attitudinal factors associated with vaccination. Public Health leaders, healthcare providers, and policymakers use this information to enhance current strategies and develop new strategies to improve protection of persons of all ages against vaccine-preventable diseases.

Performance Measures for Long Term Objective: Improve vaccination safety and effectiveness

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
1.H.: Percentage of Vaccine Events Reporting System (VAERS) reports received electronically (Output)	FY 2012: 32% (Baseline)	N/A	42%	N/A
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 2011: 326 pairs (Historical Actual)	N/A	363 pairs	N/A

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 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 our 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 identification of established or disproven associations of an adverse event (AE) with a specific vaccine (vaccine-adverse event).

Recent CDC vaccine safety findings confirmed the safety of the 2009 influenza A pandemic (H1N1) vaccine for the approximately 80 million people in the United States who received it. CDC findings confirmed thimerosal is not related to autism or other neurodevelopmental outcomes; hepatitis B vaccine does not cause multiple sclerosis (MS); vaccinations do not cause type-1 diabetes; and influenza vaccines do not increase the risk of asthma exacerbations. CDC confirmed associations of two vaccines—measles, mumps, rubella, varicella (MMRV) vaccine, and the 2010-11 trivalent inactivated influenza (TIV) vaccines—with febrile seizures in young children. The MMRV finding contributed to the ACIP recommendation to remove the preference for MMRV vaccine over MMR and varicella vaccines in May 2010. The TIV findings resulted in a revision in the Vaccine Information Statement for TIV influenza vaccine, which now cautions providers that administering the TIV influenza vaccine and the PCV-13 at the same time may increase the risk of seizures.

From 2001 to 2012, the number of diseases for which childhood vaccines increased from 10 to 16, and the number of reports submitted to VAERS more than doubled from 15,000 to 33,000. With these increases, CDC developed two new measures in FY 2012: adverse events reported electronically and early detection of possible vaccine-adverse events. HHS received approximately 30 percent of adverse events reported electronically in FY 2011 and 32 percent in FY 2012 (Measure 1.H). HHS is currently developing and implementing automation initiatives and IT enhancements that are expected to increase electronic reporting to VAERS and early detection of events. VAERS continues to be the primary system to detect early vaccine safety signals. From 2007 to 2010, “early warnings signals” of possible vaccine-adverse event associations detected by VAERS increased CDC’s vaccine-adverse event pair findings by 55 percent (increasing from 210 pairs in 2007 to 326 pairs in 2011; Measure 1.5.2).

CDC’s efforts to publicize the availability of web-based reporting available to physicians and the public have increased electronic reporting to VAERS since FY 2008. Incorporating a standardized data structure for electronic reporting by vaccine manufacturers is expected to further improve reporting upon completion by 2014. 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.

Program: Influenza Planning and Response

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
1.6.1: Increase the number of public health laboratories monitoring influenza virus resistance to antiviral drugs (Output)	FY 2012: 18 (Target Exceeded)	12	18	+6
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 ⁴ (Output)	FY 2012: 42.5% (Target Not Met)	75%	75% ⁵	Maintain
1.K: Number of Epidemiology and Laboratory Capacity (ELC) funded laboratorians and influenza coordinators assigned to state and local public health departments (Output)	FY 2012: 93 (Target Exceeded)	70	70	Maintain
1.L: Number of influenza diagnostic kits and virus reference panels distributed domestically and internationally (Output)	FY 2012: 2,245 (Target Exceeded)	2,100	2,100	Maintain
1.M: Number of virus specimens received and characterized annually from global National Influenza Centers for use in determining vaccine strain selection (Output)	FY 2012: 10,984 (Target Not Met)	11,000	11,000	Maintain

⁴This indicator score is formally assessed every other year. The instrument may be reassessed and improved in FY 2013.

⁵This measure assesses the number of countries increasing their indicator score by 5 percent over the previous year. Since the measure is not cumulative; over time, as countries achieve higher scores, it is expected that fewer countries will meet this objective.

Performance Trends: CDC exceeded the FY 2012 target of 15 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 also allows for more timely data for case investigations. Timeliness is critical to identify and contain possible clusters of resistant strains and prevent transmission. Recent evaluations of preparedness and response capabilities for 36 countries participating in CDC's National Inventory of Core Capacities for Pandemic Influenza and Response consistently demonstrate significant improvements for the 2008-2010 reporting period regarding: (1) integration of laboratory and epidemiologic surveillance; (2) timely reporting and sharing of surveillance data; (3) outbreak response capacity and containment practices, and; (4) communication of surveillance information. In FY 2012, 42.5 percent of countries achieved a five percent increase in indicator scores, compared to 94 percent in FY 2010. However, as individual countries continue to improve their core capacities, the aggregate percent of countries increasing five percent over the last reporting period will decline (Measure 1.6.3).

In FY 2010 and FY 2011, CDC enhanced state and local capacity to gather influenza epidemiology and laboratory data essential for systematic, accurate surveillance of seasonal and novel influenza viruses. In FY 2012, with a return to pre-pandemic funding, CDC provided funding 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 fully funding 32 and partially funding 61 Epidemiology and Laboratory Capacity (ELC) laboratorians and influenza coordinators at state and local health departments to provide the necessary capacity to monitor and identify influenza threats (Measure 1.K). While CDC was able to maintain the overall number of staff, more of these are partially funded than in previous years. CDC adjusted its target for FY 2014 to reflect current performance.

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 U.S. Food and Drug Administration (FDA)-approved revisions related to the configuration of the diagnostic kits. These factors increased the number of kits shipped during the reporting timeframe.
- CDC received and characterized 10,984 influenza virus specimens in FY 2012, just slightly below the target of 11,000. The number of influenza virus specimens received and characterized fluctuates by year depending on the severity and burden of the disease. CDC expects to process approximately 11,000 influenza virus specimens in FY 2014 (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.

STATE TABLES¹

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program^{1,2}				
State/City/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$7,849,253	\$5,457,963	\$5,772,959	-\$2,076,295
Alaska	\$3,428,383	\$2,477,112	\$2,120,397	-\$1,307,986
Arizona	\$11,126,450	\$8,150,828	\$8,754,545	-\$2,371,906
Arkansas	\$5,138,393	\$3,847,943	\$4,086,984	-\$1,051,410

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program^{1,2}				
State/City/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
California	\$55,709,538	\$38,817,398	\$45,816,717	-\$9,892,821
Colorado	\$8,244,057	\$5,792,459	\$6,315,820	-\$1,928,237
Connecticut	\$6,126,044	\$4,215,090	\$4,353,220	-\$1,772,823
Delaware	\$1,742,506	\$1,482,032	\$1,555,082	-\$187,425
District of Columbia (D.C.)	\$1,925,918	\$1,687,615	\$1,661,098	-\$264,820
Florida	\$26,932,503	\$18,214,251	\$20,833,263	-\$6,099,239
Georgia	\$14,410,202	\$9,886,013	\$11,816,786	-\$2,593,416
Hawaii	\$2,346,030	\$2,088,349	\$2,487,574	\$141,545
Idaho	\$3,350,438	\$2,426,609	\$2,473,578	-\$876,860
Illinois	\$13,867,107	\$9,107,485	\$10,631,195	-\$3,235,911
Indiana	\$9,774,465	\$6,430,415	\$6,866,759	-\$2,907,706
Iowa	\$5,092,865	\$3,701,211	\$3,912,205	-\$1,180,660
Kansas	\$3,431,170	\$2,869,973	\$3,730,200	\$299,030
Kentucky	\$6,037,032	\$4,306,541	\$4,865,372	-\$1,171,660
Louisiana	\$6,049,802	\$4,171,155	\$4,908,993	-\$1,140,810
Maine	\$3,183,179	\$2,737,279	\$2,848,247	-\$334,932
Maryland	\$6,917,632	\$5,026,090	\$6,326,784	-\$590,848
Massachusetts	\$10,206,663	\$6,717,458	\$7,269,519	-\$2,937,144
Michigan	\$15,819,511	\$10,649,482	\$11,394,961	-\$4,424,550
Minnesota	\$8,795,315	\$6,256,339	\$6,720,851	-\$2,074,464
Mississippi	\$4,909,071	\$3,653,798	\$3,998,631	-\$910,441
Missouri	\$8,487,364	\$5,795,419	\$6,530,503	-\$1,956,861
Montana	\$1,867,985	\$1,432,862	\$1,544,613	-\$323,372
Nebraska	\$3,613,036	\$3,025,579	\$3,132,717	-\$480,319
Nevada	\$3,686,661	\$2,455,222	\$2,993,761	-\$692,900
New Hampshire	\$2,224,244	\$1,540,614	\$1,721,505	-\$502,739
New Jersey	\$10,373,757	\$7,947,594	\$10,421,521	\$47,764
New Mexico	\$3,141,554	\$2,262,536	\$2,504,215	-\$637,339
New York	\$15,564,202	\$12,107,916	\$12,969,155	-\$2,595,047
North Carolina	\$12,649,732	\$8,033,784	\$9,720,036	-\$2,929,696
North Dakota	\$2,149,133	\$1,575,887	\$1,728,970	-\$420,163
Ohio	\$15,675,182	\$10,442,251	\$12,151,617	-\$3,523,564
Oklahoma	\$7,849,668	\$5,238,607	\$4,870,579	-\$2,979,089
Oregon	\$6,952,228	\$4,898,812	\$4,950,496	-\$2,001,732
Pennsylvania	\$16,072,145	\$10,343,509	\$11,330,650	-\$4,741,495
Rhode Island	\$3,386,863	\$2,251,166	\$1,748,253	-\$1,638,610
South Carolina	\$5,927,385	\$4,474,420	\$5,614,004	-\$313,381
South Dakota	\$2,608,651	\$1,868,623	\$2,053,071	-\$555,579
Tennessee	\$8,779,690	\$6,291,661	\$7,119,772	-\$1,659,918
Texas	\$35,444,159	\$23,878,597	\$27,426,318	-\$8,017,841

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA Number: 93.268/Section 317 Immunization Program^{1,2}				
State/City/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Utah	\$4,833,787	\$3,512,312	\$3,719,652	-\$1,114,136
Vermont	\$2,669,272	\$1,865,309	\$1,792,976	-\$876,297
Virginia	\$12,205,027	\$8,025,736	\$8,695,966	-\$3,509,061
Washington	\$9,504,090	\$6,498,425	\$7,369,543	-\$2,134,546
West Virginia	\$2,992,301	\$2,216,870	\$2,372,018	-\$620,283
Wisconsin	\$9,145,979	\$6,340,054	\$6,851,847	-\$2,294,132
Wyoming	\$1,464,778	\$1,314,814	\$1,330,810	-\$133,968
Chicago	\$5,723,868	\$4,753,885	\$4,937,445	-\$786,423
Houston³	\$2,308,028	\$2,741,239	\$2,479,194	\$171,166
New York City	\$15,647,607	\$10,553,447	\$11,300,437	-\$4,347,170
Philadelphia	\$2,867,196	\$2,338,489	\$2,346,174	-\$521,022
San Antonio	\$2,749,696	\$2,105,270	\$1,904,020	-\$845,676
American Samoa	\$551,996	\$606,519	\$616,227	\$64,231
Guam	\$1,446,803	\$1,366,377	\$1,542,852	\$96,048
Marshall Islands	\$2,382,509	\$1,845,265	\$2,570,811	\$188,302
Micronesia	\$2,982,327	\$2,217,569	\$3,718,203	\$735,876
Northern Mariana Islands	\$1,021,037	\$1,112,672	\$1,129,327	\$108,290
Puerto Rico	\$4,959,655	\$3,790,921	\$4,774,333	-\$185,322
Republic Of Palau	\$417,301	\$361,841	\$506,268	\$88,967
Virgin Islands	\$971,495	\$1,076,766	\$997,864	\$26,368
Total States/Cities/Territories	\$495,711,922	\$350,961,544	\$393,043,910	-\$102,668,012
Other Adjustments⁴	\$62,158,078	\$19,265,456	\$40,716,090	-\$21,441,988
Outbreak Vaccines	\$0	\$0	\$18,641,000	\$18,641,000
Total Resources^{5,6}	\$557,870,000	\$370,227,000	\$452,401,000	-\$105,469,000

¹This 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://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

²Includes vaccine direct assistance and immunization infrastructure/operations grant funding.

³Immunization infrastructure/operations grant funding only; vaccine direct assistance for Houston is included with Texas.

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, vaccine safety data link, special projects, and program support services.

⁵FY 2013 does not include Prevention and Public Health Fund (PPHF) funding. The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

⁶FY 2012 includes 317 and PPHF as follows: \$367,870,000 (BA) + \$190,000,000 (PPHF) = \$557,870,000; FY 2014 includes Section 317 request of \$379,941,000 and PPHF request of \$72,460,000 for a total of \$452,401,000.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 MANDATORY STATE/FORMULA GRANTS CFDA Number: 93.268/Vaccines for Children (VFC) Program¹				
State/City/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
Alabama	\$52,765,413	\$48,048,680	\$57,486,737	\$9,438,056
Alaska	\$11,243,865	\$10,300,087	\$12,188,927	\$1,888,840

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 MANDATORY STATE/FORMULA GRANTS CFDA Number: 93.268/Vaccines for Children (VFC) Program¹				
State/City/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
Arizona	\$75,265,393	\$68,538,162	\$81,975,828	\$13,437,665
Arkansas	\$38,639,138	\$35,185,502	\$42,086,076	\$6,900,574
California	\$362,487,279	\$330,086,184	\$394,864,699	\$64,778,514
Colorado	\$39,807,150	\$36,250,229	\$43,324,148	\$7,073,918
Connecticut	\$31,020,780	\$28,250,307	\$33,720,134	\$5,469,827
Delaware	\$9,179,207	\$8,360,094	\$9,957,010	\$1,596,916
District of Columbia (D.C.)	\$10,071,171	\$9,172,335	\$10,928,476	\$1,756,141
Florida	\$191,061,913	\$173,981,770	\$208,188,351	\$34,206,581
Georgia	\$110,957,133	\$101,039,563	\$120,856,061	\$19,816,498
Hawaii	\$13,716,822	\$12,494,292	\$14,833,197	\$2,338,905
Idaho	\$18,924,995	\$17,233,864	\$20,600,419	\$3,366,555
Illinois	\$88,019,299	\$80,152,807	\$95,845,859	\$15,693,052
Indiana	\$52,429,296	\$47,744,242	\$57,070,567	\$9,326,325
Iowa	\$24,222,349	\$22,058,585	\$26,344,209	\$4,285,625
Kansas	\$24,458,776	\$22,273,445	\$26,615,016	\$4,341,571
Kentucky	\$43,118,264	\$39,263,977	\$46,973,906	\$7,709,929
Louisiana	\$57,261,717	\$52,142,875	\$62,390,959	\$10,248,085
Maine	\$11,538,053	\$10,509,081	\$12,496,297	\$1,987,216
Maryland	\$53,602,599	\$48,811,626	\$58,380,607	\$9,568,981
Massachusetts	\$52,256,282	\$47,587,286	\$56,863,961	\$9,276,676
Michigan	\$81,739,515	\$74,434,883	\$88,988,677	\$14,553,794
Minnesota	\$33,099,315	\$30,142,136	\$36,012,317	\$5,870,181
Mississippi	\$40,983,536	\$37,319,979	\$44,651,077	\$7,331,098
Missouri	\$55,360,006	\$50,411,903	\$60,296,271	\$9,884,367
Montana	\$7,554,121	\$6,879,753	\$8,202,508	\$1,322,755
Nebraska	\$16,952,107	\$15,437,455	\$18,447,302	\$3,009,847
Nevada	\$31,064,665	\$28,289,158	\$33,801,950	\$5,512,792
New Hampshire	\$8,713,437	\$7,935,915	\$9,450,921	\$1,515,005
New Jersey	\$65,995,028	\$60,098,392	\$71,817,481	\$11,719,089
New Mexico	\$34,392,966	\$31,320,020	\$37,425,598	\$6,105,578
New York	\$78,936,401	\$71,886,678	\$85,801,996	\$13,915,317
North Carolina	\$97,230,979	\$88,540,229	\$105,906,915	\$17,366,686
North Dakota	\$5,400,742	\$4,918,708	\$5,861,284	\$942,576
Ohio	\$92,603,426	\$84,324,812	\$100,911,914	\$16,587,102
Oklahoma	\$53,760,227	\$48,956,109	\$58,523,386	\$9,567,277
Oregon	\$30,138,595	\$27,446,497	\$32,773,840	\$5,327,343
Pennsylvania	\$78,615,945	\$71,592,959	\$85,511,291	\$13,918,332
Rhode Island	\$11,175,363	\$10,177,922	\$12,128,431	\$1,950,510
South Carolina	\$50,481,991	\$45,971,167	\$54,944,143	\$8,972,976

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 MANDATORY STATE/FORMULA GRANTS CFDA Number: 93.268/Vaccines for Children (VFC) Program¹				
State/City/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
South Dakota	\$9,194,770	\$8,373,574	\$9,995,144	\$1,621,570
Tennessee	\$67,519,299	\$61,483,818	\$73,557,399	\$12,073,581
Texas	\$333,290,653	\$303,497,305	\$363,121,696	\$59,624,391
Utah	\$20,451,081	\$18,624,716	\$22,226,803	\$3,602,086
Vermont	\$5,867,408	\$5,344,776	\$6,335,478	\$990,702
Virginia	\$52,161,350	\$47,498,549	\$56,830,661	\$9,332,112
Washington	\$84,315,473	\$76,783,188	\$91,715,146	\$14,931,959
West Virginia	\$19,934,750	\$18,153,393	\$21,699,408	\$3,546,015
Wisconsin	\$41,279,074	\$37,590,097	\$44,942,496	\$7,352,399
Wyoming	\$4,633,070	\$4,219,867	\$5,018,545	\$798,678
Chicago	\$45,730,610	\$41,645,535	\$49,736,391	\$8,090,856
Houston²	\$716,820	\$654,856	\$716,259	\$61,403
New York City	\$119,038,695	\$108,399,359	\$129,640,846	\$21,241,486
Philadelphia	\$27,017,251	\$24,604,637	\$29,358,936	\$4,754,298
San Antonio	\$23,701,407	\$21,583,485	\$25,798,847	\$4,215,362
American Samoa	\$1,131,336	\$1,032,853	\$1,227,816	\$194,963
Guam	\$2,537,628	\$2,320,896	\$2,735,049	\$414,153
Northern Mariana Islands	\$1,921,304	\$1,754,841	\$2,048,492	\$293,651
Puerto Rico	\$66,613,816	\$60,660,176	\$72,543,355	\$11,883,179
Virgin Islands	\$1,819,272	\$1,658,753	\$1,917,564	\$258,811
Total States/Cities/Territories	\$3,175,120,325	\$2,891,454,344	\$3,456,615,076	\$565,160,732
Other Adjustments³	\$825,332,837	\$715,801,656	\$836,767,924	\$120,966,268
Total Resources^{4,5}	\$4,000,453,162	\$3,607,256,000	\$4,293,383,000	\$686,127,000

¹ This 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://www.cdc.gov/FundingProfiles/FundingProfilesRIA/>.

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

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

⁴ Total resources for FY 2012 reflect actual obligations, which did not equal total available resources. The FY 2014 estimate is an increase of \$287,442,000 above the FY 2012 estimate of \$4,005,941,000, exclusive of unobligated balances brought forward.

⁵ Total resources for FY 2013 and FY 2014 are based on the FY 2014 VFC President's Budget ten year table. The FY 2013 level represents estimated total obligations, including \$0.656 million in prior year recoveries and refunds brought forward and \$3.607 billion in transfer from CMS. The FY 2014 net increase of estimated total obligations, inclusive of prior year recoveries and refunds brought into FY 2013 totals \$686,127,000; the FY 2014 net increase of the non-expenditure transfer from CMS, exclusive of prior year recoveries and refunds brought into FY 2013 totals \$686,782,938.

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

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$1,152.964	\$1,160.108	\$1,173.942	+\$20.978
PHS Evaluation Transfer	\$0.000	\$0.000	\$3.000	+\$3.000
ACA/PPHF	\$10.000	N/A	\$0.000	-\$10.000
Total	\$1,162.964	\$1,160.108	\$1,176.942	+\$13.978
FTEs	1,198	1,191	1,191	-7

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: 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, 2012 (P.L. 112-74, Division F)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$1,176,942,000 for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections (STI), and Tuberculosis (TB) prevention, including \$3,000,000 in Public Health Service (PHS) Evaluation Transfer funds, is an increase of \$13,978,000 above the FY 2012 level. This request will continue to implement the *National HIV/AIDS Strategy* and will improve timeliness of surveillance data. The request redirects \$40 million from less efficient activities to a new Community High-Impact Prevention initiative to improve systems that link persons recently diagnosed with HIV to care, and invests \$10 million to build the infrastructure and capacity that state public health departments and community-based organizations will need to bill private insurers for infectious disease testing.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Domestic HIV/AIDS Prevention and Research	\$822.633	\$827.667	\$836.124	+\$13.491
PHS Evaluation Transfer (non-add)	\$0.000	\$0.000	\$3.000	+\$3.000
Viral Hepatitis	\$31.282	\$21.418	\$31.410	+\$0.128
ACA/PPHF (non-add)	\$10.000	N/A	\$0.000	-\$10.000
Sexually Transmitted Infections	\$161.697	\$162.729	\$161.710	+\$0.013
Tuberculosis	\$147.352	\$148.294	\$147.698	+\$0.346
Total	\$1,162.964	\$1,160.108	\$1,176.942	+\$13.978

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CDC prevents and controls HIV, viral hepatitis, STI, and TB in the United States to address CDC's overarching goal of protecting Americans from infectious diseases. 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.

HIV, viral hepatitis, STI, and TB share many social, environmental, behavioral, and biological determinants. CDC's programs make these connections and 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.

In addition to these cross-cutting approaches, 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. The result is improved efficiency, cost effectiveness, and health outcomes. CDC has developed best practices, supported demonstration projects, and encouraged PCSI activities in its categorical programs. In 2014, CDC will continue to support PCSI, by encouraging HIV, viral hepatitis, STD and TB grantees to dedicate a portion of their funding to also 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 the Pacific Islands through a single cooperative agreement with each jurisdiction in order to reduce administrative strain on these small areas.

Implementation of the Affordable Care Act will improve the prevention and control of HIV and AIDS, viral hepatitis, STIs, and TB in the United States due to increases in the proportion of the population with health insurance coverage, increased emphasis on preventive services, and prohibitions on denial of coverage to persons with pre-existing conditions. However, decreasing illness and death due to these infections remains dependent upon critical public health services at the state and local levels. CDC and its public health partners provide these critical services, including surveillance, monitoring, partner services and contact investigations, laboratory services, provider training, operational research, and outreach to populations unlikely to access clinical care. Where direct services, such as screening, are provided by public health agencies, they are often provided in outreach settings in order to reach populations that would not otherwise access these services. CDC will work closely with public health agencies to build the infrastructure and capacity that state public health departments and community-based organizations will need to bill private insurers for infectious disease testing.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$1,006.375
2010	\$1,088.345
2010 (ACA/PPHF)	\$30.367
2011	\$1,115.995
2011 (ACA/PPHF)	\$0.000
2012	\$1,152.964
2012 (ACA/PPHF)	\$10.000
2013	\$1,160.108
2013 (ACA/PPHF) ²	N/A

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

DOMESTIC HIV/AIDS PREVENTION AND RESEARCH BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
HIV Prevention by Health Departments	\$399.562	\$402.006	\$399.744	+\$0.182
National Programs to Identify and Reach High Risk Populations	\$390.762	\$393.154	\$400.985	+\$10.223
HIV Adolescent and School Health	\$32.309	\$32.507	\$35.395	+\$3.086
PHS Evaluation Transfer (non-add)	\$0.000	\$0.000	\$3.000	+\$3.000
Total	\$822.633	\$827.667	\$836.124	+\$13.491

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC is the nation's lead HIV prevention agency and is at the forefront of preventing new infections. Approximately 1.1 million Americans live with HIV infection, a total that has risen slowly since the advent of better, life-prolonging treatments. The rising number of persons living with HIV infection is increasing 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 utilizing 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.

The NHAS set three metrics for the nation's collective success at reducing new infections. By 2015, the United States aims to: (1) lower the annual number of new infections by 25 percent (from 48,600 infections in the year 2006 to 36,450 in 2015); (2) reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent (from 4.58 persons infected per 100 people with HIV to 3.2 persons infected per 100 people with HIV); and (3) increase from 79 percent to 90 percent the percentage of people living with HIV who know their HIV status (from 948,000 to 1,080,000). CDC surveillance has been used to establish the baselines for these metrics and is being used to monitor progress. To achieve these aggressive but realistic targets, the NHAS outlines three action steps: (1) intensify HIV prevention efforts in communities where HIV is most heavily concentrated; (2) expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches; and (3) educate all Americans about the threat of HIV and how to prevent it.

CDC 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 the combination of scientifically-proven, cost-effective, and scalable interventions directed to the populations who need it most. It also includes general HIV prevention education for young Americans.

CDC's approach to HIV prevention includes: (1) surveillance and epidemiology to characterize the epidemic; (2) prevention interventions, such as HIV testing, condom distribution, counseling and education for high-risk persons, partner services, and linkage to care; (3) training and capacity building for organizations providing HIV prevention services; and (4) operational research and evaluation. In addition to supporting the cost of HIV tests, CDC-funded HIV testing activities provide education for providers and at-risk populations in clinical and community settings, professional training, scientific and programmatic expertise, and oversight to ensure testing services are implemented according to recommendations. Also, CDC supports outreach activities to promote testing, conduct testing at other non-clinical venues, and to overcome obstacles for individuals who do not access clinical services and engage in care.

Budget Proposal: CDC's FY 2014 request of \$836,124,000 for domestic HIV/AIDS prevention and research is an increase of \$13,491,000 above the FY 2012 level. Several major new initiatives are

proposed. These include a \$10 million increase to improve timeliness of HIV surveillance and an increase of \$3 million in Public Health Evaluation transfers to assess and improve CDC's HIV school health programs. In addition to these increases, CDC will invest \$10 million to help HIV prevention grantees increase their capacity to seek reimbursement for covered services, as well as reallocating \$40 million in existing funds to support Community High-Impact Prevention (CHIP), a new initiative that will maximize HIV prevention through capacity-building and community-based organizations. CHIP focuses CDC resources on implementing sustainable, high-impact HIV testing and screening programs, linkage to and engagement in care, scalable and effective interventions, and public health strategies for HIV-infected and high-risk populations. More information on CHIP and the other new initiatives are provided in the HIV prevention budget sub-lines below. Detailed program overviews and budget proposals are included for each of the following:

- HIV Prevention by Health Departments
- National Programs to Identify and Reach Highest Risk Populations
- HIV Adolescent and School Health

HIV prevention is cost-saving to society. The estimated lifetime costs of treating a single person with HIV infection is \$402,000. We now know more than ever about 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 anti-HIV medications early are much less likely to transmit HIV, with up to a 96 percent reduction in transmission risk. A CDC analysis indicates, however, that only 28 percent of those infected know of their infection, are receiving care, and are on therapy that suppresses their infection. CDC has been focusing its HIV prevention efforts on improving the proportion of persons whose HIV infection is suppressed, shifting resources and activities to populations and areas most affected by HIV and to strategies most likely to yield the greatest benefit, including linking prevention activities with the healthcare sector. CDC has shifted the activities, and the allocation of resources for its health department programs. Grantees are now required to spend 75 percent of their resources on a limited set of high-impact interventions, mostly HIV testing, linkage to and engagement in care, and prevention interventions for HIV-positive persons. Grantees are expected to address their local epidemics with these strategies in combinations appropriate for them. CDC has also employed high-impact strategies for its program for young men of color who have sex with men and young transgendered persons, requiring all funded organizations to meet minimum testing targets, HIV-positivity rates, and linkage to care rates for HIV-positive individuals. In FY 2014, CDC will extend its high-impact approach to its main community-based organization program and its capacity building assistance programs through CHIP.

HIV Prevention by Health Departments

Program Overview: CDC's HIV Prevention by Health Departments program provides support to 67 state local, and territorial health departments and serves as the foundation for HIV prevention and control nationwide. In FY 2013, support for six Pacific Island jurisdictions is being provided through a consolidated program announcement addressing not only HIV, but TB, STD and viral hepatitis as well. Sixty-one state and local health departments are funded through CDC's flagship HIV prevention cooperative agreement. This program is a chief contributor to U.S. HIV prevention successes, including reductions in perinatal HIV infections, reductions in HIV transmission rates, and increases in individual knowledge of serostatus, which is someone's HIV status. The number of infants infected with HIV through perinatal transmission decreased from an estimated peak of 1,650 HIV-infected infants born in 1991 to an estimated 138 infants born in 2004. Forty-five percent of all U.S. adults, and 72 percent of adults with a known risk factor for HIV, have been tested at least once. Recently released data show that the percentage of people in the United States with HIV who know their HIV status had increased to 82 percent by 2009.

This program is also critical to the people living with HIV because health departments work to increase access to care and improve linkage to continuous and coordinated quality care and medical, prevention, and social services. CDC partners with health departments to intensify efforts to prevent HIV infection using a combination of effective, evidence-based approaches, including delivery of integrated biomedical, behavioral, and structural interventions. An example of a biomedical intervention includes taking anti-HIV drugs to reduce transmission risk, while behavioral interventions include reducing drug use behavior that increases risk for HIV infection. Structural interventions help promote health by improving a community's social, physical and economic conditions. CDC improves program effectiveness through evaluation and sharing of best practices. The HIV Prevention by Health Departments program includes awards provided through three categories:

Category A: Core prevention funding is provided to all 61 jurisdictions. With core funding, health departments design, implement, and evaluate comprehensive HIV prevention programs. CDC encourages core programs to focus on groups at highest risk for HIV. Required components are: (1) HIV testing; (2) comprehensive prevention with positives (services and programs to assist HIV-infected persons with avoiding transmitting the virus); (3) condom distribution; and (4) structural initiatives. Programs may also conduct HIV prevention interventions targeting the highest-risk HIV-negative persons; social marketing, media, and mobilization activities to raise awareness and foster testing and risk reduction; and activities to support pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) services. PrEP and nPEP are prevention methods in which people take antiretroviral drugs to try to reduce the chance of becoming HIV positive before or after having sex or sharing drug injection equipment with partners that might have HIV.

Category B: Category B continues the Expanded Testing Program that CDC started in 2007 to supplement core efforts to promote HIV testing. This program provides additional funding to 34 jurisdictions with the highest prevalence of HIV infection among African Americans, Hispanics/Latinos, injecting drug users, and men who have sex with men (MSM). In its first three years, the Expanded Testing Program resulted in more than 2.8 million tests and 18,000 newly diagnosed persons in communities disproportionately affected by HIV. The Expanded Testing Program prevented an estimated 3,381 new HIV infections and saved the healthcare system more than \$1.2 billion in lifetime HIV-related medical costs during this same time span. Category B also supports implementation of CDC's Revised Recommendations for HIV Testing in Healthcare Settings, as testing in healthcare settings accounted for 67 percent of the total HIV testing events through 2010.

Category C: Innovative demonstration projects are awarded competitively to 30 health departments to develop methods that improve the practice of prevention. Projects focus on (1) structural, biomedical, and behavioral interventions with effectiveness in reducing HIV incidence; (2) innovative testing activities to increase cost-effectiveness and identification of undiagnosed HIV; (3) increased linkage to and retention in care for people living with HIV; (4) advanced use of technology, such as provision of services via the Internet and electronic medical records; and (5) use of CD4, viral load, and other surveillance data to assess and reduce HIV transmission risk. CD4 and viral load data are key clinical indicators. HIV destroys CD4 cells that are needed for a healthy immune system. Viral load is the level of HIV in the blood, and a lower viral load reduces the risk of HIV transmission to others.

Budget Proposal: CDC's FY 2014 request of \$399,744,000 for HIV Prevention by Health Departments is an increase of \$182,000 above the FY 2012 level. CDC will remain at the forefront of preventing new infections through its leadership and guidance to state and local governments as well as community stakeholders.

Improving Routine HIV Testing Program Sustainability (\$10 million reallocation)

With \$10 million in existing funds, CDC will encourage health departments and community-based organizations to develop the infrastructure to seek reimbursement for testing for HIV and related coinfections. Under Category B of the Health Department funding opportunity announcement, grantees

are expected to work towards sustainability of routine testing activities. Grantees will aim to align policies and regulations in their jurisdictions to create an enabling environment for billing, and address structural factors that may be barriers to billing. They should also identify the technical assistance needs of sites, collaborate with appropriate partners to facilitate billing efforts, identify local resources to facilitate billing, and share information across sites on successes and barriers through peer-to-peer support.

Other FY 2014 HIV Prevention by Health Department Activities

CDC will continue to build health department capacity to implement high-impact HIV prevention strategies, including: (1) focusing HIV prevention efforts in communities and local areas where HIV is most heavily concentrated; (2) increasing HIV testing; (3) increasing awareness and educating communities about the threat of HIV and how to prevent it; and (4) reducing HIV-related disparities and promoting health equity. In FY 2014, CDC will provide approximately two million HIV tests annually. CDC expects each funded jurisdiction to achieve the following performance standards:

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1.0% rate of newly identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment.
- At least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services.

CDC will support health departments as they implement data-driven, high-impact prevention services. CDC will continue to help health departments adjust to changes in prevention science and the healthcare landscape. CDC will maintain support for health departments to use CD4 cell count, viral load, core HIV surveillance and programmatic data to improve testing, linkage, retention and re-engagement in care activities. CDC will emphasize scalable, cost-effective interventions and public health strategies in order to reach the largest number of persons in the most effective manner. CDC will train health department staff on how to implement recommendations for HIV testing, counseling, and linkage to healthcare as effective interventions for HIV-positive persons and their partners. CDC will collect data on programs and impacts at both national and local levels. Such plans will remain consistent with HHS plans for streamlining data collection and reducing reporting burden for grantees. With the Substance Abuse and Mental Health Services Administration, CDC will develop, distribute, and provide training on the operational guidelines for routine HIV testing in substance abuse treatment centers, sexually-transmitted disease (STD) clinics, primary care and in-patient hospital settings, and non-healthcare settings. These efforts will involve collaboration with providers, health plans, state Medicaid boards, and other partners to incorporate HIV screening as the current standard of care. CDC will continue to support Program Collaboration and Service Integration (PCSI) in this and other core cooperative agreements by encouraging grantees to utilize their programs to address related infections - including viral hepatitis, other STDs, and TB - and to develop capacities that can be shared across programs. CDC will facilitate voluntary testing for STDs (including syphilis, gonorrhea, and chlamydial infection), hepatitis B and C viruses, and TB in conjunction with HIV testing, as medically appropriate.

Grant Table:

HIV Prevention by Health Departments Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ²	FY 2014 President's Budget ²
Number of Awards	67	67	67
Average Award	\$5.346	\$5.346	\$5.346
Range of Awards	\$0.159–\$34.170	\$0.159–\$34.170	\$0.159–\$34.170
Number of New Awards	67	0	0
Number of Continuing Awards	0	67	67
Total Grant Award	\$358.182	\$358.182	\$358.182

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

²Beginning in FY 2013, six Pacific Island jurisdictions will be funded separately in a new cooperative agreement for HIV, viral hepatitis, STD and TB activities, but Pacific Island awards and funding for HIV Prevention are included here for completeness.

CDC funding for Category A core HIV prevention ensures a strong, nationwide network of prevention programs through cooperative agreements with 50 states, eight cities, Washington, D.C., Puerto Rico and the Virgin Islands. Category B awards support increased testing in 34 health departments with the highest prevalence of HIV infection among African Americans, Hispanics/Latinos, injecting drug users, and MSM. Over a five-year period, CDC is phasing in a funding formula for Categories A and B based on the number of people living with HIV to allocate HIV funding to jurisdictions. CDC started using this formula in FY 2012; continued use of the funding formula will ensure that federal HIV prevention funding is aligned with the epidemic across the nation, so that the largest awards go to the jurisdictions with the greatest need as determined by the number of persons living with HIV. Through Category C awards, CDC is supporting demonstration projects to implement and evaluate innovative, high-impact HIV prevention interventions. To improve effectiveness, CDC will identify lessons learned and share results across jurisdictions.

National Programs to Identify and Reach Highest Risk Populations

Program Overview: 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, and social marketing.

Capacity building is a key strategy for the promotion, delivery and sustainability of HIV prevention programs. CDC provides capacity-building assistance (CBA) for community-based organizations, health departments, and HIV prevention community stakeholders through a network of 29 CBA providers. In 2012, CBA grantees provided over 600 trainings to community-based organizations, health departments, and other community stakeholders. From a sample of these trainings, 92 percent of the participants reported being highly satisfied or somewhat satisfied with the training.

CDC provides funding and scientific support to health departments across the nation to track new HIV diagnoses and deaths. In addition, CDC works with jurisdictions to measure community viral load and other population-level markers for HIV transmission risk in order to improve public health monitoring of the epidemic and linkage to and retention in care. As a result of CDC support and assistance, 32 jurisdictions report all CD4 cell counts and viral load test results.

CDC also conducts risk behavior surveillance and medical monitoring to track the HIV epidemic. In 2012, CDC released an expanded analysis of HIV prevention through care, utilizing data from HIV care surveillance and the Medical Monitoring Project, a nationwide sample of HIV-infected persons in care. CDC's analysis demonstrated that African Americans and young people are least likely to receive ongoing care and effective treatment. Overall, only 37 percent of HIV-infected Americans are retained in care, and only 25 percent have their viral infection under control. The odds of both are lower for African

Americans (34 and 21 percent, respectively), versus whites (38 and 30 percent, respectively). Even more striking, only 15 percent of HIV-infected persons between the ages of 25 and 34 are virally suppressed, versus 31 percent of those 45-54 years of age and 36 percent of those 55-64 years of age. These data will guide national, state and local testing programs, social marketing, and health education/risk reduction efforts in severely impacted populations. CDC's monitoring systems create efficiency and coordination across the federal government. 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.

CDC works through national, regional, and other organizations to: (1) build HIV prevention capacity in directly funded community-based organizations, health departments and non-CDC-funded community-based organizations across the nation; and (2) mobilize broader efforts to address HIV in communities disproportionately impacted by HIV. CDC also raises awareness among patients, providers, and the public about HIV. In December 2011, CDC launched *Testing Makes Us Stronger* (TMUS), a campaign designed by black gay men to encourage HIV testing among black gay and bisexual men. Between the campaign launch and March 2012, TMUS generated more than 300 million media impressions across six cities (New York City, Atlanta, Baltimore, Houston, Oakland, and Washington, D.C.). In July 2012, CDC launched *the Let's Stop HIV Together* campaign, featuring more than 20 individuals with HIV sharing their personal stories alongside their friends and family. Outdoor, transit and print ads ran in 19 cities heavily affected by HIV. In 2013, expanded community engagement and social media activities are planned to reach the target audience.

To meet *National HIV/AIDS Strategy* aims, CDC develops, identifies, and adapts biomedical and behavioral interventions, and provides guidance to prevention partners. For example, as part of its biomedical intervention work, CDC published the TDF2 study in 2012, providing evidence that a daily oral dose of antiretroviral drugs traditionally used to treat HIV infection can also reduce HIV acquisition among uninfected individuals exposed to the virus through heterosexual sex.

CDC also supports demonstration projects that identify and document best practices, as well as laboratory and epidemiologic studies. Health services and operations research are conducted with the goal of increasing linkage to and retention in quality care. CDC reduces health disparities by supporting applied research to adapt and translate interventions for at-risk populations. CDC develops scientific recommendations for HIV testing and other prevention strategies based on this and other research.

Finally, CDC strengthens collaborative work across disease areas and integrates services at the patient level, also known as the client level. For example, CDC published *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs* that recommend standards to facilitate the secure collection, storage, and use of data while maintaining confidentiality. Agencies can adopt these guidelines to improve the completeness of infection reporting and maximize use of data for public health action, including the provision of integrated and comprehensive services.

Budget Proposal: CDC's FY 2014 request of \$400,985,000 for National Programs to Identify and Reach High-Risk Populations is an increase of \$10,223,000 above the FY 2012 level. In addition to its ongoing activities, this budget sub-line includes a significant new initiative and an HIV surveillance funding increase in FY 2014.

Community High-Impact Prevention - CHIP (\$40 million reallocation)

CDC will reallocate \$40 million in existing funds toward CHIP, a new initiative that will maximize HIV prevention impact through capacity-building and community-based organizations. As mentioned above, a 2012 CDC analysis of national data has demonstrated that only 37 percent of HIV-infected Americans are retained in care, and only 25 percent have their viral infection under control. Additionally, there are significant disparities among populations in the likelihood of receiving ongoing care and effective

treatment, with African Americans and young people in particular being much less likely to be receiving care. CHIP will address the gaps in HIV prevention and in the care cascade, which will result in a greater impact on HIV prevention efforts. With the goal of re-aligning their programs to comply with a shifting public health system, both capacity-building assistance providers and community-based organizations will shift their activities to emphasize those that are scalable and sustainable.

First, at least \$20 million will be included in a new capacity-building assistance funding opportunity announcement being released in FY 2014. This new funding opportunity announcement will fully reflect the high-impact approach to HIV prevention. These funds will support the capacity of community-based organizations, health departments, and HIV prevention community stakeholders to implement interventions for persons living with HIV infection and people at high risk for acquiring HIV. Grantees will be expected to provide technical assistance on high-impact strategies that will improve HIV prevention efforts and the care cascade. These include sustainable, high-impact HIV testing and screening programs, delivering comprehensive prevention for HIV-positive individuals including linkage to and engagement in care and prevention services, using data to improve viral load suppression rates, and other services that support the high-impact prevention programs of health departments and community-based organizations.

Second, CHIP will also include approximately \$20 million in reallocated resources (approximately 46 percent of the total) within the cooperative agreement that directly funds community-based organizations. In FY 2014, these grantees will implement high-impact prevention services for persons with HIV and for persons at high risk for acquiring HIV. In order to further align their prevention programs with CDC's high-impact approach to prevention, grantees will be required to:

- Cease implementation of certain evidence-based interventions that are resource-intensive and/ or not expected to have a great effect on reducing HIV incidence;
- Cease implementation of certain public health strategies that are not as effective in changing behaviors;
- Increase the use of evidence-based interventions that target persons with HIV, including linkage to and retention in care, support for adhering to antiretroviral therapy, and transmission risk reduction; and
- Increase the use of specific, scalable, high-impact interventions to avert HIV infection among people at high risk.

Evidence-based interventions and public health strategies will be evaluated based on a set of criteria including estimated magnitude of effect on risk behavior or STD incidence based on randomized studies (when available), estimated incidence of HIV infection in the targeted population, cost per client served, and operational considerations. Interventions focused on persons with HIV will be reviewed for effect on risk behavior and outcome of interest, such as linkage or retention in care, cost, and feasibility. The re-alignment of community-based organization programs will no longer support the implementation of the following evidence-based interventions: Adult Identity Mentoring (AIM); Cuidate; Focus on Youth; Modelo Intervencion Psichomedica; Nia; Real AIDS Prevention Project (RAPP); Safety Counts; Self-Help in Eliminating Life-threatening Diseases (SHIELD); Sisters Informing Sisters about Topics on AIDS (SISTA); Sisters Informing, Healing, Living, and Empowering (SIHLE); and Street Smart.

In order to rapidly implement CHIP, CDC plans to issue new program guidance for funded community-based organizations within six months of the start of the fiscal year. These requirements will be detailed in the Interim Progress Report to grantees; information regarding program directives will be included in this guidance. In order for the grantee to continue to receive funding in FY 2014, the grantee must address and comply with the directives included in the guidance. CDC expects that this realigning of activities will better enable community-based organizations to link the hard-to-reach populations they serve with

needed services and ultimately improve retention in and adherence to medical care, which will result in a greater impact on HIV prevention efforts. This will also help prepare community-based organizations for a new funding cycle anticipated to begin in FY 2015, which will likewise require that grantees follow CHIP strategies.

Improving the Quality and Efficiency of HIV Surveillance Data (\$10 million increase)

With an additional \$10 million in FY 2014 resources, CDC will improve the timeliness, quality, and efficiency of HIV surveillance data used to monitor the *National HIV/AIDS Strategy*. Specifically, CDC will develop and promote the use of standard formats for the electronic reporting of laboratory results, timely shipment of specimens to a central laboratory for incidence testing, and obtain and match death records more quickly. The increased resources will also enhance CDC's ability to monitor the burden of HIV infection and disease in the United States by supporting activities such as monitoring antiretroviral drug resistance, perinatal exposure, improving behavioral surveillance among men who have sex with men (MSM), and assessing the use of the surveillance-to-program data feedback loop.

Other FY 2014 National Programs Activities

CDC's surveillance systems are critical to improving HIV prevention. CDC will continue to fund and assist health departments as they implement CDC's core HIV surveillance system. These cooperative agreements support case surveillance, including CD4 cell count and viral load reporting, and HIV incidence surveillance. In addition, CDC will fund surveys of HIV-related behaviors among high-risk populations, including MSM, injecting drug users, and heterosexuals at increased risk. CDC will monitor clinical outcomes, behavioral risks, and exposure to and use of HIV prevention interventions among HIV-infected individuals who are receiving HIV medical care in 23 project areas in the United States. These public health monitoring investments help CDC, states, and localities target prevention activities effectively and assess progress toward reducing HIV incidence and achieving other prevention goals.

In FY 2014, CDC will continue to support Program Collaboration and Service Integration (PCSI) by encouraging grantees to utilize their programs to also address related infections, including viral hepatitis, other STDs, and TB, and to develop capacities that can be shared across programs. PCSI activities will achieve efficiencies in program management and implementation, and improve health outcomes for populations at risk of multiple infections. 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 complementary services to TB patients, a group with historically high rates of HIV. CDC will also fund 59 state and local health departments for provision of HIV testing and partner services through sexually-transmitted disease (STD) programs.

In FY 2014, CDC will support three jurisdictions to evaluate the yield and cost-effectiveness of partner notification and contact tracing techniques linked to acute HIV infection screening. CDC will also fund a six-year evaluation of a comprehensive intervention to reduce transmission risk among persons with HIV infection, which includes behavioral risk reduction, retention in care and medication adherence support. Finally, CDC will continue to develop important programmatic and scientific recommendations, including recommendations related to testing and prevention with HIV positive persons.

CDC's HIV and AIDS communication campaigns raise HIV awareness, combat HIV-related stigma, and normalize testing and other risk reduction behaviors, particularly for populations most affected by HIV/AIDS. CDC will continue to conduct a series of campaigns to re-focus national attention on this country's HIV/AIDS epidemic through the *Act Against AIDS* campaign. This multi-faceted, national communications campaign will expand social media initiatives to educate Americans about the continued threat of HIV in the United States and target populations bearing a disproportionate burden of HIV/AIDS. CDC will also continue to fund an additional 34 community-based organizations that serve young MSM

of color, young transgender persons of color, and their partners in a program that emphasizes linkage to treatment and care for HIV-positive individuals.

Grant Tables:

HIV Prevention Projects for Community-Based Organizations Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	132	132	132
Average Award	\$0.327	\$0.327	\$0.327
Range of Awards	\$0.202–\$0.537	\$0.202–\$0.537	\$0.202–\$0.537
Number of New Awards	0	0	0
Number of Continuing Awards	132	132	132
Total Grant Award	\$43.164	\$43.164	\$43.164

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.

Community-based organizations have unique capabilities to reach populations disproportionately affected by HIV. CDC will support cooperative agreements with 132 community-based organizations to provide community-level interventions in populations most affected by HIV. The current funding cycle will end in FY 2015. In FY 2014, CDC will issue program guidance that will realign current activities with the high-impact approach to HIV prevention. As a result, 43 community-based organizations will cease the implementation of evidence-based interventions and public health strategies that do not meet criteria for high-impact prevention, and increase emphasis on biomedical, behavioral, and/or structural interventions and public health strategies that will have relatively greater impact; 62 community-based organizations will cease the implementation of Comprehensive Risk Counseling and Services; and 29 community-based organizations who are currently implementing evidence-based interventions for HIV negative individuals will be required to redirect prevention efforts towards HIV-positive individuals. All (132) funded community-based organizations will be required to strengthen their linkage to, re-engagement, and retention in care activities. Examples of linkage to care models supported include: linkage to care and treatment services, including direct support and follow-up for re-engagement and retention in care; Partner Services; and, patient navigator or peer navigation models to link clients to needed services to improve retention and adherence.

HIV Surveillance Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	65	65	65
Average Award	\$0.849	\$0.921	\$1.044
Range of Awards	\$0.007–\$4.377	\$0.010–\$5.549	\$0.012–\$6.476
Number of New Awards	0	65	0
Number of Continuing Awards	65	0	65
Total Grant Award	\$55.185	\$59.882	\$67.882

¹Beginning in FY 2013, six Pacific Island jurisdictions will be funded separately in a new cooperative agreement for HIV, viral hepatitis, STD and TB activities, but Pacific Island awards and funding for HIV surveillance are included here for completeness.

CDC's core surveillance system for HIV is critical to track and characterize the domestic HIV epidemic and inform public health actions. CDC funds cooperative agreements with all states and some local health departments, and provides scientific and programmatic assistance to ensure a robust national surveillance system. The new five-year funding cycle, begun in FY 2013, places greater emphasis on the completeness of laboratory reporting of HIV-related test results, including all HIV confirmatory test results and all levels of CD4 and viral load test results. This funding cycle includes two components. All jurisdictions

are required to conduct HIV case surveillance under component A. In addition, 25 jurisdictions are funded to conduct HIV incidence surveillance through component B of this cooperative agreement.

HIV Capacity-Building Assistance Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget ¹
Number of Awards	29	29	42
Average Award	\$0.701	\$0.701	\$0.594
Range of Awards	\$0.285-\$1.351	\$0.285-\$1.351	\$0.285-\$1.351
Number of New Awards	0	0	42
Number of Continuing Awards	29	29	0
Total Grant Award	\$20.329	\$20.329	\$24.955

¹FY 2014 figures are based on projected funding for a combined program announcement for CBA program and the STD Prevention Training Centers.

Through a network of community providers, CDC provides capacity-building assistance to health departments, community-based organizations and non-CDC-funded community organizations to improve delivery of evidence-based interventions, monitoring and evaluation, and infrastructure development. In FY 2012, there were 29 such providers funded through cooperative agreements. In FY 2014, a new funding cycle will begin and will continue through FY 2018.

HIV Adolescent and School Health

Program Overview: 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 school-based education programs and practices to prevent HIV, STD, and teen pregnancy among adolescents. In 2010, persons aged 15–24 years comprised 26 percent of all new HIV infections; within this group 82.8 percent were male and 17.2 percent female. An estimated 57.4 percent of new infections were among African Americans, 19.6 percent were among Hispanics and 19.5 percent were among whites. Sexual intercourse, sexual intercourse with multiple partners, sexual intercourse without using a condom, and injection drug use are behaviors that increase risk for HIV infection. The HIV Adolescent and School Health program is unique in the federal government because it funds cooperative agreements with state, territorial, tribal, and local education agencies to help adolescents develop healthy behaviors and avoid HIV and STDs while creating healthy school environments for all students.

CDC monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults through the Youth Risk Behavior Surveillance System. Additionally, CDC provides national data on school-based health policies, programs, and practices; such data are not monitored elsewhere in the government. CDC also translates research findings, develops science-based guidance, assesses policies and programs, and develops tools for schools to implement interventions and programs.

CDC's HIV adolescent and school health program has contributed to the success of protecting the health of adolescents through decreases in sexual risk behaviors. In July 2012, CDC published an analysis of trends in HIV-related risk behaviors among high school students using data from the biennial Youth Risk Behavior Survey for the period 1991–2011. The results of that analysis indicated among high school students from 1991–2009, there was a 15 percent reduction in the proportion of students who had ever had sexual intercourse and a 32 percent increase in the use of a condom during last sexual intercourse. From 1991–2011, the proportion of African American high school students who have ever had sexual intercourse declined from 82 percent to 60 percent. CDC also reported decreases in sexually transmitted infections. For example, in 2009 rates of gonorrhea among persons aged 15–19 years decreased for the second year in a row. Improvements in school health practices between 2000 and 2006 study results

showed the percentage of middle schools and high schools in which health services staff provided HIV counseling, testing, and referrals increased from 11.8 percent to 39.1 percent.

The risk for acquiring HIV infection during adolescence and early adulthood starts with initiation of sexual behavior or injection drug use, and initiation of contributing behaviors such as use of alcohol and other drugs. All persons need to understand the threat of HIV and how to prevent it. 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. Youth Risk Behavior Survey data for the period 1991–2011 showed that although the percentage of students overall who had ever had sexual intercourse decreased significantly from 54.1 percent in 1991 to 47.4 percent in 2011, the entirety of this decrease was achieved in the first decade and the prevalence of ever having had sexual intercourse did not change significantly after 2001.

Budget Proposal: CDC's FY 2014 request of \$35,395,000 for HIV Adolescent and School Health, including \$3,000,000 in Public Health Service Evaluation transfers to assess and refine core school health activities, is an increase of \$3,086,000 above the FY 2012 level. Consistent with NHAS, CDC works to improve school health education for HIV, STD and teen pregnancy prevention. CDC disseminates evidence-based guidance, supports evaluation research, and provides funding and technical assistance to help state, territorial, and local education agencies implement exemplary sexual health education, link students to sexual health services including HIV and STD testing, and create safe and supportive environments for all students, particularly those at greatest risk for HIV infection and other STDs.

In 2014, CDC will use a \$3 million increase in PHS Evaluation Transfer funds to assess and refine its core activities, examining their alignment with NHAS and effectiveness in achieving NHAS aims. Specifically, CDC will examine the extent to which schools have revised policies, practices, and services to align with their self-assessments, their adoption of instructional strategies and curricula that are consistent with scientific evidence of effectiveness and national education standards, and new approaches to teacher training. CDC will conduct case studies to identify effective strategies establishing school-based sexual health services for sexually-active youth. CDC will also evaluate programs to provide safe environments, free of bullying and harassment, for youth, particularly those at greatest risk for HIV infection and other STDs.

To reduce the percentage of adolescents who engage in sexual risk behaviors, CDC will intensify efforts in communities where HIV cases are the highest. In FY 2014, CDC will fund and support states and school districts to: 1) increase implementation of evidence-based sexual health education programs in schools; 2) create more supportive school environments for adolescents at highest risk for HIV; and 3) increase HIV counseling and testing among adolescents.

At this level of funding, targeted state, district, and national non-governmental activities will be maintained through fewer, but larger, cooperative agreement awards. CDC will monitor trends through the use of school-based surveillance systems to measure the prevalence of HIV and other health risk behaviors among adolescents and track school health policies and practices to prevent them.

CDC will provide scientific and programmatic expertise and leadership to state, local and other federal programs, synthesize research to make it available to practitioners, and work to bring a youth focus to CDC's other HIV and STD programs. CDC improves the quality of school health education through resources such as the school health index (a comprehensive self-assessment and planning tool for school health programs), tools to help school districts select health education curricula that are consistent with scientific evidence of effectiveness and national education standards, and teacher training. The agency's efforts are expected to result in the adoption and maintenance of health-protecting behaviors—especially abstinence and condom use—among adolescents in the United States.

Partners are critical in reaching communities with the highest rates of HIV prevalence and addressing health inequities that are most associated with these communities. CDC will continue to work with education and public health partners to increase prevention efforts in schools.

Grant Table:

HIV Prevention for Adolescent and School Health Grant Table¹

(dollars in millions)	FY 2012 Enacted ²	FY 2013 CR ³	FY 2014 President's Budget ³
Number of Awards	71	29	29
Average Award	\$0.160	\$0.225	\$0.400
Range of Awards	\$0.029–\$0.227	\$0.100–\$0.650	\$0.100–\$0.650
Number of New Awards	0	29	0
Number of Continuing Awards	71	0	29
Total Grant Award	\$11.360	\$6.525	\$11.600

¹ Reflects HIV prevention funding to state, tribal, local, and territorial education agencies.

² CDC's budget for Adolescent and School Health in FY 2012 was reduced by \$10 million. To accommodate the reduction while maintaining funding for all grantees, CDC decreased average FY 2012 award levels for education agencies and national non-governmental organizations.

³ A new funding cycle is beginning in FY 2013 and will align 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 1 (FY 2013) will be substantially less than for FY 2014 and beyond. Additionally, significantly fewer awards are being anticipated for HIV prevention in the new funding cycle, but as the cycle progresses there will be higher average funding levels commensurate with required activities.

In FY 2013, CDC is beginning a new five-year HIV adolescent and school health cooperative agreement with four components: (1) school-based surveillance, (2) HIV prevention, (3) capacity-building assistance, and (4) school-centered HIV/STD prevention for young men who have sex with men. The grant table above only reflects awards under the HIV prevention component. CDC expects to provide fewer awards, through a competitive process, at a higher average amount than in previous years. States and cities with high rates of HIV infection will be required to implement targeted activities for youth at disproportionate risk of infection, including young MSM, homeless youth, and youth in alternative schools. CDC anticipates funding 29 state and local education agencies to provide young people with the skills and knowledge needed to avoid infection with HIV and other STDs, thereby reducing disease transmission.

VIRAL HEPATITIS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$21.282	\$21.418	\$31.410	+\$10.128
ACA/PPHF	\$10.000	N/A	\$0.000	-\$10.000
Total	\$31.282	\$21.418	\$31.410	+\$0.128

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: CDC leads implementation of the *HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis* to respond to the growing public health threat of viral hepatitis. Between 3.5 and 5.3 million Americans are living with chronic viral hepatitis infection, and between 45 to 85 percent of them are unaware of their infection and are not receiving any medical care for their infection. CDC works with state and local health departments, community-based organizations and other partners to prevent new viral hepatitis infections and reduce hepatitis-related illness and death.

CDC identifies populations most at risk for viral hepatitis, characterizes sources of transmission, and monitors the disease burden and the impact of CDC prevention efforts through epidemiologic studies and

surveillance. CDC conducts laboratory research to assess the performance of new screening tests and monitor the circulation of variant strains that may not be prevented by current vaccines or responsive to therapies. CDC develops recommendations for hepatitis A virus and hepatitis B virus (HBV) vaccination of infants and at-risk adult populations based on this research. (Programs providing immunization to infants and adults do so with support from CDC's Vaccines for Children and Section 317 Immunization Programs.) Infants born to women who are infected with hepatitis B receive special attention, as these infants are at highest risk for developing chronic HBV infection and liver cancer later in life. CDC's epidemiologic and laboratory studies also inform HBV and hepatitis C virus (HCV) screening recommendations. In August 2012, CDC published *Recommendations for the Identification of Chronic Hepatitis C Virus Infection Among Persons Born During 1945–1965*, as three quarters of persons with HCV are in this birth cohort.

CDC helps state and local health departments in preventing and controlling viral hepatitis. With its public health partners, CDC helps conduct outbreak investigations. Through these efforts, potentially exposed persons are identified, screened, and referred for treatment if indicated. In the recent 2012 multi-state viral hepatitis outbreak, CDC's viral hepatitis laboratory genetically characterized the virus that infected the healthcare worker who was the outbreak's source, and both the laboratory and the epidemiology team then helped to identify persons in several states whose infections were likely transmitted by him.

CDC supports viral hepatitis coordinators in 48 states, the District of Columbia, the Pacific Islands, New York City and Philadelphia who work to incorporate viral hepatitis prevention into HIV, STI, immunization and other programs serving populations at risk. In a limited number of sites, CDC also supports testing and referral to care for populations especially affected by chronic HBV and HCV infection. CDC develops and distributes materials in a wide variety of formats both to educate populations at risk for infection and to train healthcare providers, public health professionals and social services providers about hepatitis prevention and testing strategies to reach those persons at risk for chronic infection.

Budget Proposal: CDC's FY 2014 request of \$31,410,000 for Viral Hepatitis is an increase of \$128,000 above the FY 2012 program level.

CDC will use funds to address the goals in the *HHS Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis*. CDC will seek to: (1) reduce viral hepatitis-related illness and death by expanding access to testing for persons at risk for chronic infection; (2) link infected persons to appropriate medical care and treatment; (3) improve interventions to prevent HCV transmission among adolescents and young adults; (4) encourage HBV vaccination for at-risk adults; (5) increase and improve case management of infants born to HBV-infected mothers; and (6) raise awareness about viral hepatitis among at-risk persons and educate healthcare providers about viral hepatitis prevention, care and treatment. In addition, CDC will continue to reduce the incidence of hepatitis A and hepatitis B through a national vaccination strategy targeting infants and young children through the immunization program.

CDC will continue to fund viral hepatitis coordinators to provide leadership for viral hepatitis prevention activities; a limited number of testing and referral to care sites serving populations disparately affected by chronic HBV and HCV infection; community awareness activities and materials; and provider education programs. Also, CDC will continue to fund active surveillance—investigating case reports to ascertain demographic and infection risk information about patients and disease transmission trends in the community—adding a small number of statistically representative jurisdictions to those currently funded. 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 and will financially and technically support a limited number of states to encourage the use of electronic medical records to improve the diagnosis of and care for persons living with chronic viral hepatitis. 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 also

address related infections, e.g., HIV and other STDs, and to develop capacities that can be shared across programs, including HIV, STD and TB.

In FY 2014, CDC will continue to analyze the long-term effectiveness of hepatitis A virus and HBV vaccines, assess the role of vaccination in preventing transmission among populations not currently recommended to receive these vaccinations, and monitor and assess efforts to improve diagnosis of HBV and HCV infections.

Grant Table:

Viral Hepatitis Cooperative Agreement Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	54	52	52
Average Award	\$0.094	\$0.102	\$0.102
Range of Awards	\$0.019–\$0.192	\$0.019–\$0.250	\$0.019–\$0.250
Number of New Awards	0	52	0
Number of Continuing Awards	54	0	52
Total Grant Award	\$5.076	\$5.301	\$5.301

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.

CDC awards funding through competitive cooperative agreements to 48 states, the District of Columbia, New York City and Philadelphia to support viral hepatitis coordinators who leverage existing capacities to increase viral hepatitis preventive services for at-risk populations. They also promote the use of CDC recommendations for hepatitis vaccination, screening, and linkage to care in the healthcare provider community, raise awareness of the importance and prevalence of viral hepatitis among at-risk populations, and identify and implement strategies to improve hepatitis A virus and hepatitis B virus vaccination coverage among vulnerable populations. CDC will also fund one award to a technical assistance provider with expertise in viral hepatitis that further supports the viral hepatitis coordinators in the states and localities. A new five-year funding cycle began in FY 2013.

SEXUALLY TRANSMITTED INFECTIONS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$161.697	\$162.729	\$161.710	+\$0.013

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC has a long history of successful, cost-effective prevention of sexually transmitted diseases (STDs), also known as sexually transmitted infections (STIs), and their sequelae. STD sequelae are harmful, associated medical conditions that include poor reproductive outcomes such as pelvic inflammatory disease and infertility, and increased risk of HIV infection. Notable accomplishments include preventing 32 million cases of gonorrhea, saving \$3.7 billion over a 33-year period ending in 2003, reducing the overall rate of primary and secondary syphilis by 90 percent from 1990 to 2000, and annual prevention of 21,000 cases of pelvic inflammatory disease and 4,000 cases of tubal factor infertility resulting in potential healthcare cost savings of \$45 to \$77 million each year. Despite these remarkable successes, STDs such as chlamydia, gonorrhea, and syphilis remain the most common reportable infections in the nation today. CDC estimates that there are about 20 million new sexually transmitted infections every year, costing the U.S. healthcare system nearly about \$16 billion in direct medical costs alone.

CDC focuses on preventing infections among the population groups with the highest burden of infection: (1) adolescents and young adults, and (2) men who have sex with men (MSM). CDC data indicate that adolescents and young adults represent half of all new STD cases, but make up only one fourth of the U.S. population. CDC also addresses individual and social factors and other determinants of health that affect STD outcomes.

CDC assures the provision of quality STD services in both the public and private sectors through several means: (1) providing direct scientific and programmatic expertise to grantees and others in the field; (2) conducting and publishing STD prevention research; (3) facilitating peer to peer sharing of best practices; (4) training; (5) educating providers, patients, and the public; (6) developing guidelines and recommendations for STD prevention and control nationally; and (7) serving as a national STD gold standard reference laboratory. For example, CDC has found concerning patterns of declining susceptibility to the last antibiotic available for treatment of gonorrhea, leading the agency to issue updated guidelines in August 2012. Gonorrhea is a very complex bacterium that continuously evolves to become resistant to each antibiotic recommended for treatment. CDC's guidelines outline additional follow-up steps providers should take to closely monitor for failure of the injectable antibiotic ceftriaxone, the only remaining recommended drug proven effective for treating gonorrhea. In addition, through regional training centers, CDC helps state and local STD prevention programs prevent the spread of chlamydia and gonorrhea, especially among adolescents. These efforts are vital, as chlamydia and gonorrhea pose serious public health concerns, including infertility, and in the case of gonorrhea, potential antibiotic resistance and increased HIV transmission.

The agency also trains physicians on STD treatment guidelines that highlight special populations, including MSM, adolescents, and incarcerated populations. Recently, 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 sites. Enrollment of patients for the pilot phase of this project is complete. 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 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.

Budget Proposal: CDC's FY 2014 request of \$161,710,000 for Sexually Transmitted Infections is an increase of \$13,000 above the FY 2012 level. CDC will concentrate on four priority areas to guide STD prevention and maximize long term impact—adolescents and young adults, MSM, multi-drug resistant gonorrhea, and congenital syphilis. CDC will also work to increase healthcare providers' knowledge and skills related to STDs, as well as provide funding and scientific and programmatic assistance to states and territories.

- Adolescents and young adults—CDC will continue to work with partners to increase prevention and outreach efforts to address the high proportion of incidence in adolescents and young adults. For example, CDC will provide accurate STD-related information, data, and public health messages to the partner organizations that sponsor *GYT: Get Yourself Tested*, an award-winning multimedia campaign to raise STD awareness among young people. 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.

- Men who have sex with men—CDC will fund state and local health departments to implement local prevention efforts to reduce 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. In addition, CDC will support clinical provider training and outreach to increase the use of laboratory screening tests for non-genital chlamydia and gonorrhea among MSM.
- Multi-drug resistant gonorrhea—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.
- Congenital syphilis—CDC will strengthen partnerships with healthcare providers 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. CDC will also continue development of guidelines for screening and treatment of STDs, STD diagnostics, and laboratory practice. Twelve 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 will provide financial and technical support to state and local health departments to control STDs in their jurisdictions (see table below). 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 also address related infections, e.g., HIV, viral hepatitis, and to develop capacities that can be shared across programs, including HIV, viral hepatitis and TB.

Implementation of the health insurance expansion provisions of the Affordable Care Act (ACA) in 2014 will likely lead to increased provision of STD screening for certain populations by non-grandfathered private health plans without cost sharing. Medicaid expansion will also increase coverage for STD screening. CDC will work with public health agencies to develop the capacity to bill for services covered through insurance. Because STDs disproportionately affect population groups that traditionally have difficulty accessing care, public health departments have a critical role in linking individuals to care. CDC's current STD prevention activities are complementary but not redundant to ACA provisions, and include funding state, territorial, and select local health departments. Grantees use most of their CDC funding on personnel costs needed to implement CDC's STD Prevention Program Operations Guidelines in order to strengthen STD assessment and assurance functions. Assessment includes surveillance, evaluation, and identifying gaps in services at the community level. Assurance includes addressing current and emerging community health needs and threats, as well as 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.

Grant Table:

Sexually Transmitted Disease Prevention Cooperative Agreement Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ²	FY 2014 President's Budget ²
Number of Awards	65	65	65
Average Award	\$1.555	\$1.555	\$1.555
Range of Awards	\$0.043–\$6.724	\$0.043–\$6.724	\$0.043–\$6.724
Number of New Awards	0	0	59
Number of Continuing Awards	65	65	6
Total Grant Award	\$101.075	\$101.075	\$101.075

¹Awards include funding to address HIV coinfection.

²Beginning in FY 2013, six Pacific Island jurisdictions will be funded separately in a new cooperative agreement for HIV, viral hepatitis, STD and TB activities, but STD funding for these jurisdictions is noted here for completeness. The six continuing awards noted in FY 2014 are the Pacific Island grantees.

CDC awards the majority of its STD funds to state and local health departments through cooperative agreements. A new five-year cooperative agreement cycle will begin in January 2014. This new cycle will include 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 this program, 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. The STD cooperative agreement supports and improves the ability of public health departments to: (1) design, implement, and evaluate state and local STD programs; (2) assure low-income women have access to infertility services and promote interventions that prevent STD-related infertility; (3) screen for and prevent syphilis among hard to reach populations, such as MSM; (4) focus on integration of screening for congenital syphilis during antenatal visits; and (5) implement the Gonococcal Isolate Surveillance Project in eligible jurisdictions. Grantees implementing these programs must primarily focus their efforts on the prevention of chlamydia, gonorrhea, and syphilis among disproportionately impacted populations. Ultimately, these cooperative agreements will increase identification and treatment of STD cases and reduce STD rates in the U.S. population.

TUBERCULOSIS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$147.352	\$148.294	\$147.698	+\$0.346

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC works 24/7 to protect the United States from tuberculosis (TB), particularly from those threats posed by global TB and drug-resistant TB. CDC's TB program reversed a deadly TB resurgence during the late 1980s and early 1990s which was caused by decreased funding for TB programs, changes in demographics, and the HIV epidemic. The resurgence resulted in more than 52,000 excess cases of TB disease. Thanks to a concerted federal, state, and local response, TB incidence is now at its lowest since national reporting began in 1953. Annual new TB cases have decreased from 26,673 in 1992 to 10,528 in 2011, a 60 percent reduction. The United States now has among the lowest TB incidence rates in the world. However, the rate of decline in TB has slowed, reflecting the difficulty of preventing TB in vulnerable populations. The majority (61 percent) of U.S. TB cases are among persons born outside this country, reflecting the higher TB prevalence in other parts of the world.

Since TB is endemic in many other countries, is spread through the air from person to person, can be latent and become reactivated, and since inappropriate or interrupted TB treatment can lead to drug

resistance, intensive TB prevention and control programs are needed to protect communities. To maintain TB control and ultimately eliminate TB from the United States, CDC provides funding and personnel to all 50 states, ten large cities, and eight territories. CDC also provides scientific and programmatic assistance, training, and education on TB control and elimination; monitors the occurrence of TB; and supports epidemiologic, laboratory, and clinical research. CDC's unique TB expertise allows the agency to assist in outbreak investigations across the country and serve as a national reference laboratory for TB.

CDC recently published research and guidelines for curing people with latent TB infection (which can lead to TB disease) over a shorter period of time. The new regimen cuts the number of doses of antibiotics from 270 taken over nine months to 12 taken over three months. This regimen is also easier for patients to tolerate. The use of this new, shorter course of treatment will make it easier for patients to complete therapy, which can ultimately reduce the number of new cases of TB disease. In addition, in 2009 CDC's TB Laboratory Branch developed and implemented the Molecular Detection of Drug Resistance (MDDR) Service, a national clinical referral service which provides rapid confirmation of multidrug-resistant and extensively drug-resistant TB. The results provided by the MDDR Service affect not only decisions about individual patient management, but also those related to infection control and public health interventions designed to limit additional morbidity and mortality among those exposed to a person with tuberculosis. Rapid confirmation of drug resistant tuberculosis and guidance on selection of an effective drug regimen will reduce the delay in adequate treatment, and translate into decreased transmission of TB, thereby protecting others from acquiring infection.

CDC funds state and local TB programs to investigate and report every case of TB in their community to prevent the spread of the disease. Specifically, health departments identify TB cases, test them for drug-resistance, manage the treatment of people with TB disease, identify infected contacts, and provide community training and outreach. CDC coordinates national surveillance data and provides outbreak investigation assistance and program support to health departments.

Budget Proposal: CDC's FY 2014 request of \$147,698,000 for TB is an increase of \$346,000 above the FY 2012 level. TB can be misdiagnosed and inappropriately treated, resulting in prolonged transmission among families and communities, as well as months of debilitating illness for the patient. To combat this problem, beginning in 2013 CDC will fund five regional training and medical consultation centers to assure an adequate supply of workers with training in TB diagnosis and treatment. Many physicians in the U.S. have never seen a TB case during their training, and are unfamiliar with TB diagnosis and treatment. These centers offer medical consultation to physicians who are treating TB patients, particularly those with complicated or drug resistant cases. The agency's aim is to increase the percentage of persons newly diagnosed with drug-sensitive TB who complete treatment within 12 months, increase the percentage of culture-positive TB patients who receive testing for drug susceptibility, and increase the percentage of newly infected contacts of persons with smear-positive TB who complete treatment for TB infection.

CDC will continue to fund and provide technical support to state and local TB programs. This support forms the critical backbone of TB control in the U.S. 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 also address related infections and to develop capacities that can be shared across programs, including HIV, STD, and viral hepatitis.

CDC will continue to develop better TB diagnostic tools and address the significant limitations of current therapies, including harmful side effects. CDC is evaluating uptake of its newly-developed regimen to treat latent TB infection and prevent future cases of disease, and will work with the Food and Drug Administration (FDA) and others to monitor the use of a newly available drug, the first of its kind in 40 years, for multi-drug resistant TB. In addition, CDC will fund research to improve TB therapy in children and in persons with HIV infection, diabetes, other co-morbidities, and drug-resistant TB. Moreover, CDC will support programmatic research to develop more efficient means to control TB in the future. Successful results will allow the United States to protect its residents from TB in the wake of continued

challenges posed by high global levels of TB and drug-resistant TB. To further reduce the importation of TB cases into this country, CDC will build TB surveillance, program, laboratory, and health systems capacity in countries with high burdens of TB, TB/HIV coinfections, and drug-resistant TB, as well as in other countries of strategic interest for domestic TB elimination efforts.

Healthcare services are only a small part of the work that must be done to keep TB under control. Health departments must also conduct screening, preventive therapy, contact investigations, surveillance, outbreak investigations, and training to local providers. This expertise does not exist in and is not provided by the private sector. Moreover, clinical and applied TB research, as conducted by the TB Trials Consortium and the TB Epidemiologic Studies Consortium, is not conducted by the private sector. Eighty percent of CDC's budget for TB prevention is directed toward these time- and resource-intensive state and local public health activities. The remaining 20 percent of CDC funding for TB supports national efforts such as guideline development, outbreak control, maintaining a national reference laboratory for TB, and monitoring national program performance.

Grant Table:

TB Prevention and Control Cooperative Agreement Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ^{2,3}	FY 2014 President's Budget ³
Number of Awards	68	68	68
Average Award	\$1.344	\$1.344	\$1.344
Range of Awards	\$0.869–\$8.599	\$0.869–\$8.599	\$0.869–\$8.599
Number of New Awards	0	0	0
Number of Continuing Awards	68	68	68
Total Grant Award	\$91.392	\$91.392	\$91.392

¹ Awards include funding to address HIV coinfection.

² In FY 2013, the funding formula will be revised.

³ Beginning in FY 2013, six Pacific Island jurisdictions will be funded separately in a new cooperative agreement for HIV, viral hepatitis, STD and TB activities, but TB funding for Pacific Island grantees is noted here for completeness.

CDC supports health departments in all 50 states, 10 big cities, Washington, D.C., 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. Four of these grantees also serve as regional training and technical assistance centers. Through these cooperative agreements, CDC protects Americans from TB, including drug-resistant TB.

CDC-WIDE HIV/AIDS FUNDING

Fiscal Year	Domestic HIV/AIDS Prevention and Research (Infectious Disease)	Other Domestic HIV Prevention	Global AIDS Program¹	CDC-Wide HIV Total²
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 CR	\$827,667,000	\$0	\$131,993,000	\$959,660,000
2014 President's Budget	\$836,124,000	\$0	\$131,942,000	\$968,066,000

¹Amounts for the Global 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 AIDS do not include President's Emergency Plan for AIDS Relief (PEPFAR) funding.

²From FY 2004 to FY 2007, 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 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.

³In 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.

⁴HIV/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.

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

⁶FY 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.

⁷FY 2012 and FY 2013 funding levels have been made comparable to the FY 2014 request to reflect the proposed FY 2014 BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data. Funding levels prior to FY 2012 have not been made comparable to the FY 2014 request.

PERFORMANCE

Program: Domestic HIV/AIDS Prevention and Research

NHAS Performance Measures and CDC Contextual Indicators for Long Term Objective: Reduce new HIV infections¹

Contextual Indicators	Most Recent Result	FY 2015 Target
2.1.1: Decrease the annual HIV incidence (Outcome)	FY 2010: 47,500 (Historical Actual)	36,450
2.1.2: Reduce the HIV transmission rate per 100 persons living with HIV (Outcome)	FY 2009: 3.9 (Historical Actual)	3.2
2.1.3: Increase the percentage of people living with HIV who know their serostatus (Outcome)	FY 2009: 81.9% (Historical Actual)	90.0%

¹ Some results have been updated based on improved methodologies.

Performance Measures for Long Term Objective: Reduce new HIV infections

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
2.1.7: Increase the proportion of adolescents (grades 9–12) who abstain from sexual intercourse or use condoms if currently sexually active ¹ (Outcome)	FY 2011: 86.8% (Target Not Met)	N/A	N/A	N/A
2.1.8: Reduce the proportion of persons with an HIV diagnosis at later stages of disease within three months of diagnosis ² (Outcome)	FY 2010: 27.7% (Baseline)	26.3%	22.9%	-3.4

¹ Targets and results are set and reported biennially. The FY2013 target is 86.9%.

² Per the HHS Secretary's memo (4/11/12) on implementing a common set of core indicators, to be implemented across federal agencies, CDC has revised this indicator definition to conform with the cross-agency definition.

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 Indicator	Most Recent Result	FY 2015 Target
2.2.1: Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis (Outcome)	FY 2010: 80.3% (Historical Actual)	85.0%

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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 2010: 72.5% (Target Exceeded)	72.0%	75.0%	+3.0
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 2010: 58.8% (Target Not Met but Improved)	66.0%	67.0%	+1.0
2.2.4: Increase the number of states that report all CD4 and viral load values for HIV surveillance purposes (Output)	FY 2012: 32 (Target Exceeded)	31	33	+2
2.2.5: Increase the number of states with mature, name-based HIV surveillance systems (Output)	FY 2011: 50 (Target Exceeded)	50	50	Maintain
2.2.6: Reduce the number of new AIDS cases among adults and adolescents per 100,000 population (Outcome)	FY 2010: 13.0 (Target Exceeded)	12.9	12.5	-0.4

Performance Trends: Since the advent of improved HIV treatments in the mid-1990s, the numbers of people with HIV who go on to develop AIDS and die with 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 18,000 in 2009. 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 eight percent from 2006 to 2009 to a total of 1,148,200 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 in 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.² About 50,000 people contract HIV each year, and while the lifetime medical care and treatment costs for these individuals total approximately \$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.³ A recently published study assessed the cost effectiveness of CDC-funded prevention

² 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.

³ Farnham P, et al. Medical costs averted by HIV prevention efforts in the United States, 1991—2006. JAIDS 2010. 54:565-7.

programs conducted by health departments and found that they are cost-saving.⁴ 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 2011.⁵

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 unacceptably high. In July 2010, the administration released the National HIV/AIDS Strategy (NHAS) that established new priorities for preventing HIV infection, improving the health of people living with HIV, and reducing HIV-related disparities. In response, CDC developed a new HIV strategic plan that emphasizes the efficient and strategic allocation of prevention resources to achieve maximal impact on the HIV epidemic. In addition, CDC has aligned its HIV-related long-term measures and targets with NHAS.

Reducing HIV incidence is NHAS' and CDC's primary goal. HIV incidence declined significantly from approximately 130,000 cases per year in the mid-1980s to approximately 50,000 cases per year today due to numerous federal, state, local government and community response efforts (Measure 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 most recent analysis of HIV incidence data reveal signs of an encouraging decrease in new HIV infections among heterosexual black women from 2008–2010, which is contributing to a decrease overall among heterosexual women. Since the number of people living with HIV has increased as a result of new treatments, HIV incidence alone is not a good indicator of the effects of HIV prevention programs. HIV transmission rates, which are calculated based on the number of people living with HIV, declined by 48 percent over the last 12 years (from an estimated 7.5 transmissions per 100 persons living with HIV in 1997 to 3.9 transmissions in 2009) (Measure 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. In 2010, all CDC-funded HIV testing programs conducted approximately 3.3 million HIV tests and further increased routine HIV testing in healthcare and community settings. CDC's Expanded HIV Testing Initiative prevented 3,381 new HIV infections in its first three years and saved an estimated \$1.2 billion in direct medical costs.⁶ Those living with HIV who know their serostatus increased from 80.6 percent in 2006 to 81.9 percent in 2009 (Measure 2.1.3). In 2010, 27.7 percent of persons diagnosed with HIV were diagnosed late in the course of infection (Measure 2.1.8).

When someone tests positive for HIV, it is important that he or she receive HIV medical care, partner services to confidentially notify and provide prevention services to sexual or drug-sharing partners who may be infected, and other prevention services to reduce the risk of future HIV transmission. CDC data from 14 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 2010, the percent of people diagnosed with HIV who were linked to care within three months of diagnosis increased from 65.0 percent to 80.3 percent (Measure 2.2.1).⁷ CDC will be better able to assess national progress as more areas provide complete CD4 and viral load data in the coming years. CDC also increased referrals to Partner Services programs that notify partners who may be infected. CDC increased referrals to partner services for people diagnosed with HIV in publically-funded HIV testing sites from 69.4 percent in 2009 to 72.5 percent in 2010, exceeding the 2010 target (Measure 2.2.2). CDC slightly

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

⁵ 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/hiv/aids/upload/7029-07.pdf>. Accessed on 1/5/2012.

⁶ Hutchinson A et al. 2012). Return on public health investment: CDC's Expanded HIV Testing Initiative. *JAIDS* 2012. 59: 281-6.

⁷ Office of National AIDS Policy. National HIV/AIDS Strategy. Washington, DC: Office of National AIDS Policy; 2010.

increased referrals for these individuals to other HIV prevention services from 2009 to 2010, but did not meet the target (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 percent of diagnosed cases are reported). All 50 states have adopted CDC's recommendations for confidential name-based HIV surveillance, and because all 50 states had mature, name-based HIV surveillance systems in 2011, exceeding the 2011 target, CDC is now able to incorporate HIV surveillance data from more states in its analyses (Measure 2.2.5). 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. In 2012, 32 states reported 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 to monitor disease progression using surveillance data. From 2009 to 2010, CDC reported that new diagnoses of AIDS dropped from 13.5 (baseline) to 13.0 per 100,000, exceeding the 2010 target of 13.3 (Measure 2.2.6).

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 be cost effective. For example, every dollar invested in school 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 overall who ever had sexual intercourse decreased significantly from 54.1 percent in 1991 to 47.4 percent in 2011. Condom use at most recent sexual intercourse among students currently having sexual intercourse increased from 46.2 percent in 1991 to 60.2 percent in 2011. Although CDC did not meet its FY 2011 target, 86.8 percent 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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
2.6.1: Reduce the rate of new cases of hepatitis A (per 100,000 population) (Outcome)	FY 2010: 0.5 (Target Exceeded)	0.9	0.4	-0.5
2.6.2: Reduce the rate of new cases of hepatitis B (per 100,000 population) (Outcome)	FY 2010: 1.1 (Target Exceeded)	1.5	1.0	-0.5
2.6.4: Increase the number of state and local health departments reporting acute and chronic viral hepatitis data of sufficient quality to be analyzed in national surveillance reports ¹ (Output)	FY 2011: 8 (Historical Actual)	10	10	Maintain

¹As of FY 2013, CDC expanded the scope of this measure to also include chronic viral hepatitis, which is reflected in FY 2014 targets.

Performance Trends: In the United States, the 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, HAV incidence decreased approximately 95 percent nationwide since 1995. The 2010 rate of 0.5 cases per 100,000 surpasses the Healthy People 2010 target of 2.4 cases per 100,000 and is the lowest rate of new cases recorded to date. CDC expects that the expansion of 2006 recommendations for routine hepatitis A vaccination, which now include all children in the 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 2010 target of 4.5 cases per 100,000, and the 2010 rate of 1.1 cases per 100,000 is the lowest rate of new cases recorded historically (Measures 2.6.2). Declines over the past decade are linked to the successful vaccination strategy, as well as increases in screening and awareness. More than 95 percent 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 percent 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 acquisition in that population. Previously, CDC reported on the portion of persons tested for HBV among minority communities experiencing health disparities. However, as of 2012, CDC discontinued the REACH data collection due to shifts in resources.

Hepatitis C incidence declined from 290,000 cases per year to an estimated 17,000 per year between 1989 and 2010, largely as a result of decreases in infections among injection drug users (IDU), and successful efforts to screen the U.S. blood supply. However, transmission among IDUs and outbreaks of hepatitis C related to healthcare settings remain important transmission sources. Further, between 2.7 and 3.9 million Americans are infected with HCV, and most are unaware of their infection. On the basis of data from prospective and retrospective cohorts, an estimated 20 percent of infected persons will progress to cirrhosis 20 years after infection, and up to five percent will die from HCV-related liver disease. Modeling studies forecast substantial increases in morbidity and mortality among persons with chronic hepatitis C as they age into their third, fourth, and fifth decades living 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. 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 expanding current HCV screening and care to include routine one-time screening of all persons born between 1945 to 1965 (compared with risk-based screening) would reduce deaths due to hepatitis C by 82,300 at a cost of \$15,700 per quality-adjusted life year (QALY) gained. For these reasons, CDC has recommended that all persons in this birth cohort receive a one-time screening for HCV. Through the Prevention and Public Health Fund, CDC supported a limited number of sites for chronic hepatitis B and C testing and referral to care in 2012.

CDC assists states in improving viral hepatitis surveillance in order to provide more complete demographic information on individuals with chronic viral hepatitis infection. Currently eight jurisdictions completed the enhanced reporting needed for national reports of acute hepatitis A, B, and C, and chronic HBV and HCV infection. These are Colorado, Connecticut, Minnesota, New Mexico, New York City, New York State, Oregon, 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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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 2011: 90,000 (Target Not Met but Improved)	84,709	98,800	+14,091
2.7.2a: Reduce the percentage of high-risk women aged 16–20 infected with chlamydia (Outcome)	FY 2011: 11.61% (Historical Actual)	12.98%	12.52%	-0.46
2.7.2b: Reduce the percentage of high-risk women aged 21–24 infected with chlamydia (Outcome)	FY 2011: 7.69% (Historical Actual)	7.84%	7.6%	-0.24
2.7.4a: Reduce the rate of gonorrhea per 100,000 population in women aged 16–20 (Outcome)	FY 2011: 663.0 (Historical Actual)	714.56	702.2	-12.36
2.7.4b: Reduce the rate of gonorrhea per 100,000 population in women aged 21–24 (Outcome)	FY 2011: 536.9 (Historical Actual)	533.41	524.2	-9.2
2.7.5: Reduce the racial disparity of gonorrhea in women aged 16–24 (is black: white ratio) (Outcome)	FY 2011: 13.6:1 (Historical Actual)	13.2 :1	12.7 :1	-0.5
2.7.6a: Increase the proportion of sexually active women aged 16–20 enrolled in Medicaid health plans who are screened for Chlamydia infections (Outcome)	FY 2011: 54.9% (Target Not Met but Improved)	60.0%	63.6%	+3.6
2.7.6b: Increase the proportion of sexually active women aged 16–20 enrolled in commercial health plans who are screened for Chlamydia infections (Outcome)	FY 2011: 41.5% (Target Not Met but Improved)	48.7%	53.8%	+5.1
2.7.6c: Increase the proportion of sexually active women aged 21–24 enrolled in Medicaid health plans who are screened for Chlamydia infections (Outcome)	FY 2011: 63.4% (Target Not Met but Improved)	69.4%	74.7%	+5.3
2.7.6d: Increase the proportion of sexually active women aged 21–24 enrolled in commercial health plans who are screened for Chlamydia infections (Outcome)	FY 2011: 48.4% (Target Not Met but Improved)	54.8%	60.7%	+5.9

Performance Measures for Long Term Objective: Eliminate congenital syphilis

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
2.9.1: Reduce the incidence of primary & secondary syphilis in women aged 15–44 (per 100,000 population) (Outcome)	FY 2011: 2.1 (Historical Actual)	3.0	2.95	-0.05
2.9.2: Reduce the incidence of congenital syphilis (per 100,000 live births) (Outcome)	FY 2011: 8.5 (Target Exceeded)	18.5	9.9	-8.6
2.9.3: Increase percentage of pregnant women screened for syphilis at least one month before delivery (Outcome)	FY 2010: 84.8% (Historical Actual)	80.6 %	81.9%	+1.3

Performance Trends: 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 the health outcomes of the nation but will be cost-effective because of the high, and increasing, economic burden associated with STIs and their sequelae.⁸ 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 about \$2,500–\$37,000 per quality-adjusted life year (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 cause 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 113,000 in 2010, and then decreased to 90,000 visits in 2011 (Measure 2.7.1). While CDC is encouraged by the apparent decline in PID in 2011, one data point showing a decrease is not sufficient to accurately predict reasonable revised targets for 2014 and beyond. CDC is unable to revise its target based upon one data point demonstrating a decline in one year after an incline in the prior year; CDC will revisit these targets to determine whether they should be revised after obtaining the 2012 data point.

Reported chlamydial infections rates among women have been increasing annually since the late 1980s, when the United States established public programs for screening and treatment of women to avert PID and related complications. This reflects expanded chlamydia screening activities, the use of increasingly sensitive diagnostic tests, increased emphasis on case reporting from providers and laboratories, and improvements in the information systems used for reporting. However, it also may 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 percent reduction in PID incidence (Measures 2.7.1–2.7.6).

The Healthcare Effectiveness Data and Information Set (HEDIS) contains a measure which assesses chlamydia screening coverage of sexually active young women who receive medical care through

⁸ Chesson HW, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. Perspectives on Sexual and Reproductive Health 2004, 36(1): 11–19. Also: Maciosek, M, et al. Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis. American Journal of Preventive Medicine, 2006; (31) 1, 52–61.

commercial or Medicaid managed care organizations. Although Chlamydia screening is expanding, many women who are at risk are still not being tested—reflecting, in part, the lack of awareness among some healthcare providers and the limited resources available to support these screenings. In 2011, the median Chlamydia test positivity rate among women aged 15–24 years was 8.3 percent among those who were tested during visits to selected family planning clinics (range: 3.8 percent to 15.9 percent). Chlamydia test positivity among women aged 15–24 years screened in family planning clinics increased in most HHS regions during 2007–2011.

- Among sexually-active women aged 16–20 years enrolled in Medicaid health plans, chlamydia screening rates increased from 54.6 percent in 2010 to 54.9 percent in 2011 (Measures 2.7.6a).
- Among sexually-active women aged 21–24 years enrolled in Medicaid health plans, chlamydia screening rates increased from 62.3 percent in 2010 to 63.4 percent in 2011 (Measures 2.7.6c).
- Among sexually-active women aged 16–20 years in commercial plans, chlamydia screening rates increased from 40.8 percent in 2010 to 41.5 percent in 2011 (Measures 2.7.6b).
- Among sexually-active women aged 21–24 years in commercial plans, chlamydia screening rates increased from 45.7 percent in 2010 to 48.4 percent in 2011 (Measures 2.7.6d).

Following a 74 percent decline in the rate of reported gonorrhea during 1975–1997, the overall gonorrhea rate plateaued for 10 years. A decline during 2006–2009 led to the lowest rate since national reporting began. Since 2009, the rate has increased about six percent. From 1997–2006, gonorrhea rates in men and women were similar. Recently, the rates in women have been somewhat higher than rates in men.

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 (Measure 2.9.1, 2.9.2, 2.9.3). After 14 years of decline, reported congenital syphilis cases reached a historic low of 339 cases in 2005. Reported cases increased from 2006–2008, but have since decreased to 360 cases in 2011, a 19 percent decrease since 2008 (Measures 2.9.1 and 2.9.2). The incidence of congenital syphilis per 100,000 live births steadily declined from 10.1 percent in 2009 to 8.5 percent in 2011, exceeding the 2011 target of 17.7 percent (Measure 2.9.2). CDC dramatically lowered its targets for 2014 based upon promising declines from 2009–2011. If results continue to be better than expected in 2012, CDC will lower targets further for 2015.

The overall primary and secondary syphilis rate in the United States declined 89.7 percent from 1990–2000, then increased each year from 2001 through 2009. In 2010, the overall rate decreased for the first time in 10 years and held steady in 2011.

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
2.8.1: Decrease the rate of cases of tuberculosis among U.S. born persons (per 100,000 population) (Outcome)	FY 2011: 1.5 (Target Exceeded)	1.7	1.5	-0.2
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 2009: 87.7% (Target Not Met but Improved)	88.0%	88.0%	Maintain

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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 overall U.S. Tuberculosis (TB) cases (10,528 cases in 2011, or 3.4 per 100,000 population and 1.5 for U.S. born population) since national reporting began in 1953. 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 TB prevention, control, and laboratory activities contribute to TB elimination (defined as a case rate of less than one case per million population). In 2009, 87.7 percent of patients completed a curative course of treatment for TB (Measure 2.8.2), slightly below the target of 88 percent. This is an increase over the 1994 baseline of 67.6 percent and an improvement from the previous year. However, because completion of therapy is harder for programs serving vulnerable populations, including persons affected by homelessness, incarceration, substance abuse, or travel across borders, CDC did not meet its target. Since TB treatment completion is the most effective way to reduce the spread of TB and prevent its complications, continuing to increase the proportion of patients completing treatment is the highest priority for CDC's TB program.

CDC also supports efforts in public health laboratories to genetically map TB specimens to develop a database to better understand and halt the spread of the disease. CDC met its 2011 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.

CDC has revisited its measures and revised targets to reflect realistic but ambitious achievement given current federal, state, and local funding for TB. Research funded by CDC through the TB Trials Consortium identified a new regimen for treatment for latent TB infection (LTBI) 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.

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.

STATE TABLES

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS			TB ELIMINATION & LABORATORY PROGRAM	STI PREVENTION PROGRAM
	FY 2012 Prevention Projects	FY 2012 Surveillance	Total	FY 2012 Enacted ⁵	FY 2012 Enacted ⁶
Alabama ^{1 7}	\$3,302,339	\$746,762	\$4,049,101	\$1,055,293	\$1,862,869
Alaska ^{2 4 7}	\$1,217,318	\$168,131	\$1,385,449	\$394,329	\$426,036
Arizona ^{1 7}	\$4,178,906	\$1,004,964	\$5,183,870	\$1,357,599	\$1,380,832
Arkansas ¹	\$1,672,521	\$225,261	\$1,897,782	\$599,581	\$1,251,023
California ¹	\$17,154,189	\$2,196,304	\$19,350,493	\$7,772,644	\$5,722,613
Colorado ^{1 2 3 4 7}	\$4,708,286	\$1,016,590	\$5,724,876	\$541,965	\$1,111,545
Connecticut ^{1 2 3 7}	\$5,454,822	\$968,296	\$6,423,118	\$606,622	\$759,680
Delaware ^{1 2 3}	\$1,405,574	\$227,767	\$1,633,341	\$281,176	\$374,875
District of Columbia ^{2 3 4}	\$6,479,228	\$1,986,767	\$8,465,995	\$629,219	\$1,239,677
Florida ^{2 3 7}	\$28,707,706	\$3,917,740	\$32,625,446	\$7,600,472	\$4,518,225
Georgia ^{2 3}	\$7,717,403	\$1,128,484	\$8,845,887	\$2,723,695	\$3,860,120
Hawaii ¹	\$1,977,792	\$196,028	\$2,173,820	\$740,189	\$384,384
Idaho ^{1 2 3 4 7}	\$821,800	\$124,551	\$946,351	\$177,962	\$422,604
Illinois ^{2 3 4 7}	\$4,607,314	\$804,194	\$5,411,508	\$1,510,493	\$2,188,606
Indiana ¹	\$2,921,999	\$804,176	\$3,726,175	\$683,131	\$1,762,669
Iowa ^{2 3 4 7}	\$1,223,831	\$372,131	\$1,595,962	\$353,361	\$768,628
Kansas ^{2 3 4 7}	\$1,300,621	\$623,369	\$1,923,990	\$402,824	\$838,492
Kentucky ^{1 7}	\$1,665,679	\$213,699	\$1,879,378	\$692,606	\$963,950
Louisiana ^{2 3 4}	\$6,875,109	\$1,599,216	\$8,474,325	\$1,303,149	\$2,304,536
Maine ¹	\$1,213,626	\$89,642	\$1,303,268	\$178,347	\$303,825
Maryland ^{1 2 3 4 7}	\$9,212,827	\$1,452,280	\$10,665,107	\$1,290,850	\$1,303,150
Massachusetts ^{1 2 3 7}	\$7,346,706	\$1,359,750	\$8,706,456	\$1,544,910	\$1,586,330
Michigan ^{2 3 4}	\$6,714,857	\$1,762,472	\$8,477,329	\$840,709	\$2,738,967
Minnesota ^{2 3 7}	\$2,909,482	\$479,978	\$3,389,460	\$1,054,226	\$1,076,961
Mississippi ^{1 2 3 7}	\$2,816,120	\$445,555	\$3,261,675	\$780,815	\$1,431,958
Missouri ⁷	\$4,215,691	\$699,711	\$4,915,402	\$638,898	\$2,082,298
Montana	\$1,159,132	\$74,858	\$1,233,990	\$186,820	\$303,600
Nebraska ⁷	\$1,297,071	\$156,627	\$1,453,698	\$213,427	\$455,535
Nevada ^{1 2 3 4}	\$2,452,681	\$587,523	\$3,040,204	\$565,970	\$707,547
New Hampshire ^{1 2 4}	\$1,196,820	\$142,964	\$1,339,784	\$231,862	\$285,304
New Jersey ^{1 2 3 7}	\$16,903,650	\$2,695,897	\$19,599,547	\$4,090,643	\$3,237,259
New Mexico ⁷	\$2,140,641	\$284,459	\$2,425,100	\$354,177	\$775,072
New York ^{1 2 3 4}	\$23,161,114	\$2,482,720	\$25,643,834	\$2,179,101	\$2,980,303
North Carolina ¹	\$6,819,495	\$923,509	\$7,743,004	\$1,866,622	\$2,966,558

NARRATIVE BY ACTIVITY

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

BUDGET REQUEST

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS			TB ELIMINATION & LABORATORY PROGRAM	STI PREVENTION PROGRAM
	FY 2012 Prevention Projects	FY 2012 Surveillance	Total	FY 2012 Enacted ⁵	FY 2012 Enacted ⁶
North Dakota ¹²³⁷	\$710,257	\$168,406	\$878,663	\$159,325	\$263,059
Ohio ²³⁷	\$6,048,850	\$772,384	\$6,821,234	\$1,158,894	\$3,310,918
Oklahoma ¹⁷	\$1,958,549	\$337,889	\$2,296,438	\$732,571	\$1,173,249
Oregon ¹⁷	\$2,761,903	\$351,624	\$3,113,527	\$608,621	\$1,023,584
Pennsylvania ¹²³⁴⁷	\$5,955,672	\$930,804	\$6,886,476	\$864,140	\$2,067,992
Rhode Island	\$2,013,605	\$223,869	\$2,237,474	\$320,815	\$404,025
South Carolina ¹⁷	\$6,088,285	\$780,422	\$6,868,707	\$1,292,727	\$1,599,414
South Dakota ⁷	\$672,265	\$74,859	\$747,124	\$273,222	\$291,134
Tennessee ¹²³⁴⁷	\$5,041,420	\$794,223	\$5,835,643	\$1,463,728	\$2,325,364
Texas ¹²³⁴⁷	\$16,190,775	\$2,397,573	\$18,588,348	\$7,603,900	\$6,637,195
Utah ²³⁴⁷	\$1,272,065	\$285,714	\$1,557,779	\$282,832	\$481,240
Vermont	\$1,561,189	\$94,820	\$1,656,009	\$153,000	\$182,956
Virginia ¹²³⁴⁷	\$6,732,225	\$1,463,216	\$8,195,441	\$1,470,152	\$1,905,995
Washington ¹⁷	\$4,413,608	\$1,272,104	\$5,685,712	\$1,442,292	\$2,577,276
West Virginia ¹⁷	\$1,249,602	\$158,005	\$1,407,607	\$319,797	\$710,887
Wisconsin ²³⁴⁷	\$2,678,044	\$521,507	\$3,199,551	\$472,239	\$965,585
Wyoming ¹	\$767,270	\$74,699	\$841,969	\$193,264	\$266,887
Subtotal, States	\$259,067,934	\$42,664,493	\$301,732,427	\$64,225,206	\$80,562,791
Baltimore	\$3,557,646	-	\$3,557,646	\$437,983	\$1,457,050
Chicago ¹	\$8,217,282	\$987,994	\$9,205,276	\$1,753,115	\$2,285,183
Detroit	-	-	-	\$480,033	-
Fulton Co., GA	\$4,981,734	-	\$4,981,734	-	-
Houston ¹²³⁴	\$7,115,040	\$1,484,814	\$8,599,854	\$2,084,838	-
Los Angeles ²³⁴	\$16,279,765	\$2,398,541	\$18,678,306	\$4,822,980	\$3,771,120
New York City	\$34,169,951	\$4,377,245	\$38,547,196	\$8,481,929	\$6,717,174
Philadelphia ¹²³	\$7,280,905	\$846,677	\$8,127,582	\$853,725	\$2,558,823
San Diego	-	-	-	\$1,661,557	-
San Francisco ¹²³	\$9,525,313	\$1,254,420	\$10,779,733	\$2,426,426	\$1,542,189
Subtotal, Cities	\$91,127,636	\$11,349,691	\$102,477,327	\$23,002,586	\$18,331,539
American Samoa ¹	\$195,829	\$6,846	\$202,675	\$96,765	\$63,002
Guam	\$374,092	\$24,953	\$399,045	\$409,252	\$116,622
Marshall Islands ¹	\$158,999	\$9,021	\$168,020	\$135,734	\$136,402
Micronesia ¹	\$223,177	\$11,582	\$234,759	\$184,143	\$56,463
Northern Mariana Islands ¹	\$264,000	\$11,356	\$275,356	\$282,459	\$119,323
Palau ²⁴	\$239,347	\$29,547	\$268,894	\$127,397	\$43,440

NARRATIVE BY ACTIVITY

HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED INFECTIONS, AND TUBERCULOSIS PREVENTION
BUDGET REQUEST

	HIV/AIDS CORE PREVENTION AND SURVEILLANCE PROGRAMS			TB ELIMINATION & LABORATORY PROGRAM	STI PREVENTION PROGRAM
	FY 2012 Prevention Projects	FY 2012 Surveillance	Total	FY 2012 Enacted ⁵	FY 2012 Enacted ⁶
Puerto Rico^{1 2 3 4}	\$5,912,683	\$957,006	\$6,869,689	\$788,605	\$1,419,927
Virgin Islands	\$629,949	140,106	\$770,055	\$86,938	\$192,472
Subtotal, Territories	\$7,998,076	\$1,190,417	\$9,188,493	\$2,111,293	\$2,147,651
TOTALS:	\$358,193,646	\$55,204,601	\$413,398,247	\$89,369,085	\$101,041,981

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

² This Surveillance grantee is one of 35 states that received supplemental funds for one or more HIV/AIDS Surveillance activities.

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

⁴ Award includes supplemental funds for HIV/AIDS Surveillance: Enhancing Security and Confidential Practices and Infrastructure.

⁵ Amounts reflect new funding and include HIV/TB coinfection funds.

⁶ Amounts reflect new funding and include HIV/STD coinfection funds.

⁷ In addition, this grantee received unobligated dollars from prior years to offset the new award.

EMERGING AND ZOO NOTIC INFECTIOUS DISEASES

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$310.393	\$312.366	\$380.664	+\$70.271
ACA/PPHF	\$51.750	N/A	\$51.750	\$0.000
Total	\$362.143	\$312.366	\$432.414	+\$70.271
FTEs	1,137	1,131	1,131	-6

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: PHS A §§ 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)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$432,414,000 for Emerging and Zoonotic Infectious Diseases, including \$51,750,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of \$70,271,000 above the FY 2012 level to reduce healthcare associated infections, improve food safety, and invest in advanced molecular detection and response. CDC will provide data on highly antibiotic-resistant infections, triggering the “Detect and Protect” strategy that identifies pathogens and transmission within and between facilities, and will use data to find problem areas in high-use Medicaid facilities. CDC will implement its provisions of the Food Safety Modernization Act. The agency also will invest \$40 million in a new Advanced Molecular Detection Initiative in bioinformatics and genomics. The Initiative will result in measurable improvements in the quality, nature, and timeliness of CDC’s laboratory-based core surveillance programs and will ensure effective responses to infectious disease outbreaks.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Core Infectious Diseases	\$225.728	\$227.163	\$226.754	+\$1.026
National Healthcare Safety Network	\$19.071	\$19.192	\$31.562	+\$12.491
Food Safety	\$32.618	\$32.826	\$49.223	+\$16.605
Quarantine	\$32.976	\$33.185	\$33.125	+\$0.149
Federal Isolation and Quarantine (non-add)	N/A	\$0.000	\$1.000	N/A
Advanced Molecular Detection and Response to Infectious Disease Outbreaks	\$0.000	\$0.000	\$40.000	+\$40.000
ACA/PPHF	\$51.750	N/A	\$51.750	\$0.000
Total	\$362.143	\$312.366	\$432.414	+\$70.271

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CDC is the global leader in protecting Americans and people around the world from infectious diseases, which are constantly changing and responsible for millions of illnesses and deaths. CDC works with partners at local, state, national, and international levels, providing scientific expertise and recommendations. CDC aims to protect Americans from infectious diseases by detecting infectious agents and preventing their spread in communities.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	225.404
2010	\$261.174
2010 (ACA/PPHF)	\$20.000
2011	\$252.443
2011(ACA/PPHF)	\$51.750
2012	\$310.393
2012 (ACA/PPHF)	\$51.750
2013	\$312.366
2013 (ACA/PPHF) ²	N/A

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CORE INFECTIOUS DISEASES BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$225.728	\$227.163	\$226.754	+\$1.026

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC is home to the country's leading experts and gold standard laboratories in infectious disease prevention and control. These experts and laboratories detect and track a range of microbes, respond to outbreaks (such as the 2012 fungal meningitis outbreak), and serve as an early warning system to rapidly identify new infectious disease threats. To accomplish this, CDC invests in a flexible public health system at national, state, and local levels. This includes: (1) building and maintaining a sufficient and competent public health workforce; (2) creating and supporting tracking systems; (3) supporting modern and efficient laboratories with well-trained laboratory staff; (4) preparing and equipping outbreak investigation and response teams; and (5) developing effective epidemiologic, statistical, analytic, and communication tools. CDC provides scientific and programmatic expertise and conducts public health research to further support infectious disease prevention efforts.

CDC supports state and local health departments primarily through two infectious disease programs—the Epidemiology and Laboratory Capacity for Infectious Diseases Programs (ELC) and the Emerging Infections Programs (EIP). Established in 1995, the ELC and EIP assist states, localities, and territories to track and respond to infectious disease threats and maintain core epidemiology and laboratory capacity, by providing a foundation for state activities for a variety of infectious diseases. The ELC provides funding to all states, U.S. territories, Washington, D.C., and the six largest local health departments. The EIP awards grants to support a network of 10 state public health departments and their partners, forming a national resource for infectious disease surveillance, prevention, and control. This core EIP surveillance generates reliable estimates of the incidence of infections and provides the foundation for epidemiologic studies to ascertain risk factors, multiple diseases, and prevention strategies. The ELC and EIP are essential in CDC's comprehensive work to prevent and control emerging infectious diseases.

Budget Proposal: CDC's FY 2014 request of \$226,754,000 for core infectious diseases is an increase of \$1,026,000 above the FY 2012 level. CDC's core infectious diseases budget includes a number of CDC's infectious disease activities such as—but not limited to—vector-borne diseases, Lyme disease, chronic fatigue syndrome, prion, emerging infections, antimicrobial resistance, and high-consequence pathogens (formerly hantavirus/special pathogens). The following sections describe select core infectious diseases activities: (1) vector-borne diseases, (2) high-consequence pathogens, (3) respiratory pathogens, (4) antimicrobial resistance, and (5) healthcare-associated infections.

Vector-Borne Diseases

CDC's vector-borne disease program is the focal point of the nation's capacity to detect, control, and prevent exotic and domestic bacteria and viruses transmitted by mosquitoes, ticks, fleas, and other vectors. CDC experts combine active intramural research and service with extramural support to state and local health departments, addressing constant risks to the United States from emerging and invasive pathogens arising anywhere in the world. In 2012, an outbreak of West Nile virus, unknown in the United States before 1999, was one of the worst West Nile outbreaks on record. In the same year, Puerto Rico faced thousands of cases of dengue, another mosquito-transmitted virus that causes as many as 100 million infections globally each year. Dengue transmission has been documented in Florida, Hawaii, and Texas, often appearing after long intervals of no reported cases. Nearly 30,000 Americans are infected each year with the tick-transmitted Lyme disease bacterium, and the geographic range in the United States is steadily expanding.

In FY 2014, the United States will confront new threats from domestic and invasive vector-borne pathogens. To address those threats, CDC will

1. Assist county, state, tribal, and territorial health authorities, as well as international partners, to detect, prevent, and control diseases spread by mosquitoes, ticks, fleas, and other vectors. CDC staff will conduct fieldwork and research to explain why and how citizens are at risk for vector-borne disease and evaluate the efficacy of prevention efforts.
2. Conduct multi-faceted surveillance. CDC will operate and fund the National Arboviral Surveillance System (ArboNET), the national surveillance system for arthropod-borne viruses. This integrated network funds staff in 49 states, Puerto Rico, and six large municipalities to conduct human case investigations, collect and analyze mosquitoes and other specimens, perform laboratory analysis, and submit information to CDC for analysis and wide dissemination. TickNET, a system in states with high incidence of tick-borne diseases, will both conduct surveillance and actively study practical prevention measures for Lyme disease and other tick-borne infections.
3. Expand training and education for healthcare providers, public health professionals, and the public. CDC will use tools such as a continuing medical education course on severe dengue case management pioneered by CDC and now required for licensure by the Puerto Rico Department of Health. CDC will use communication science to improve the accessibility and readability of web pages and other public outreach tools.
4. Develop, test, and deploy innovative disease prevention techniques. These include a novel, highly efficacious botanical pesticide for controlling Lyme disease and other tick-borne diseases. Another example is an inexpensive, rapid, and robust point-of-care "dipstick" plague diagnostic tool for use in Africa. CDC also is dedicated to pioneering techniques with commercial partners such as an award-winning dengue vaccine that will be concluding Phase II clinical trials in FY 2014. CDC and industry partners will continue development of a unique vaccine designed to stop Lyme disease transmission in the animal host.
5. Implement innovative approaches to disease management at home and abroad. In 2014, CDC scientists will refine and expand a successful pilot project on reservations that uses new tools,

behavioral modification, and veterinary support to prevent Rocky Mountain spotted fever. CDC will complete the evaluation of its commercially licensed rodent bait boxes as a method for Lyme disease prevention, and CDC will conclude the evaluation of a Japanese encephalitis vaccine in Cambodia.

The 2012 West Nile virus epidemic, one of the largest in the country's history, illustrated the need for continued vigilance for unpredictable vector-borne pathogens such as arboviruses. ArboNET was essential to the early detection of the 2012 West Nile virus outbreak, facilitating early, focused deployment of CDC and state experts to the field for advice, technical assistance, and evaluation of emergency spraying efforts. A CDC analysis to be completed in FY 2014, will describe the total estimated costs for hospitalized West Nile virus cases and deaths from 1999 – 2012. As the national diagnostic reference center for vector-borne disease, CDC will continue to monitor the emergence and epidemic potential of vector-borne pathogens that threaten the United States both domestically and abroad.

Other recent epidemic responses by CDC included the investigation of dengue fever among health workers in Haiti and a project to reduce deaths from Rocky Mountain spotted fever on an Apache reservation in Arizona.

In FY 2014, the United States will confront new threats from domestic and invasive vector-borne pathogens. To address those threats, CDC will continue its close, successful cooperation with county, state, tribal, territorial, and international health authorities to maintain national readiness using tailored strategies and innovative tools. The program will invest in and improve ArboNET and TickNET (a similar surveillance network in 16 Lyme disease-endemic states). CDC will continue work with local authorities to conduct surveillance, research, education, and prevention activities to reduce transmission of Lyme disease, West Nile virus, dengue virus, and Rocky Mountain spotted fever, and will respond rapidly to emergent epidemics. CDC will continue to serve as the national diagnostic center for vector-borne viruses and bacteria, and will continue its collaboration with industrial and academic partners to develop and test state-of-the-art methods for vector-borne disease detection, prevention, and control, including new diagnostic assays, as well as novel natural repellents and insecticides.

High-Consequence Pathogens

CDC conducts disease detection and control activities that protect the United States from disease, disability, and death caused by dangerous viral, bacterial, prion, and unknown infectious agents. These include Hantavirus pulmonary syndrome, Ebola and Marburg hemorrhagic fevers, rabies, monkeypox, anthrax, smallpox, and Creutzfeldt-Jakob disease. CDC maintains Biosafety level (BSL)-3 and BSL-4 laboratories that support epidemiology, research, and prevention efforts to reduce the public health threat of these highly hazardous and infectious pathogens. Many of these pathogens are considered bioterrorism threats and are regulated as select agents. CDC assists state, tribal, local, and territorial health departments as well as federal partners in investigations of suspected domestic cases of known high-consequence pathogens and of infectious diseases of unknown cause. CDC also provides specialized training, and laboratory and epidemiologic assistance to global partners and ministries of health in support of investigations of outbreaks of high-consequence pathogens.

In FY 2012, CDC completed development of a National Laboratory Training Network course to improve laboratory practices in rabies diagnostics for 28 state and local public health laboratories. CDC also performed strain typing and serological testing on specimens from a 2011 inhalation anthrax case in Minnesota, the results of which will inform further policy recommendations for anthrax treatment using investigational new drugs. CDC provides specialty expertise and support to domestic and international partner organizations to assist in outbreak detection and response in order to prevent the spread of disease caused by dangerous or unknown infectious agents. In FY 2012, CDC responded to four Marburg/Ebola outbreaks in Africa in one month. CDC's implementation of a viral hemorrhagic fever (VHF) surveillance program in Uganda, including enhancing laboratory capacity at the Uganda Virus Research Institute, has

been critical to the rapid diagnosis and containment of recent Ebola cases in Africa. In addition, CDC, in conjunction with the National Park Service and the California Department of Public Health, investigated an outbreak of Hantavirus pulmonary syndrome (HPS) in people who stayed at Yosemite National Park in the summer of 2012.

In FY 2014, CDC will support surveillance and pathogen discovery efforts critical to rapid identification of new emerging pathogens, including those associated with high-fatality outbreaks. As part of this effort, in FY 2011, CDC began the activation of MicrobeNet, a web-based tool for the rapid identification and classification of microbial pathogens using gene sequence comparisons. Developing a pipeline for bacterial species identification will allow multiple analyses on a new or rapidly emerging pathogen to be performed in hours, rather than days or weeks. CDC aims for broader release of MicrobeNet in FY 2014. CDC investigates suspected domestic cases of known high-consequence pathogens and infectious diseases of unknown cause reported to CDC, and provides laboratory reference and epidemiologic support for state and local health departments and federal agencies, such as the Food and Drug Administration (FDA), National Institutes of Health (NIH), and the Department of Defense. CDC also will continue making investments to develop global capacity to handle specimens safely and perform initial screening assays, and will recommend appropriate response activities at selected laboratories—particularly those 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. Increased global travel is exacerbating the rapid dissemination of new and previously identified pathogens. Because many of these high-consequence pathogens can have a high case fatality rate, often with no licensed vaccines or specific therapies for treatment, CDC continues to explore ways to prevent human infections by utilizing One Health Initiative approaches that promote global collaboration between human and veterinary medicine. As part of these efforts, CDC will improve diagnostic capabilities for orthopoxvirus disease worldwide and develop integrated ecologic and epidemiologic studies for monkeypox that focus on understanding the transmission of the virus from animals to humans. CDC is working on tools and approaches that promote early identification of human monkeypox illnesses in order to minimize the spread of the disease among people during outbreaks.

Respiratory Pathogens

CDC supports domestic and international surveillance, epidemiologic, and laboratory activities to detect existing and emerging respiratory and related disease threats, including monitoring for changes in vaccine-preventable diseases (VPDs). CDC uses its epidemiologic and laboratory findings to identify and evaluate effective prevention strategies. For example, CDC completed a project of the Active Bacterial Core (ABC) surveillance system. The project demonstrated sustained impact of pneumococcal conjugate vaccine (PCV7), reducing the risk of invasive bacterial diseases caused by vaccine serotypes by 99 percent in children targeted by vaccine, and by over 90 percent among older age groups (over 18 years) who are protected by herd immunity. CDC also provides leadership and scientific expertise for global introduction of new vaccines and VPD surveillance, including supporting the development and introduction of a new meningitis vaccine in African countries that experience meningitis epidemics, and evaluating the global impact of rotavirus and rubella vaccine programs.

In FY 2014, CDC will support epidemiologic and laboratory surveillance for existing and emerging respiratory diseases. Specific activities will include: (1) continued funding of ABC surveillance sites in 10 states to monitor respiratory bacterial pathogens, such as Group A and Group B *Streptococcus*, and antibiotic resistance; (2) improving diagnostic capacity to support multi-pathogen Taqman Array Card technology; (3) conducting etiology and disease-burden studies to document causes of death for children under age five in developing countries; and (4) identifying the disease burden in the U.S. elderly population. CDC will develop and implement prevention strategies to reduce the respiratory disease burden by conducting perinatal screening to prevent Group B streptococcal disease, implementing the *Get Smart* campaign to reduce unnecessary antibiotic use, and informing future prevention efforts for cytomegalovirus infections in pregnant women and their babies. CDC’s ongoing epidemiologic and

laboratory activities for non-influenza respiratory viruses allow the agency to maintain the expertise to respond to emerging viruses such as the recently detected novel coronavirus.

Antimicrobial Resistance

CDC leads the fight to combat diseases that result from antimicrobial resistance (AR), through surveillance, reference laboratories, research, and educational and prevention initiatives that focus on the most critical and immediate AR pathogens, including Methicillin-resistant *Staphylococcus aureus* (MRSA), *Streptococcus pneumoniae*, *Neisseria meningitidis*, *Neisseria gonorrhoeae*, and *Candida*. CDC monitors disease, deaths, and resistance trends caused by resistant pathogens of public health importance in food, humans, and agriculture. CDC uses surveillance and laboratory data to monitor resistance rates, inform and guide prevention efforts, and evaluate effectiveness of prevention initiatives. CDC also works with states and healthcare facilities to promote appropriate antimicrobial use and build collaborations to prevent regional transmission of infections caused by resistant pathogens. CDC works with states and other partners to develop and evaluate education campaigns promoting appropriate use of antibiotics (i.e., stewardship) in physician's offices (e.g., Get Smart: Know When Antibiotics Work) as well as campaigns in hospital and non-hospital settings (e.g., Get Smart for Healthcare).

In FY 2014, CDC will measure the agency's success in preventing the spread of harmful carbapenem-resistant Enterobacteriaceae (CRE) infections in healthcare facilities through focused interventions aimed at decreasing the proportion of hospitals with carbapenem-resistant *Klebsiella* spp. or *Escherichia coli* (*E. coli*) healthcare-associated infections each year through 2015. These pathogens were selected as they are the most common CRE pathogens found in central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and surgical site infections (SSI).

Resistant bacteria pose a serious threat to people in the United States and around the world. For example, in 2001, CDC laboratories detected a novel and difficult to treat pathogen named carbapenem-resistant Enterobacteriaceae (CRE). CRE infections are an urgent AR challenge for several reasons. Invasive infections with CRE are associated with mortality rates exceeding 40 percent and can spread rapidly in healthcare settings. CRE infections also have the potential to move from healthcare-exposed patients into the community. CRE infections are highly resistant to antimicrobials. Current CRE prevention strategies are based on identification of patients with CRE, followed by implementation of transmission-based precautions. In the past two years, CDC provided states with laboratory diagnostic support and technical expertise, as well as scientific and programmatic expertise in prevention of CRE infection. Working with state health agencies and other partners to assess the scope of the problem and to contain the spread of resistant pathogens before they become an epidemic is an agency priority.

In FY 2014, CDC funding will support improved understanding of the molecular mechanisms of resistance, as well as the development of new clinical diagnostic tests to detect AR pathogens, improve clinical decision-making, and speed infection control strategy implementation. CDC will lead core laboratory activities to assess optimal patient treatment, and will develop strategies to prevent the spread of emerging AR pathogens across the United States, serving as a national and international reference laboratory, performing antimicrobial susceptibility tests, and responding to diagnostic needs for new and emerging healthcare-associated pathogens. CDC will use national, regional, and local surveillance data to: (1) detect and track emerging AR pathogens, (2) identify situations where multidrug resistant pathogens are increasing, and (3) publish the first state-specific report on significant AR problems. CDC will pilot three regional prevention collaborative projects to detect emerging AR problems and implement infection control measures to prevent spread of AR pathogens. CDC will work with state public health departments to improve and strengthen their clinical and public health laboratories to detect AR pathogens accurately. CDC also will continue education campaigns (stewardship initiatives) that promote safer, more effective antimicrobial use in outpatient, inpatient, and non-medical settings.

Healthcare-Associated Infections

The Healthcare-associated Infections (HAIs) program provides national leadership in HAI prevention and the scientific foundation for state and federal healthcare facility regulatory requirements. The program consists of complementary prevention components: outbreak response and control, prevention research, guideline development, communications science, and gold standard laboratory testing and identification of HAI pathogens. These activities complement and are informed by the National Healthcare Safety Network (NHSN) tracking capabilities described below. HAIs are a critical public health problem, occurring in all settings where patients receive medical care, including hospital and non-hospital settings. In hospitals alone, CDC estimates that one in 20 hospitalized patients acquires an HAI, while over one million HAIs occur across the healthcare spectrum each year at a cost of over \$30 billion. CDC demonstrates HAI prevention success by measuring reductions in HAIs, including setting national targets for reductions in central line-associated bloodstream infections (CLABSI) (50 percent reduction by 2013) and methicillin-resistant *Staphylococcus aureus* (MRSA) (50 percent reduction by 2013).

CDC provides states and healthcare facilities with rapid HAI outbreak control. In the 2012 outbreak of fungal meningitis and other infections associated with contaminated medications, CDC provided critical epidemiologic and laboratory response to confirm the cause of the outbreak and coordinated a rapid, intensive communications effort to 14,000 patients along with federal, state, local, and territorial public health partners. Outbreaks serve as signals and drivers of HAI prevention. In 2012, outbreak investigations addressed HAIs from emerging pathogens, contaminated devices and products, and major breaches in infection prevention. Outbreak investigations provide critical information used to assess populations at risk and to identify prevention strategies. CDC measures its success in preventing these HAI threats through containment of infections, and addressing the threats through rapid response to outbreaks. CDC uses patient notifications, development, and dissemination of treatment guidance to target HAI prevention campaigns during outbreaks and across the spectrum of healthcare, recognizing the importance of interpreting and communicating science to patients, clinicians, and other public health partners.

In FY 2014, CDC will:

- Work to eliminate HAIs with a focus on drug-resistant infections. An increasing number of HAIs are caused by bacteria resistant to currently available antibiotics (multi-drug resistant organisms). These issues are further complicated by the fact that patients are frequently transferred between facilities (e.g., nursing homes to hospitals), which can facilitate rapid spread of HAI pathogens. To support this work, CDC will maintain critical core laboratory capacities, including acting as a national and international reference laboratory, performing antimicrobial susceptibility tests, and responding to environmental and diagnostic needs for new and emerging healthcare-associated pathogens. Identifying and evaluating these pathogens is critical to assessing appropriate patient treatment and to developing strategies to avoid the spread of emerging pathogens across the United States.
- Respond to and control HAI outbreaks, such as those related to contaminated medications, transmission of drug-resistant infections through healthcare exposures, blood transfusion, organ and tissue transplantation, and errors in injection practices. CDC will provide gold-standard laboratory testing, including microbial analysis of the healthcare environment that is essential for rapid response to outbreaks and protection of patients. CDC will support critical core laboratory capacities, including acting as a national and international reference laboratory for HAI-related pathogens, testing medical devices for contamination, developing and evaluating new diagnostic tests for HAIs, and performing antimicrobial susceptibility tests. Earlier detection and control of these outbreaks will save lives by helping to prevent the spread of HAIs within and between healthcare settings, as well as inform strategies to prevent the spread of emerging pathogens across the United States.

- Develop evidence-based infection prevention guidelines with the Healthcare Infection Control Practices Advisory Committee (HICPAC) and professional organizations that will provide the scientific foundation for HAI prevention interventions and support federal initiatives such as Partnership for Patients, HHS National Action Plan to Prevent HAIs: Roadmap to Elimination.
- Translate specific guidelines into tools surveyors at the Centers for Medicare & Medicaid Services (CMS) can use for healthcare facility surveys and certification to improve the quality of care in hospital and non-hospital settings. CDC also will develop additional tools, such as checklists, and communicate evidence-based practices to help clinicians and facilities, including outpatient settings, accelerate adoption of infection prevention guidelines such as tools to prevent the transmission of CRE and other Multi-Drug-Resistant Organisms (MDROs).
- Work with state and local health departments and strengthen relationships with federal agencies (e.g., CMS, the Environmental Protection Agency, and the Food and Drug Administration) and partners to communicate and disseminate HAI prevention best practices, including management of emerging HAI threats, injection safety errors, and infections caused by contaminated medical products. These activities inform and support healthcare facility, state, local, and national HAI prevention efforts across all healthcare settings, as well as broader federal initiatives to eliminate HAIs.

NATIONAL HEALTHCARE SAFETY NETWORK BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$19.071	\$19.192	\$31.562	+\$12.491

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's National Healthcare Safety Network (NHSN) is the national HAI tracking system that serves as the standard for monitoring HAI problems in the United States. NHSN provides a single, integrated HAI reporting system with standardized reporting definitions and surveillance methods. Healthcare facilities use NHSN to apply real-time, validated data for local practice improvement (e.g., long-term acute care and non-hospital settings such as dialysis facilities and ambulatory surgery centers) as well as regional HAI prevention. NHSN data also are used to monitor the impact of prevention projects through Prevention Epicenters and the HAI component of the EIP. State health departments use NHSN data to pinpoint regional problem areas for intervention and implement public reporting mandates. Federal agencies use NHSN data to promote quality care by preventing HAIs through early detection, regional initiatives, and payment incentives (e.g., CMS quality incentive programs). NHSN also provides critical data for HHS national HAI prevention initiatives, monitoring progress, and informing next steps for prevention (e.g., HHS National Action Plan to Prevent HAIs: Roadmap to Elimination, HHS Partnership for Patients initiative).

CDC has been successful in extending the number of healthcare facilities able to use NHSN data for HAI prevention and demonstrating prevention progress toward national HAI targets. In 2012, data showed significant progress (compared to 2008 baseline) in CLABSI (41 percent reduction), saving up to 5,000 lives and an estimated \$83 million in healthcare costs. Additional progress toward national HAI targets includes reductions in surgical site infections (17 percent) and CAUTI (7 percent).

To further support national HAI elimination efforts, CDC accelerates prevention research through the Prevention Epicenters, addressing scientific gaps in HAI detection and prevention. In 2011, the Prevention Epicenters conducted a unique study to evaluate strategies to reduce MRSA in intensive care units (ICUs). The study, which included federal, academic, and healthcare delivery system representatives, found that treating all ICU patients as if they have MRSA, prior to testing, can reduce the

infections from MRSA and other germs by nearly 40 percent. Similarly, HAI prevention research conducted in 2011 with the Chicago Prevention Epicenter identified that long-term acute care hospitals (LTACHs) were an important amplifier of CRE transmission in the region. This led to the development of a prevention package in 2012 that all LTACHs across the Chicago area are implementing and evaluating.

Budget Proposal: CDC's FY 2014 request of \$31,562,000 for NHSN is an increase of \$12,491,000 above the FY 2012 level to reduce healthcare associated infections in more than 1,800 additional facilities. CDC will continue to provide data for national HAI elimination and with the increase will target HAI prevention in two critical areas. CDC will (1) focus on NHSN's Multi-Drug-Resistant Organism (MDRO) module and the new Antimicrobial Use and Resistance Module (AUR) to provide ward-specific and facility-wide data on highly antibiotic resistant infections that will trigger the "Detect and Protect" strategy that identifies pathogens and transmission within and between facilities in a region; and (2) target HAI prevention, using NHSN data to find problem areas in high-use Medicaid facilities.

In FY 2014, CDC will use NHSN's MDRO and AUR Modules to generate ward-specific and facility-wide data on antimicrobial resistance using electronic data sources. These data will be used to identify, analyze, and target areas that contribute to the spread and amplification of *C. difficile* and other serious healthcare-related infections caused by multi-drug resistant organisms. CDC will use NHSN to compare regional pathogen and drug resistance patterns in selected states to provide data to clinicians, facilities, public health officials, industry, and the public. These data are crucial to understand national trends in antimicrobial resistance-related HAIs. CDC's Prevention Epicenter researchers will be funded to develop novel strategies to detect and prevent antimicrobial resistance, translating technologic advances and new information from surveillance, outbreak investigations, and epidemiologic studies into interventions that target specific healthcare settings and patient populations.

To ensure that HAI prevention reaches everyone, CDC will work with CMS under a new "Equality in Quality" prevention program to identify high-use Medicaid facilities that are outliers with high rates of HAIs. Using NHSN data, CDC and CMS will work with state health departments to target prevention programs specifically to improve the quality of care in these facilities and lower Medicaid spending for state and federal governments. CDC and CMS will evaluate the HAI prevention success and cost savings of this effort to determine whether other facilities could benefit.

CDC will continue to provide NHSN as a shared platform for healthcare facilities to monitor and prevent infections locally and for state health departments and others to systematically track HAIs and benchmark quality improvement. CDC will build on its partnership with CMS to ensure the availability of NHSN facility-level data on the HHS Hospital Compare website as part of CMS's quality incentive programs.

In 2014, CDC will extend HAI reporting of CLABSI and CAUTI in non-ICU acute care settings from 610 in 2012 to 5,000 in 2014; from 250 long-term acute care facilities in 2012 to 430 in 2014; and from 50 rehabilitation centers in 2012 to 1,200 in 2014. In 2014, CDC and CMS will collaborate on a plan to extend NHSN reporting of SSIs to ambulatory surgery centers (ASCs). In addition to extending NHSN reporting to new settings, CDC will continue CLABSI, CAUTI, SSI, MRSA, and *C. difficile* infection reporting in 5,000 hospitals, and bloodstream infection reporting in 5,000 dialysis facilities.

By the end of 2014, CDC also will extend national surveillance of HAIs by type of infection reported to NHSN through an increase in the number of hospitals reporting SSIs from 2,800 in 2012 to approximately 4,000 in 2014; through an increase in hospitals reporting *C. difficile* from 1,450 to approximately 4,500; and through an increase in hospitals reporting MRSA from 1,650 to approximately 4,500.

CDC and CMS will continue working together to develop and refine validation methods and best practices to support validation of CLABSI and SSI in all 50 states. These validation activities will ensure the accuracy and completeness of HAI data reported to NHSN, a necessity for healthcare quality improvement, burden estimates, public reporting, and payment purposes. CDC will support the expansion of state validation efforts to include additional types of HAIs (i.e., CAUTI, MRSA, *C. difficile*) and will

continue to work with the National Quality Forum and professional partners to define and refine metrics, and further standardize HAI data collection. CDC also will simplify reporting for NHSN users by improving and extending electronic data collection in NHSN, allowing healthcare facilities to report additional types of HAIs using simple, automated methods. CDC will work with healthcare facilities, states, and health data system vendors to refine and increase the use of automated methods to collect and transmit HAI data to inform prevention activities at local, regional, and national levels. All of these efforts will avoid duplicate systems for HAI tracking and validation, increase healthcare transparency and accountability, and ensure that states and federal agencies use uniform standards to track and measure HAIs.

Grant Table:

National Healthcare Safety Network Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	16	16	21
Average Award	\$0.172	\$0.172	\$0.417
Range of Awards	\$0.005–\$0.430	\$0.005–\$0.430	\$0.016–1.100
Number of New Awards	0	0	5
Number of Continuing Awards	16	16	16
Total Grant Award	\$2.749	\$2.749	\$8.757

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

In FY 2014, CDC will fund five additional awardees through existing cooperative agreement programs, including the ELC, the Prevention Epicenter Research program, and Public Health Partnerships. The FY 2014 grants will provide ward-specific, facility-wide NHSN data on highly antibiotic resistant healthcare-associated infections, target HAI prevention in high-use Medicaid facilities using NHSN data, promote HAI data validation to ensure data accuracy, and explore extension of HAI prevention efforts to ASCs, in collaboration with CMS. The funding also enables state health departments to include stakeholders (e.g., academic institutions, group purchasers, insurers, hospitals, state or local public health laboratories, clinical laboratories, patient advocates and healthcare consumers, quality improvement organizations, infectious disease and infection control professional societies, and state hospital associations) in the implementation of HAI prevention programs. CDC bases continuation funding on competitively determined awards. Grantees currently consist of 16 state health departments. The grants enhance surveillance; improve response time to healthcare-related disease outbreaks; and apply knowledge from the surveillance data to decrease illness and death associated with healthcare delivery.

FOOD SAFETY BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$32.618	\$32.826	\$49.223	+\$16.605

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's Food Safety Program began as part of the agency's enteric (gastrointestinal) disease efforts in the late 1940s and aims to reduce the estimated 48 million illnesses, 128,000 hospitalizations, and 3,000 deaths of Americans of all ages each year caused by pathogens in contaminated food. Significant progress has been made in reducing human illness caused by three major pathogens. For example, by 2011, compared to the 1996–1998 base line, *Campylobacter* had decreased by 22 percent; *Listeria* had decreased by 35 percent, and Shiga toxin-producing *E. coli* O157 had decreased by 42 percent. These decreases accounted for over 500,000 averted illnesses and approximately

\$100 million in direct medical costs saved in calendar year 2010 alone. Foodborne illnesses will continue to threaten public health, despite food industry efforts and improvements in the U.S. food safety system. This is due to: (1) the complex, changing nature of the food supply and infectious foodborne pathogens; (2) the growing proportion of food from countries with less-developed food safety systems; (3) the speed with which contaminated food can be shipped across the country; and (4) reductions in resources over the past several years for state and local public health agencies to respond to outbreaks.

CDC's unique role in food safety is to provide the vital link between illness in people and the food safety system by: (1) tracking emerging foodborne illness trends; (2) identifying and investigating outbreaks to stop illnesses and identify gaps in the food safety system; (3) providing information to the Food and Drug Administration (FDA), the U. S. Department of Agriculture's (USDA) Food Safety and Inspection Service (FSIS), and the food industry to guide and prioritize interventions for food safety prevention; (4) providing expert advice, guidance, training, and education for state and local governments, other partners, and consumers; and (5) tracking whether prevention efforts are working. CDC utilizes strong partnerships with state and local public health agencies, FDA, and USDA to lead critical food safety networks. These include the Foodborne Diseases Active Surveillance Network (FoodNet), which CDC funds in 10 state public health agencies and CDC's National Molecular Subtyping Network for Foodborne Disease Surveillance (PulseNet), which CDC supports in all 50 states to provide DNA "fingerprinting" of pathogens from humans, such as *E. coli*, *Salmonella*, and *Listeria*, allowing illnesses from a common strain to be linked. The national surveillance, outbreak detection and response, and prevention efforts that CDC supports depend on state and local public health agencies. CDC provides cooperative agreement funding through the ELC and EIP to all state health departments and some local agencies. The funding maintains and reinforces public health capacity to track illnesses, detect and respond to outbreaks in state and local areas, and provide support for surveillance networks.

CDC drives improvements in foodborne outbreak detection and response through the Foodborne Diseases Centers for Outbreak Response Enhancement (FoodCORE) program, and the Integrated Food Safety Centers of Excellence, which work to develop, assess, implement, and disseminate new tools and methods to improve surveillance, outbreak detection, and response. CDC also provides new tools to support state and local health departments and laboratories. These include: (1) a better laboratory method for rapidly characterizing *Salmonella* that leads to more rapid outbreak detection and response, and (2) a toolkit to support state and local implementation of outbreak response guidelines. In 2011, CDC-supported partners in Colorado rapidly detected and investigated an outbreak of *Listeria* illnesses, linked them to cantaloupe, and worked with CDC, FDA, and other agencies to stop the deadly outbreak, preventing additional illnesses and deaths.

Budget Proposal: CDC's FY 2014 request of \$49,223,000 for food safety activities is an increase of \$16,605,000 above the FY 2012 level. Approximately one-half of the requested increase in funds will go to state and some 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 enable CDC to implement its provisions of the Food Safety Modernization Act (FSMA). CDC's FSMA provisions include: (1) enhancing and integrating surveillance systems, (2) upgrading the PulseNet system, (3) improving timeliness of outbreak detection and response in states through the FoodCORE program, which will be expanded from seven to 10 sites and result in approximately 30 to 45 additional worker positions, (4) attributing illnesses to specific food commodity groups to aid in prevention efforts, (5) tracking the effectiveness of food safety prevention measures, and (6) supporting FSMA's Integrated Food Safety Centers of Excellence. These investments will help restore and improve state and local capacity to track foodborne illness and will ensure faster responses to outbreaks, thereby preventing additional illnesses, hospitalizations, and deaths.

CDC's Food Safety Program will strengthen foodborne disease surveillance systems. CDC will support and improve PulseNet in all 50 states and FoodNet systems in all 10 sites to increase the completeness and accuracy of surveillance data, and will expand CaliciNet coverage, the reporting systems that track

norovirus, by supporting the existing five regional Centers so they can assist additional states with characterizing norovirus outbreaks. CDC also will improve the quality of reports from investigated foodborne outbreaks to the National Outbreak Reporting System, and will improve core CDC foodborne diseases reference laboratory functions needed to support states by verifying the identification of known pathogens and characterizing novel pathogens.

CDC will improve the integration, analysis, usability, and sharing of data with food safety partners. CDC will intensify efforts to reduce data gaps and improve linkages across surveillance systems. To support additional external and independent analyses of data, CDC will increase the amount and accessibility of foodborne illness data shared with public health partners, regulatory agencies, industry, academia, and the public. CDC will guide policies and practices by accelerating efforts to link human illnesses more accurately to specific foods and determine which food products and settings present the highest risks through CDC's Food Safety Program and the Interagency Food Safety Analytics Collaborative (IFSAC). IFSAC is a partnership among CDC, FDA, and USDA/FSIS that uses advanced analytical methods for attributing illness to specific foods.

CDC's Food Safety Program will continue to support food-related outbreak investigations and will develop improved laboratory and epidemiological tools for rapid identification and investigation of outbreaks. CDC will: (1) lead the effort among FoodCORE and Integrated Food Safety Centers of Excellence sites to implement and disseminate best practices and standards for interviewing ill people, (2) conduct environmental assessments and coordinate investigations across jurisdictions, (3) refine and enhance IT tools for the collection and sharing of outbreak investigation data, and 4) support ongoing and new projects of the Council to Improve Foodborne Outbreak Response (CIFOR). Support to CIFOR includes a toolkit that aids state and local agencies in implementing the CIFOR Guidelines for Foodborne Disease Outbreak Response, developing guidelines for industry, examining legal authorities at the state and local level, and developing standard performance metrics and recommended targets that state and local agencies can use to demonstrate their public health performance and effectiveness for better overall health outcomes.

CDC designated five Integrated Food Safety Centers of Excellence (Centers) in FY 2012, as required by FSMA. The training and educational efforts led by these Centers will focus on methods for foodborne disease diagnosis, surveillance, pathogen identification, outbreak investigation, and control. The Centers will serve a critical role in transferring best practices and tools in food safety surveillance and outbreak response to state and local public health programs and the food industry. CDC provided funding to the Centers, which are based in state health departments and partner with academic institutions and others. The Centers will serve as a resource to state and local public health programs to help train state and local personnel in best practices related to food safety and to conduct research on ways to improve our nation's food safety system. The Centers will be instrumental in implementing CIFOR guidelines and other projects described above in order to train state and local investigators and improve overall performance of foodborne surveillance and outbreak response.

CDC's PulseNet outbreak detection system relies on isolates from culture-based testing methods, which are the long-held standard in testing of specimens from patients with foodborne and other infections. The food industry and regulatory agencies also use critical outbreak-generated information to identify gaps in the food safety system and to guide food industry prevention efforts. However, more and more diagnostic tests that do not use culture are being developed and marketed for clinical use, and these tests may soon replace culture-based tests, necessitating fundamental changes in our public health efforts to track and control infectious diseases. The new testing technologies generally utilize specimens that are incompatible with the 17-year-old PulseNet technology and the systems public health laboratories use to determine the specific subtype of bacteria that is causing an outbreak, the deadliness of the pathogen subtype, and the resistance of the identified pathogen to antibiotics. Modernizing our systems to meet these challenges through new technologies and expanding laboratory capabilities is a priority for CDC. If we are unable to keep pace with this technological expansion, CDC and all states will lose most of their

capabilities to detect and stop widespread foodborne illness outbreaks. To meet this fundamental challenge to our nation's food safety system, CDC will leverage new capacity from investment in Advanced Molecular Detection and Response to Infectious Disease Outbreaks to lead a sustained effort with technology companies, consumer groups, academia, public health experts, regulatory agencies, and others to develop new strategies and technologies. Delayed investment in this effort would likely result in the loss of federal, state, and local agencies' ability to respond quickly and efficiently to foodborne disease outbreaks, as well as a gradual loss of quality in the food supply—which could result in higher numbers of foodborne-related illnesses, hospitalizations, and deaths.

Grant Table:

Food Safety Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	59	59	59
Average Award	\$0.177	\$0.177	\$0.313
Range of Awards	\$0.010–\$0.696	\$0.010–\$0.696	\$0.017–\$1.228
Number of New Awards	59	0	0
Number of Continuing Awards	0	59	59
Total Grant Award	\$10.479	\$10.479	\$18.479

¹Reflects awards funded by CDC's Food Safety budget authority and excludes PPHF funding.

In FY 2014, CDC will fund 59 awardees through competitive cooperative agreements. CDC bases continuation funding on competitively determined awards made in 2012, and awardees include all states and some local health agencies. The funding enables states to prevent foodborne illnesses, hospitalizations, and deaths by investigating and stopping outbreaks and by improving our nation's food safety system. CDC awards food safety grants for outbreak surveillance and reporting to CDC. Grants also support training to increase capacity for detection, investigation, and control of outbreaks, as well as supplies, training, and equipment to maintain and improve diagnostic capabilities. Grantees also participate in critical food safety networks—OutbreakNet, PulseNet, FoodNet, FoodCORE, CaliciNet, and the Integrated Food Safety Centers of Excellence. Specifically, grantees will use the funding to: (1) detect and respond to foodborne illness outbreaks, (2) gather data to estimate the national health burden of foodborne illnesses and to determine whether prevention progress is occurring, and (3) improve outbreak responses in all states.

QUARANTINE AND MIGRATION BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$32.976	\$33.185	\$33.125	+\$0.149
Federal Isolation and Quarantine (non-add)	N/A	\$0.000	\$1.000	N/A

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's global migration health and quarantine activities work to protect Americans' health by preventing the introduction, transmission, and spread of communicable diseases into the United States. CDC carries out unique regulatory responsibilities and implements cost-effective public health programs to address infectious disease health risks associated with immigration, refugee resettlement, expatriates, travelers and other migrating populations. CDC uses specialized knowledge of the complex issues surrounding border and migration health, including legal and regulatory issues and strong relationships with non-traditional partners, to have a greater impact. CDC trains and leverages these

partners, including 50,000 Customs and Border Protection agents, 600 panel physicians, and 3,000 civil surgeons, for the execution of frontline public health response. Programmatic goals include:

- Improving U.S. health security by preventing the importation and spread of infectious diseases to the United States through mobile populations
- Advancing U.S. health equity by improving the health of refugees and immigrants coming to the United States

Immigrant, Refugee, and Migrant Health: *Preventing Illness and Reducing Healthcare Costs* – CDC protects the health of the public by promoting and improving the health of refugees, immigrants, and migrants who are coming to the United States. CDC monitors the occurrence of disease in refugee camps, oversees required medical screening, runs field programs in Kenya and Thailand, partners to improve access to medical care and preventive health services, and provides important information to state and local health departments to continue follow-up care for immigrants and refugees. CDC reduces healthcare costs by implementing cost-effective interventions overseas for refugees and immigrants.

Quarantine and Border Health Services: *Protecting Americans' Health* – CDC protects American health security by using regulatory authority and working with partners at ports of entry and along the U.S.-Mexico border to assure that people, animals, and animal products are not transmitting diseases that could spread in the United States.

Travelers' Health: *Keeping Americans Healthy during Travel and Living Abroad* – CDC supports safe and healthy international travel by providing information about the many health risks that travelers and expatriates face. By tracking and analyzing occurrences of disease and injury throughout the world, CDC helps U.S. travelers and their healthcare providers stay informed about potential health risks while visiting or living in other countries. The CDC Health Information for International Travel: The Yellow Book is regarded as the gold standard travel medicine reference for healthcare providers.

Budget Proposal: CDC's FY 2014 request of \$33,125,000 for Quarantine and Migration is an increase of \$149,000 above the FY 2012 level. Within this amount, \$1,000,000 is to remain available until expended for quarantine-related medical and transportation costs. 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. 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. Cases are extremely variable in terms of frequency and cost. CDC will request replenishment based on analysis of past expenditures, when the fund drops below \$500,000.

With level funding in FY 2014, CDC will continue to implement public health programs to protect receiving U.S. communities, provide cost savings to the U.S. healthcare system, and respond to the needs of these populations.

Protecting the Health of Immigrants, Refugees, and Migrants — CDC will continue to use cost-effective interventions to improve the health of refugees and immigrants coming to the United States. For example, the diagnosis and treatment of 1,000 cases of TB prior to arrival in the United States saves more than \$30 million each year in U.S. healthcare costs. Programmatic goals include:

- Increasing the proportion of applicants for U.S. immigration screened for TB and treated under the most recent CDC guidelines from 78 percent in 2011 to 85 percent in 2014
- Increasing the percentage of U.S.-bound refugees in five pilot countries receiving routine vaccinations before coming to the United States from 36 percent in 2012 to 70 percent in 2014

- Increasing the percentage of immigrants and refugees with a TB condition that requires medical notification to state and local public health for medical follow-up after arrival in the United States from 71 percent in 2010 to 85 percent in 2014

Protecting and Improving the Health of Globally Mobile Populations — CDC will continue activities to respond to illness at ports of entry through leadership of 20 U.S. Quarantine Stations and along the U.S.-Mexico border; build partnerships with Mexican public health officials; and conduct research, science, and preparedness to improve the health of migrating populations and prevent the spread of diseases. Programmatic goals include:

- Establishing a bi-national public health strategy for the United States and Mexico for coordinated disease control and surveillance by 2016
- Improving preparedness and response capacity at U.S. ports of entry through enhancement of planning, exercise, response, and communication
- Reducing the risk of imported zoonotic disease through the oversight and enhancement of CDC's regulations pertaining to animals and animal products, communication, and research

Protecting Health of Travelers and Expatriates — CDC will continue activities to ensure travelers leave and return to the United States healthy, both to protect their own health and that of others. Programmatic goals include:

- Publishing an updated 2014 Yellow Book and developing mobile applications for clinicians and travelers
- Increasing the probability that vulnerable travelers will seek pre-departure travel medicine consultations and have high rates of vaccine coverage and anti-malarial prophylaxis when recommended

Grant Table:

Quarantine and Migration Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	31	28	28
Average Award	\$0.159	\$0.167	\$0.167
Range of Awards	\$0.010–\$1.295	\$0.010–\$1.295	\$0.010–\$1.295
Number of New Awards	20	4	0
Number of Continuing Awards	11	24	28
Total Grant Award	\$4.928	\$4.683	\$4.683

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

In FY 2014, CDC will fund 28 quarantine and migration health-related awards to support 16 different cooperative agreements with partners in the United States and internationally. The total for extramural funds in the FY 2013 President's Budget and the FY 2014 request differs from the FY 2012 Enacted Budget because CDC priorities for the Division of Global Migration and Quarantine cooperative agreements have changed in relation to other Division expenditures. The awards help protect the health of U.S. communities, migrants, immigrants, refugees, and international travelers. They improve the tracking of disease outbreak trends and build epidemiologic capacity among eligible states and domestic and international partners. The awards are a mix of sole source, limited eligibility, and competitive. Awardees include 13 states along the U.S.-Mexico border and those with large proportions of annual arrivals of immigrants and refugees, one county, and one university; 10 international organizations that facilitate

infectious disease surveillance and outbreak response capacity; the TB Regional Training and Medical Consultation Centers; the Public Health Foundation; and the International Society of Travel Medicine.

**ADVANCED MOLECULAR DETECTION AND RESPONSE TO INFECTIOUS DISEASE OUTBREAKS
BUDGET REQUEST**

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$0.000	\$0.000	+\$40.000	+\$40.000

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: Advances in laboratory technologies such as high-throughput genome sequencing, along with improved capabilities in the field of bioinformatics, stand to revolutionize our ability to control infectious diseases, enabling faster, more accurate, and cost-effective ways of preventing, detecting, and responding to known, emerging, and resistant pathogens. CDC currently lacks the capacity to keep pace with this rapidly changing field, threatening the agency's ability to effectively protect public health. Modernizing CDC's infectious disease laboratories and building its bioinformatics capacities are essential to ensure that the expanding use of these new technologies brings strong benefits for public health.

In 2011, CDC convened a panel of external consultants with expertise in the fields of bioinformatics and laboratory information technology. The panel reviewed the current state of bioinformatics resources across CDC's infectious diseases laboratories, and identified a number of critical gaps relative to other similarly purposed programs. CDC asked panelists to provide input on the best strategies to develop and maintain the bioinformatics expertise and infrastructure needed to sustain the high quality laboratory and epidemiologic science that policy makers, the scientific community, and the public expect of the agency. The panel found that CDC runs the risk of not being able to meet its basic public health mission unless it keeps pace with major technologic advances in the diagnosis and characterization of infectious agents.

Genetic sequencing tools generate massive amounts of data that can be used to obtain a more detailed level of information on infectious pathogens. This detailed information can then be used to develop and improve diagnostic tests, more accurately detect and respond to outbreaks and the emergence of new pathogens, and better understand and characterize antibiotic resistance. A critical component in this process, however, is ensuring the availability of advanced computing capacities and highly trained bioinformatics staff to manage and translate these sequence data into meaningful information for public health action.

The use of next-generation sequencing tools in clinical and public health microbiology is quickly becoming routine, offering more rapid, less labor-intensive, and less expensive means of diagnosing infections, compared to traditional culture-based methods. The availability and increasing use of these tools is bringing exciting opportunities for infectious disease control, along with new expectations for CDC, including provision of bioinformatics support. This shift 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 three years, many traditional methods for detecting and characterizing pathogens will be replaced or supplemented by genome-based methods, and many of these programs must change or adapt to the advent of new, data-driven technologies.

Budget Proposal: CDC's FY 2014 request of \$40,000,000 for the crosscutting Advanced Molecular Detection and Response to Infectious Disease Outbreaks initiative is an increase of \$40,000,000 above the FY 2012 level. This initiative represents a fundamental change and modernization in CDC's current public health microbiology and bioinformatics capabilities, which depend on the core capacities,

expertise, and leadership derived from this initiative. Laboratory techniques for the identification and characterization of infectious diseases have vastly changed over the past decade. These changes require substantial investments in bioinformatics expertise, database development, data warehousing, and analytics. Without sustained commitments and investment in this area, CDC's ability to derive meaningful information for public health from increasingly complex biological data sets will be jeopardized. As a result, the development of effective public health recommendations and policy will suffer. This initiative is critical to maintain CDC's standing as the nation's premier public health agency and its mission to protect Americans' health.

The investment will enable CDC to make substantial progress on the goals of:

- Strengthening essential national surveillance systems by re-tooling them to make use of the most recent technologic advances. The movement away from use of culture-based clinical diagnostic methods to faster and less expensive nucleic acid amplification technologies threatens the future of many of CDC's laboratory-based surveillance systems, including PulseNet, the Gonococcal Isolate Surveillance Program, and the National Antimicrobial Resistance Monitoring System, all of which rely on culture-based specimens. 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. 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 detect and respond to outbreaks in near real time, with unparalleled accuracy and speed. When conversion to new technology is completed, states no longer will need to submit cultures to CDC for identification. Instead, they may submit genome sequences from organisms of concern and obtain immediate answers.

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 appropriate, effective outbreak responses. After the first year of the expanded initiative, CDC will have moved toward the use of high-throughput sequencing and bioinformatics for major outbreaks, expanded the use of genomic sequencing for surveillance and outbreak investigations, and established highly curated reference databases for pathogen sequences. This request requires strategic and sustained investment in the following five areas. They are critical to CDC's ability to leverage and incorporate genome-scale molecular epidemiology as an essential component of the nation's public health system, and to adapt to the growing role of non-culture-based diagnostics.

Improved pathogen identification and detection using genomics and other high-throughput technologies

This component will expand DNA sequencing and other molecular techniques and analysis capabilities and expertise at CDC. It will support identification of targets for pathogen detection, identification, sub-specific strain typing, and markers for detection of drug resistance, vaccine development, and microbial virulence. A core team of experts in bioinformatics, pathogen genomics, and other technical specialties will 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. CDC will establish training fellowships with academic institutions to address future bioinformatics workforce needs. CDC also will make significant investment in networking infrastructure at CDC, enabling rapid transfer of large genomic datasets for analysis in collaboration with external partners, such as the National

Center for Biotechnology Information, Oak Ridge, and other national laboratories. The agency will establish partnerships and cooperative agreements with these and other groups with expertise in high-performance computing, pathogen genomics, and bioinformatics. This will allow for 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. This component will enable rapid progress toward modernizing PulseNet and other critical laboratory-based surveillance systems that are threatened by the move from older, culture-based diagnostic methods.

Adaptation of new diagnostics to meet evolving public health needs

Culture and polymerase chain reaction (PCR)-based laboratory diagnostics are slow, insensitive, and costly. This part of the initiative will enable CDC to establish leading capability to adapt the next generation of rapid, semi-automated, point-of-care molecular tests to meet evolving public health needs. As a result, the agency will significantly enhance its ability to pinpoint early threats and outbreaks; develop new diagnostic tests during outbreaks; better characterize infections, including those caused by highly resistant healthcare-associated pathogens, such as *Clostridium difficile*, MRSA, and CRE; and increase the level of detail and quality of information for biosurveillance and response activities.

Help for states to meet future bioinformatics and genomics needs in a coordinated manner

Public health laboratories will need to transition from culture-based methods to new molecular technologies. 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 by providing access for state and local public health laboratories, and other partners. This will require the purchase of specialized equipment, which includes high-performance servers and workstations, sequencers and reagents, data storage, service contracts, networking and support, and software licensing. CDC will implement support for state and local public health laboratories through training grants, and by funding support for staff and equipment. Outbreak response activities will be more effective and better integrated as CDC accelerates the rate at which it makes information about microbial pathogens accessible to partners.

Implementation of enhanced, sustainable, and integrated laboratory information systems

The existing Laboratory Information Management System (LIMS) has limited capability to share information between laboratories inside and outside CDC, or with other CDC databases, such as MicrobeNet and PulseNet, and will need to be electronically integrated with the other aspects of this initiative. The current LIMS is an integral component of laboratory services, and this component of the initiative will adapt LIMS to the new diagnostics and to data and knowledge management systems CDC develops through the initiative. CDC also will implement 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.

Development of tools for the prediction, modeling, and early recognition of emerging infectious diseases

Current modeling systems 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 current systems. CDC will modify and upgrade existing modeling systems to provide comparable improvements to models and their predictions. For example, using available influenza surveillance data sources, models can predict future levels of disease, illness, and death from seasonal influenza across the globe, and emergence of resistant influenza strains. This component of the request 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 the prediction and modeling of infectious disease pathways and processes, where pinpointing early threats, outbreaks, and opportunities for disease prevention are most important. This will greatly improve CDC's capability to derive actionable information from "big data" (e.g., terabyte or larger datasets), and apply this information to guide public health actions.

If CDC is not able to adapt and move toward the long-term public health solution proposed by AMD advances, outbreaks will last longer and affect more people, resulting in more medical costs. If CDC continues to rely on cultures when few culture isolates are left to fingerprint for PulseNet, the ability of that system to detect outbreaks will erode and disappear. Some large and widespread outbreaks will go undetected and unchecked. For example, without PulseNet, the large outbreak of salmonellosis from tuna in sushi could still be going on now, with as many as 100 cases each month, as could the listeriosis outbreak from soft imported cheese that was stopped last year.

CDC will accomplish some of these activities in collaboration with the Association of Public Health Laboratories (APHL), a national organization serving all states and territories to advance public health laboratory capacity. CDC expects to award a cooperative agreement to APHL, which in turn will distribute necessary resources to its network of laboratories to build capacity in bioinformatics. As an outcome, states will be better equipped to prevent, detect, and respond to infectious disease threats and conditions.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
ACA/PPHF	\$51.750	N/A	\$51.750	\$0.000

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

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

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

Epidemiology and Laboratory Capacity/Emerging Infections Program

CDC is enhancing the ability of state, local, and territorial ELC and EIP grantees to strengthen and integrate capacity for detecting and responding to infectious diseases and other public health threats. The ELC Program collaborates closely with the Public Health Informatics Program in the Office of Surveillance, Epidemiology, and Laboratory Services to monitor and support implementation of electronic laboratory records (ELR). EIP grantees are making long-needed improvements to their infrastructure with the coordination, training, and information technology necessary to manage the numerous and varied EIP program activities and studies. Specifically, the ELC/EIP platform aim is to increase:

- Epidemiology capacity: Increase numbers of better trained and properly equipped epidemiology staff to provide rapid, effective, and flexible response to infectious disease threats.
- 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's goal is to (a) eliminate HAIs in all healthcare settings, (b) strengthen state public health infrastructure for activities related to monitoring, response, and prevention, and (c) continue regional prevention initiatives across all healthcare settings (e.g., nursing homes, long-term acute care facilities, dialysis facilities, rehabilitation facilities). CDC will support the critical public health role of state health departments to implement and ensure adherence to HAI prevention practices. CDC will build on the success of investments in preventing HAIs to ensure improved leadership and coordination of the state HAI activities by state health departments. Using the ELC Grant Program, CDC will support states that have implemented HAI prevention initiatives effectively through program development and policy implementation. Funding will help states maintain sustainable programs that will work across the healthcare system to maximize HAI prevention efforts through collaboration with public health partners and healthcare partners, such as CMS quality improvement organizations, hospital associations, and consumer groups.

These funds also will help support coordination at the state level of all HHS activities including the HHS Partnership for Patients initiative, HHS HAI Action Plan, Quality Improvement Programs, and state hospital associations.

Grant Table:

ACA/PPHF Healthcare-Associated Infections Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	50	N/A	50
Average Award	\$0.185	N/A	\$0.185
Range of Awards	\$0.034-\$0.670	N/A	\$0.034-\$0.670
Number of New Awards	0	N/A	0
Number of Continuing Awards	50	N/A	50
Total Grant Award	\$9.288	N/A	\$9.288

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

These 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.

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
<u>3.5.1</u> : Increase the percentage of laboratories (large commercial/independent and hospital) using Electronic Laboratory Reporting (ELR) in Grantee Jurisdictions ¹ (Intermediate Outcome)	FY 2011: 23% (Target Not Met, but Improved)	37%	57%	+20

¹Targets reflect ACA/PPHF funding.

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
<u>3.E</u> : Establish and maintain state TickNet sites to collect and submit data for Lyme and other tick-borne diseases (Output)	FY 2012: 19 (Target Exceeded)	16	16	Maintain

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
<u>3.2.1</u> : Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children (Outcome)	FY 2010: 55.8 (Target Not Met, but Improved)	48	48	Maintain
<u>3.2.2</u> : Decrease the proportion of hospitals with carbapenem-resistant <i>Klebsiella spp.</i> or <i>Escherichia coli</i> (<i>E. coli</i>) healthcare-associated infections	CY 2011: 6.54% (Baseline)	N/A	3.00%	N/A

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
<u>3.3.2a</u> : Reduce the incidence (per 100,000 population) of healthcare associated invasive Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) infections (Outcome) ¹	CY 2011: 20.06 (Historical Actual)	N/A	12.18	N/A
<u>3.3.3</u> : Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR) ^{2,3} (Outcome)	CY 2011: 0.59 (Target Exceeded)	0.6	0.4	-0.2

¹ This measure was revised during FY 2012 from an estimated total number of invasive MRSA cases to reflect the incidence of healthcare associated invasive MRSA cases. Results and targets have been updated to reflect incidence rates.

² The Standardized Infection Ratio (SIR) is calculated by dividing the actual (observed) infections by the predicted infections using data gathered through the CDC National Healthcare Safety Network (NHSN). The measure aligns with the FY 2012-FY 2013 Agency Priority Goal on Improving Patient Safety.

³ Targets do not reflect ACA/PPHF funding.

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 reduces errors and duplicate reporting. This yields cost savings for public health and clinical health and more rapid control of infectious disease outbreaks. Although labs in grantee areas utilizing ELR increased from 17 percent in FY 2010 to 23 percent in FY 2011, CDC did not meet its FY 2011 target (Measure 3.5.1). To improve the percentage of laboratories sending ELR, CDC grantees are upgrading their technical infrastructure, surveillance systems, and laboratory Information Management systems (LIMS). Grantees are also engaging with clinical, commercial, and other labs in their jurisdictions to target laboratories that send meaningful volumes of lab reports to them. CDC's technical support group is assisting grantees and the Association of Public Health Laboratories in accelerating ELR implementation and tracking progress toward the targets. CDC estimates ELR reporting will increase approximately 10-20 percent per year by the end of FY 2014.

Vector-borne Performance Trends: Tick-borne diseases have been increasing in the United States (U.S.) in the last decade. For example, confirmed and probable cases of Lyme disease rose to 33,097 in 2011, up from 23,763 confirmed cases reported in 2002; cases of spotted fever rickettsiosis, including Rocky Mountain spotted fever, rose to 2,802, up from 1,104 confirmed cases reported in 2002. Reducing the impact of tick-borne diseases demands capacity throughout affected areas of the U.S. to better identify risks and respond effectively using tailored prevention strategies. CDC used additional, one-time resources during FY 2012 to temporarily increase the number of TickNet sites from 16 in FY 2011 to 19 in FY 2012, exceeding its FY 2012 target (Measure 3.E). CDC expanded epidemiology and lab capacity in three non-core sites (those other than Lyme disease). 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 in the case of Lyme disease, for establishing national prevention goals that are based on validated intervention methods and approaches.

Antimicrobial Resistance Performance Trends: Preventing antimicrobial resistance (AR) through disciplined physician prescribing behaviors as well as detecting and preventing the spread of emerging AR strains is essential to prevent and control AR threats. CDC's Get Smart: Know When Antibiotics Work program focuses on reducing antibiotic prescribing rates for children to reduce the number of antibiotic resistant infections. Ear infections among children under five years of age result in more

antibiotic prescriptions than any other clinical diagnosis. The annual number of antibiotic prescriptions for ear infections remains high with a rate of 55.8 prescriptions per 100 children under five years of age (Measure 3.2.1). CDC exceeded targets from 2005-2007, and the rate improved during this time. However, the physician prescribing rate increased in 2008 and 2009, and CDC did not meet its targets as a result. In 2010, the rate improved, but not enough for CDC to meet its target. While providers are reluctant to change prescribing patterns for childhood ear infections, physicians have changed their prescribing behavior for other conditions like the common cold. There has been a 24 percent decrease in prescribing rates for ambulatory visits in children less than 15 years of age. CDC collaborates with external partners, such as the American Academy of Pediatrics, to target physician prescribing behavior through appropriate antibiotic-use messages as well as identifying ways for physicians to incorporate messages, reminders, and education into the clinical workflow. In addition, CDC has increased its use of current technology (social media, television ads, YouTube) to educate the general public about when it is appropriate to request antibiotics from their (or their children's) provider.

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 pneumonia 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). Working 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. CDC developed a new measure for carbapenem-resistant *Klebsiella spp* and *Escherichia coli (E.coli)* during CY 2012. In CY 2011, 6.54 percent of hospitals reporting into CDC's National Healthcare Safety Network (NHSN) reported carbapenem-resistant *Klebsiella spp* or *E. coli* infections (Measure 3.2.2).

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 (hospital onset and healthcare-associated invasive MRSA in other healthcare settings, e.g., dialysis centers) infections continued to decline from CY 2008 baseline, decreasing from 21.76 infections per 100,000 population in CY 2010 to 20.06 in CY 2011 (Measure 3.3.2a). In CY 2011, CLABSIs decreased 41 percent (0.59 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.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
<u>3.1.1b:</u> Reduce the incidence of infection (per 100,000 population) with three key foodborne pathogens: <i>Escherichia coli</i> O157:H7 (Outcome)	FY 2011: 0.98 (Target Exceeded)	1.00	0.90	-.10
<u>3.1.1c:</u> Reduce the incidence of infection (per 100,000 population) with three key foodborne pathogens: <i>Listeria monocytogenes</i> . (Outcome)	FY 2011: 0.28 (Target Not Met but Improved)	0.26	0.24	-.02

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
<u>3.1.1d</u> : Reduce the incidence of infection (per 100,000 population) with three key foodborne pathogens: <i>Salmonella</i> species. (Outcome)	FY 2011: 16.47 (Target Not Met but Improved)	13.93	13.30	-0.63
<u>3.B</u> : Cumulative number of Public Health Laboratories certified for CaliciNet to detect and type norovirus (Output)	FY 2012: 28 (Target Exceeded)	27	32	+5

Performance Trends: Concerted prevention efforts by CDC, regulatory partners, and industry have resulted in significant progress in reducing the incidence of major foodborne infections. For example, between FY 2011 and the 1996-1998 baseline, the incidence of *Listeria* infection decreased about 35 percent and the incidence of *Escherichia coli* (*E. coli*) O157 infection decreased about 42 percent. In 2011, FoodNet surveillance documented that the reduction in incidence of *E. coli* O157 infection exceeded the FY 2011 target of less than one case per 100,000 population (Measure 3.1.1b). However, from FY 2010 to FY 2011 the incidence of *E. coli* O157 infections increased by 0.08. The reason for this is unclear, but may be due in part to large multi-state outbreaks in 2011, including one that implicated hazelnuts and another that implicated Lebanon bologna.

CDC aligns its Food Safety targets with national targets for Healthy People 2020 objective.

In 2011, CDC did not meet its target for the reduction of *Listeria* infections. However, *Listeria* infection rates remained relatively constant compared to 2010, despite a 28 state outbreak associated with cantaloupe in the fall of 2011 (Measure 3.1.1c). The cantaloupe outbreak, the deadliest foodborne illness outbreak in nearly 90 years, resulted in more than 30 deaths and one miscarriage. CDC efforts led to swift recognition of the problem and identification of the food source, preventing additional hospitalizations and deaths. In recent years, major efforts by the processed meat/hotdog industry have been an important contributor to reducing contamination by *Listeria*. Additionally, CDC collaborates closely with state and local health departments, the Food and Drug Administration (FDA), and the U.S. Department of Agriculture's (USDA) Food Safety and Inspection Service to implement the National *Listeria* Action Plan and reduce cases through efficient risk management, empowering consumers, and improving consumer safety.

Despite a 6.5 percent decrease in *Salmonella* infection rates from FY 2010, CDC did not meet its FY 2011 target (Measure 3.1.1d). If an annual 6-7 percent decrease in the *Salmonella* infection rate continues, CDC will meet or even exceed its FY 2014 target. *Salmonella* remains the most commonly reported infection in FoodNet, but the decline suggests that evidence-based prevention practices are helping. For example, public health surveillance and foodborne illness outbreak investigations led by CDC have been used by: 1) the FDA to explain the need for its proposed "Produce Rule," that aims to reduce illnesses caused by pathogens in produce; 2) USDA's efforts to improve the safety of poultry products, and 3) food industry leaders to develop new strategies to reduce contamination of food. In addition to regular collaboration with FDA and USDA, CDC is partnering with FDA on an HHS Agency Priority Goal spanning FY 2012 and FY 2013 to lower the incidence of illness caused by the type of *Salmonella* often found in shell eggs. Collectively, these activities should result in reductions in the incidence of *Salmonella* illnesses in our nation over the coming years.

CDC has steadily increased the number of states with public health laboratories certified to detect norovirus—a foodborne infection common in long-term care facilities, restaurants, and schools—from 15 states in FY 2008 to 28 states in FY 2012, exceeding the FY 2012 target (Measure 3.B). The expanded surveillance capacity resulted in the detection of more outbreaks, increasing from eight in 2008 to 148 in FY 2012.

Program: National Healthcare Safety Network

Performance measure for National Healthcare Safety Network

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
3.3.4: Increase the number of hospitals and other selected healthcare settings that report into the National Healthcare Safety Network (NHSN) ¹ (Output)	FY 2012: 10,900 (Target Exceeded)	6,500	13,500	+7,000

¹Targets do not reflect ACA/PPHF funding.

Performance Trends: CDC's National Healthcare Safety Network (NHSN) provides customizable data for action that drives healthcare-associated infection (HAI) prevention at healthcare facilities, state, and national levels by focusing prevention activities, benchmarking prevention success, and monitoring progress toward national prevention targets. CDC exceeded its FY 2012 target to increase the number of facilities reporting to NHSN (Measure 3.3.4). CDC is well positioned to meet, if not exceed, its FY 2014 target as preliminary data demonstrate CDC expanded tracking capacity from 5,200 facilities from December 2011 to over 11,000 facilities through December 2012, including more than 5,500 dialysis facilities. Since 2010, CDC has quadrupled the number of healthcare facilities reporting data for HAI prevention. To simplify reporting for healthcare facilities and improve the accuracy of data reported, CDC supports electronic reporting of HAI data (e.g., electronic sampling of denominator data) by increasing the number of facilities using electronic data sources to detect and report HAIs. NHSN informs CDC's strategic efforts to assess local, state, and national HAI trends, and strengthens HAI prevention across healthcare settings.

Program: Quarantine and Migration

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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)	70%	85%	+5
3.4.3: Increase the likelihood of travelers seeking pre-travel medical advice for travel to Africa and Asia. (Outcome)	FY 2009: 4.4 (Target Not Met)	10	11	+1
3.4.4: Increase 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) ¹	FY 2011: 78% (Target Exceeded)	74%	85%	+11

¹ CDC erroneously reported FY 2010 results as 81 percent in the FY 2013 President's Budget. The actual result was 71 percent.

Performance Trends: CDC ensures that immigrants, refugees, and travelers receive required medical screening, health education, and disease treatment before coming to or leaving the United States. CDC screened of 78 percent of United States-bound immigrants per the 2007 Tuberculosis technical instruction

(TB TI), exceeding its FY 2012 target (Measure 3.4.2). CDC has exceeded its targets since 2008, resulting in the identification and treatment of 1,000 cases of Tuberculosis (TB) yearly in refugees and immigrants and yielding \$15 to \$25 million in savings to U.S. healthcare. In FY 2011, CDC implemented the revised TB medical screening guidance for all immigration applicants in Bangladesh, Cameroon, Columbia, El Salvador, Guatemala, Malaysia, Singapore, South Korea, and Thailand (<http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-implementation.html>). CDC has increased its use of technology, including webinars, to maximize global TB TI training efforts and reduce costs.

CDC currently focuses its pre-travel outreach and educational activities on travelers to Africa and Asia because of the high disease risk for travel to these continents. Europe and Oceania are developed areas where there is low risk for infectious disease as a whole. Thus, the likelihood of a U.S. traveler seeking pre-travel advice before visiting these countries is likely to be relatively constant and low, providing an adequate group to determine trends in pre-travel advice-seeking behavior in those visiting both Asia and Africa. Although CDC did not meet its FY 2009 target, travelers to Asia and Africa were 4.4 times more likely to seek travel advice than travelers to Europe, Australia, and New Zealand (Measure 3.4.3). CDC experienced delays in receiving FY 2010 and FY 2011 data and is assessing alternatives for obtaining the data. CDC is improving efforts to increase the number of travelers to Africa and Asia seeking pre-travel medical advice through enhancements to CDC's travel health website, publication of the 2014 Yellow Book, and mobile applications to better serve clinicians and travelers.

Since 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 2011, CDC increased medical follow-ups to 78 percent, up from the 71 percent achieved in FY 2010 and exceeding the FY 2012 target. CDC has improved reliability of the Electronic Disease Notification (EDN) system by establishing a web-based TB follow-up reporting system, allocating resources to establish a stable workforce in the EDN Data Entry Center, providing timely notifications to health departments, improving functionality of the system, and conducting one-on-one correspondence with state TB coordinators to complete follow-up.

STATE TABLES^{1,2,3}

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283, 93.521 (ACA) EPIDEMIOLOGY AND LABORATORY CAPACITY FOR INFECTIOUS DISEASES (ELC)				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$1,375,353	\$614,883	\$1,375,353	\$0
Alaska	\$1,601,883	\$515,497	\$1,601,883	\$0
Arizona	\$2,159,077	\$1,204,019	\$2,159,077	\$0
Arkansas	\$1,077,166	\$511,128	\$1,077,166	\$0
California	\$4,401,103	\$2,195,239	\$4,401,103	\$0
Colorado	\$2,466,331	\$1,246,838	\$2,466,331	\$0
Connecticut	\$1,711,758	\$715,395	\$1,711,758	\$0
Delaware	\$852,293	\$391,023	\$852,293	\$0
Florida	\$2,314,685	\$832,857	\$2,314,685	\$0
Georgia	\$1,603,261	\$529,013	\$1,603,261	\$0
Hawaii	\$1,064,932	\$557,288	\$1,064,932	\$0
Idaho	\$945,792	\$452,294	\$945,792	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283, 93.521 (ACA) EPIDEMIOLOGY AND LABORATORY CAPACITY FOR INFECTIOUS DISEASES (ELC)				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Illinois	\$2,222,102	\$756,420	\$2,222,102	\$0
Indiana	\$1,472,357	\$406,073	\$1,472,357	\$0
Iowa	\$2,739,299	\$812,720	\$2,739,299	\$0
Kansas	\$1,293,699	\$494,382	\$1,293,699	\$0
Kentucky	\$1,014,686	\$267,587	\$1,014,686	\$0
Louisiana	\$1,143,068	\$782,537	\$1,143,068	\$0
Maine	\$1,243,583	\$483,586	\$1,243,583	\$0
Maryland	\$2,046,114	\$975,513	\$2,046,114	\$0
Massachusetts	\$1,911,326	\$811,155	\$1,911,326	\$0
Michigan	\$2,652,232	\$1,110,726	\$2,652,232	\$0
Minnesota	\$2,738,330	\$1,405,913	\$2,738,330	\$0
Mississippi	\$1,150,320	\$594,733	\$1,150,320	\$0
Missouri	\$1,234,215	\$769,741	\$1,234,215	\$0
Montana	\$1,079,232	\$526,601	\$1,079,232	\$0
Nebraska	\$1,361,223	\$784,076	\$1,361,223	\$0
Nevada	\$1,252,904	\$512,515	\$1,252,904	\$0
New Hampshire	\$1,096,692	\$667,595	\$1,096,692	\$0
New Jersey	\$1,431,047	\$1,048,141	\$1,431,047	\$0
New Mexico	\$1,294,136	\$622,054	\$1,294,136	\$0
New York	\$2,943,514	\$1,366,931	\$2,943,514	\$0
North Carolina	\$1,655,498	\$839,934	\$1,655,498	\$0
North Dakota	\$856,448	\$648,619	\$856,448	\$0
Ohio	\$2,495,442	\$1,293,959	\$2,495,442	\$0
Oklahoma	\$818,836	\$419,665	\$818,836	\$0
Oregon	\$2,247,737	\$1,223,938	\$2,247,737	\$0
Pennsylvania	\$1,928,215	\$1,020,323	\$1,928,215	\$0
Rhode Island	\$1,141,040	\$666,546	\$1,141,040	\$0
South Carolina	\$1,493,895	\$853,978	\$1,493,895	\$0
South Dakota	\$1,077,260	\$425,250	\$1,077,260	\$0
Tennessee	\$1,531,610	\$1,116,952	\$1,531,610	\$0
Texas	\$1,228,535	\$1,106,735	\$1,228,535	\$0
Utah	\$1,874,466	\$1,007,638	\$1,874,466	\$0
Vermont	\$1,461,173	\$714,307	\$1,461,173	\$0
Virginia	\$1,873,452	\$868,073	\$1,873,452	\$0
Washington	\$2,202,024	\$1,360,285	\$2,202,024	\$0
West Virginia	\$952,908	\$668,589	\$952,908	\$0
Wisconsin	\$2,593,558	\$1,156,364	\$2,593,558	\$0
Wyoming	\$1,167,994	\$723,870	\$1,167,994	\$0
Subtotal States	\$83,493,803	\$41,079,498	\$83,493,803	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283, 93.521 (ACA) EPIDEMIOLOGY AND LABORATORY CAPACITY FOR INFECTIOUS DISEASES (ELC)				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Chicago	\$630,773	\$289,034	\$630,773	\$0
Houston	\$1,571,792	\$1,012,963	\$1,571,792	\$0
Los Angeles County	\$1,566,219	\$684,272	\$1,566,219	\$0
New York City	\$3,346,742	\$1,795,691	\$3,346,742	\$0
Philadelphia	\$965,349	\$394,238	\$965,349	\$0
Washington, D.C.	\$773,110	\$362,268	\$773,110	\$0
Subtotal Cities	\$8,853,985	\$4,538,466	\$8,853,985	\$0
American Samoa	\$88,402	\$88,402	\$88,402	\$0
FSM (Fed. States of Micronesia)	\$93,619	\$93,619	\$93,619	\$0
Guam	\$280,730	\$280,730	\$280,730	\$0
Mariana Islands	\$109,529	\$109,529	\$109,529	\$0
Marshall Islands	\$119,772	\$119,772	\$119,772	\$0
Palau	\$162,992	\$87,906	\$162,992	\$0
Puerto Rico	\$399,120	\$265,265	\$399,120	\$0
U.S. Virgin Islands	\$82,001	\$82,001	\$82,001	\$0
Subtotal Territories	\$1,336,165	\$1,127,225	\$1,336,165	\$0
Total States/Cities/Territories	\$93,683,953	\$46,745,188	\$93,683,953	\$0

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

² FY 2012 includes actuals from the Affordable Care Act Prevention and Public Health Fund.

³ At the time of the budget submission, PPHF funds for FY 2013 have not been allocated and are not included.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$800.316	\$805.432	\$620.189	-\$180.127
PHS Evaluation Transfer	\$0.000	\$0.000	\$0.000	\$0.000
ACA/PPHF	\$411.050	N/A	\$415.904	+\$4.854
Total	\$1,211.366	\$805.432	\$1,036.093	-\$175.273
FTEs	984	979	979	-5

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: 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)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$1,036,093,000 for Chronic Disease Prevention and Health Promotion, including \$415,904,000 from the Affordable Care Act Prevention and Public Health Fund is an overall decrease of \$175,273,000 below the FY 2012 level. The FY 2014 request includes an increase of \$13,837,000 for Tobacco Prevention and Control. The FY 2014 request also includes Affordable Care Act Prevention and Public Health Fund investments of \$136,340,000 for Community Transformation Grants, \$5,000,000 for the Million Hearts™ program, \$4,000,000 for Let's Move/Healthy Weight Task Force Activities, and \$2,500,000 for Hospitals Promoting Breastfeeding activities.

The FY 2014 request for Breast and Cervical Cancer is a decrease of \$38,003,000 below the FY 2012 level, and the FY 2014 request for Colorectal Cancer is a decrease of \$3,881,000 below the FY 2012 level reflecting increased coverage for these services through health reform. Additionally, while CDC will continue to encourage coordination of program investments, CDC's FY 2014 supports separate categorical funding requests for CDC's chronic disease prevention budget lines: Heart Disease and Stroke; Diabetes; Arthritis and Other Conditions; Nutrition, Physical Activity, and Obesity Prevention; Health Promotion; and School Health. CDC will continue to encourage program coordination in a number of ways, including combined funding opportunity announcements, such as the one described below; supporting common program management; and streamlining public health activities addressing chronic disease, including surveillance, interventions for shared risk factors (e.g., poor diet, smoking), and evaluation.

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 these diseases and associated risk factors by funding programs in states, tribes, territories, and local communities across the nation. 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: (1) preventing and controlling the

leading causes of disease and disability, including tobacco use, obesity, heart disease and stroke, diabetes, and cancer; (2) promoting community health, oral health, safe motherhood, infant health, and healthy behaviors (such as physical activity and nutrition); and (3) maintaining surveillance systems to track and monitor behavioral risk factors. CDC translates research into innovative prevention strategies and tools to bring the latest scientific findings to communities. Together, CDC's evidence-based chronic disease programs reach millions of Americans to improve health and prevent disease. CDC requests authority to allow CDC and grant recipients to reallocate up to five percent of grant funds across the selected chronic disease prevention and health promotion activities to enhance coordination and strengthen collaborative work across activities. Because chronic diseases and their risk factors share many social, environmental, behavioral, and biological determinants and are often managed by the same or similar organizations, health promotion and prevention efforts require significant collaboration. This collaborative orientation allows grantees the flexibility needed to maximize resources and structure programs in a more comprehensive manner.

In FY 2013, the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is supporting the implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors in states. Four chronic disease prevention programs—Diabetes, Heart Disease and Stroke Prevention, Nutrition, Physical Activity, and Obesity, and School Health—are included in the funding opportunity announcement: *"State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health."* Collectively, these programs support a set of complementary activities and intervention strategies in the four chronic disease domains:

- Epidemiology and surveillance
- Supportive environments
- Improvements in health systems
- Community-clinical linkages.

Combining these programs into a single FOA encourages states to implement a cohesive set of evidence- and practice-based interventions that address multiple chronic diseases and risk factors. These interventions are implemented in multiple settings (e.g., schools, communities, healthcare, and work sites). The interventions are more purposefully aligned and coordinated and thus are more likely to achieve measurable health impacts collectively and for each of the categorical programs. This combined approach reduces duplication, allowing more funds to be used for program activities, and encourages states 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 FOA contains two components:

- **Basic, Non-Competitive Component:** This component will support basic health protection and health promotion activities and targeted 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 Washington, D.C. CDC will hold states accountable for achieving specific outcomes in the core related to cross-cutting expertise, such as surveillance, policy, communications, evaluation, and health systems. Funding for this component is determined by a funding formula that includes factors for population size and poverty. The average funding award for this component is approximately \$550,000.

- Competitive, Enhanced Component:** This component will build on and extend activities supported with basic funding to achieve even greater reach and impact. CDC will fund up to 25 states for implementation of evidence- and practice-based interventions to improve physical activity, nutrition, and reduce obesity, diabetes, heart disease, and stroke. The competitive component is comprised of strategies that have strong evidence of producing a measurable public health impact when implemented at a systems level. Funding for this component is determined by a funding formula based on population size; the range of awards for the enhanced component will be \$1.0 million to \$3.0 million.

Grant Table:

Combined FOA Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget ^{1,2}
Number of Awards	N/A	51	51
Range of Awards	N/A		
- Core	N/A	\$0.502 to \$0.745	\$0.502 to \$0.745
- Enhanced	N/A	\$1.000 to \$3.000	\$1.000 to \$3.000
Number of New Awards	N/A	51	0
Number of Continuing Awards	N/A	0	51
Total Grant Award	N/A	Amount determined based on sum of state awards for the 4 programs	Amount determined based on sum of state awards for the 4 programs

¹In FY 2013, CDC issued a new five-year combined FOA 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. The total grant award reflects the sum of the four state grant allocations to the new combined FOA

²The FY 2013 combined FOA consists of two components: the Basic component, which will fund all 50 states and DC, and a Competitive component, which will fund up to 25 states with an average award size of \$1.8 million.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,3}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Tobacco Prevention and Control	\$198.523	\$116.262	\$212.360	+\$13.837
ACA/PPHF (non-add)	\$83.000	N/A	\$95.000	+\$12.000
Nutrition, Physical Activity and Obesity	\$47.202	\$37.440	\$47.400	+\$0.198
ACA/PPHF (non-add)	\$10.000	N/A	\$0.000	-\$10.000
School Health ²	\$14.681	\$14.775	\$14.703	+\$0.022
Health Promotion	\$19.016	\$19.137	\$19.062	+\$0.046
Prevention Research Centers	\$28.912	\$19.033	\$25.041	-\$3.871
ACA/PPHF (non-add)	\$10.000	N/A	\$0.000	-\$10.000
Heart Disease and Stroke	\$58.762	\$59.138	\$58.870	+\$0.108
Diabetes	\$69.120	\$69.561	\$79.260	+\$0.140
ACA/PPHF (non-add)	\$10.000	N/A	\$0.000	-\$10.000
Cancer Prevention and Control ³	\$371.544	\$363.855	\$329.660	-\$41.884
ACA/PPHF (non-add)	\$10.000	N/A	\$173.064	+\$163.064
Breast and Cervical Cancer (non-add)	\$212.563	\$213.923	\$184.560	-\$28.003
WISEWOMAN (non-add)	\$21.413	\$21.550	\$21.413	\$0.000
Colorectal Cancer (non-add)	\$44.458	\$44.742	\$40.577	-\$3.881
Oral Health	\$15.878	\$15.980	\$15.921	+\$0.043
Safe Motherhood and Infant Health	\$49.124	\$49.437	\$49.322	+\$0.198
Arthritis and Other Chronic Diseases	\$26.614	\$26.785	\$26.654	+\$0.040
Racial and Ethnic Approaches to Community Health (REACH)	\$53.940	\$14.029	\$0.000	-\$53.940
ACA/PPHF (non-add)	\$40.000	N/A	\$0.000	-\$40.000

NARRATIVE BY ACTIVITY
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION
BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,3}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Community Transformation Grants	\$226.000	N/A	\$146.340	-79.660
ACA/PPHF (non-add)	\$226.000	N/A	\$136.340	-\$89.660
Million Hearts™ (ACA/PPHF)	\$0.000	N/A	\$5.000	+\$5.000
Workplace Wellness (ACA/PPHF)	\$10.000	N/A	\$0.000	-\$10.000
Healthy Weight Task Force Obesity Activities (ACA/PPHF)	\$5.000	N/A	\$4.000	-\$1.000
Hospitals Promoting Breastfeeding (ACA/PPHF)	\$7.050	N/A	\$2.500	-\$4.550
Total	\$1,211.366	\$805.432	\$1,036.093	-\$175.273

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²In FY 2012, HIV school health activities were transferred from the National Center for Chronic Disease Prevention and Health Promotion to the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention.

³The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary..

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$983.686
2010	\$865.445
2010 (ACA/PPHF)	\$58.933
2011	\$773.987
2011 (ACA/PPHF)	\$300.950
2012	\$800.316
2012 (ACA/PPHF)	\$411.050
2013	\$805.432
2013 (ACA/PPHF) ²	N/A

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

TOBACCO PREVENTION AND CONTROL BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$115.523	\$116.262	\$117.360	+\$1.837
ACA/PPHF	\$83.000	N/A	\$95.000	+\$12.000
Total	\$198.523	\$116.262	\$212.360	+\$13.837

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: Tobacco use is the single most preventable cause of disease, disability, and death in the United States. The program's primary goal is to reduce the proportion of U.S. adults who are current smokers from 19 percent in 2011 to 18 percent over the next three years and to reduce the number of adolescents who are current smokers from 18.1 percent in 2011 to 17.9 percent in 2014. This decline would result in approximately 2.3 million fewer current smokers. This goal is part of CDC's strategy to prevent the leading causes of disease, disability, and death.

CDC is the lead federal agency for comprehensive tobacco control. Evidence confirms that comprehensive tobacco control programs, such as those funded by CDC, reduce tobacco use. CDC funding and programs support state tobacco control programs, which reduce tobacco use by establishing

smoke-free policies, reducing the social acceptability of tobacco use, helping users quit, and preventing tobacco use initiation. States that invest heavily in comprehensive tobacco control have seen cigarette sales drop more than twice as much as the United States as a whole, and youth and adult smoking prevalence declines faster as spending for tobacco control programs increases.

CDC also conducts groundbreaking research and surveillance on tobacco use, translating science into best practices that help states plan, implement, evaluate, and sustain their own programs. For example, CDC has conducted essential research to build the scientific evidence of secondhand smoke exposure risks, the health effects of secondhand smoke exposure, and the impact of smoke-free policies on eliminating this exposure. Monitoring various indicators regarding smoking and tobacco use, as well as those related to secondhand smoke, is important to understand how to eliminate the tobacco use epidemic. This work includes surveillance on current state smoke-free policies in worksites, restaurants, and bars. Surveillance data indicate that between 2005 and 2012, the percentage of the U.S. population covered by smoke-free laws increased from 13.5 percent to 48.9 percent. However, these data also indicate that increases in smoke free coverage has stalled in the past two years, as no state has enacted a comprehensive smoke-free law since 2010, leaving a significant portion of the U.S. population unprotected.

In FY 2012, CDC launched a new, national tobacco education mass-media campaign, *Tips from Former Smokers*. Between the March 19, 2012 campaign launch and June 10, 2012, calls to state quitlines generated an additional 207,519 calls to 1-800-QUIT-NOW (a 132% increase) compared corresponding weeks in 2011, achieving a total of more than 365,000 calls to the Quitlines throughout the term of the campaign. CDC estimates that over the next three years, this campaign will drive quit attempts that will decrease national medical costs and productivity losses by \$170 million.

Budget Proposal: CDC's FY 2014 request for Tobacco Prevention and Control of \$212,360,000 including \$95,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an increase of \$13,837,000 above the FY 2012 level. At this funding level, CDC will continue the activities described above and invest in expanding educational efforts. CDC will use the increase to expand the national mass-media 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 those smokers who wish to quit. This campaign will build on the education campaign implemented in FY 2012 and FY 2013—a cost-effective way to prompt smokers to quit. With the increase in resources, CDC estimates that the campaign will prompt an additional 750,000 quit attempts, resulting in 50,000 to 64,000 quitters.

This request also continues support for all states with tobacco control scientific and programmatic expertise. Through the National Tobacco Control Program funding cycle that began in 2009, CDC supports comprehensive programs through a five-year cooperative agreement with all 50 states, Washington, D.C., eight U.S. territories/jurisdictions, and eight tribal-serving organizations. In addition, CDC funds six national networks to reduce tobacco use among specific populations, including African Americans, American Indians/Alaska Natives, Asian Americans/Pacific Islanders, Hispanics/Latinos, lesbians and gays, and persons of low socioeconomic status.

CDC will also continue to conduct and disseminate state-of-the-art tobacco prevention research, including research through CDC's Tobacco Laboratory, which conducts critical research on toxic and addictive substances in tobacco products, tobacco smoke, and in people who use tobacco or who are exposed to secondhand smoke.

CDC will support smoking cessation services through tobacco prevention programs in 50 states, two territories, and Washington, D.C., to maintain and augment the national network of tobacco cessation quitlines to support the increase in quit attempts due to the education campaign. Stakeholders will use National Quitline Data Warehouse data to evaluate state quitline progress. CDC will also use resources on priority areas: sustaining critical state tobacco prevention and control programs and tobacco control surveillance, as well as addressing emerging public health concerns about non-combustible and other nontraditional tobacco products.

Grant Table:

Tobacco Prevention and Control Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget ²
Number of Awards	51	51	51
Average Award	\$1.181	\$1.181	\$1.181
Range of Awards	\$0.532–\$1.872	\$0.532–\$1.872	\$0.532–\$1.872
Number of New Awards	0	0	51
Number of Continuing Awards	51	51	0
Total Grant Award	\$60.321	\$60.321	\$60.321

¹Funding for these awards is from CDC's discretionary budget authority and does not include any funds from the Affordable Care Act Prevention and Public Health Fund.

²FY 2014 will be the first year of a new cooperative agreement.

CDC will continue to support state comprehensive tobacco programs, focusing on preventing tobacco use initiation among youth and young adults, promoting cessation, eliminating secondhand smoke exposure, and identifying and eliminating tobacco-related disparities. The National Tobacco Control Program's goals for 2009–2014 are to:

- Eliminate secondhand smoke exposure
- Promote quitting among adults and youth
- Prevent initiation among youth
- Identify and eliminate disparities among population groups.

Awardees are held accountable for annual spending and progress toward predetermined objectives, outlined in CDC's Best Practices for Comprehensive Tobacco Control Programs.

CDC will issue a new funding announcement for the planned continuation of activities in early February 2014. Grantees include all 50 states and Washington, D.C. CDC determines funding levels by the state or jurisdiction's population, the state's spending history, and the application's technical merit and quality. At the end of this funding cycle, CDC expects grantees to achieve identified tobacco prevention program goals, such as reducing smoking initiation.

NUTRITION, PHYSICAL ACTIVITY, AND OBESITY BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$37.202	\$37.440	\$47.400	+\$10.198
ACA/PPHF	\$10.000	N/A	\$0.000	-\$10.000
Total	\$47.202	\$37.440	\$47.400	+\$0.198

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview:

Overweight and obesity and their associated health problems have a significant economic impact on the U.S. healthcare system. CDC estimates that in 2008 alone adult obesity-related medical costs, across all payers, totaled \$147 billion.⁹ In 2012, CDC released a study estimating U.S. adult obesity levels may

⁹Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. "Annual Medical Spending Attributable to Obesity; Payer and Service Specific Estimate," Health Affairs 2009; 28(5):w822-w831, Published online July 27, 2009; 10.1377/hlthaff.28.5.w822.

reach 42 percent by 2030 and cost the nation \$549.5 billion in healthcare costs. These data illustrate that continued research and implementation of practice-based nutrition and physical activity interventions can reduce healthcare costs, improve employee productivity, and save the nation billions of dollars.

CDC's nutrition, physical activity, and obesity program addresses an important contributor to disease, disability, and death by emphasizing the need to create environments that support healthy eating and active living habits as early in life as possible; and to enhance access to healthier, affordable foods, and physical activity so these habits are easy to adopt throughout one's lifespan.

Key program accomplishments include:

- **Maternity Practices in Infant Care and Nutrition survey 2007–2011:** Data from this survey informs hospital administrators of evidenced-based practices for quality maternity care, ultimately informing public health practice. With this data, CDC is able to track maternity care practices, such as number of births in baby-friendly hospitals. In 2007, when CDC first began to track the number of births in baby-friendly hospitals, the rate was 1.8 percent; by 2012, the rate more than tripled to 6.2 percent. Data from this report—which is shared with hospital administrators—may have helped administrators become more aware of what practices they could improve that would help them achieve U.S. Baby-Friendly Hospital certification.
- **Physical Activity Access and Outreach:** The *2008 Physical Activity Guidelines* represent the first federal guidelines for physical activity in the United States. They provide evidenced-based recommendations for the public (six years of age and older), on the level of physical activity needed to achieve health and well-being. In support of the 2008 Guidelines, CDC has identified the following strategic priorities: (1) enhancing access and outreach to promote physical activity, and (2) environmental support for walking. In 2012, CDC released the *More People Walk to Better Health Vital Signs* report, which highlighted improvements in the number of adults who walk for physical activity, from 56 percent in 2005 to 62 percent in 2010.
- **Weight of the Nation HBO series:** CDC staff provided scientific review to HBO, which created a documentary on obesity focusing on clinical, policy and environmental, and community strategies to address this widespread public health epidemic. The documentary provides information about what individuals can do to help themselves and their families live healthier lives as well as presents information about agriculture, food marketing, the food industry, racial and socioeconomic disparities, and physical inactivity. The impact of the HBO documentary was national, and its benefits continue as state and local organizations host screenings and convene key leaders and decision makers to discuss environmental improvements and other interventions to reduce obesity rates among U.S. children, adolescents and adults. Since its launch, there have been over 20 million unique impressions generated on CDC's Facebook page. Over 25,000 visitors made "Take Action Commitments" on the official site, generating thousands of social media impressions.

Budget Proposal: CDC's FY 2014 request of \$47,400,000 for Nutrition, Physical Activity, and Obesity is an increase of \$198,000 above the FY 2012 level. CDC continues to make a difference in reversing U.S. obesity rates. 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. Current investments to improve dietary quality and increase physical activity are contributing to the plateau in the rate of increase of obesity and leading to declines in obesity rates among some population groups. These improvements are due in part to increased adoption of healthy lifestyle choices. For example, the latest CDC data (2011) indicate that 68.3 percent of U.S. adults now engage in some leisure time physical activity on a routine basis.

At this funding level, CDC will coordinate national obesity prevention efforts through core public health activities, including: (1) conducting surveillance to measure obesity prevalence, (2) conducting research and evaluation to determine practices that work to reduce obesity, and (3) expanding setting-based obesity prevention practices (e.g., early care and education centers, hospitals, schools, and worksites). CDC will also work with the healthcare system to reduce obesity by improving hospital and provider practices to ensure patients receive the support and encouragement necessary to adopt healthier behaviors. CDC will prioritize investigating interventions that overcome barriers to healthy eating and active living, especially among population groups and communities with disproportionately high rates of obesity.

CDC will continue to support a national comprehensive nutrition and physical activity program which will include an emphasis on interventions and environmental supports to promote healthy eating and active living. Key recipient activities will include increasing fruit and vegetable consumption, rates of physical activity, breastfeeding, and water consumption as well as providing information on the health effects of risk behaviors such as poor dietary quality and sedentary lifestyles.

CDC will also continue to lead obesity prevention research. For instance, CDC will provide leadership and scientific advice on childhood obesity research through the National Collaborative on Childhood Obesity Research (NCCOR), in partnership with the Robert Wood Johnson Foundation, National Institutes of Health, and the U.S. Department of Agriculture. This innovative public-private partnership works to leverage funds for childhood obesity prevention research by enhancing coordination of research activities and developing research tools to evaluate potential solutions. In 2011–2012, NCCOR released a publicly available catalogue of surveillance systems that compares more than 85 data resources related to childhood obesity, and a web-based registry of more than 800 measures related to diet and physical activity behaviors.. These two systems provide the public health community information on data that can be used for obesity research and for the evaluation of obesity interventions.

CDC will continue to fund the Nutrition and Obesity Policy, Research, and Evaluation Network and the Physical Activity Policy Research Network, which bring together national academic experts to determine the most effective solutions for increasing access to affordable, healthy foods and beverages and opportunities to engage in safe physical activity where people live, work, learn, and play (e.g. communities, schools, early education programs, childcare centers, and worksites). The networks help to fill real-world research gaps and disseminate community-tested, scalable interventions to state and local level decision makers and business leaders. Recent accomplishments include documenting key factors that increase the use of active modes of transportation in communities, such as walking or biking, and ways to increase the availability of safe, free drinking water for students throughout the school day. Research findings will help identify strategies that can be adopted in municipalities across the nation and improve the health of children and their communities. CDC will also continue to develop and disseminate materials to other agencies on ways to implement the 2011 General Services Administration/HHS Health and Sustainability Guidelines for Federal Concessions and Vending Operations to improve the health of the federal workforce.

Protecting, promoting, and supporting breastfeeding is another key strategy toward improving the health of mothers and infants. CDC is committed to increasing breastfeeding rates throughout the United States and to encouraging recommended breastfeeding practices within hospitals and other community-based settings. Key activities include: (1) researching, monitoring, and evaluating optimal breastfeeding practices and the link between breastfeeding and obesity prevention; (2) monitoring U.S. breastfeeding rates; (3) making national recommendations on breastfeeding and infant feeding best practices; and (4) analyzing and disseminating information about hospital-based maternity care practices that promote breastfeeding initiation, duration, and exclusivity. CDC provides technical assistance to states, communities, and some tribes to implement evidence-based policy and environmental strategies that support breastfeeding and conducts research to identify and address barriers.

With the fourth year of Affordable Care Act mandatory funding, CDC will provide support to Nemours, a non-profit children's health system, as part of the Let's Move! Initiative to improve nutrition, breastfeeding support, physical activity, screen time practices, and policies in early care and education centers. Nemours is focusing its work in 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 that will help these states improve the nutrition and physical activity environment in their centers. Through FY 2014, CDC will reach approximately 42,250 children (birth to five years of age), with the goal of improving overall health and creating positive habits that will stay with them throughout their lives. By the end of the four-year program, CDC expects to have increased access to healthier food and beverages, as well as opportunities for more physical activity, reaching at least 84,500 children.

Grant Table:

Nutrition, Physical Activity, and Obesity Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget ^{1,2}
Number of Awards	25	51	51
Average Award	\$0.714	N/A	N/A
Range of Awards	\$0.411–\$1.011	N/A	N/A
Number of New Awards	0	51	0
Number of Continuing Awards	25	0	51
Total Grant Award	\$17.850	\$17.850	\$17.850

¹In FY 2013, CDC issued a new five-year combined FOA as described in the summary section of this request; the cooperative agreement contains four programs, including the Nutrition, Physical Activity, and Obesity program. The total grant award reflects program specific state grant allocation to new combined FOA.

²The FY 2013 combined FOA consists of two components: the Basic component, which will fund all 50 states and DC, and a Competitive component, which will fund up to 25 states with an average award size of \$1.8 million. This grant table reflects the basic component of the new combined FOA, though CDC will track categorical funding, including funding from the Nutrition, Physical Activity, and Obesity budget line.

Beginning in FY 2013, the CDC state-based obesity prevention program will be coordinated with the heart disease and stroke, school health, and diabetes state programs through a new competitive five-year cooperative agreement. This new funding opportunity will permit states to continue their obesity prevention efforts while leveraging the momentum and resources of other health promotion programs.

CDC anticipates funding all 50 states and Washington, D.C. at a basic level for nutrition, physical activity, and obesity, with opportunities for a smaller number of enhanced awards that emphasize intervention implementation and evaluation. This restructured approach to this cooperative agreement will allow CDC to improve chronic disease prevention efforts as a whole.

SCHOOL HEALTH BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ^{1,2}	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$14.681	\$14.775	\$14.703	+\$0.022

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²In FY 2012, HIV school health activities were transferred from the National Center for Chronic Disease Prevention and Health Promotion to the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

Program Overview: Schools play a critical role in promoting children's health and safety to help children develop lifelong healthy habits. Establishing healthy behaviors during childhood is easier and more effective than attempting to reverse unhealthy behaviors during adulthood. This work supports CDC's overarching goal to prevent the leading causes of disease, disability, and death.

CDC currently funds 22 states and one tribe to implement quality school health programs in school districts and provide training in evidence-based interventions. These grantees work to:

- Implement physical education programs that adhere to the national standards for K–12 physical education.
- Increase opportunities for students to participate in physical activity before, during, and after school.
- Ensure nutritious foods on K–12 campuses.
- Prevent tobacco use among students.
- Address food allergies and exposures in schools.
- Promote life-long healthy eating and physical activity habits.

CDC's grantees have demonstrated the power of school health-based partnerships to improve children's health. In 2011, the number of states promoting optimal physical education standards at all grade levels in schools increased to 26 states. Other examples of state successes include South Carolina, which established a model comprehensive tobacco-free school policy and hosted community roundtables to promote adoption and implementation of the model policy, impacting up to 406,000 students. In addition, Idaho's Health Education and Physical Education Standards, established in January 2010, now align with national health and physical education standards and define the knowledge and skills students need to be health literate and physically active for a lifetime.

CDC also funds 10 non-governmental organizations to help schools and communities across the country create environments that foster wellness and encourage healthy choices. These organizations provide capacity-building assistance to education and health agencies, community-based organizations, institutions of higher learning, and other organizations to improve health and educational outcomes among children and adolescents. For example, the American Academy of Pediatrics (AAP) engages teams of education agency, health agency, and pediatrician representatives in 50 local education agencies to address school-based health services policies and practices. AAP also provides professional development, customized capacity-building assistance to school health services teams, as well as facilitating peer learning and support through an online community.

Budget Proposal: CDC's FY 2014 request of \$14,703,000 for School Health is an increase of \$22,000 above the FY 2012 level. CDC's School Health program specializes in this unique setting and is working with grantees over the next five years to increase quality physical activity in schools, increase the availability of nutritious foods in schools, reduce tobacco use and initiation, and increase the coordination and management of multiple chronic conditions in schools. CDC also works to provide guidance on managing food allergies in schools.

At this funding level, CDC will continue the activities described above, including support to state governments to build school and school district capacity to implement high quality, cost-effective, school-based health programs through the Combined Chronic Disease Program. Funded activities will include the implementation of evidence-based interventions to address priority risk behaviors and support to school districts in managing chronic conditions. Grantees will focus on implementing and evaluating interventions. CDC will then disseminate the best practices gleaned from these investments to improve school health efforts across the country.

CDC's support of School Health grantees and non-funded programs includes: (1) evaluating the impact of innovative school health strategies; (2) synthesizing research findings to identify effective school health policies and practices, and providing assistance and professional development to help schools implement these policies and practices; and (3) developing and disseminating tools to help schools implement evidence-based health policies and practices. CDC will continue to provide scientific and programmatic

support to states, local areas, and tribes to improve the quality of school health programs by issuing science-based guidance, and supporting program implementation and evaluation. CDC will continue to provide professional development and training to states and school districts in using CDC-developed tools. Overall, these investments will move the nation toward greater reductions in tobacco use initiation, increased availability of nutritious foods in schools, increased opportunities for quality physical activity, and improved management of multiple chronic conditions.

Grant Tables:

School Health Program Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget ¹
Number of Awards	23	51	51
Average Award	\$0.330	N/A	N/A
Range of Awards	\$0.226–\$0.428	N/A	N/A
Number of New Awards	0	51	0
Number of Continuing Awards	23	0	51
Total Grant Award	\$7.595	\$7.050	\$7.050

¹In FY 2013, CDC issued a new five-year combined FOA as described in the summary section of this request; the cooperative agreement contains four programs, including the School Health program. The total grant award reflects program specific state grant allocation to new combined FOA.

Note: Please refer to combined FOA description to determine basic and enhanced funding levels for FOA.

CDC competitively awards cooperative agreements to states, local school districts, and tribes. In FY 2013, the School Health Program grant will be integrated with the combined funding opportunity announcement described above. CDC anticipates funding all 50 states and Washington, D.C. at a basic level for school health activities, with opportunities for several enhanced awards that emphasize intervention implementation and evaluation. This restructured approach to this grant will allow CDC to improve chronic disease prevention efforts as a whole.

School Health Non-Governmental Organization Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	8	8	8
Average Award	\$0.247	\$0.247	\$0.247
Range of Awards	\$0.242–\$0.275	\$0.150–\$0.325	\$0.150–\$0.325
Number of New Awards	0	0	0
Number of Continuing Awards	8	8	8
Total Grant Award	\$1.976	\$1.976	\$1.976

CDC will continue to fund national non-governmental organizations to focus on physical activity and physical education, nutrition, tobacco-use prevention and management of chronic conditions. These organizations are funded through competitive five-year cooperative agreements first awarded in FY 2011. At the end of FY 2016, grantees expect to demonstrate evidence of having strengthened the capacity of states and local school districts to implement school health programs that support quality physical education and physical activity, promote healthy foods, and manage chronic conditions.

HEALTH PROMOTION BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$19.016	\$19.137	\$19.062	+\$0.046

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

Program Overview: Through the Health Promotion budget, CDC works in a number of key areas to address emerging causes of disease, death, and disability. CDC conducts and funds epidemiological research to define the public health burden of understudied—but significant—chronic diseases. CDC also works to define the extent and public health impact of emerging chronic disease and health promotion issues and identify 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. Health Promotion currently includes the following programs:

- Alzheimer’s Disease and Healthy Aging
- Chronic Kidney Disease
- Community Health Promotion
- Excessive Alcohol Use
- Glaucoma
- Inflammatory Bowel Disease
- Interstitial Cystitis
- Visual Screening Education.

Alzheimer’s Disease and Healthy Aging

Alzheimer’s disease was the sixth leading cause of death in 2011. Maintaining cognitive health is among the top issues affecting older adults and is of high public concern as the U.S. population ages. CDC’s public health response to Alzheimer’s disease, the Healthy Brain Initiative, funds surveillance efforts, expands the evidence base on interventions for improving cognitive health, and translates that research into effective public health practice in states and communities.

Chronic Kidney Disease

Chronic kidney disease (CKD) is our nation’s ninth leading cause of death and is a serious and growing problem. Approximately 20 million U.S. adults 20 years of age and older have CKD, and most of them are unaware of their condition. 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 people at high-risk. In addition, CDC supports the National CKD Surveillance System to document the burden of CKD and its risk factors in the U.S. population and track progress of efforts to prevent, detect, and manage CKD. Through an interactive website, users can create customized graphics and maps of surveillance data. Departments of health, state and local officials, and the general public use the maps and data for program planning and decision-making, to identify the burden of CKD in their communities, and to identify high-risk populations for interventions and health education. In addition, the National CKD Surveillance System will help monitor Healthy People 2020 objectives related to kidney disease.

Excessive Alcohol Use Prevention

Excessive alcohol consumption kills an average of 80,000 people annually and shortens lives by an average of 30 years. CDC improves public health surveillance of binge drinking and underage drinking, conducting epidemiological analyses on drinking through the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System.

Glaucoma

Nearly 2.2 million Americans aged 40 years and older have glaucoma—an eye disease that is asymptomatic 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 2012, through a new three-year cooperative agreement entitled “Improving Access to Eye Care among Persons at High Risk for Glaucoma”, CDC funded the University of Alabama–Birmingham and Wills Eye Institute (Philadelphia) in the amount of \$950,000 each. The awardees will conduct demonstration projects to improve glaucoma screening, referral, and treatment for high risk populations. CDC also awarded a \$250,000 evaluation contract to conduct a rigorous and comprehensive evaluation of these glaucoma projects. The evaluation will identify accomplishments, needs, and best practices for improving glaucoma screening, referrals, and treatment for populations at the greatest risk.

Inflammatory Bowel Disease

Up to two million people in the United States live with inflammatory bowel disease (IBD). CDC’s IBD work concentrates on building the science to better understand IBD and the factors that predict the disease course, as well as support for epidemiologic research studies to understand the causes of IBD, learn why the course of illness varies among individuals, and determine what factors may improve outcomes.

Interstitial Cystitis

Interstitial Cystitis (IC), or bladder pain syndrome, is more common in women than men, and the most recent epidemiologic research suggests that up to 12 percent of women may have early symptoms of IC.

The primary focus of CDC’s efforts is to promote public awareness and partnerships, provide IC education for the general public and for healthcare providers, and develop and enhance communication channels to improve interaction and information sharing among those with IC, their family members, and healthcare providers. CDC is partnering with The Interstitial Cystitis Association (ICA) to develop and implement programs to enhance public awareness and health provider knowledge regarding interstitial cystitis.

Visual Screening Education

More than 3.4 million Americans aged 40 years and older are either blind or are visually impaired, and millions more are at risk for developing vision impairment and blindness. CDC’s Vision Health Initiative promotes vision health across the population, 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 the 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 impact access to—and the quality of—eye care.

Budget Request: CDC’s FY 2014 request of \$19,062,000 for Health Promotion activities is an increase of \$46,000 above the FY 2012 level.

CDC’s overarching approach to the Health Promotion program concentrates on using modest investments to further prevention of leading and emerging causes of disease, disability, and death. Priority areas across CDC’s Health Promotion activities include:

- Enhancing surveillance to better understand the national burden of these diseases.
- Strengthening the science base to identify what works to prevent and control these diseases.
- Increasing awareness of these diseases.
- Encouraging effective disease management.

CDC will use FY 2014 funds to continue to advance science and effective public health response across chronic disease prevention and health promotion, define the burden of emerging conditions, identify high-impact opportunities for public health intervention, and develop and disseminate effective interventions

and public health responses. CDC will also assess disease 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.

Alzheimer's Disease

CDC will continue to fund the Alzheimer's Association approximately \$713,000 a year through a competitively awarded, five-year (FY 2010–2014) cooperative agreement. With these funds, the Alzheimer's Association will promote knowledge and awareness of Alzheimer's as a public health issue, assess the impact and burden of cognitive impairment and caregiving through the support of new and ongoing data collection through the state-based Behavioral Risk Factor Surveillance System, and increase Alzheimer's disease and cognitive health awareness among the general public and health professionals by developing and disseminating state and national reports about cognitive impairment. In FY 2014, CDC will also continue in its role as a federal member on the National Advisory Council on Alzheimer's Research, Care, and Services, which is developing a national plan to address Alzheimer's and related disorders.

Chronic Kidney Disease

By funding the University of California at San Francisco and the University of Michigan, CDC will continue to support a National Chronic Kidney Disease Surveillance System to monitor CKD burden, awareness, risk factors, and care. These two universities have been competitively awarded, five-year cooperative agreements (FY 2011–FY 2015) at approximately \$375,000 each. In FY 2014, the grantees will continue to develop, implement, and maintain, the National CKD Surveillance System and focus on updating CKD surveillance data, identifying new data sources for CKD surveillance at the state and local level, disseminating CKD surveillance data through an interactive website and evaluation.

CDC will also continue to study the science of CKD to better understand how the disease develops, and how it can create serious health problems such as kidney failure and or premature death. This research is critical, as it will help identify new approaches to best assist those groups in the U.S. population who are significantly impacted by the health effects of CKD.

Excessive Alcohol Use Prevention

CDC conducts systematic reviews on population-based interventions to prevent excessive alcohol consumption, and provides tools and resources to support recommended strategies. FY 2014 funding will also support two full-time alcohol epidemiologists in New Mexico and Michigan—states with the highest prevalence of binge drinking and alcohol-attributable deaths—to continue public health surveillance on underage and binge drinking specific to their states and assist in prevention program design, implementation, and evaluation. These epidemiologists also support other states, upon request, regarding prevention strategies. In FY 2014, CDC will issue a new competitive funding opportunity announcement to monitor youth exposure to alcohol advertising, assess the public health impact, and analyze and disseminate findings to public health professionals and the public.

Glaucoma

CDC will continue to fund two organizations at approximately \$950,000 each through a two-year (FY 2012–FY 2014) cooperative agreement to improve glaucoma screening, referral, and treatment for populations experiencing disparities in access to care. The University of Alabama-Birmingham project will develop a community-based, cost-efficient intervention to detect glaucoma and provide longitudinal care, targeting at-risk African Americans aged ≥ 40 years. The Wills Eye Institute is conducting outreach to underserved communities in Philadelphia with an emphasis on African Americans over 50 years and other races/ethnicities over 60 years to provide educational workshops, perform onsite ocular examinations to detect glaucoma in these high-risk persons, and provide onsite management, treatment,

follow-up examinations, and referrals for those diagnosed with glaucoma or suspected of having glaucoma. Overall the projects are expected to reach 12,000 persons at high-risk for glaucoma.

Inflammatory Bowel Disease

In FY 2014, CDC will continue to fund the Crohn's & Colitis Foundation of America (CCFA) approximately \$450,000 through a competitively awarded, five-year (FY 2010–FY 2014) cooperative agreement. The funding supports an epidemiological research study to estimate IBD prevalence and incidence, define the demographic and clinical characteristics of IBD, and understand its impact on health. Moreover, CDC and CCFA support the Ocean State Crohn's and Colitis Registry in Rhode Island, conducted by investigators at Harvard Medical School and the Warren Alpert Medical School of Brown University. With CDC support, the CCFA also has developed or published manuscripts on several IBD topics, including: racial/ethnic disparities in mortality among IBD patients, the initial evaluation of patients diagnosed with IBD, and the incidence estimates of newly diagnosed IBD in Rhode Island. CDC expects grantees to conduct further epidemiological analyses to aid in clinical practice and treatment.

Interstitial Cystitis

CDC will continue to fund the Interstitial Cystitis Association approximately \$563,000 each year through a five-year (FY 2010–FY 2014), competitively awarded cooperative agreement. The Interstitial Cystitis Association, a national organization serving IC patients and healthcare providers, is developing, implementing, and evaluating a national campaign to increase public awareness of and provider education on IC through various media and health provider outreach toolkits. These efforts support people afflicted with IC by providing them valuable information about IC and improved care opportunities.

Vision Screening Education

CDC will continue collaborating with Johns Hopkins University, the University of Miami, the University of Alabama at Birmingham, and Wills Eye Institute 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. With \$1,000,000 in dedicated funding, these organizations are funded at \$250,000 each through a five-year competitive cooperative agreement (FY 2010–FY 2014). As a result of these efforts, the 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 due to eye screening recommendations. The information gained will be used for decision-making, assessment, and capacity-building at the national, state, and local levels.

PREVENTION RESEARCH CENTERS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$18.912	\$19.033	\$25.041	+\$6.129
ACA/PPHF	\$10.000	N/A	\$0.000	-\$10.000
Total	\$28.912	\$19.033	\$25.041	-\$3.871

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: Prevention Research Centers (PRCs) are a network of 37 academic research institutions located in 27 states that conduct applied public health prevention research on new ways to promote health and prevent disease, especially in areas with high chronic disease disparities. These partners form collaborations with health departments, educational boards, and the private sector to lead community-based participatory research. PRCs compare health promotion strategies to assess how cost-effective and economically feasible they are for low-income communities. This program provides the

intervention research needed to support CDC’s goal of preventing leading causes of disease, disability, and death.

The PRC network also works on special interest projects, which provide CDC and other federal agencies the opportunity to competitively fund specific, short-term research projects and to collaborate on priority health issues key to prevention efforts, such as healthy aging, obesity, physical activity, and epilepsy.

The PRC program is a research model that bridges the gap between scientific findings and public health practice. Participants from the target community aid in identifying each PRC’s research priorities, to meet community needs and create the evidence base for cost-effective, sustainable interventions. For example, an economic analysis of Group Health Cooperative Medicare enrollees participating in the PRC-developed Enhance Fitness program at least once per week had significantly fewer hospitalizations—approximately 7.9 percent fewer hospitalizations, and \$1,057 lower average annual healthcare costs per individual compared to nonparticipants. This program is now recommended by the CDC Arthritis program and the Administration for Community Living and implemented across the country.

PRCs build sustained partnerships with public health departments and communities to ensure their research has direct application in real-world settings. For example, Not on Tobacco, a teen smoking cessation program, was developed and tested in schools by a PRC and multiple partners, including schools, the American Lung Association, and the state health department. To date, more than 150,000 teens have participated in 48 states and research shows that one in six participants quits smoking.

Budget Proposal: CDC’s FY 2014 request of \$25,041,000 for Prevention Research Centers is \$3,871,000 below the FY 2012 level. In FY 2014, CDC will fund new cooperative agreement awards through a competitive peer-reviewed process. For every \$1 invested in PRCs in FY 2010, the PRCs generated an average of \$5.38 in additional research funds from non-federal sources. CDC anticipates funding fewer centers at higher award levels with the intent to more quickly leverage research findings to build a portfolio of promising community prevention interventions for wide dissemination. CDC will use FY 2014 funds to focus PRC research on ways to maximize public health resources and reduce healthcare costs, primarily on the leading causes of disease and disability. Through their projects, PRCs expect to reach nearly 30 million people, including those in underserved communities such as racial and ethnic minorities, rural populations, and the disabled. CDC will continue providing scientific and programmatic expertise to PRCs and moving successful intervention strategies from PRC communities to communities nationwide.

PRCs also will train the public health workforce and develop training tools for practitioners. In 2014, PRCs will conduct professional trainings on health topics such as program evaluation, health literacy, and social marketing for an anticipated 10,000 people, including community agency representatives and public health employees of state, county, and local governments.

CDC will test and evaluate effective interventions identified by PRCs that target costly chronic conditions, and recommend interventions to be replicated in other communities. CDC will produce and disseminate case studies of effective interventions, tested by PRCs, to significantly impact public health and the health of communities. CDC will also use investments to ensure PRCs maintain support for PRC research strategies and communication between funded academic centers, other partners, and the community.

Grant Table:

Prevention Research Centers Grant Table

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR	FY 2014 President’s Budget
Number of Awards	37	32	32
Average Award	\$0.577	\$0.573	\$0.573
Range of Awards	\$0.300–\$0.620	\$0.573	\$0.573

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR	FY 2014 President's Budget
Number of New Awards	0	0	32
Number of Continuing Awards	37	32	0
Total Grant Award	\$21.349	\$18.336	\$18.336

¹In FY 2012, CDC awarded 32 Comprehensive Research Centers at \$620,000 each and awarded five Developmental Research Centers at \$300,000 each.

CDC competitively awards cooperative agreements for PRCs. Schools of public health and schools of medicine or osteopathy with an accredited preventive medicine residency are eligible to apply. A new five-year funding opportunity announcement is expected in FY 2013. At the end of this five-year cooperative agreement, PRCs expect to have produced and disseminated research findings that demonstrate intervention effectiveness in key areas of chronic disease prevention and other leading causes of death and disability. At the end of five years, PRCs collectively will have conducted at least 50 community-based participatory research studies that address the priority areas specific to their community, and in many cases, are relevant for broader dissemination on a national scale.

HEART DISEASE AND STROKE BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$58.762	\$59.138	\$58.870	+\$0.108

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

Program Overview: Heart disease and stroke are the first and fourth leading killers in the nation, and total costs in the United States associated with cardiovascular disease exceed \$312.6 billion annually. Fortunately, public health approaches, including lifestyle interventions, pharmacological interventions, and comprehensive community and society-level interventions for lowering cardiovascular disease risk factors (e.g., high blood pressure and cholesterol levels) are very cost-effective and even cost-saving ways to reduce the heart disease and stroke burden. These efforts support CDC's goal to prevent the leading causes of disease, disability, and death.

CDC works with public and private partners to prevent, detect, and treat risk factors for heart disease and strokes and ensure that state and local health departments—as well as local clinicians—are skilled and engaged in public health practices.

Additionally, CDC tracks and improves the quality of acute stroke care through the Paul Coverdell National Acute Stroke Registry. In FY 2012, CDC released a new competitive three-year funding opportunity announcement for the continuation of the Coverdell Registry, which increased the number of funded states from 6 to 11. This new funding opportunity expands quality improvement activities for acute stroke treatment, including pre-hospital care and post-hospital transitions of care.

To help prevent and control high blood pressure, CDC also promotes the reduction of sodium intake. Reducing per capita sodium intake to 2,300 mg/day could prevent 11 million cases of hypertension annually. CDC has developed the Sodium Reduction in Communities Program, funding six communities in three states (California, Kansas, and New York) through a three-year competitive cooperative agreement (FY 2010–FY 2012). Grantees have demonstrated reductions in sodium content of meals served in specific locations, such as community or senior centers, by 10 percent; school lunches by 20 percent; and up to 14 percent of menu items in some restaurants. CDC is learning from program results to determine best practices to support state and local efforts to reduce sodium consumption and educate the public. CDC will continue to fund communities to build upon these lessons learned with a new competitive Funding Opportunity Announcement for FY 2013–2015.

CDC also co-leads the Million Hearts™ initiative with the Centers for Medicare and Medicaid Services. Million Hearts™ is a national public-private initiative launched by HHS to prevent one million heart attacks and strokes by 2017. Million Hearts™ represents the first system-wide—governmental and non-governmental—commitment to drastically improve cardiovascular disease prevention. CDC provides leadership and communications support for the initiative, which includes a number of complementing public and private activities under its umbrella. Key Million Hearts™ strategies include:

- **Promoting the “ABCS” of clinical prevention** (appropriate Aspirin therapy for high-risk patients, Blood-pressure control, Cholesterol control, and Smoking cessation). CDC is working with partners, local and state health departments, and clinicians across the nation to increase focus on the ABCS, improve the use of health information technology such as electronic health records (EHR) to capture the ABCS, and promote clinical innovations such as better utilization of team-based care to improve care quality and coordination.
- **Empowering Americans to make heart-healthy choices** to reduce the need for future treatment by reducing tobacco use, increasing access to smoke-free air, and reducing intake of sodium and trans-fats.

Budget Proposal: CDC’s FY 2014 request \$58,870,000 for Heart Disease and Stroke is an increase of \$108,000 above the FY 2012 level.

At this funding level, CDC will coordinate national heart disease and stroke prevention efforts through core public health activities, including: (1) conducting surveillance to track and monitor trends in cardiovascular risk factors and diseases, (2) conducting research and evaluation to support evidence-based practice and implement public health strategies to address the burden of heart disease and stroke, and (3) expanding heart disease and stroke prevention practices. CDC will prioritize the use of culturally appropriate approaches to promote heart disease and stroke prevention among racial, ethnic, and other priority populations.

CDC will continue to support a national comprehensive heart disease and stroke prevention programs focusing on the “ABCS” of clinical prevention through the Combined Chronic Disease Program. Programs will prioritize work to improve uncontrolled blood pressure through partnerships with health systems and establishing clinical-community linkages for patient self-management of chronic diseases. In addition, CDC will support the Paul Coverdell National Acute Stroke Registry (PCNASR), to ensure that all Americans receive the highest quality acute stroke care available to reduce untimely deaths, prevent disability, and avoid recurrent strokes.

CDC will also continue to fund the Mississippi Department of Health through a five-year cooperative agreement (FY 2010–FY 2014) for the Mississippi Delta Health Collaborative. This Collaborative is designed to prevent heart disease, stroke, and related chronic diseases in Mississippi’s 18-county Delta Region, a rural, high-burden area in the northwest region of the state.

To support these programs—and heart disease and stroke prevention generally—CDC will continue to provide scientific and programmatic assistance to all states. CDC will also continue to conduct research and surveillance on heart disease and stroke prevention, and 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.

CDC’s scientific and programmatic expertise will directly support the Million Hearts™ initiative. CDC will advance its work around sodium reduction, cardiovascular disease surveillance, program evaluation, and translational research. CDC will continue to develop and disseminate tools to promote heart disease and stroke prevention, such as fact sheets, guides, and consumer resources, with a particular focus on blood pressure control and sodium reduction.

Grant Table:

National Heart Disease and Stroke Prevention Program Grant Table

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR	FY 2014 President's Budget ^{2,3}
Number of Awards	42	51	51
Average Award	\$0.565	\$0.555	\$0.555
Range of Awards	\$0.315–\$1.500	\$0.550–\$2.350	\$0.550–\$2.350
Number of New Awards	0	51	51
Number of Continuing Awards	42	42	51
Total Grant Award	\$23.730	\$24.000	\$24.000

¹In FY 2013, CDC issued a new five-year combined FOA as described in the summary section of this request; the cooperative agreement contains four programs, including the Heart Disease and Stroke program. The total grant award reflects program specific state grant allocation to new combined FOA.

Note: Please refer to combined FOA description to determine basic and enhanced funding levels for FOA.

In FY 2013, the Heart Disease and Stroke Program Grant will be integrated with the combined funding opportunity announcement described above. CDC anticipates funding all 50 states and Washington, D.C. at a basic level for heart disease and stroke prevention activities, with opportunities for several enhanced awards that emphasize intervention implementation and evaluation. This restructured approach to this grant will allow CDC to improve chronic disease prevention efforts as a whole.

Paul Coverdell National Acute Stroke Registry Program Grant Table

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR	FY 2014 President's Budget Request
Number of Awards	11	11	11
Average Award	\$0.356	0.356	\$0.356
Range of Awards	\$0.275–\$0.356	\$0.275–\$0.356	\$0.275–\$0.356
Number of New Awards	11	0	0
Number of Continuing Awards	0	11	11
Total Grant Award Amount	\$3.925	\$3.925	\$3.925

¹In FY 2012, awards was funded under a continuation of the previous cooperative agreement first awarded in FY 2001.

The Paul Coverdell National Acute Stroke Registry Program is a three-year cooperative agreement competitively awarded to eleven states. In FY 2014, CDC will continue to fund state-based registries to conduct activities to improve quality care and transition of care from first contact with EMS through in-hospital care and transition to next care provider, and build upon lessons learned. The current funding cycle for this FOA runs through June 29, 2015.

WISEWOMAN

Program Overview: Women in the WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) program are screened for cardiovascular risks (high blood pressure, high cholesterol, diabetes, body mass index, and smoking) during their National Breast and Cervical Cancer Early Detection Program (NBCCEDP) office visit. This integrates efforts for these important screenings, maximizing resources and reach. The priority ages for participants are from 40-64 years. Participants receive risk reduction counseling based on their results, and are referred to appropriate community resources and/or lifestyle programs. Clinicians, skilled counselors, and dietitians provide healthy lifestyle counseling and interventions based on identified risk factors. Between 2008 and December 31, 2011, the WISEWOMAN program provided 170,319 screenings, found 8,729 cases of previously undiagnosed high blood pressure, 6,775 cases of previously undiagnosed high cholesterol, and 2,661 previously undiagnosed cases of diabetes among participants.

Budget Proposal: CDC's FY 2014 request for WISEWOMAN of \$21,413,000 is level with FY 2012. Funding for the WISEWOMAN program is requested through the Breast and Cervical Cancer budget line. WISEWOMAN will continue to fund up to 21 state health departments and tribal organizations to help women reduce their risk for heart disease, stroke, and other chronic conditions by providing risk factor screenings, lifestyle interventions, and referrals. Screenings activities include assessing blood pressure, cholesterol, glucose, weight, height, personal medical history, family medical history and health behavior. In FY 2014, WISEWOMAN programs will concentrate efforts on blood pressure control through lifestyle programs, including healthy lifestyle counseling and referrals for clinical intervention. This program will also support the Million Hearts™ initiative described above to improve cardiovascular health outcomes. CDC will continue to support WISEWOMAN grantees through programmatic and scientific expertise; national evaluation; dissemination of tools and best practices; analysis of existing or proposed systems, strategies and services; and providing leadership in the development and implementation of program plans and data sets consistent with funding requirements and national initiatives. CDC also assists in devising training systems for practitioners, researchers, and other professionals; numbers and types of trainings will be determined by funded programs' needs.

Grant Table:

WISEWOMAN Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	20	Up to 21	Up to 21
Average Award	\$0.852	\$0.760	\$0.760
Range of Awards	\$0.320–\$1.627	\$0.500–\$2.000	\$0.500–\$2.000
Number of New Awards	0	Up to 21	0
Number of Continuing Awards	20	0	Up to 21
Total Grant Award	\$17.040	\$18.060	\$18.060

¹A new funding opportunity announcement begins in FY 2013.

CDC will competitively award four-year cooperative agreements for WISEWOMAN among states, territories, and tribal organizations. WISEWOMAN is funded through the National Breast and Cervical Cancer Early Detection Program. At the end of this four-year period, CDC expects that these programs will have completed 160,000 screenings to assess women's cardiovascular risk, and provided intervention services to those in need of them.

DIABETES BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Budget Authority	\$69.120	\$69.561	\$79.260	+\$10.140
ACA/PPHF	\$10.000	N/A	\$0.000	-\$10.000
Total	\$79.120	\$69.561	\$79.260	+\$0.140

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: Nearly 26 million Americans have diabetes and over 200,000 people die each year of related complications; approximately 6.2 million Americans have diabetes and do not know it. Studies have found that improved blood sugar control benefits people with diabetes. In general, every percentage point drop in A1C blood test (e.g., from 8 percent to 7 percent) reduces the risk of other complications (e.g., eye, kidney, and nerve diseases) by 40 percent. To improve health outcomes for people with diabetes and those at risk for developing type 2 diabetes, CDC provides public health leadership, conducts research, and works through partnerships to translate science into interventions that can be applied in real-

word settings to prevent and control diabetes and its complications. These efforts support CDC's goal to prevent the leading causes of disease, disability, and death.

Through the five-year cooperative agreement (new agreement beginning in 2013), CDC funds the Diabetes Prevention and Control Program in all 50 states, Washington, D.C., and eight territories to implement cross-cutting approaches to diabetes prevention and control that increases access to diabetes self-management education and lifestyle change interventions to prevent or delay onset of type 2 diabetes. For example, the Kansas program dramatically improved diabetes care through the Kansas Quality of Care project, which saw improvements across multiple diabetes indicators that have been proven to reduce complications. The percentage of people receiving A1C blood tests improved from 46 percent to 87 percent, eye exams from 19 percent to 43 percent, foot exams from 26 percent to 56 percent, and blood pressure checks from 36 percent to 88 percent. These improved screening rates are proven to prevent complications such as blindness, amputations, heart attacks, and strokes.

Founded on strong scientific evidence, CDC's National Diabetes Prevention Program (National DPP) puts into practice the groundbreaking clinical trial finding that type 2 diabetes can be prevented or delayed through lifestyle intervention. CDC's National DPP is designed to bring to communities the evidence-based lifestyle change intervention for preventing type 2 diabetes. The program is comprised of four components:

- Workforce training
- The Diabetes Prevention Recognition Program, which provides quality assurance and recognition for organizations that deliver the lifestyle change program
- Lifestyle change program delivery at intervention sites and support for employers and insurers to offer the program as a reimbursed health benefit
- Program marketing to increase participation and better educate the public about type 2 diabetes.

CDC estimates that this program could save the U.S. healthcare system approximately \$5.7 billion over 25 years.

As part of the National DPP, CDC funds six organizations to: (1) establish a lifestyle change program in multiple states for populations at high risk for type 2 diabetes, (2) recruit and facilitate training for lifestyle coaches to deliver the lifestyle change program, (3) educate employers in multiple states about the benefits and cost savings of offering the program as a covered health benefit for employees, and (4) educate public and private insurers about the benefits and cost savings of reimbursing organizations delivering the lifestyle change program. Additionally, CDC supports the National Business Coalition on Health to work with employers and insurers to offer an evidence-based lifestyle change program as a covered health benefit for employees, and to reimburse organizations delivering the program using a pay-for-performance model of reimbursement.

Budget Proposal: CDC's FY 2014 request of \$79,260,000 for Diabetes is an increase of \$140,000 above the FY 2012 level.

At this funding level, CDC will coordinate national diabetes prevention and control efforts through core public health activities, including: (1) conducting surveillance to track and monitor trends and document the public health burden of diabetes and its complications, (2) conducting 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), (3) enhancing primary prevention efforts by expanding access to lifestyle change programs in community settings to prevent type 2 diabetes, and (4) improving the delivery and quality of effective preventive healthcare services.

CDC will continue to support a national comprehensive diabetes prevention and control activities through the Combined Chronic Disease Program with an emphasis on coordinating system-wide strategies that

work together to reduce burden and prevent complications of diabetes and improve the quality of care for people with or at-risk for diabetes. Programs will work toward increasing clinical-community linkages to support prevention, patient self-management and control of diabetes. CDC will prioritize implementation of strategies aimed at eliminating diabetes-related health disparities. CDC will provide guidance and scientific and programmatic support to the programs and their partners. In addition, CDC will evaluate the reach and impact of National Diabetes Education Program products.

CDC will support 17 tribes and tribal organizations through the Native Diabetes Wellness Program, working with community and national partners that focus on the availability of traditional healthy foods and other strategies to eliminate the gaps in health equity for American Indian and Alaska Native communities. CDC's Native Diabetes Wellness Program currently supports 17 American Indian and Alaska Native communities through cooperative agreements to develop effective strategies for diabetes care and prevention, including promoting healthy eating strategies.

CDC will maintain funding for up to six organizations under the National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations—another competitive five-year cooperative agreement—to mobilize communities and assist them to effectively plan, develop, implement, and evaluate community-based interventions to reduce the risk factors that influence the burden of diabetes in communities. The National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations funds organizations to evaluate community-based interventions in disproportionately affected racial and ethnic groups and underserved communities, such as Appalachia.

CDC will also continue to support the National Diabetes Prevention Program, as well as efforts to evaluate the program and ensure intervention providers are meeting established program standards. Through the Diabetes Training and Technical Assistance Center, CDC will continue to expand the diabetes prevention workforce by training lifestyle coaches to deliver the lifestyle change program. CDC will promote education and outreach efforts to expand referrals to the National Diabetes Prevention Program. CDC's Diabetes Prevention Recognition Program sets science-based standards to assure program quality, and recognizes organizations shown to effectively deliver a lifestyle change program in which participants reduce their risk of type 2 diabetes by achieving 5–7 percent weight loss and increasing physical activity to 150 minutes a week. Organizations that adhere to the Diabetes Prevention Recognition Program standards will receive CDC recognition and place themselves in a position to petition insurers for reimbursement for the costs to deliver the lifestyle change program.

Additionally, CDC will continue to fund six organizations to expand and sustain the National DPP by bringing to communities evidence-based lifestyle change programs designed to prevent type 2 diabetes among people at high risk.

CDC will fund national surveillance systems to identify key disparities and track progress related to levels of diabetes risk factors, preventive care delivery, complications, incidence, and rates of microvascular and macrovascular complications. CDC will conduct state-of-the-art research, effectiveness studies, and economic studies to prioritize interventions and policies and disseminate information and tools to improve diabetes education and awareness.

CDC's scientific and programmatic expertise in diabetes supports a variety of efforts to advance knowledge, build capacity, and develop tools to help eliminate disparities and improve public health practice. CDC assists grantees to mobilize community partners and develop, implement, and evaluate community-based interventions. CDC also conducts surveillance and research through the National Diabetes Surveillance System. The National Diabetes Surveillance System collects and maintains data; monitors the burden of diabetes throughout the United States; identifies high-risk groups; and documents trends in diabetes incidence, prevalence, disability, and mortality. Communities use the information from the National Diabetes Surveillance System to identify areas of need, guide decision-making, set priorities, plan strategies for interventions, and document intervention impact and progress toward public health targets and performance goals.

Grant Tables:

Diabetes State Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget ^{1,2}
Number of Awards	53	51	51
Average Award	\$0.514	N/A	N/A
Range of Awards	\$0.200–\$1.000	N/A	N/A
Number of New Awards	0	51	0
Number of Continuing Awards	53	0	51
Total Grant Award	\$26.000	\$26.000	\$26.000

¹In FY 2013, CDC issued a new five-year combined FOA as described in the summary section of this request; the cooperative agreement contains four programs, including the Diabetes program. The total grant award reflects program specific state grant allocation to new combined FOA. Note: Please refer to combined FOA description to determine basic and enhanced funding levels for FOA.

In FY 2013, the Diabetes Program Grant will be integrated with the combined funding opportunity announcement described above. CDC anticipates funding all 50 states and Washington, D.C. at a basic level for diabetes prevention and control, with opportunities for several enhanced awards that emphasize intervention implementation and evaluation. This restructured approach to this grant will allow CDC to improve chronic disease prevention efforts as a whole.

Diabetes Tribes Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	17	17	17
Average Award	\$0.100	\$0.100	\$0.100
Range of Awards	\$0.094–\$0.100	\$0.094–\$0.100	\$0.094–\$0.100
Number of New Awards	0	0	0
Number of Continuing Awards	17	17	17
Total Grant Award	\$1.700	\$1.700	\$1.700

CDC competitively awards funding through a five-year cooperative agreement (2008–2013) to seventeen tribes to address priority areas in diabetes prevention and control. 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 Indian country.

Diabetes Territories Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	6	6	6
Average Award	\$0.106	\$0.106	\$0.106
Range of Awards	\$0.058–\$0.200	\$0.058–\$0.200	\$0.058–\$0.200
Number of New Awards	0	0	0
Number of Continuing Awards	16	16	6
Total Grant Award	\$0.635	\$0.635	\$0.635

CDC competitively awards funding through a five-year cooperative agreement (2008–2013) to six territories to address priority areas in diabetes prevention and control. 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.

National Diabetes Prevention Program Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	6	N/A	6
Average Award	\$0.875	N/A	\$0.875
Range of Awards	\$0.750–\$1.003	N/A	\$0.750–\$1.003
Number of New Awards	6	N/A	0
Number of Continuing Awards	0	N/A	6
Total Grant Award	\$6.750	N/A	\$6.750

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

In FY 2012, CDC awarded six organizations cooperative agreements to expand and sustain the National Diabetes Prevention Program by delivering a diabetes lifestyle change program to people with pre-diabetes. The length of the cooperative agreement is four years.

Awards were made through a competitive process, based on technical merit and application quality. Factors taken into consideration included geographic diversity of populations with a high burden of type 2 diabetes. During this funding cycle, CDC expects grantees to achieve an increased number of participants in the National Diabetes Prevention Program, an increased number of employers who offer the lifestyle intervention program as a covered health benefit for employees, and an increased number of private and public payers reimbursing organizations that deliver the lifestyle intervention.

CANCER PREVENTION AND CONTROL BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,3}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Cancer Prevention and Control (Program Level)^{2,3}	\$371.544	\$363.855	\$329.660	-\$41.884
Budget Authority	\$361.544	\$363.855	\$156.596	-\$204.948
ACA/PPHF	\$10.000	N/A	\$173.064	+\$163.064
Breast and Cervical Cancer (non-add)	\$212.563	\$213.923	\$184.560	-\$28.003
Breast and Cervical Cancer Screening Supplement (non-add)	\$10.000	N/A	--	-\$10.000
Colorectal Cancer (non-add)	\$44.458	\$44.742	\$40.577	-\$3.881

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²The totals include funding for the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), which is authorized through the National Breast and Cervical Cancer Early Detection Program. Activities for this program are administered through CDC's Heart Disease and Stroke Program and described in that section of the budget.

³The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: CDC's public health approach to cancer prevention and control is essential to reducing illness and death from cancer, the second leading cause of death in the United States. CDC focuses on increasing access to quality cancer screening; enhancing cancer surveillance data to inform programmatic and research efforts; supporting a comprehensive approach in states, tribes, and territories to reduce the highest burden cancers; translating scientific knowledge into practice; and conducting applied research. In FY 2012, CDC began a new five-year cooperative agreement with states, territories, and tribes or tribal organizations to support and improve coordination among three national programs: (1) the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), (2) the National Program of Cancer Registries (NPCR), and (3) the National Comprehensive Cancer Control Program (NCCCP). CDC's cancer prevention and control work supports the agency's priority to prevent the leading causes of disease, disability, and death.

The NBCCEDP provides clinical screening and diagnostic services to low-income, uninsured, and underinsured women. These services are critical. For instance, when compared to women not screened

between ages 50 and 74 years, screening mammography reduces death cancer deaths by 17 percent. Between program inception in 1991 and December 2011, NBCCEDP-funded programs have served more than 4.2 million women and provided more than 10.4 million breast and cervical cancer screening examinations. Programs have diagnosed 54,276 breast cancers; 3,113 invasive cervical cancers; and 147,455 premalignant cervical lesions, of which 41 percent were high-grade. Furthermore, in FY 2012 CDC received an additional \$10 million from the Affordable Care Act Prevention and Public Health Fund to support the NBCCEDP. CDC anticipates an additional 50,000 women will be served, enabling grantees to increase the number of breast and cervical cancer screenings provided by the program.

The NPCR funds state cancer registries to collect, manage, and analyze data about cancer cases for 96 percent of the U.S. population. In 2011, 41 central registries provided targeted reports on incidence and late-stage diagnosis of screening-amenable cancers. Public health application of such data, for example, can enable states or communities to identify areas with lower cancer screening and tailor outreach to increase screening among underserved populations.

CDC's NCCCP brings together robust 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 state. The NCCCP provides the evidence base to develop and implement approaches aimed at primary prevention (e.g., reducing exposure to tobacco), detecting cancers early when they are more treatable (e.g., colorectal cancer screening), increasing access to treatment, and improving the quality of life of cancer survivors.

In FY 2009, CDC launched the Colorectal Cancer Screening Program (CRCCP), which funds states and tribal organizations through five-year cooperative agreements to implement population-based approaches to increase colorectal cancer screening rates among men and women 50 years of age and older. The program emphasizes evidence-based screening promotion activities to increase population-level screening rates, while providing limited direct screening services to underserved people. Grantees work with various healthcare systems, workplaces, and insurers to improve and increase delivery of colorectal cancer screenings. Approximately two-thirds of funding is used to implement colorectal cancer screening promotion practices such as small and mass media, client/provider reminders, patient navigation, and provider assessment and feedback. Up to one-third of program dollars are used to provide cancer screening and diagnostic follow-up services to low-income, uninsured, or underinsured men and women age 50 to 75. Since program inception in 2009 through December 2011, CDC-funded programs have screened 19,899 clients, diagnosing 50 colorectal cancers and 2,917 cases of pre-cancerous polyps.

Data collection and evaluation are key components of all CDC cancer prevention and control programs. CDC assesses program costs and impact, informs future action, tests innovative interventions, and allocates funding based on data analysis. Examples include an extensive annual assessment of CRCCP grantee activities to monitor progress in achieving program goals and a promising practices study to identify effective NBCCEDP grantee practices. CDC also evaluates program performance as part of various criteria used to allocate annual funding. For example, the NBCCEDP assesses grantee performance in meeting 11 core quality screening indicators, and the NPCR evaluates cancer registries performance in meeting standards for data completeness, timelines, and quality. Monitoring data on the screening behaviors of providers and patients for colorectal cancer, breast and cervical cancers has led to the identification of specific actions to improve screening rates and the effectiveness of cancer screening.

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 Proposal: CDC's FY 2014 request of \$329,660,000 for Cancer Prevention and Control, including \$173,064,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall decrease of \$38 below the FY 2012 level. The FY2014 request is a decrease of \$38,000,000 below the FY 2012 level for direct cancer screenings for breast, cervical, and colorectal cancer that are now covered through health reform. The request also reflects elimination \$10 million of one-time PPHF funding in FY 2012.

Through the Affordable Care Act (ACA) most health plans are required to cover mammograms and other cancer screenings without co-pays or deductibles. In 2014, the Affordable Care Act (ACA) provides for expanded health insurance coverage through new state health insurance exchanges and Medicaid expansion. 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 healthreform 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.

Because ACA will afford greater access to coverage for these screening services, the size of the populations eligible for the NBCCEDP and CRCCP are expected to shrink. Even with reduced FY 2014 funding, CDC anticipates serving a larger proportion of the eligible population than currently served through the NBCCEDP. In addition, CDC estimates the elimination of up to five state or tribal Colorectal Cancer Control Programs, reducing CDC's investment in public health efforts to address this screening amenable cancer.

In 2011, existing funding enabled the NBCCEDP to serve approximately 14 percent of women eligible for breast cancer screening and approximately 9 percent of women eligible for cervical screening. A George Washington University (GWU) study estimated the change in insurance coverage for women eligible for the NBCCEDP after ACA implementation in 2014. The study assumes that all states will opt to expand Medicaid and estimates that in 2009; 4.5 million women were eligible for breast cancer screening. By 2014, this study estimates that approximately 2.8 million of these women will gain insurance coverage and at least 1.7 million will remain uncovered and eligible for breast cancer screening. In 2009, 11.3 million women were eligible for cervical cancer screening. By 2014, the study predicts that approximately 6.8 million women will gain insurance coverage and at least 4.5 million will remain uncovered and eligible for cervical cancer screening.

Access to health insurance coverage is not the only factor that limits participation in cancer screening. Numerous barriers to screening exist, including patient factors such as income, education, and lack of awareness; and provider or clinical system factors such as lack of physician availability or appropriate physician recommendation. CDC surveillance and research have documented that current screening rates are too low for certain disparate populations that may have access to coverage but encounter these other barriers. In 2014 and beyond, CDC's cancer screening programs will complement the benefits provided through the ACA by building upon their extensive capacity and existing linkages with the clinical care system to increase cancer screening on a population level while still providing direct services to the most vulnerable in the areas where it is not covered by insurance. The CRCCP will serve as a model that uses evidence-based screening promotion practices along with targeted screening provision to increase screening rates population-wide. The Budget transitions funding for activities that are provided by insurance and focuses on linkage to care, which is more aligned with CDC's mission.

In FY 2014, CDC will continue to support breast and cervical cancer screening and diagnostic services through the NBCCEDP for underserved women in 50 states, Washington, D.C., five territories, and 11 tribal organizations. CDC will support colorectal cancer screening programs in approximately 24 states and tribes or tribal organizations to deliver quality colorectal cancer screening for people age 50 and older. Funding for these programs will enable grantees to emphasize organized approaches to increase

population-level screening rates, support enhanced education and outreach including using new modalities such as social media, and promote patient navigation to ensure appropriate screening and follow-up. Grantees will work with healthcare systems, federally qualified health centers, state Medicaid offices, employers, and private insurers to implement systematic approaches to improve cancer screening participation through direct invitation and client/provider reminder systems. Grantees will also assure quality screening using the model systems CDC has developed to ensure timely diagnosis and treatment of positive screening tests.

CDC will continue to support the National Program of Cancer Registries (NPCR) in 45 states, Washington, D.C., Puerto Rico, and the U.S. Pacific Island jurisdictions to collect vital data about cancer cases and deaths. These cancer registries 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 NPCR will continue to make investments to enhance electronic reporting from all facilities; foster data linkages with other surveillance systems; improve early case capture, especially for pediatric cancers; and facilitate research through improved data access and management.

CDC will maintain support of the National Comprehensive Cancer Control Program (NCCCP) in 50 states, Washington, D.C., seven tribal organizations, and seven U.S. territories. The NCCCP will continue to support 13 demonstration programs to support interventions to improve social and physical environments to make adopting healthy behaviors easier, make accessing quality clinical care more convenient, and make successfully managing post-treatment follow-up more probable. Intervention settings include healthcare systems, communities, schools, and worksites.

CDC will continue to conduct and disseminate state-of-the-art cancer prevention research through the Cancer Prevention and Control Research Networks and through the NCCCP Cancer Control Coalitions, and support education and awareness activities to reduce illness and death related to breast cancer in young women, and prostate, ovarian, and skin cancers.

Grant Tables:

National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grant Table

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR	FY 2014 President's Budget
Number of Awards	67	67	67
Average Award	\$2.355	\$2.355	\$1.959
Range of Awards	\$0.238–\$8.693	\$0.238–\$8.693	\$0.189–\$7.488
Number of New Awards	67	0	0
Number of Continuing Awards	0	67	67
Total Grant Award	\$159.259	\$159.259	\$131.259

¹FY 2012 marks the start of a new five-year cooperative agreement (FY 2012–FY 2016) to states, Washington, D.C., territories, and tribal organizations.

CDC awards NBCCEDP funding through a competitive process. Funding levels for the cooperative agreement are determined based on a variety of factors, including the technical merit of the application, previous funding and spending history, state/jurisdiction population, and grantee capacity to meet established program standards or performance indicators. At the end of this funding period, CDC expects NBCCEDP grantees to have expanded the use of evidence-based interventions that will increase population-level screening rates for uninsured and insured women.

National Program of Cancer Registries (NPCR) Grant Table

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR	FY 2014 President's Budget
Number of Awards	48	48	48
Average Award	\$0.775	\$0.775	\$0.775
Range of Awards	\$0.248–\$3.095	\$0.248–\$3.095	\$0.248–\$3.095
Number of New Awards	48	0	0
Number of Continuing Awards	0	48	48
Total Grant Award	\$37.215	\$37.215	\$37.215

¹FY 2012 marks the start of a new five-year cooperative agreement (FY 2012–FY 2016) to states, Washington, D.C., Puerto Rico, and the U.S. Pacific Island jurisdictions.

CDC awards NPCR funding through a competitive process. Funding levels for the cooperative agreement are determined based on a variety of factors, including the technical merit of the application, previous funding and spending history, state/jurisdiction population, and grantee capacity to meet established program standards or performance indicators. At the end of this five-year funding cycle, CDC expects NPCR programs to maintain 48 cancer registries that provide high-quality data while expanding electronic reporting to cancer registries and enhancing use of registry data.

National Comprehensive Cancer Control Program (NCCCP) Grant Table¹

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ²	FY 2014 President's Budget
Number of Awards	65	N/A	65
Average Award	\$0.303	N/A	\$0.303
Range of Awards	\$0.147–\$0.518	N/A	\$0.147–\$0.518
Number of New Awards	65	N/A	0
Number of Continuing Awards	0	N/A	65
Total Grant Award	\$19.695	N/A	\$19.695

¹FY 2012 marks the start of a new five-year cooperative agreement (FY 2012–FY 2016) to states, Washington, D.C., territories, tribes, and tribal organizations.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

CDC awards NCCCP funding competitively. Funding levels for the cooperative agreement are determined based on a variety of factors, including the technical merit of the application, previous funding and spending history, state/jurisdiction population, and grantee capacity to meet established program standards or performance indicators. At the end of this five-year funding cycle, CDC expects NCCCP grantees will 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.

Colorectal Cancer Control Program (CRCCP) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	29	29	24-25
Average Award	\$0.885	\$0.885	\$0.885
Range of Awards	\$0.362–\$1.497	\$0.362–\$1.497	\$0.362–\$1.497
Number of New Awards	0	0	24-25
Number of Continuing Awards	29	29	0
Total Grant Award	\$25.676	\$25.676	\$21.676

CDC awards CRCCP funding competitively. Funding levels for the cooperative agreement are determined based on a variety of factors, including the technical merit of the application, previous funding and spending history, state/jurisdiction population, and grantee capacity to meet established

program standards or performance indicators. The CRCCP's goal is to increase colorectal (colon) cancer screening rates among men and women aged 50 years and older from about 64 percent to 80 percent in the funded states by 2014.

ORAL HEALTH BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$15.878	\$15.980	\$15.921	+\$0.043

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

Program Overview: Although tooth decay is largely preventable, it remains the most common chronic disease of children aged 6 to 11 years (25 percent) and adolescents aged 12 to 19 years (59 percent). CDC leads federal, national, and state initiatives to prevent oral diseases including early childhood caries (tooth decay) in toddlers and young children by monitoring health trends, translating research to practice, and advancing safe and effective strategies that can improve oral health and reduce dental care expenditures. For example, CDC data show that 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 percent increase in the delivery of school-based sealants in states with CDC funding, which saved an estimated \$1 million in Medicaid dental expenditures.¹⁰

Budget Proposal: CDC's FY 2014 request of \$15,921,000 for Oral Health is an increase of \$43,000 above the FY 2012 level.

Bolstered by a strong evidence base, CDC's Oral Health Program funds 20 oral health programs in state health departments through a \$7 million cooperative agreement program to strengthen the nation's oral health infrastructure; extend the use of proven, but underutilized, strategies to prevent oral diseases; and to reduce inequalities in oral health. Oral health activities within CDC-funded states have led to decreases in dental costs through increased access to optimally fluoridated water and school based dental sealant programs. Essential components of a comprehensive oral health program include: (1) a health agency with a an appropriately staffed dental program, (2) a robust surveillance system to monitor and report disease burden, and (3) a state oral health plan developed and carried out by a variety of governmental, non-profit, and corporate partners. As a result of these partnerships, state health agencies have leveraged federal dollars to gain support from private insurers for evidence-based programs, especially community based sealant programs. In 2011, over 2,500 community water systems demonstrated optimal levels of fluoridation for 12 consecutive months.

In FY 2014, CDC will continue efforts to expand access to optimally fluoridated water systems nationwide, monitor and assess health trends, identify new interventions, 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. In addition, CDC is working closely with HHS to update recommendations for optimal fluoridation levels in community water systems.

CDC will continue to fund two national, non-governmental organizations through five-year cooperative agreements to assist states in implementing effective program strategies and building basic capacity in monitoring disease burden and risk factors. These efforts will also support states as they assess and implement changes designed to improve population oral health. Along with its national partners, CDC provides consultation and expertise to all states, collects and shares best practices, and supports oral health leadership in state health departments nationwide. CDC's activities include analyzing state and

¹⁰Source: Unpublished CDC data.

national oral health data, promoting oral health literacy and public awareness of the burden of oral disease and the strategies to reduce this burden, and developing tools to promote oral health and public health practice. CDC monitors the public's access to community water fluoridation and increases the quality of community water fluoridation programs by training state and local fluoridation engineers. 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. In addition, CDC staff work through a network of partners, including dental practitioners, to increase the use of clinical and preventive services, guide infection control practices in dental offices, and inform advances in dental technology.

Additional activities to advance oral health include documenting the association between chronic periodontal (gum) disease and other chronic diseases, such as diabetes. Both tobacco use and diabetes can increase one's risk for developing and the severity of periodontal disease. Tobacco control and prevention activities reduce the incidence of oral cancer and periodontal disease. Findings from previous national surveys likely underestimated the prevalence of periodontal disease, which is expected to increase as the U.S. population ages—increasing the need for preventive and treatment services. Therefore, CDC has prioritized its surveillance efforts to expand NHANES data collection to document the prevalence and severity of periodontal disease in the nation. State oral health programs are encouraged to partner with other chronic disease and maternal and child health partners to address common risk factors including poor nutrition, tobacco use, and lack of access to preventive care. For example, several states coordinate collection of tooth decay and body mass index data to achieve greater of scale and coordinate with other chronic disease prevention efforts.

In FY 2014, CDC-funded states will increase the number of high-risk children receiving dental sealants by targeting schools with a high percentage of students on free and reduced-cost meal programs.

Grant Table:

Oral Health Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	20	20	20
Average Award	\$0.311	\$0.311	\$0.311
Range of Awards	\$0.235–\$0.355	\$0.200–\$0.350	\$0.200–\$0.350
Number of New Awards	0	20	0
Number of Continuing Awards	20	0	20
Total Grant Award	\$6.220	\$6.220	\$6.220

¹CDC will announce a new five-year funding opportunity announcement in FY 2013.

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. Critical components of past successful state grants include: (1) use of evidence-based interventions, (2) ability to conduct oral health surveillance activities, (3) capacity to monitor and evaluate activities and report outcomes, and (4) identification and targeting of program efforts to high-risk populations.

At the end of this funding cycle (July 31, 2013 to July 30, 2018), CDC expects grantees to: (1) increase the number of funded states that have an oral health surveillance system to 100 percent; (2) increase by 10 percent the proportion of children in state-funded or coordinated programs aged six to nine years who have received dental sealants on one or more permanent teeth; and (3) increase by 2 percent the proportion of the funded states' population served by community water systems with optimally fluoridated water.

SAFE MOTHERHOOD AND INFANT HEALTH BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$49.124	\$49.437	\$49.322	+\$0.198

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

Program Overview: Approximately six million women become pregnant in the United States each year, with 10 percent of those women experiencing difficulty getting pregnant or staying pregnant. Roughly two million women experience pregnancy loss and thousands experience pregnancy complications. About 37 percent of births in the United States were unintended at the time of conception, which is associated with an increased risk of problems for mother and baby (e.g., delaying prenatal care). Even among intended pregnancies, complications may include preterm birth and physical and psychological conditions that negatively affect the health of mother or baby. Preterm birth is the most frequent cause of infant death and is the leading cause of long-term neurological disabilities in children. It also costs the U.S. healthcare system more than \$26 billion each year. CDC's efforts to promote safe, healthy pregnancy and motherhood support the agency's overall goal to prevent leading causes of disease, disability, and death.

Building maternal and child health (MCH) competency in states, tribes, and localities is essential to improving the overall health of mothers, children, and families. CDC, in collaboration with the Health Resources and Services Administration, provides direct assistance through the MCH Epidemiology Program (MCHEP) by assigning CDC epidemiologists to public health agencies to maintain, develop, and support maternal and child health epidemiologic efforts. In FY 2012, CDC placed 13 MCH epidemiologists in nine states, one in the U.S./Mexico border region, two in tribal entities, and one with CityMatCH, a national partner. Through a contract with the Council of State and Territorial Epidemiologists, CDC also placed six fellows in six states. MCHEP assignees enhance states' ability to effectively apply scientific evidence to improve the overall health of mothers, children, and families.

CDC conducts surveillance activities using both internal resources and external awards. CDC's national and state-based surveillance systems are vital to understanding changes in maternal and infant health, trends, and disparities. Through cooperative agreements, CDC also supports sudden, unexpected infant death (SUID) case registries in nine states. In the two years since the program's inception, grantees have improved data completeness, relationships with medical examiner/coroner and state vital statistics offices, established new local and state protocols and policies for infant death investigations, and implemented community-based infant death prevention recommendations such as safe sleep messages.

CDC works to monitor the outcomes (efficacy and safety) of technologies that affect reproduction through the National Assisted Reproductive Technology (ART) Surveillance System. Results for 2010 (the most recent data available) indicate that 147,260 ART cycles were performed at 443 reporting clinics in the United States, resulting in the delivery of 61,564 infants. CDC contracted with three states (Florida, Massachusetts, and Michigan) to develop surveillance data on maternal and infant health outcomes after ART by linking National ART Surveillance System data with vital records and expanding linkages to other data (e.g., hospital discharge data, birth defects registries, and cancer registries). This pilot is a first step toward developing a national surveillance system of ART maternal and infant health outcomes and strengthening CDC's capacity to evaluate outcomes.

CDC compiles annual data from vital records provided voluntarily by all 50 states, New York City, and Washington, D.C. through its Pregnancy Mortality Surveillance System to identify and describe rates and causes of pregnancy-related deaths. Data from the Pregnancy Mortality Surveillance System serves as a source for recommending effective strategies to reduce maternal deaths and associated disparities.

Budget Proposal: CDC's FY 2014 request of \$49,322,000 for Safe Motherhood and Infant Health is an increase of \$198,000 above the FY 2012 level.

The 2014 budget request supports CDC's ongoing safe mother and infant health activities. CDC's work provides critical scientific findings to build the evidence base for maternal and child health issues. For instance, CDC increased its annual dissemination of evidence-based findings from 106 in 2008 to 120 in 2012, totaling over 500 CDC findings disseminated over the past five years. CDC also conducts national and state-based surveillance to monitor practices in maternal and infant health, including prenatal care, pre-term delivery, unintended pregnancy, breastfeeding, smoking, alcohol use, cardiovascular disease, and other chronic conditions.

In FY 2014, CDC will continue to provide direct assistance to states through maternal and child health epidemiologists and graduate-level fellows. CDC anticipates assigning 12 MCH epidemiologists and four fellows in 16 states. CDC will continue to monitor maternal and infant health trends through its state-based and national surveillance systems. Annually, CDC publishes and disseminates the Assisted Reproductive Technology (ART) Success Rates surveillance report to help potential ART users make informed decisions regarding the technology. This publication provides information on the average chance of having a child by using ART, and reports on the expertise and laboratory quality of clinics that provide ART services.

Through continuation of a five-year cooperative agreement, CDC will support the Pregnancy Risk Assessment Monitoring System (PRAMS) across 40 states and New York City to collect population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS data are routinely used by CDC and state public health agencies to monitor changes in maternal and child health indicators, and to plan and review state maternal and infant health programs. For example, Mississippi and New York enhanced their PRAMS surveys by adding targeted questions to learn more about teen pregnancy, contraceptive use, and repeat pregnancies in their states. The Sudden Unexpected Infant Death Case Registry Pilot Program, a state-based surveillance system, builds on existing child death review programs to identify at-risk populations and target prevention activities.

The Safe Motherhood Program will continue to advance reproductive health science and practice through applied research and surveillance. CDC will study preterm birth to better understand its impact and advance new strategies for prevention. In an effort to prevent severe maternal complications and maternal morbidity, CDC will investigate patterns in pregnancy-related mortality to identify causes, gaps in health services, and differences among racial and ethnic groups in an effort to refine the indicators of severe complications and establish standards for severe maternal morbidity surveillance. Additionally, CDC will continue to support three state-based Perinatal Quality Collaboratives (California, New York, and Ohio) through cooperative agreements to identify ways to improve quality of care and health outcomes for women and newborns.

Grant Table:

Pregnancy Risk Assessment Monitoring System (PRAMS) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	41	41	41
Average Award	\$0.143	\$0.143	\$0.143
Range of Awards	\$0.121–\$0.190	\$0.121–\$0.190	\$0.121–\$0.190
Number of New Awards	0	0	0
Number of Continuing Awards	41	41	41
Total Grant Award	\$5.863	\$5.863	\$5.863

CDC awards PRAMS funding through a five-year, competitive cooperative agreement (FY 2011–FY 2015) to states and local governments, and tribes and territories designated as registration areas for vital statistics. The purpose of this funding is to identify groups of women and infants at risk for health problems, monitor changes in health status, and measure progress in improving the health of mothers and infants. In FY 2014, CDC will support PRAMS in 40 states and New York City. At the end of this

funding cycle, CDC expects grantees to (1) collect high quality data to monitor risk factors for maternal and infant health, (2) use the data to develop or modify public health programs or policies that address maternal and infant health, (3) satisfy established response rate (65 percent) requirements through data collection efforts, and (4) make PRAMS data available for analysis by internal and external researchers.

Teen Pregnancy Prevention

Program Overview: Despite recent declines in teen birth rates, substantial racial and ethnic disparities in teen pregnancy rates persist. These disparities carry significant social and economic costs. Teen pregnancy accounts for nearly \$11 billion per year in costs to U.S. taxpayers, and is a significant contributor to high school dropout rates among girls. CDC works with communities, states, and national organizations to identify underserved populations at risk for teen pregnancy, particularly among minority communities; identify teen pregnancy risk factors; and advance strategies based on applied research to reduce teen pregnancy. As part of the President's Teen Pregnancy Prevention Initiative, and in collaboration with other HHS operating divisions, CDC provides scientific and programmatic assistance to nine, non-CDC-funded state- and community-based organizations to evaluate the impact of a multi-component, community level effort on reducing teen birth rates in 10 targeted communities. These communities target African American and Latino/Hispanic youth aged 15–19 and focus on increasing access to reproductive healthcare services, increasing the use of effective interventions, and educating community leaders and partners on evidence-based strategies to reduce teen pregnancy. CDC funds five national organizations through cooperative agreements to provide training and technical assistance to these communities. These five organizations have held over 65 trainings/workshops and 20 webinars with the teen pregnancy prevention grantees covering topics such as how to work with schools, how to engage parents, how to engage the Latino community, and strategies to address health disparities.

Budget Proposal: CDC's FY 2014 request of \$17,215,000 to support teen pregnancy prevention activities is a decrease of \$119,000 below the FY 2012 level. CDC will continue to conduct intervention research and surveillance to identify teens at increased risk for pregnancy and new ways to prevent teen pregnancies. Activities include studying the trends and patterns of reproductive health service use among sexually active adolescents, as well as the characteristics of teens who give birth. Other activities include developing a surveillance compendium that will synthesize key data indicators from several national surveillance systems to present a comprehensive picture of sexual and reproductive health of adolescents in the United States. The compendium will cover reproductive health outcomes, related risk and protective behaviors, and use of reproductive health and related services, as well as prevalence, disparities, and trends. In FY 2014, CDC will publish the compendium in the Morbidity and Mortality Weekly Report and will disseminate it among teen pregnancy prevention partners.

CDC promotes sexual and reproductive health by translating science into practice to reduce sexual risk behaviors. CDC monitors and assures the safety of contraceptive methods for women and teens in collaboration with a variety of non-governmental, professional, and service organizations such as the World Health Organization and the American College of Obstetricians and Gynecologists. Together, CDC and partners develop recommendations and disseminate guidance for contraceptive use and design tools for providers. For example, CDC released the United States Selected Practice Recommendations for Contraceptive Use on how to safely and effectively use contraceptive methods. These guidelines serve as a companion to the United States Medical Eligibility Criteria that assists healthcare providers when counseling women, men, and couples about contraceptive method choice.

In FY 2014, CDC will evaluate the usage and impact of the United States Medical Eligibility Criteria and the United States Selected Practice Recommendations for Contraceptive Use, as well as provide updates to both as new evidence emerges. In FY 2014, CDC will continue to provide scientific and programmatic guidance to 10 communities to implement and evaluate the impact of a multi-component, community-level effort to reduce teen birth rates. CDC will conduct an in-depth evaluation in two communities to determine changes in youth access to prevention services and in youth abstinence and contraceptive use.

CDC also will continue to fund five national organizations to provide training to these communities, based on ongoing assessment of community needs.

ARTHRITIS AND OTHER CHRONIC DISEASES BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$26.614	\$26.785	\$26.654	+\$0.040

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

Program Overview: Arthritis continues to be the most common cause of disability in the United States, with approximately 50 million adults reporting diagnosed arthritis. 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. Moreover, through a five-year cooperative agreement awarded competitively in 2011, CDC works with the Arthritis Foundation (\$972,000) and National Association of Chronic Disease Directors (\$613,000) to enhance intervention dissemination and delivery, and to identify and promote physical activity and self-management education. These efforts address CDC's overarching goal of preventing leading causes of disease, disability, and death.

Grantees have demonstrated progress in providing more arthritis management options for people with this condition. For example, California identified populations with multiple chronic conditions and worked across health department programs (i.e., from Tobacco, Maternal and Child Health, and Aging) to expand self-management education and physical activity interventions.

CDC's scientific work better defines risk factors, improves surveillance, and evaluates intervention effectiveness for arthritis. A recent CDC meta-analysis documented that two interventions, the Arthritis Self-Management Program and the Chronic Disease Self-Management Program, reduced fatigue, depression, and health distress, and fostered healthy behaviors such as exercise and stress management.

Epilepsy, a chronic neurological condition, affects about two million Americans and results in an estimated \$15.5 billion in medical costs and lost productivity. CDC's Epilepsy Program aims to make communities safer for people with epilepsy through a multi-year cooperative agreement with the National Epilepsy Foundation (FY 2011–FY 2015, funded at \$3,290,000 in FY 2012). The Epilepsy Foundation implements programs to enhance public awareness and promote local and national partnerships, education, and communication. For example, accredited training for police and emergency first responders provides instruction on how best to protect the safety and rights of individuals having seizures, while also ensuring first responder safety. Over 60,000 personnel have received this training through online, class, and train-the-trainer sessions.

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.

Budget Proposal: CDC's FY 2014 request of \$26,654,000 for Arthritis and Other Chronic Diseases is an increase of \$40,000 above the FY 2012 level.

CDC will work closely with grantees to improve and increase self-management attitudes and behaviors among persons with arthritis. CDC's Arthritis Program awards grants to 12 state health departments to expand access to arthritis interventions. Specifically, the competitive five-year cooperative agreements (FY 2012–FY 2016) require grantees to embed arthritis interventions, such as the Chronic Disease Self-Management Program and Enhance Fitness, in healthcare delivery systems. 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 more accessible.

CDC will continue to fund the Epilepsy Foundation to develop and implement programs to enhance epilepsy public awareness and promote partnerships, education, and communication at local and national levels.. Furthermore, CDC's epilepsy outreach program for veterans has provided epilepsy education and training to over 6,000 veterans, almost 400 health professionals, and over 1,000 family members, volunteers, and advocates.

CDC also plans to continue support for the Managing Epilepsy Well Network, composed of four Prevention Research Center academic institutions, to conduct research that promotes self-management and improved quality of life using innovative methods to overcome transportation and stigma barriers. 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. CDC also supports epidemiological studies to define epilepsy incidence and prevalence in various populations, including research to identify and explain disparities. For instance, research is underway to broaden knowledge of the characteristics of childhood epilepsy and determine the frequency of associated secondary disabilities. CDC will continue to support these important efforts in FY 2014.

CDC provides funding to carefully designed, population-based registries to estimate lupus prevalence and incidence among different racial and ethnic groups. In FY 2012, CDC funded California, New York City, and the Indian Health Service to develop credible estimates of lupus incidence and prevalence among Hispanics, Asians, and American Indians/Alaska Natives. In addition, two previously funded sites (Georgia and Michigan, which completed a similar project for lupus among African Americans and whites) are conducting follow-up studies to gain a better understanding of lupus natural history, risk factors, and treatment in these populations.

CDC-supported, population-based lupus registries have contributed to the development of more accurate estimates of the disease, particularly among minority populations. In FY 2012, CDC made one award for a follow-up cohort study, and plans to fund at least one more to provide a broader perspective on issues such as treatment, healthcare access, and natural history, as well as on factors associated with these outcomes. These types of cohort studies can address important research, practice, and intervention questions only through long-term commitment, which remains a potential barrier to success.

CDC's overarching goals for the Arthritis and Other Conditions program are to improve quality of life and well-being among those affected by these chronic conditions by increasing access and availability of evidence-based interventions, conducting surveillance to measure burden, using data to inform decision making and set priorities, strengthening the science base of effective strategies, increasing awareness, and promoting health equity.

Grant Tables:

Arthritis State Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	12	12	12
Average Award	\$0.425	\$0.425	\$0.425
Range of Awards	\$0.200–\$0.500	\$0.200–\$0.500	\$0.200–\$0.500
Number of New Awards	12	12	0
Number of Continuing Awards	0	0	12
Total Grant Award	\$5.100	\$5.100	\$5.100

¹The FY 2013 President's Budget proposed to consolidate Arthritis and Other Chronic Diseases into the Coordinated Chronic Disease Prevention and Health Promotion Program.

CDC competitively awards five-year cooperative agreements to state health departments to improve the quality of life of people with arthritis. CDC released a new funding opportunity announcement in FY 2012. CDC's Arthritis Program awarded grants to 12 state health departments to improve the quality of life of people with arthritis by expanding access to evidence-based arthritis interventions. 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 and decision making, and implement health communications campaigns.

Lupus Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	5	5	3
Average Award	\$0.800	\$0.800	\$0.800
Range of Awards	\$0.400–\$1.800	\$0.400–\$1.800	\$0.400–\$1.800
Number of New Awards	2	2	0
Number of Continuing Awards	3	3	3
Total Grant Award	\$4.000	\$4.000	\$2.400

¹In FY 2014, CDC is funding three lupus registry sites (California, New York City, and the Indian Health Services). Previously, in FY 2012, CDC funded five sites: California, Georgia, Michigan, New York City, and the Indian Health Service.

In FY 2012, CDC funded three states and New York City for lupus activities through competitive cooperative agreements. Additionally, CDC funded the Indian Health Service for a lupus registry via an interagency agreement in order to reach a large population of American Indians/Alaska Natives. CDC plans to fund lupus registries in three sites in FY 2014 to focus on identifying disparities in lupus among specific populations, including Hispanics, Asians, American Indians/Alaska Natives, and African Americans. Through CDC funding, three of the existing registries are completing their data gathering and analysis, and two have already completed these important tasks. Follow-up cohort studies are expected to add to the understanding of the natural history of lupus, risk factors, and treatment.

COMMUNITY TRANSFORMATION GRANTS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$0.000	\$0.000	\$10.000	+\$10.000
ACA/PPHF	\$226.000	N/A	\$136.340	-\$89.660
Total	\$226.000	\$0.000	\$146.340	-\$79.660

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: The Community Transformation Grants (CTG) program, authorized and funded through the Affordable Care Act, is a community-based chronic disease prevention initiative to support CDC's goal to reduce the risk factors responsible for the leading causes of preventable death and disability in the United States: tobacco use, obesity, and uncontrolled high blood pressure and high cholesterol. The CTG program's goal is to create healthier communities by making healthy living easier and more affordable where people live, work, play, and go to school.

In FY 2012, approximately 94 percent of the total program expenditures were extramural; 21.6 percent of the total funding for CTG awards was directed at rural and frontier areas.

CTG funds awards across four major categories: (1) Implementation, (2) Capacity Building, (3) National Networks, and (4) Small Communities.

- **Implementation** awards (\$89.6M beginning in FY 2011) enable localities and states to select interventions from a menu of proven strategies, such as increasing physical activity in schools, ensuring access to safe options for bicycling and walking, increasing access to nutritious foods in childcare settings, reducing tobacco and secondhand smoke exposure in multi-unit housing and on campuses, and improving systems to better control high blood pressure and high cholesterol.
- **Capacity Building** awards (\$10.9M beginning in FY 2011) to localities and states help communities establish a solid foundation for community-based prevention efforts through assessment of community health needs and by developing multi-sector coalitions committed to improving community health.
- **National Network** awardees extend CTG strategies to additional communities. Acceleration National Networks increase impact by providing resources to 29 local affiliates and organizations across the country, focusing on rural and frontier communities. Dissemination National Networks work across sectors and leverage existing network coalitions to support, communicate, and strengthen the evidence-based strategies of the CTG program nationally.
- **Small Community** awards, new as of FY 2012, aim to improve health in communities with populations under 500,000. The CTG Small Communities program funds 40 organizations across the country. Of these grantees, 33 awardees represent sectors other than public health, such as education, healthcare, business, and community groups. The CTG Small Communities grant programs were fully funded in FY 2012; thus, no additional funds are requested.

CTG awardees help improve health, reduce health disparities, and control healthcare spending. The University of Texas-Austin, for example, has provided protection from exposure to second hand smoke and other tobacco-related products for over 51,000 students, 24,000 faculty and staff, and annual visitors. Limiting tobacco exposure helps to prevent tobacco-related illness such as lung cancer, asthma, and high blood pressure. Additionally, through the Summit County, Ohio, Accountable Care Community—a coalition of employers, health systems and clinics, medical and pharmacy schools, institutions of higher education, faith-based organizations, numerous social service and philanthropic agencies—approximately 85 percent of the county's population now has access to primary and preventive care services.

CTG awardees are leveraging the federal CTG investment to build additional local support for community health. For example, through the California CTG efforts, the California Community Transformation Initiative secured a financial and in-kind investment of over \$1 million from The California Endowment, a statewide health foundation. This investment provided funding for five new counties to engage in CTG activities (serving approximately eight million Californians) and to coordinate statewide efforts to disseminate best practices, media and messaging, and evaluation strategies.

National Network awardees have also demonstrated progress toward CTG goals. The YMCA of the USA, a National Network grantee, is supporting its local affiliates in implementing healthy eating and physical activity standards in early childhood and afterschool settings, focusing specifically on African-American and/or Hispanic Latino populations. The Community Anti-Drug Coalitions of America, a Dissemination National Network, is increasing effective dissemination of tobacco-free living strategies through training and guidance to multi-sector coalitions and national partners, which include law enforcement officials, medical professionals, local business owners, and school administrators.

Budget Proposal: CDC's FY 2014 request of \$146,340,000 including \$136,340,000 from the Affordable Care Act's Prevention and Public Health Fund for Community Transformation Grants is \$79,660,000 below the FY 2012 level.

The small communities component of the CTG program was fully funded in FY 2012, thus new resources are not needed for these projects. The proposed FY 2014 funding will fully support the remaining Community Transformation Grants.

CDC will continue investing in states and communities to reduce risk factors for the leading preventable causes of death and disability in the United States. In FY 2014, CDC will continue to fully support CTG programs begun in FY 2011, which will be in the fourth year of a five-year funding cycle, including the National Networks that extend and disseminate CTG's proven strategies to additional communities. CDC will also continue to fully support the activities of the CTG Small Communities awardees that were forward-funded at the end of FY 2012.

Additionally, CDC will use the funding to support CDC's scientific experts and program management in order to ensure communities use the best available research and move efficiently toward program goals as well as continue to build national capacity for sustaining community health efforts, even in areas that do not directly receive CDC funding. Scientific expertise, consultation, monitoring performance, evaluation, and dissemination of evidence-based practices are some of the most valuable tools CDC offers. Contracts support key program activities including communication, evaluation, and training. Scientific and programmatic support of awardees ensures a greater return on investment through maximizing the population impacted, reducing health disparities, and aligning grantee activities with the best scientific evidence. The CTG program reaches 130 million Americans across the country. Programmatic interventions increase the number of Americans with access to tobacco free environments, healthy food and beverage options, opportunities for safe physical activity, and access to systems that support the control of high blood pressure and high cholesterol. CTG activities also increase the evidence base for strategies that have high impact, and disseminate lessons learned across the country, thereby building national capacity for community health. These interventions will contribute to reduced tobacco use and secondhand smoke exposure, reduced obesity and overweight, and increased control of high blood pressure and cholesterol, addressing CDC's goal of preventing the leading causes of death and disability.

Grant Tables:

Community Transformation Grants Tables

Implementation and Capacity-Building Awardees

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ²	FY 2014 President's Budget
Number of Awards	61	N/A	61
Average Award	\$1.697	N/A	\$1.697
Range of Awards	\$0.147–\$10.000	N/A	\$0.147–\$10.000
Number of New Awards	0	N/A	0
Number of Continuing Awards	61	N/A	61
Total Grant Award	\$103.547	N/A	\$103.547

¹The original CTG program remains level funded in FY 2012, FY 2013, and FY 2014.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

National Networks Awardees

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ²	FY 2014 President's Budget
Number of Awards	6	N/A	6
Average Award	\$0.650	N/A	\$0.650
Range of Awards	\$0.300–\$1.3000	N/A	\$0.300–\$1.3000
Number of New Awards	0	N/A	0
Number of Continuing Awards	6	N/A	6
Total Grant Award	\$3.900	N/A	\$3.900

¹The original CTG program remains level funded in FY 2012, FY 2013, and FY 2014.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

Small Communities Awardees

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ²	FY 2014 President's Budget
Number of Awards	40	N/A	N/A
Average Award	\$1.766	N/A	N/A
Range of Awards	\$0.200–\$7.884	N/A	N/A
Number of New Awards	40	N/A	N/A
Number of Continuing Awards	0	N/A	N/A
Total Grant Award	\$70.655	N/A	N/A

¹The CTG Small Communities grant was fully funded in FY2012, thus no additional funds are required to support this program.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

In FY 2011, CDC competitively awarded five-year cooperative agreements to 61 state and local government agencies, tribes, territories, and nonprofit organizations in 36 states. Additionally, a separate FY 2011 competition awarded cooperative agreements to six national networks of community-based organizations. In FY 2012, a new competition awarded 40 grants to a wide range of governmental and non-governmental organizations representing small communities with populations under 500,000. At the end of five years, grantees will demonstrate measured improvements in priority areas: lower tobacco use and initiation, reduced obesity rates, and increases in the number of patients with their blood pressure and cholesterol under control. Grantees are expected to reach four out of 10 Americans.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
ACA/PPHF	\$411.050	N/A	\$415.904	+\$4.854

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The following activities are included:

- Tobacco Campaign and Quitlines – \$95,000,000 (included in the Tobacco Prevention and Control narrative)
- Community Transformation Grants – \$136,340,000 (included in the Community Transformation Grants narrative)
- Million Hearts™ – \$5,000,000
- Let's Move/Healthy Weight Task Force Activities – \$4,000,000
- Hospitals Promoting Breastfeeding – \$2,500,000

Million Hearts™

CDC's FY 2014 request includes \$5,000,000 in Prevention and Public Health Fund investments to support Million Hearts™, a national public-private initiative developed to prevent one million heart attacks and strokes by 2017. These investments will support selected heart disease and stroke prevention activities within the Million Hearts™ initiative that directly complement Community Transformation Grant cardiovascular disease prevention activities. The Million Hearts™ initiative will provide \$5,000,000 to promote medication management through counseling and pharmacy support in selected communities. CDC will work with grantees to improve medication adherence among high-risk individuals using nurses as case managers with pharmacist support of medication management; in addition grantees will make referrals for individuals at high-risk to community services and lifestyle interventions.

Let's Move/Healthy Weight Task Force Activities

Childhood obesity has more than tripled in the past 30 years, putting our nation's youth at immediate and long-term risk for developing costly, preventable chronic diseases and early morbidity. CDC studies show that many of the nation's children are already obese by the time they enter kindergarten, and that obesity among the nation's youth has more severe and damaging long-term consequences than adult onset obesity. Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure, and in a population-based sample of 5- to 17-year-olds, 70 percent of obese youth had at least one risk factor for cardiovascular disease. In the long term, obese youth are more likely than youth of normal weight to become overweight or obese as adults and more likely to have increased risk of heart disease, type 2 diabetes, stroke, certain types of cancer, and osteoarthritis.

CDC's public health expertise, especially in the areas of applied research and surveillance, positions the organization to identify evidence-based and promising practices to promote healthful behaviors such as healthy eating and active living and thereby contribute to efforts to reduce childhood obesity. CDC will continue its support of the Let's Move Initiative and the HHS Healthy Weight Task Force, both of which aim to improve dietary and physical activity behaviors through setting-based and population-level interventions (e.g., Let's Move Child Care and Healthy Beginnings). With its public and private partners, CDC can continue efforts to support interventions that promote healthy habits, especially in nutrition and physical activity among the nation's children.

Hospitals Promoting Breastfeeding

Breastfeeding significantly reduces health risks for infants, which in turn reduces medical care needs and healthcare costs. The medical care needs for non-breastfed infants are greater than those of their breastfed counterparts, requiring, on average per annum, an estimated 2.2 million excess medical visits, 228,760 more days of hospitalization, and 657,146 more prescriptions. Suboptimal breastfeeding rates cost the country at least \$13 billion annually, including at least \$3.4 billion in avoidable direct and indirect medical costs. Notwithstanding, more women express the intent to initiate breastfeeding than actually do; and those that are able to initiate often express an interest in breastfeeding longer than what they are able to accomplish. CDC breastfeeding promotion efforts are designed to support women in meeting their personal breastfeeding goals. CDC invests in improvements to maternity care practices as one strategy to assist women in meeting their breastfeeding goals. The maternity care practices in infant feeding and care survey has been conducted biennially since 2007 in U.S. hospitals providing maternity care services, to assess practices and policies that support breastfeeding initiation and duration. The 2009 survey showed that hospitals across the United States scored an average of 65 out of 100 in an assessment of their practices in support of breastfeeding. More hospital support is needed to assist women in meeting their breastfeeding goals.

Protecting, promoting, and supporting breastfeeding is a key strategy to improve the health of mothers and infants. In FY 2014, CDC's request includes \$2,500,000 in Prevention and Public Health Fund investments to fund states to develop or enhance initiatives to build support for breastfeeding, including promoting action steps from the 2011 Surgeon General's Call to Action to Promote Breastfeeding and the 2009 CDC Recommended Community Strategies and Measurements to Prevent Obesity in the U.S. CDC will provide funding, and scientific and programmatic guidance to states to build their infrastructure to support non-governmental organizations that assist mothers who choose to breastfeed, and collaborate with hospitals to promote and create a breastfeeding-friendly environment. This effort aims to improve breastfeeding duration, particularly among low-income mothers and in geographical areas with low rates of breastfeeding duration. These activities will complement CDC's existing work to promote breastfeeding practices.

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	2015 Target
Coronary Heart Disease: Reduce the annual age-adjusted rate of coronary heart disease deaths (per 100,000 population)	FY 2009: 116.1	108.6
Stroke: Reduce the annual age-adjusted rate of stroke deaths (per 100,000 population)	FY 2009: 38.9	36.4
Diabetes: Reduce the annual age-adjusted rate of diabetes-related deaths (per 100,000 population)	FY 2008: 73.1	68.5

Chronic diseases are the leading causes of death and disability in the United States, and account for 70 percent 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.

CDC has achieved success in the past decade in coronary heart disease mortality and stroke mortality. From 2000 to 2009, the annual age-adjusted rate of coronary heart disease and stroke deaths has steadily declined from 186.9 to 116.1 per 100,000. During the same timeframe, the annual age-adjusted rate of stroke deaths declined from 60.8 to 38.9 per 100,000. The age-adjusted rate of diabetes-related deaths has also declined from 2005 (77.0 per 100,000) to 2008 (73.1 per 100,000). Prior to 2005, the diabetes-related death rates consistently ranged between 76 per 100,000 and 78 per 100,000. This recent trend is the first time in a decade the rate has improved two years in a row.

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 healthful 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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.6.2: Reduce per capita cigarette consumption in the U.S. per adult age 18+ (Outcome)	FY 2011: 1,232 (Target Met)	1,150	986	-164
4.6.3: Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers (Intermediate Outcome)	FY 2011: 19.0% (Target Not Met but Improved)	20.0%	18.0%	-2
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)	56.9%	57.7%	+0.8

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.6.5: Reduce the proportion of adolescents (grade 9 through 12) who are current cigarette smokers ¹ (Intermediate Outcome)	FY 2011: 18.1% (Target Exceeded)	18.6%	17.9%	-0.7
4.C: Number of calls received by Tobacco Cessation Quitlines ² (Output)	FY 2011: 1,192,822 (Target Not Met but Improved)	1,704,000	1,500,000	-204,000
4.D: Number of persons provided cessation counseling and/or medications by Tobacco Cessation Quitlines ² (Output)	FY 2011: 415,430 (Target Not Met)	704,800	570,100	-134,700
4.G: Number of state health departments and other organizations (e.g., local health departments) requesting advertising campaign materials through the Media Campaign Resource Center ² (Output)	FY 2012: 597 (Target Exceeded)	250	625	+375

¹The 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 tracks closely with YRBSS. To obtain data on an annual basis, CDC conducts the NYTS in the intervening years.

²Targets reflect ACA/PPHF funding.

Performance Trends: Reducing tobacco use is a CDC and an HHS priority. It is also an HHS Agency Priority Goal (2012-2013) to which CDC, FDA, NIH, SAMHSA, 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 U.S. declined from 1,507 to 1,232 between 2008 and 2011, demonstrating that current smokers are smoking fewer cigarettes (Measure 4.6.2). CDC estimates cigarette consumption will continue to decrease through FY 2014. Additionally, the percentage of current adult smokers decreased from 20.6 percent in 2009 to 19.0 percent in 2011 (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 percent and 23.0 percent from 2003 to 2007 and then declining slightly from 20.0 percent to 18.1 percent from 2007 to 2011 (Measure 4.6.5).

The percentage of the U.S. population covered by comprehensive state and/or local laws that make workplaces, restaurants, and bars 100 percent smoke-free has increased significantly since 2005. Between 2005 and 2012, the percentage of the population covered by smoke-free laws increased from 13.5 percent to 48.9 percent (Measure 4.6.4). On average, states and communities that enact strong smoke-free policies realize a 17 percent 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 2011, the tobacco Quitlines received 1,192,822 calls (a four percent increase over 2010) and provided cessation counseling and/or medications to 415,430 persons (Measure 4.C and 4.D). The launch of CDC's Tips from Former Smokers campaign in March 2012 has generated 207,519 additional calls (a 132 percent 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. As the National Tobacco Education Campaign efforts continue through FY 2014, CDC estimates calls to the Quitline and persons provided cessation counseling/medications will increase.

FY 2014 targets for Measures 4.C and 4.D reflect changes to data collection methodology. 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 2012, health departments and other organizations made 597 requests for materials. Looking forward, CDC expects requests for advertising campaign materials to slightly increase through FY 2014 (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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.11.10: Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese ^{1,2} (Intermediate Outcome)	FY 2010: 35.7% (Historical Actual)	35.1%	34.4%	-0.7
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) ^{1,2} (Intermediate Outcome)	FY 2009: 0.83 (Historical Actual)	N/A	N/A	N/A
4.11.9: Increase the proportion of adults (age 18 and older) that engage in leisure-time physical activity ² (Intermediate Outcome)	FY 2011: 68.3% (Target Exceeded)	68.0%	68.6%	+0.6
4.12.1: Increase in the number of states with nutrition standards for foods and beverages provided in early care and education centers ³ (Output)	FY 2011: 9 (Target Not Met)	12	16	+4
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 ³ (Output)	FY 2011: 5 (Target Not Met)	10	14	+4
4.11.7: Increase the proportion of infants that are breastfed at 6 months ³ (Intermediate Outcome)	FY 2009: 47.2% (Preliminary)	54.1%	57.3%	+3.2

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

²Targets reflect, in part, impact of ACA/PPHF funding.

³Targets reflect ACA/PPHF funding. Based on NCHS methodology changes in 2011, the linear progression model for HP2020 will affect targets beginning with FY 2014. Future targets will be adjusted accordingly to meet the trajectory for the 2020 target of 60.6%.

Performance Trends: Obesity (BMI ≥ 30) increases the risk of many health conditions, including heart disease, stroke, high blood pressure, and cancer. Following decades of significant increase, the rate of increase for obesity has plateaued in recent years. In 2008, obesity-related medical care costs were approximately \$147 billion; medical care payers spent \$1,429 more per year on obese beneficiaries compared to those of normal weight. CDC estimates the adult obesity rate will increase by 33 percent by 2030, resulting in an estimated adult obesity prevalence of 42 percent if current individual diet and

physical activity behaviors persist. However, if the U.S. held obesity rates to 2010 levels, the combined savings in medical care expenditures over the next two decades would be \$549.5 billion.

In 2010, 35.7 percent of adults and 16.9 percent 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). The U.S. obesity rate was 15 percent (NHANES II survey) for years 1976-1980, which reflected a change of only 1.6 percentage points over the previous twenty-year period. By 1999-2000, NHANES data showed the obesity rate increased to 30.9 percent, 15.9 percentage points over the previous twenty-year period. The 2009-2010 obesity rate of 35.7 percent reflects a 4.8 percentage point increase in obesity rates compared to 1999-2000 data. Although recent data reflects a plateau in adult obesity rates nationally, the rate of increase among some population groups, such as Hispanic and American Indian/Alaskan Native low-income children, continues to rise.

To curtail obesity, CDC invests in population-level approaches to improve nutrition as well as physical education practices and standards.

- Nutrition: In 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.
- Physical activity: The proportion of adults that engage in leisure-time physical activity has steadily increased from 63.8 percent in 2008 to 68.3 percent in 2011, exceeding the 2011 target (Measure 4.11.9).
- Physical education and nutrition standards: In 2011, the first year CDC monitored states' performance, five states met the *Caring for Our Children: Health and Safety Guidelines for Early Care and Education* obesity-related physical activity standards, and nine states met the nutrition standards for early care and education settings. These results are unchanged from 2010. CFOC updated its methodology requirements in 2011. As a result, CDC's targets for FY 2013 and beyond reflect the new requirements (Measures 4.12.1 and 4.12.4).

Research indicates mothers who receive quality maternity care that includes support for breastfeeding are more likely to breastfeed. Breastfed babies are at less risk for health complications such as obesity, diabetes, respiratory and ear infections, and sudden infant death syndrome. Preliminary results for 2009 show that 47.2 percent of U.S. infants were breastfed at six months of age, compared to 44.3 percent in 2008, representing an almost four percent increase from the 2006 baseline of 43.5 percent (Measure 4.11.7). Final data will be available August 31, 2013. Increases in the percent of infants who are still exclusively breastfed at six months, though modest, are moving towards the Healthy People 2020 objective of 60.6 percent. CDC expects breastfeeding duration to increase, especially as more hospitals (a) adopt standards monitored under 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.

CDC continues to promote effective strategies for improving dietary quality, physical activity, and reducing obesity including: working with communities and schools to increase access to water instead of high calorie alternatives; implementing joint use agreements to provide safe recreational opportunities for community members; and developing partnerships to promote procurement policies to improve dietary quality in worksites, hospitals and schools.

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.12.3: Increase the percent of high school students who attend physical education classes on one or more days in an average week when they were in school ¹ (Intermediate Outcome)	FY 2011: 51.8% (Target Not Met)	N/A	N/A	N/A
4.Q: Number of states with policies that promote optimal physical education standards at all grade levels in schools (Output)	FY 2011: 26 (Target Exceeded)	25	27	+2

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

Performance Trends: Childhood obesity has almost tripled in the past 30 years. In the late 1970s, the prevalence of childhood obesity was 6.5 percent for children ages 6-11 and 5.0 percent for adolescents ages 12-19. Childhood obesity prevalence continued to increase from 18.2 percent in 2009 to 18.8 percent in 2010. In 2010, approximately 12 million children and adolescents were obese.

CDC’s School Health program partners with state health departments, state education agencies, and schools to address the obesity epidemic through school-based physical education practices and standards. In 2011, 51.8 percent of high school students attended physical education classes on one or more days in an average school week, a decline from the 2009 levels of 56.4 percent (Measure 4.12.3).

In 2011, 26 states had policies that promote optimal physical education at all grade levels in schools, an increase of four states from 2010 (Measure 4.Q). With CDC support, the West Virginia Department of Education recently adopted the Institute of Medicine’s Nutrition Standards for Foods in Schools, ensuring that WV schools have one of the strongest nutrition policies in the country. The adoption of these standards ensures that all food and beverages available for sale in West Virginia schools are healthy options.

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.11.5: Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (<140/90) (Intermediate Outcome)	FY 2010: 46% (Target Not Met)	50%	50%	Maintain
4.11.6: Reduce consumption of sodium in the population aged 2 years and older (milligrams per day) (Intermediate Outcome)	FY 2010: 3,266 (Target Not Met)	3,050	2,805	-245

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.N: Increase the number of blood pressure screenings provided by the WISEWOMAN program (Output)	FY 2011: 47,342 (Target Not Met but Improved)	50,000	52,000	+2,000
4.O: Number of evidence-based tools disseminated to promote sodium and hypertension reduction and awareness (Output)	FY 2012: 65 (Target Met)	65	101	+36

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. In 2010, CDC did not meet the target for the proportion of adults with high blood pressure who have it controlled. However, between 2008 and 2010, the rate increased slightly from 45 to 46 percent (Measure 4.11.5). With the launch of the CDC/CMS Million Hearts™ Initiative, federally coordinated efforts are coalescing to promote the "ABCS" of clinical prevention (appropriate aspirin therapy, blood pressure control, cholesterol management, and smoking cessation).

CDC's Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program has steadily increased the number of blood pressure screenings from 34,185 in 2008 to 47,342 in 2011, although CDC did not meet its 2011 target (Measure 4.N). As constrained resources have limited the program's ability to expand screening efforts, the WISEWOMAN program is working to increase screening capacity by leveraging and expanding partnerships, drawing on the expertise and resources of those entities with similar goals to improve cardiovascular health.

About 90 percent of Americans consume more sodium than is recommended for a healthy diet. While CDC did not meet the FY 2010 target for reducing average sodium intake, between FY 2008 and FY 2010 sodium consumption slightly declined from 3,330 milligrams per day to 3,266 milligrams per day (Measure 4.11.6). In FY 2012, CDC disseminated 65 evidence-based tools to promote sodium and hypertension reduction awareness; meeting the FY 2012 target and continuing a trend of disseminating more tools annually since 2009 (Measure 4.O). In February 2012, CDC released the "Where's the sodium" Vital Signs report, contributing to federal partners' efforts to affect blood pressure control through decreased sodium intake. CDC expanded the available science related to biomarker measurement of sodium through a calibration study and a planned analysis of urine collection data through NHANES. Results will be available in 2013, and three papers are in development. Finally, two "Sodium Reduction in Communities" grantees are developing and piloting tools to assist restaurants in implementing sodium reduction strategies. With these efforts, CDC expects to reach 2014 sodium and hypertension awareness and reduction targets.

Program: Diabetes

Performance Measures for Long Term Objective: Improve prevention, detection, and management of diabetes.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.11.3: Increase the proportion of the diabetic population with an A1c value less than 7% ¹ (Intermediate Outcome)	FY 2010: 53.5% (Historical Actual)	54.6%	55.6%	+1.0

¹This 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 one percent reduction in A1c levels (e.g., from nine percent to eight percent), the risk of developing eye, kidney, or nerve disease decreases by 40 percent. From 2007–2010 (2007-2008, 2009-2010 NHANES data sets), approximately 53.5 percent of the diabetic population had an A1c value less than seven percent, the upper threshold for acceptable diabetes management and control. 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 of for the shift. Therefore, CDC re-released the results in March 2012 with no changes.

CDC-funded activities focus on working with health systems to increase access to and delivery of care for people with diabetes to prevent complications. Diabetes self-management education (DSME) and chronic disease self-management (CDSM) are two proven interventions with demonstrable health impact employed by CDC and its partners. CDC will expand DSME and CDSM use among grantees and support CDSM in community settings to reach vulnerable populations with greatest burden/risk for diabetes.

For example, the CDC-funded Kansas Diabetes Prevention and Control Program (DPCP) implemented the multiyear Kansas Diabetes Quality of Care Project. The DPCP provides training on implementing the Chronic Disease Electronic Management System and collects and analyzes data to help providers evaluate the systems changes they make to assure improved care for the 8,500 Kansans with diagnosed diabetes currently in the diabetes registry. After the Quality Care Project implementation, the DPCP reported: the percentage of people receiving A1c blood tests improved from 46 percent to 87 percent; receiving eye exams increased from 19 percent to 43 percent; receiving foot exams increased from 26 percent to 56 percent; and receiving blood pressure checks increased from 36 percent to 88 percent.

Program: Cancer Prevention and Control

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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 2009: 105.4 (Target Exceeded)	102.5	100.5	-2
4.9.2: Increase the percent of adults age 50 to 75 receiving colorectal cancer screenings (Intermediate Outcome)	FY 2010: 65.4% (Historical Actual)	66.0% ¹	70.0%	+4

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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 2012: 41 (Target Exceeded)	38	45	+7
4.K: Number of breast cancer screenings provided by the National Breast and Cervical Cancer Early Detection Programs (NBCCEDP) (Output)	FY 2011: 339,703 (Target Exceeded)	327,000 ¹	289,953 ¹	-37,047
4.L: Number of breast cancer cases detected by National Breast and Cervical Cancer Early Detection Programs (NBCCEDP) (Output)	FY 2011: 5,655 (Target Exceeded)	5,556 ¹	4,926 ¹	-630
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 2011: 18 (Target Met)	19	19	Maintain

¹Targets do not reflect ACA/PPHF funding.

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 decreased from 106.7 per 100,000 women in 2008 to 105.4 per 100,000 women in 2009, exceeding CDC's target of 105.5 per 100,000 (Measure 4.9.1). When compared to those not screened among this age group, mammography screening reduces breast cancer deaths by 17 percent. 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 1,297,211 breast cancer screenings between 2008 and 2011 and detecting 16,612 cases of breast cancer since 2009. In 2011, NBCCEDP screened 339,703 women for breast cancer and detected 5,655 cases, exceeding 2010 levels (Measures 4.K and 4.L). In 2011, the NBCCEDP served approximately 14 percent of women eligible for breast cancer screening and approximately nine percent of women eligible for cervical screening. Implementation of the Affordable Care Act will significantly increase the total number of women who have access to cancer screening. This will decrease the population eligible for CDC screenings, but CDC anticipates serving a larger *proportion* of the eligible population than currently served. Therefore, CDC will continue to provide direct screening to eligible women, and link women to needed care. Because of decreased resources (budget authority only) in FY 2014, CDC will screen 37,047 fewer low-income, high-risk women and detect 630 fewer breast cancers (Measures 4.K and 4.L).

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 2008 and 2010, with 65.4 percent of adults aged 50-75 screened in 2010 compared to 63.1 percent in 2008. Data for 2012 will be available in June 2013 (Measure 4.9.2).

CDC's Colorectal Cancer Control Program (CRCCP) funds 25 states and four tribal organizations to provide access to colorectal cancer screening to low-income and uninsured or underinsured men and women and to increase population-level screening rates by promoting evidence-based strategies such as patient/provider reminder systems. Patient navigation guides an individual through the process of completing colorectal cancer screening and is associated with improving patients' adherence to screening process. CDC grantees support patient navigation in a variety of ways including paying navigators to provide services, developing capacity to conduct navigation, or providing training to improve the quality of navigation. The number of grantees promoting the use of patient navigation and support as an evidence-based strategy to increase colorectal cancer screening rates increased from 17 in 2010 to 18 in 2011 (Measure 4.M). Reduced funding in FY 2014 may result in the elimination of up to five grantees (reduced from 29 to 24). Therefore, by holding the FY 2014 target steady with FY 2012 levels, approximately 80 percent of CDC grantees are expected to successfully implement patient navigation that yields increases in screening rates. Data for 2012 will be available in March 2013 (Measure 4.M).

State and local surveillance data provided through cancer registries, enables health departments and other public health stakeholders to identify and target screening interventions to areas/populations with high incidence of cancer and those with high occurrence of late-stage diagnosis. The number of National Program of Cancer Registries (NPCR) grantees providing targeted reports on incidence and late-stage diagnosis of screening-amenable cancers increased from 34 in 2010 to 41 in 2012, exceeding the FY 2012 target of 38 (Measure 4.9.3). CDC programs and grantees use data to improve program efficiency and reach targeted populations. For example, grantees using registry data have been able to identify counties with the greatest cancer burden, and use the data for program planning to increase breast cancer screening, diagnosis, and patient navigation in underserved areas.

Program: Oral Health

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.7.1: Increase the proportion of the people served by community water systems who receive optimally fluoridated water (Intermediate Outcome)	FY 2010: 73.9% (Target Not Met)	75.5%	76.5%	+1
4.H: Number of community water systems at optimal levels for 12 months in a row (Output)	FY 2011: 2,500 (Target Exceeded)	1,701	2,650	+949

Performance Trends: CDC is working with states and communities to increase the percent of the U.S. population with access to optimally fluoridated water. CDC continues to support the Healthy People 2020 objective of 79.6 percent of the population on public water systems who receive optimally fluoridated water. Fluoridation of public water systems increased from 62.1 percent in 1992 to 73.9 percent in 2010. CDC's 2014 target of 76.5 percent represents an almost 3.5 percent increase over the 2010 result. More than 2,500 community water systems demonstrated optimal levels of fluoridation for 12 consecutive months in 2011 (Measure 4.H). The trend of community water systems with optimal fluoridation levels has fluctuated in the past between slightly less than 1,400 to more than 1,600 from 2009-2010. In 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. HHS previously recommended a range of 0.7mg/L to 1.2 mg/L. This reduction may partially explain the dramatic increase in the number of water systems reporting optimal

fluoridation levels. Other factors contributing to the increase are an increase in the number of states reporting monthly data and an increase in the number of water systems reporting consistently. A final decision from HHS on the recommended level is forthcoming.

To increase the percentage of the population who receive optimally fluoridated water, CDC is enhancing the Water Fluoridation Reporting System's capacity to provide support for those submitting data. CDC is also developing a Web-based training program to increase the number of people who can receive training on community water fluoridation engineering requirements.

Due to varying levels of community and state support for fluoridation and resource constraints in states that hamper their ability to replace aging fluoridation equipment, these measures are increasingly challenging to achieve. Improving the percentage of the population on public water systems with optimally fluoridated water requires a substantial priority shift in a few larger metropolitan areas, as well as some medium sized communities. CDC's efforts to increase awareness about the benefits of and recommendation for fluoridated water include: (a) coordinating messaging with national, state, and community partners; and, (b) publicizing the new HHS recommendation for optimal fluoridation levels once final. In addition, CDC continues to work with state and local communities to identify innovative funding sources to cover the costs of fluoridation equipment, and provide expertise and data to support the cost benefits of fluoridated water. In FY 2012, CDC awarded a contract to develop a communications plan to assist states with increasing public knowledge regarding the benefits of community water fluoridation.

Program: Safe Motherhood and Infant Health

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.8.1: Reduce birth rates among adolescent females aged 15 to 19 years in targeted communities (per 1,000 births) ¹ (Intermediate Outcome)	FY 2011: 68.3 (Baseline)	64.8	58.5	-6.3
4.8.2: Increase the number of reporting areas that provide optimal data for assessing preconception health practices, gaps, and barriers related to maternal and infant health using the Pregnancy Risk Assessment Monitoring System (PRAMS) ² (Intermediate Outcome)	FY 2012: 41 (Target Met)	41	41	Maintain
4.8.3: Increase the number of new evidence-based findings disseminated annually to inform the delivery of effective maternal/child health and reproductive health interventions (Output)	FY 2012: 120 (Target Exceeded)	105	120	+15
4.I: Number of youth reached with evidence-based teen pregnancy prevention services across 10 CDC funded communities (Output)	FY 2011: 0 (Baseline) ³	12,500	14,000	+1,500

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
4.J: Number of maternal and child health (MCH) assignees providing epidemiologic support to national, state, or local MCH agencies (Output) ⁴	FY 2012: 19 (Target Met)	19	19	Maintain

¹This measure is based on preliminary data. Final data will be available in December 2013.

²Starting in 2012, all PRAMS funded states will include a core set of questions to assess preconception health in surveys. Targets for FY 12 forward reflect the number of reporting areas expected to be using PRAMS.

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

⁴Number reflects the total number of MCH assignees and Council of State and Territorial Epidemiologists (CSTE)

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 U.S. had the highest teen birth rate among industrialized nations in 2010, with 34.3 births per 1,000 women ages 15 to 19, and annual societal costs of approximately \$11 billion. Based on preliminary data, the teen birth rate in the 10 funded communities decreased from 71.8 per 1,000 in 2009 to 68.3 per 1,000 in 2011 (Measure 4.8.1). CDC identified these ten communities as grantees because they had significantly higher than average teen birth rates at the time of application.

Continued reduction in teen birth rates in the funded communities will strengthen the evidence base for effective interventions and evaluation of the sustained impact of these programs. State- and community-based grantees will evaluate the impact of innovative, multi-component, community-wide initiatives to reduce teen birth rates, increase youth access to evidence-based programs, and increase linkages to community-based clinical services. CDC estimates that over 100 program implementation partners will reach 14,000 youth in 2014, contributing to a reduction of teen birth rates, an increase in the number of youth abstaining from or delaying sexual intercourse, and an increase in contraceptive use among sexually-active youth (Measure 4.I). FY 2011 baseline results for Measure 4.I are delayed and will be available February 2013.

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 2012, 41 sites (40 states and New York City) collected data using PRAMS, which represents 78 percent of live births in the U.S. In 2012, CDC realigned the core set of questions for all 41 sites to help them measure health indicators and optimize the availability of data needed to improve national population-based estimates of preconception health. Currently, only six of the PRAMS sites collected additional data for assessing preconception health practices, gaps, and barriers related to maternal and infant health (Measure 4.8.2).

Translation and dissemination of epidemiologic research findings is vital to ensuring that evidence-based findings are integrated into healthcare 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 106 in 2008 to 120 in FY 2012, 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. Additionally, through CDC's Maternal and Child Health Epidemiology Program, in FY 2012, CDC placed 13 maternal and child health epidemiologists in nine states, the U.S./Mexico Border Region, two tribal entities and one national partner, as well as six Council of State and Territorial Epidemiologists Applied Epidemiology Fellowship research professionals in six states.

The assignments resulted in improved MCH research activities in the field, data use, networking, increased mentoring opportunities, and informed decision-making (Measure 4.J).

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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. (Outcome) ¹	FY 2011: 28.9% (Baseline)	N/A	28.0%	N/A

¹ This 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). BRFSS methodological changes to improve sampling and weighting are reflected in the 2011 results. Shifts in prevalence estimates for 2011 might not represent trends in risk factor prevalence in the population but instead might 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. CY 2011 baseline data for physical activity levels show almost 29 percent of adults diagnosed with arthritis in states funded by CDC were physically inactive (Measure 4.11.1). To increase the level of physical inactivity 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.

Program: Community Transformation Grants

Performance Measures for Long-Term Objective: Reduce the risk factors responsible for the leading causes of preventable death and disability in the US -- tobacco use, obesity, and uncontrolled high blood pressure and high cholesterol.

Measure 4.13.1: Number of people with increased access to smoke-free or tobacco-free environments in settings such as workplaces, restaurants, and bars; multi-unit housing; schools and campuses; and outdoor places (e.g., parks, beaches).

Measure 4.13.2: Number of people with increased access to environments with healthy food or beverage options in schools, afterschool programs, early childcare settings, workplaces, and other community settings.

Measure 4.13.3: Number of people with increased access to physical activity opportunities in schools, afterschool programs, early childcare settings, workplaces, and other community settings.

Measure 4.13.4: Number of people with access to systems that support control of high blood pressure and of high cholesterol in healthcare and other community settings.

Performance Trends: The Community Transformation Grants (CTG) program, authorized and funded through the Affordable Care Act, is a community-based chronic disease prevention initiative to reduce the risk factors responsible for the leading causes of preventable death and disability in the U.S.: tobacco use, obesity, uncontrolled high blood pressure, and high cholesterol. CDC's CTG program targets these modifiable risk factors for chronic disease with evidence-based interventions in order to: increase the number of Americans with access to tobacco free environments, healthy food and beverage options; increase the opportunities for safe physical activity; and, increase systems or opportunities that support control of high blood pressure and high cholesterol. Increased access to healthy opportunities in the CTG-funded communities will contribute to declines in death and disability due to tobacco use, obesity and heart disease and stroke.

Through community-level investments, the CTG program builds upon and supports the long-term objectives and performance measures of several long-standing CDC programs including: the Tobacco Prevention and Control program to reduce tobacco use and second-hand smoke exposure (related measures 4.6.3 through 4.6.5); the Nutrition, Physical Activity, and Obesity program to reduce and prevent obesity (related measures 4.11.9, 4.11.10, 4.12.1, 4.12.3); and the Heart Disease and Stroke program to increase blood pressure control (Measure 4.11.5). Additionally, the CTG program and awardees participate in both the Million Hearts™ Initiative, and community-level efforts focused on clinical preventive services to reduce high blood pressure and high cholesterol. The CTG program also supports the long-term goals captured by CDC's contextual indicators for Chronic Disease Prevention and Health Promotion: reductions in coronary heart disease deaths, stroke deaths, and diabetes-related deaths. CTG activities in funded communities will contribute to these longer-term national outcomes.

In FY 2012, the CTG program began its first year of implementation and data collection in funded communities. Targets for CTG performance measures will be established in December 2013 when Year 1 data become available. Specific accomplishments to date include:

- The University of Texas Austin has provided protection from exposure to second hand smoke and other tobacco-related products for over 51,000 students, 24,000 faculty and staff, and annual visitors. In addition, Harford County, Maryland has ensured that 1,000 employees and 245,000 residents benefit from smoke-free protections on all properties owned, leased, and operated by the county, including indoor and outdoor recreation facilities.
- New York City is promoting breastfeeding at 33 hospitals via participation in the "Latch on NYC" initiative to support a mother's choice to breastfeed and limit the promotion of infant formula, benefitting approximately 100,000 mothers and newborns each year.
- The New Mexico Department of Health is increasing access to physical activity opportunities for over 50,000 children by creating active outdoor school spaces for public use during non-school hours and increasing the number of safe routes to schools.
- South Carolina now has an additional 75 primary care practices who have signed a Business Associates Agreement that will ensure delivery of high blood pressure and high cholesterol care to 300,000 adults and 150,000 pediatric patients. In addition, the Los Angeles County Department of Health has increased access to clinical preventive services to control high blood pressure and cholesterol through the implementation of team-based approaches with more than 100 clinical entities, reaching approximately 200,000 adults in the LA County area.

The evidence-based strategies being implemented by CTG awardees are based upon the best available science as outlined in CDC's Community Guide and build upon the lessons learned over 10 plus years of CDC's community-based approaches to maximize chronic disease prevention including Communities Putting Prevention to Work, Racial and Ethnic Approaches to Community Health, and Healthy Communities programs.

STATE TABLES

These state tables are snapshots 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/>.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919/ National Breast and Cervical Cancer Early Detection Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget¹	FY 2014 +/- FY 2012
Alabama	\$3,037,037	\$3,037,037	N/A	N/A
Alaska	\$2,232,272	\$2,232,272	N/A	N/A
Arizona	\$2,365,779	\$2,365,779	N/A	N/A
Arkansas	\$2,600,486	\$2,600,486	N/A	N/A
California	\$6,878,103	\$6,878,103	N/A	N/A
CA Public Health Institute	\$0	\$0	N/A	N/A
Colorado	\$3,681,532	\$3,681,532	N/A	N/A
Connecticut	\$1,192,129	\$1,192,129	N/A	N/A
Delaware	\$1,049,867	\$1,049,867	N/A	N/A
Washington, D.C.	\$510,020	\$510,020	N/A	N/A
Florida	\$4,800,000	\$4,800,000	N/A	N/A
Georgia	\$4,130,000	\$4,130,000	N/A	N/A
Hawaii	\$1,134,616	\$1,134,616	N/A	N/A
Idaho	\$1,777,813	\$1,777,813	N/A	N/A
Illinois	\$6,315,920	\$6,315,920	N/A	N/A
Indiana	\$2,000,000	\$2,000,000	N/A	N/A
Iowa	\$2,660,235	\$2,660,235	N/A	N/A
Kansas	\$2,269,995	\$2,269,995	N/A	N/A
Kentucky	\$2,680,066	\$2,680,066	N/A	N/A
University of Kentucky	\$0	\$0	N/A	N/A
Louisiana	\$0	\$0	N/A	N/A
Louisiana State University	\$1,693,558	\$1,693,558	N/A	N/A
Maine	\$1,692,904	\$1,692,904	N/A	N/A
Maryland	\$4,538,523	\$4,538,523	N/A	N/A
Massachusetts	\$2,266,695	\$2,266,695	N/A	N/A
Michigan	\$8,693,584	\$8,693,584	N/A	N/A
Minnesota	\$4,409,466	\$4,409,466	N/A	N/A
Mississippi	\$2,111,748	\$2,111,748	N/A	N/A
Missouri	\$2,905,217	\$2,905,217	N/A	N/A
Montana	\$2,167,744	\$2,167,744	N/A	N/A
Nebraska	\$2,793,001	\$2,793,001	N/A	N/a
Nevada	\$2,357,718	\$2,357,718	N/A	N/A
New Hampshire	\$1,484,330	\$1,484,330	N/A	N/A
New Jersey	\$2,787,555	\$2,787,555	N/A	N/A
New Mexico	\$3,271,548	\$3,271,548	N/A	N/A

NARRATIVE BY ACTIVITY
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION
BUDGET REQUEST

New York	\$8,269,773	\$8,269,773	N/A	N/A
North Carolina	\$3,307,063	\$3,307,063	N/A	N/A
North Dakota	\$1,362,021	\$1,362,021	N/A	N/A
Ohio	\$4,197,806	\$4,197,806	N/A	N/A
Oklahoma	\$1,241,041	\$1,241,041	N/A	N/A
Oregon	\$2,182,532	\$2,182,532	N/A	N/A
Pennsylvania	\$2,585,219	\$2,585,219	N/A	N/A
Rhode Island	\$1,544,551	\$1,544,551	N/A	N/A
South Carolina	\$3,092,870	\$3,092,870	N/A	N/A
South Dakota	\$811,951	\$811,951	N/A	N/A
Tennessee	\$1,197,505	\$1,197,505	N/A	N/A
Texas	\$6,467,652	\$6,467,652	N/A	N/A
Utah	\$2,244,920	\$2,244,920	N/A	N/A
Vermont	\$997,700	\$997,700	N/A	N/A
Virginia	\$2,578,483	\$2,578,483	N/A	N/A
Washington	\$4,432,050	\$4,432,050	N/A	N/A
West Virginia	\$4,050,607	\$4,050,607	N/A	N/A
Wisconsin	\$3,125,115	\$3,125,115	N/A	N/A
Wyoming	\$683,359	\$683,359	N/A	N/A
Indian Tribes	\$7,179,861	\$7,179,861	N/A	N/A
American Samoa	\$238,433	\$238,433	N/A	N/A
Guam	\$392,840	\$392,840	N/A	N/A
Marshall Islands	\$0	\$0	N/A	N/A
Micronesia	\$0	\$0	N/A	N/A
Northern Mariana Islands	\$242,796	\$242,796	N/A	N/A
Palau	\$561,725	\$561,725	N/A	N/A
Puerto Rico	\$0	\$0	N/A	N/A
University of Puerto Rico	\$330,000	\$330,000	N/A	N/A
Virgin Islands	\$0	\$0	N/A	N/A
Total	\$157,807,334	\$157,807,334	\$146,499,614	-\$12,800,000

¹ CDC is unable to provide FY 2014 estimates for individual grantees at this time. The proposed \$12,800,000 would not be applied evenly across all grantees, as the program takes into account various factors in making funding decisions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283/National Comprehensive Cancer Control Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$310,000	\$310,000	\$310,000	N/A
Alaska	\$341,400	\$341,400	\$341,400	N/A
Arizona	\$281,400	\$281,400	\$281,400	N/A
Arkansas	\$306,533	\$306,533	\$306,533	N/A
California	\$0	\$0	\$0	N/A
CA Public Health Institute	\$552,918	\$552,918	\$552,918	N/A

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283/National Comprehensive Cancer Control Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Colorado	\$455,000	\$455,000	\$455,000	N/A
Connecticut	\$214,500	\$214,500	\$214,500	N/A
Delaware	\$277,900	\$277,900	\$277,853	N/A
Washington, D.C.	\$200,000	\$200,000	\$200,000	N/A
Florida	\$383,000	\$383,000	\$383,000	N/A
Georgia	\$246,817	\$246,817	\$246,817	N/A
Hawaii	\$256,000	\$256,000	\$256,000	N/A
Idaho	\$305,000	\$305,000	\$305,000	N/A
Illinois	\$224,300	\$224,300	\$224,300	N/A
Indiana	\$255,000	\$255,000	\$255,000	N/A
Iowa	\$520,300	\$520,300	\$520,300	N/A
Kansas	\$352,917	\$352,917	\$352,917	N/A
Kentucky	\$0	\$0	\$0	N/A
University of Kentucky	\$442,400	\$442,400	\$442,400	N/A
Louisiana	\$0	\$0	\$0	N/A
Louisiana State University	\$430,900	\$430,900	\$430,900	N/A
Maine	\$406,400	\$406,400	\$406,400	N/A
Maryland	\$259,200	\$259,200	\$259,200	N/A
Massachusetts	\$748,666	\$748,666	\$748,666	N/A
Michigan	\$732,800	\$732,800	\$732,800	N/A
Minnesota	\$480,900	\$480,900	\$480,900	N/A
Mississippi	\$234,300	\$234,300	\$234,300	N/A
Missouri	\$260,400	\$260,400	\$260,400	N/A
Montana	\$316,400	\$316,400	\$316,400	N/A
Nebraska	\$350,000	\$350,000	\$350,000	N/A
Nevada	\$255,000	\$255,000	\$255,000	N/A
New Hampshire	\$268,500	\$268,500	\$268,500	N/A
New Jersey	\$464,800	\$464,800	\$464,800	N/A
New Mexico	\$340,100	\$340,100	\$340,100	N/A
New York	\$639,000	\$639,000	\$639,000	N/A
North Carolina	\$750,000	\$750,000	\$750,000	N/A
North Dakota	\$346,100	\$346,100	\$346,100	N/A
Ohio	\$440,900	\$440,900	\$440,900	N/A
Oklahoma	\$200,000	\$200,000	\$200,000	N/A
Oregon	\$518,300	\$518,300	\$518,300	N/A
Pennsylvania	\$553,100	\$553,100	\$553,100	N/A
Rhode Island	\$324,256	\$324,256	\$324,256	N/A
South Carolina	\$303,200	\$303,200	\$303,200	N/A

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.283/National Comprehensive Cancer Control Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
South Dakota	\$234,000	\$234,000	\$234,000	N/A
Tennessee	\$316,100	\$316,100	\$316,100	N/A
Texas	\$440,700	\$440,700	\$440,700	N/A
Utah	\$565,900	\$565,900	\$565,900	N/A
Vermont	\$255,000	\$255,000	\$255,000	N/A
Virginia	\$231,700	\$231,700	\$231,700	N/A
Washington	\$589,700	\$589,700	\$589,700	N/A
West Virginia	\$306,700	\$306,700	\$306,700	N/A
Wisconsin	\$274,100	\$274,100	\$274,100	N/A
Wyoming	\$260,900	\$260,900	\$260,900	N/A
Indian Tribes	\$1,948,100	\$1,948,100	\$1,948,100	N/A
American Samoa	\$200,000	\$200,000	\$200,000	N/A
Guam	\$250,000	\$250,000	\$250,000	N/A
Marshall Islands	\$200,000	\$200,000	\$200,000	N/A
Micronesia	\$516,200	\$516,200	\$516,200	N/A
Northern Mariana Islands	\$200,000	\$200,000	\$200,000	N/A
Palau	\$200,000	\$200,000	\$200,000	N/A
Puerto Rico	\$0	\$0	\$0	N/A
University of Puerto Rico	\$210,000	\$210,000	\$210,000	N/A
Virgin Islands	\$0	\$0	\$0	N/A
Total	\$22,747,707	\$22,747,707	\$22,747,707	N/A

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS Combined FOA Programs				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted CFDA# 93.988/ Diabetes Prevention and Control Program	FY 2012 Enacted CFDA # 93.945/ Nutrition, Physical Activity, Obesity Program	FY 2012 Enacted CFDA# 93.283/ Heart Disease and Stroke Prevention Program	FY 2012 Enacted CFDA# 93.938/ School Health Program
Alabama	\$291,564	\$0	\$385,761	\$0
Alaska	\$423,568	\$0	\$499,025	\$0
Arizona	\$248,934	\$0	\$321,250	\$305,728
Arkansas	\$464,177	\$617,959	\$1,048,128	\$315,009
California	\$1,042,839	\$703,373	\$525,592	\$426,974
CA Public Health Institute	\$0	\$0	\$0	\$0
Colorado	\$506,276	\$656,030	\$315,232	\$323,844

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS Combined FOA Programs				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted CFDA# 93.988/ Diabetes Prevention and Control Program	FY 2012 Enacted CFDA # 93.945/ Nutrition, Physical Activity, Obesity Program	FY 2012 Enacted CFDA# 93.283/ Heart Disease and Stroke Prevention Program	FY 2012 Enacted CFDA# 93.938/ School Health Program
Connecticut	\$252,782	\$0	\$350,000	\$323,934
Delaware	\$386,912	\$0	\$0	\$0
Washington, D.C.	\$260,834	\$0	\$321,381	\$0
Florida	\$694,394	\$0	\$1,054,514	\$0
Georgia	\$306,689	808,407	\$819,415	\$0
Hawaii	\$327,804	493,992	\$330,113	\$0
Idaho	\$330,219	\$0	\$343,457	\$227,398
Illinois	\$849,070	\$0	\$385,137	\$0
Indiana	\$312,007	\$419,268	\$0	\$0
Iowa	\$229,862	\$836,773	\$458,750	\$0
Kansas	\$716,078	\$0	\$637,807	\$0
Kentucky	\$681,698	\$0	\$380,000	\$369,000
University of Kentucky	\$0	\$0	\$0	\$0
Louisiana	\$202,000	\$0	\$341,671	\$0
Louisiana State University	\$0	\$0	\$0	\$0
Maine	\$340,473	\$0	\$1,155,913	\$253,805
Maryland	\$301,587	\$0	\$325,000	\$0
Massachusetts	\$854,983	\$963,147	\$1,144,341	\$337,385
Michigan	\$947,905	\$940,541	\$400,000	\$427,500
Minnesota	\$912,163	\$621,687	\$449,751	\$225,686
Mississippi	\$292,533	\$0	\$429,973	\$306,709
Missouri	\$470,322	\$0	\$1,221,993	\$0
Montana	\$598,450	\$829,871	\$1,098,195	\$0
Nebraska	\$271,399	\$698,900	\$337,373	\$0
Nevada	\$344,404	\$0	\$0	\$0
New Hampshire	\$294,478	\$476,685	\$0	\$0
New Jersey	\$478,533	\$782,723	\$332,114	\$297,500
New Mexico	\$433,792	\$584,158	\$0	\$0
New York	\$986,305	\$1,011,757	\$1,293,389	\$294,000
North Carolina	\$887,205	\$972,749	\$1,299,949	\$413,732
North Dakota	\$244,261	\$0	\$350,000	\$324,000
Ohio	\$734,631	\$0	\$379,479	\$288,313
Oklahoma	\$244,892	\$0	\$350,000	\$0
Oregon	\$797,756	\$0	\$342,103	\$0
Pennsylvania	\$521,086	\$0	\$0	\$0
Rhode Island	\$757,903	\$791,448	\$310,654	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS Combined FOA Programs				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted CFDA# 93.988/ Diabetes Prevention and Control Program	FY 2012 Enacted CFDA # 93.945/ Nutrition, Physical Activity, Obesity Program	FY 2012 Enacted CFDA# 93.283/ Heart Disease and Stroke Prevention Program	FY 2012 Enacted CFDA# 93.938/ School Health Program
South Carolina	\$662,914	\$745,205	\$1,100,000	\$372,476
South Dakota	\$256,442	\$0	\$0	\$382,500
Tennessee	\$268,653	\$411,770	\$350,000	\$0
Texas	\$975,730	\$748,584	\$399,793	\$0
Utah	\$888,327	\$446,643	\$948,228	\$0
Vermont	\$241,164	\$0	\$0	\$0
Virginia	\$372,906	\$0	\$1,000,000	\$0
Washington	\$974,690	\$905,807	\$1,000,000	\$382,413
West Virginia	\$915,069	\$577,978	\$579,658	\$368,941
Wisconsin	\$851,800	\$804,545	\$345,526	\$382,431
Wyoming	\$217,638	\$0	\$0	\$0
Indian Tribes	\$1,700,000	\$0	\$0	\$245,620
American Samoa	\$58,377	\$0	\$0	\$0
Guam	\$200,000	\$0	\$0	\$0
Marshall Islands	\$86,301	\$0	\$0	\$0
Micronesia	\$144,200	\$0	\$0	\$0
Northern Mariana Islands	\$72,478	\$0	\$0	\$0
Palau	\$73,754	\$0	\$0	\$0
Puerto Rico	\$237,869	\$0	\$0	\$0
University of Puerto Rico	\$0	\$0	\$0	\$0
Virgin Islands	\$202,000	\$0	\$0	\$0
Total	\$29,643,082	\$17,850,000	\$25,460,665	\$7,594,898

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919/Tobacco Prevention and Control Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
Alabama	\$1,326,917	\$1,326,917	\$1,326,917	\$0
Alaska	\$1,053,595	\$1,053,595	\$1,053,595	\$0
Arizona	\$1,272,921	\$1,272,921	\$1,272,921	\$0
Arkansas	\$1,104,566	\$1,104,566	\$1,104,566	\$0
California	\$1,862,181	\$1,862,181	\$1,862,181	\$0
CA Public Health Institute	\$0	\$0	\$0	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919/Tobacco Prevention and Control Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
Colorado	\$1,326,308	\$1,326,308	\$1,326,308	\$0
Connecticut	\$1,045,164	\$1,045,164	\$1,045,164	\$0
Delaware	\$631,960	\$631,960	\$631,960	\$0
Washington, D.C.	\$529,574	\$529,574	\$529,574	\$0
Florida	\$1,854,794	\$1,854,794	\$1,854,794	\$0
Georgia	\$1,092,460	\$1,092,460	\$1,092,460	\$0
Hawaii	\$786,135	\$786,135	\$786,135	\$0
Idaho	\$1,141,438	\$1,141,438	\$1,141,438	\$0
Illinois	\$1,097,095	\$1,097,095	\$1,097,095	\$0
Indiana	\$1,024,280	\$1,024,280	\$1,024,280	\$0
Iowa	\$959,190	\$959,190	\$959,190	\$0
Kansas	\$1,285,359	\$1,285,359	\$1,285,359	\$0
Kentucky	\$1,087,817	\$1,087,817	\$1,087,817	\$0
University of Kentucky	\$0	\$0	\$0	\$0
Louisiana	\$1,101,612	\$1,101,612	\$1,101,612	\$0
Louisiana State University	\$0	\$0	\$0	\$0
Maine	\$951,046	\$951,046	\$951,046	\$0
Maryland	\$1,205,315	\$1,205,315	\$1,205,315	\$0
Massachusetts	\$1,556,431	\$1,556,431	\$1,556,431	\$0
Michigan	\$1,656,861	\$1,656,861	\$1,656,861	\$0
Minnesota	\$1,076,844	\$1,076,844	\$1,076,844	\$0
Mississippi	\$1,104,566	\$1,104,566	\$1,104,566	\$0
Missouri	\$1,156,691	\$1,156,691	\$1,156,691	\$0
Montana	\$961,793	\$961,793	\$961,793	\$0
Nebraska	\$1,209,112	\$1,209,112	\$1,209,112	\$0
Nevada	\$852,583	\$852,583	\$852,583	\$0
New Hampshire	\$1,040,636	\$1,040,636	\$1,040,636	\$0
New Jersey	\$1,274,834	\$1,274,834	\$1,274,834	\$0
New Mexico	\$1,106,918	\$1,106,918	\$1,106,918	\$0
New York	\$1,873,958	\$1,873,958	\$1,873,958	\$0
North Carolina	\$1,672,280	\$1,672,280	\$1,672,280	\$0
North Dakota	\$1,154,592	\$1,154,592	\$1,154,592	\$0
Ohio	\$1,364,363	\$1,364,363	\$1,364,363	\$0
Oklahoma	\$1,326,840	\$1,326,840	\$1,326,840	\$0
Oregon	\$1,094,341	\$1,094,341	\$1,094,341	\$0
Pennsylvania	\$1,288,610	\$1,288,610	\$1,288,610	\$0
Rhode Island	\$1,151,165	\$1,151,165	\$1,151,165	\$0
South Carolina	\$1,192,781	\$1,192,781	\$1,192,781	\$0
South Dakota	\$963,055	\$963,055	\$963,055	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.919/Tobacco Prevention and Control Program				
State/Local/ Territory/Tribal Grantee	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2013
Tennessee	\$1,172,920	\$1,172,920	\$1,172,920	\$0
Texas	\$1,840,527	\$1,840,527	\$1,840,527	\$0
Utah	\$1,215,563	\$1,215,563	\$1,215,563	\$0
Vermont	\$1,139,143	\$1,139,143	\$1,139,143	\$0
Virginia	\$994,856	\$994,856	\$994,856	\$0
Washington	\$1,410,842	\$1,410,842	\$1,410,842	\$0
West Virginia	\$1,170,947	\$1,170,947	\$1,170,947	\$0
Wisconsin	\$1,191,137	\$1,191,137	\$1,191,137	\$0
Wyoming	\$814,229	\$814,229	\$814,229	\$0
Indian Tribes	\$1,865,340	\$1,865,340	\$1,865,340	\$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	\$879,528	\$879,528	\$879,528	\$0
University of Puerto Rico	\$0	\$0	\$0	\$0
Virgin Islands	\$201,675	\$201,675	\$201,675	\$0
Total	\$64,654,116	\$64,654,116	\$64,654,116	\$0

BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

(dollars in millions)	FY 2012 Enacted ^{1,2}	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$141.792	\$142.696	\$67.148	-\$74.644
ACA/PPHF	N/A	N/A	\$74.796	N/A
Total	\$141.792	\$142.696	\$141.944	+\$0.152
FTEs	240	239	239	-1

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

² FY 2012 and FY 2013 Health and Development for People with Disabilities line has been comparably adjusted to reflect the transfer of \$6.7 million for the Paralysis Resource Center (Christopher Reeve) to the Administration for Community Living (ACL).

Enabling Legislation Citation: PHS Act 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 Early Act §§ 3,5 (42 U.S.C. 247b-4f* and 42 U.S.C. 247b-4g).

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$141,944,000 for Birth Defects and Developmental Disabilities is an increase of \$152,000 above the FY 2012 level and reflects the transfer for the Paralysis Resource Center to the Administration for Community Living (ACL).

(dollars in millions)	FY 2012 Enacted ^{1,2}	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Child Health and Development	\$67.701	\$68.132	\$67.744	+\$0.043
<i>Budget Authority</i>	<i>\$67.701</i>	<i>\$68.132</i>	<i>\$23.098</i>	<i>-\$44.603</i>
<i>ACA/PPHF</i>	<i>N/A</i>	<i>N/A</i>	<i>\$44.646</i>	<i>N/A</i>
Health and Development for People with Disabilities	\$53.495	\$53.836	\$53.528	+\$0.033
<i>Budget Authority</i>	<i>\$53.495</i>	<i>\$53.836</i>	<i>\$23.378</i>	<i>-\$30.117</i>
<i>ACA/PPHF</i>	<i>N/A</i>	<i>N/A</i>	<i>\$30.150</i>	<i>N/A</i>
Public Health Approach to Blood Disorders (BA)	\$20.596	\$20.728	\$20.672	+\$0.076
Total	\$141.792	\$142.696	\$141.944	+\$0.152

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

² FY 2012 and FY 2013 Health and Development for People with Disabilities line has been comparably adjusted to reflect the transfer of \$6.7 million for the Paralysis Resource Center (Christopher Reeve) to the Administration for Community Living (ACL).

CDC programs provide credible, science-based public health information on the impact of birth defects, disabilities, and blood disorders on Americans; identify the risk factors and causes of these conditions; and translate science into action, enhancing the potential for full, productive living for many individuals in these vulnerable populations. These activities support CDC's goal of preventing the leading causes of disease, disability, and death. CDC promotes the health of babies, children, and adults, helping them live life to the fullest by:

- Demonstrating the impact of birth defects, disabilities, and blood disorders on Americans through cutting-edge surveillance, research, and science.
- Widely disseminating research findings and recommendations, translating science into public health action.
- Advancing efforts to prevent birth defects and enhance the quality of life for individuals with disabilities and blood disorders.

FUNDING HISTORY^{1,2}

Fiscal Year	Dollars (in millions)
2009	\$138.022
2010	\$143.626
2011	\$136.072
2012	\$141.792
2013	\$142.696

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²FY 2012 and FY 2013 Health and Development for People with Disabilities line has been comparably adjusted to reflect the transfer of \$6.7 million for the Paralysis Resource Center (Christopher Reeve) to the Administration for Community Living (ACL).

CHILD HEALTH AND DEVELOPMENT BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$67.701	\$68.132	\$23.098	-\$44.603
Autism (non-add)	\$23.055	\$23.202	\$23.098	+\$0.043
ACA/PPHF	N/A	N/A	\$44.646	N/A
Total	\$67.701	\$68.132	\$67.744	+\$0.043

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's core activities in child health and development focus on surveillance, public health research, and prevention. CDC's goals include preventing birth defects and developmental disabilities, and reducing adverse impacts for people who have them. CDC operates three principal programs in surveillance and research, including the National Birth Defects Prevention Study (NBDPS), the Autism and Developmental Disabilities Monitoring (ADDM) Network, and the Study to Explore Early Development (SEED). To improve infant and child health, CDC builds on these model programs, addressing critical child health issues such as autism, craniofacial defects, fetal alcohol syndrome, neural tube defects (NTDs), and congenital heart defects (CHD).

Budget Proposal: CDC's FY 2014 budget request of \$67,744,000 for Child Health and Development is an increase of \$43,000 above the FY 2012 level. The FY 2014 President's Budget request does not propose the consolidation of several budget lines proposed in the FY 2013 President's Budget. These funds will enable CDC to continue monitoring birth defects; researching the modifiable risk factors for major birth defects, including gene-environment interactions; translating birth defects research findings into practice and prevention strategies; enhancing monitoring of autism and developmental disabilities; and researching high-priority factors that may cause autism, such as the interaction of genes and specific environmental factors.

In FY 2014, CDC is planning several activities to meet the needs of child health and development. CDC will work to understand how to decrease the risk of major birth defects among women with high-risk conditions, such as maternal diabetes and obesity, by further exploring the role of physical activity and

diet quality. CDC will prevent alcohol-exposed pregnancies through dissemination of CHOICES, promotion of alcohol screening and brief intervention, and through ongoing efforts to educate healthcare professionals on the prevention, identification, and management of fetal alcohol spectrum disorders. CDC will also examine how environmental and occupational factors might increase the risk of having a baby with a major birth defect, through the new multi-site Birth Defects Study to Evaluate Pregnancy Exposures (BD-STEPS).

CDC will provide leadership and scientific and programmatic expertise through the National Birth Defects Prevention Network to enhance the birth defects surveillance infrastructure and increase the usefulness of surveillance data. CDC will serve as coordinator and data repository for one of the largest population-based birth defects surveillance data sets in the United States. These data are a source for ongoing epidemiological investigations into the occurrence of birth defects and into the survival of those born with birth defects.

Birth Defects

CDC will support improved state and local birth defects surveillance capacity through investment in programs that track birth defects and refer individuals with birth defects to medical and social services. The current NBDPS and future BD-STEPS complement this surveillance system and work to prevent major birth defects resulting from modifiable risk factors, such as maternal diabetes, obesity, nutrition (i.e., folic acid intake), smoking, alcohol, and medication use during pregnancy.

Fetal Alcohol Syndrome

CDC will work with multiple partners to support dissemination of CHOICES, an innovative program that works to prevent alcohol-exposed pregnancies in high-risk women. National and state partners are implementing this program in primary care settings, including sexually transmitted infection (STI) clinics, family planning clinics, community health centers, and several American Indian communities. Two project sites (located in Baltimore, Maryland and Denver, Colorado) have successfully integrated CHOICES into clinics serving high-risk women. To date, over 60 percent of the women enrolled in CHOICES at these sites reduced their risk of alcohol-exposed pregnancy. Their results will inform current and future programmatic efforts.

Folic Acid

CDC will continue efforts to eliminate folic acid-preventable neural tube defects (NTDs) by monitoring health disparities, working to determine optimal blood folate levels for NTD prevention, and providing information on the benefits of folic acid fortification. The agency's expertise in surveillance and research informs innovative strategies for prevention.

Infant Health

CDC worked with the American Academy of Pediatrics (AAP) to develop a web-based FASD toolkit for pediatric providers which will be disseminated and promoted upon release. This toolkit will be a premier resource for medical providers with practical uses ranging from diagnosis and management tools to information for families.

Autism

The FY2014 request includes \$23,098,000 for autism activities. CDC will monitor autism among four-year-old and eight-year-old children to improve early identification of the disorder. CDC will begin analyzing the initial results from the Study to Explore Early Development (SEED), the largest study of its kind, helping to identify factors that may put children at risk for autism.

CDC will support work in developmental disabilities through the multi-state ADDM Network. This network provides the gold standard for estimating the prevalence of autism and describing the characteristics of children with autism and other developmental disabilities. CDC will continue its

investigation into the causes of autism through the Centers for Autism and Developmental Disabilities Research and Epidemiology (CADDRE), located in six states (California, Colorado, Georgia, Maryland, North Carolina, and Pennsylvania) with a Data Coordination Center in Michigan. The CADDRE Network is conducting the SEED, which currently is the largest study in the United States to help identify factors that may put children at risk for autism and other developmental disabilities. The CADDRE Network has been able to leverage \$6.6 million in CDC funds to establish the infrastructure to conduct research and secure \$15 million in additional funding from public, private, and non-profit partners. CDC used this additional funding to expand research into a variety of areas including pregnancy exposures, autoimmunity, clinician training, diagnosis in rural settings, and genotyping.

Grant Tables:

Birth Defects and Surveillance of Fetal Deaths Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	29	29	29
Average Award	\$0.336	\$ 0.336	\$0.336
Range of Awards	\$0.010–\$0.931	\$0.010–\$0.931	\$0.010–\$0.931
Number of New Awards	3	9	2
Number of Continuing Awards	26	20	27
Total Grant Award	\$9.744	\$9.744	\$9.744

In FY 2014, CDC will fund 29 competitive birth defects awards to track birth defects and stillbirths, collect and analyze data on birth defects risk factors, refer individuals born with birth defects to appropriate medical and social services, and implement prevention strategies to reduce the occurrence of birth defects. These grants enhance surveillance, improve knowledge of preventable risk factors, and decrease birth defects. Grantees consist of 17 state/territory health departments, five academic research centers, six non-profit organizations, and one international grantee.

Craniofacial Malformations Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	25	25	25
Average Award	\$0.052	\$0.052	\$0.052
Range of Awards	\$0.010–\$0.400	\$0.010–\$0.400	\$0.010–\$0.400
Number of New Awards	1	8	2
Number of Continuing Awards	24	17	23
Total Grant Award	\$1.300	\$1.300	\$1.300

In FY 2014, CDC will fund 25 competitive craniofacial malformation awards to monitor craniofacial malformations, examine modifiable causes, provide improved data on the longer-term outcomes for those affected, and develop strategies to increase access to healthcare services. These grants enhance the health of those born with craniofacial malformations. Grantees consist of 17 state health departments, seven academic research centers, and one non-profit organization.

Fetal Alcohol Syndrome Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	14	14	9-14
Average Award	\$0.211	\$0.211	\$0.211
Range of Awards	\$0.203–\$0.500	\$0.203–\$0.500	\$0.203–\$0.500
Number of New Awards	1	0	0

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Continuing Awards	13	14	9-14
Total Grant Award	\$2.954	\$2.954	\$2.954

In FY 2014, CDC will fund nine to 14 competitive fetal alcohol syndrome awards to provide training to medical and allied health students and practitioners and implement and evaluate prevention strategies to reduce alcohol-exposed pregnancies. These grants enhance efforts to increase knowledge and awareness among women of reproductive age and healthcare providers regarding alcohol use during pregnancy as well as reduce the risk of alcohol-exposed pregnancy. Grantees consist of at least two health service corporations, one professional organization, one private organization, and five academic research centers.

Folic Acid Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	2	2	1-2
Average Award	\$0.386	\$0.386	\$0.386
Range of Awards	\$0.100–\$0.673	\$0.100–\$0.673	\$0.100–\$0.673
Number of New Awards	1	0	0
Number of Continuing Awards	1	2	1-2
Total Grant Award	\$0.772	\$0.772	\$0.772

In FY 2014, CDC will fund one to two non-competitive folic acid awards to increase folic acid intake among women of reproductive age, support NTD prevention efforts, and enhance surveillance and monitoring of NTDs and blood folates. This grant award will support one multilateral organization (World Health Organization) for surveillance and prevention efforts.

Spina Bifida Surveillance Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	15	15	15
Average Award	\$0.026	\$0.026	\$0.026
Range of Awards	\$0.010–\$0.250	\$0.010–\$0.250	\$0.010–\$0.250
Number of New Awards	0	0	0
Number of Continuing Awards	15	15	15
Total Grant Award	\$0.390	\$0.390	\$0.390

In FY 2014, CDC will fund fifteen competitive spina bifida awards to improve surveillance capacity, better understand the epidemiology, and identify modifiable causes of spina bifida. These grants enhance health through the identification and implementation of strategies to prevent spina bifida. Grantees consist of 13 state health departments, one academic institution, and one international academic research center.

Infant Health Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	6	6	3-6
Average Award	\$0.089	\$0.089	\$0.089
Range of Awards	\$0.020–\$0.250	\$0.020–\$0.250	\$0.020–\$0.250
Number of New Awards	3	0	0
Number of Continuing Awards	3	6	3-6
Total Grant Award	\$0.534	\$0.534	\$0.534

In FY 2014, CDC will fund three to six competitive infant health awards to strengthen global NTD surveillance, support global efforts to increase folic acid intake among women of reproductive age, and improve early identification of autism and other developmental disabilities. Grantees are non-government organizations.

Infant Health (Hearing Loss) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	2	2	1-2
Average Award	\$0.150	\$0.150	\$0.150
Range of Awards	\$0.100–\$0.200	\$0.100–\$0.300	\$0.100–\$0.300
Number of New Awards	0	2	0
Number of Continuing Awards	2	0	1-2
Total Grant Award	\$0.300	\$0.300	\$0.300

In FY 2014, CDC will provide support through one to two competitive cooperative agreements to develop guidelines for medical home providers to reduce loss-to-follow-up/documentation of infants identified with hearing loss. CDC also funds research through a cooperative agreement to improve loss-to-follow-up/documentation through screening at Women, Infants, and Children visits.

Autism Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	22	22	8-22
Average Award	\$0.575	\$0.575	\$0.575
Range of Awards	\$0.025–\$1.520	\$0.025–\$1.520	\$0.025–\$1.520
Number of New Awards	3	0	0-14
Number of Continuing Awards	19	22	8
Total Grant Award	\$12.640	\$12.640	\$12.640

In FY 2014, CDC anticipates funding 8-22 competitive autism awards to enhance surveillance and research for autism and other developmental disabilities, monitor prevalence and contributing risk factors, and better inform policies and programs for prevention and services. Current grantees consist of one state health department, 15 academic research centers, one research institute (with two awards), and four non-profit organizations. These grants enhance surveillance programs for autism and other developmental disabilities; support research on risk and protective factors for autism; and identify and evaluate strategies to reduce racial/ethnic disparities in the identification of autism and other developmental disabilities.

HEALTH AND DEVELOPMENT FOR PEOPLE WITH DISABILITIES

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$53.495	\$53.836	\$23.378	-\$30.117
ACA/PPHF	N/A	N/A	\$30.150	N/A
Total	\$53.495	\$53.836	\$53.528	+\$0.033

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's Health and Development for People with Disabilities program supports a wide range of surveillance, public health practice, and research activities designed to monitor the health status, and prevent secondary health conditions for people with disabilities. CDC collaborates with a variety of federal, state, private, and non-profit partners to address public health challenges facing the 20 percent of

Americans who have a disability. CDC supports programmatic activities through cooperative agreements with grantees.

These activities represent our nation's public health commitment to supporting populations with disabilities. CDC's commitment to serving individuals with disabilities builds a strong public health framework for the disabled community, 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 Proposal: CDC's FY 2014 request of \$53,528,000 for Health and Development for People with Disabilities is an increase of \$33,000 above the FY 2012 level. FY 2014 includes a proposed transfer of \$6,700,000 for the Paralysis Resource Center (Christopher Reeve) to the Administration for Community Living (ACL). CDC's FY 2014 request does not propose the consolidation of several budget lines proposed in the FY 2013 President's Budget. CDC will use these funds to document the scope and magnitude of disabilities by investing in public health surveillance activities. This will allow CDC to identify and highlight public health issues associated with human development, reduce disabilities-associated health disparities, and promote the health and wellbeing of people with disabilities. This effort includes progression of the Disability and Health Data System (DHDS) as CDC seeks to expand the utility of this innovative information resource.

Disability and Health

CDC will improve developmental outcomes for children and adolescents, collaborating with the Administration on Children and Families (ACF) to incorporate CDC's Legacy for Children program into Head Start. Incorporation of this proven public health intervention will enable pilot Head Start states (Florida, Georgia, Kentucky, Mississippi) to improve child health and development at the earliest developmental stages.

Recognizing that lifelong challenges are associated with disabilities, CDC also promotes health in adults with disabilities. CDC will continue to collaborate with major public health partners to support a variety of public health practice and resource centers focused on improving the health and quality of life for people with Attention Deficit/Hyperactivity Disorder (ADHD), Fragile X, limb loss, and paralysis. Partners include Children and Adults with ADHD, Fragile X Clinical and Research Consortium, and Amputee Coalition.

To document and disseminate disability and health data, in 2012, CDC implemented an innovative approach to surveillance, establishing the Disability and Health Data System (DHDS). The DHDS is an interactive, disability-surveillance tool that helps CDC and states develop fiscally responsible, evidence-based programs that include people with disabilities. For the first time, state-based disability data are housed in a central, Web-based location with on-demand access. In FY 2014, DHDS will help identify research opportunities and provide evidence for better health and wellness opportunities for people with disabilities, by allowing a comparison of people with and without disabilities across different health measures. The data system allows for a customized view of disability and health data in states, making it easy to understand health disparity information and identify trends. The system offers policymakers at all levels critical health information about people with disabilities, and complements CDC's state-based surveillance activities as well as the targeted surveillance and research activities on Tourette syndrome, muscular dystrophy, and spina bifida.

CDC plans to revise its approach to intellectual disabilities with the establishment of dual funding tracks focused on research and non-research program activities. CDC awarded four grants in FY 2012 to address the research efforts focused on reducing the health disparities among people with intellectual disabilities and the non-research efforts focused on improving the health of people with intellectual disabilities.

Early Hearing Detection and Intervention

This funding request continues support for the Early Hearing Detection and Intervention (EHDI) program. Working in collaboration with the Health Resources and Services Administration (HRSA), CDC funds state and territorial health departments to ensure all newborns are screened, assessed for hearing loss, and receive appropriate intervention services. With a 97 percent screening rate, CDC is now working with partners to ensure that appropriate follow-up services reach infants who screen positive for hearing loss. Timely intervention can prevent delays in speech and hearing, as well as the substantial medical and educational costs associated with such delays.

The EHDI program will widen its support for development of the electronic system capacity of EHDI awardees. This support will enhance the awardees' ability to collect and exchange data accurately, effectively, securely, and consistently between the EHDI Information System and electronic health record systems, to improve the loss-to-follow-up for infants who failed infant hearing screenings and ensure that these infants receive necessary treatment.

Spina Bifida

CDC will support the national effort toward electronic medical records (EMR). CDC's partner, the Spina Bifida Association, launched a pilot of the Spina Bifida Electronic Medical Record in three sites (Children's Hospital of Alabama, Children's Hospital Los Angeles, and Children's Hospital Colorado). This project examines the use of an EMR system in spina bifida clinics. Condition-specific EMRs provide a record-keeping mechanism to collect and track patient- and population-specific data points over time. This contributes to care coordination and better outcomes, as well as measures of effectiveness of clinical care. The project includes a demonstration of the usefulness of EMRs as well as the process to populate both a hospital administrative record and a condition-specific record without duplication of effort.

Congenital Heart Defects

CDC continues to expand work on congenital heart disease through cooperative agreements to monitor the number of adolescents and adults with congenital heart defects. This investment will improve understanding of the epidemiology of congenital heart defects across the life span, and will help direct future efforts that could improve the lives of those born with a congenital heart defect.

Grant Tables:

Disability and Health Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	18	18	18
Average Award	\$0.300	\$0.300	\$0.300
Range of Awards	\$0.200–\$0.300	\$0.200–\$0.300	\$0.200–\$0.300
Number of New Awards	18	0	0
Number of Continuing Awards	0	18	18
Total Grant Award	\$5.400	\$5.400	\$5.400

In FY 2014, CDC will fund 18 competitive awards to state disability and health programs. These grants support specific health promotion activities and health disparities surveillance. The state-based programs also address environmental barriers, such as inaccessible healthcare facilities and examination equipment, and provide training and communication to public health and healthcare providers about disability.

Early Hearing Detection and Intervention (EHDI) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	52	52	49-52
Average Award	\$0.150	\$0.150	\$0.150
Range of Awards	\$0.083–\$0.190	\$0.083–\$0.190	\$0.150–\$0.170
Number of New Awards	0	0	0
Number of Continuing Awards	52	52	49-52
Total Grant Award	\$7.800	\$7.800	\$7.800

In FY 2014, CDC will fund 49-52 competitive EHDI awards to provide support and scientific and programmatic expertise to state/territory public health departments (or their designated entity) to develop and implement state/territory EHDI tracking and surveillance systems. These grants enhance newborn screening and assessment for hearing loss and appropriate interventions. Grantees consist of 49-52 state and territorial health departments or their bona fide agent.

Muscular Dystrophy Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	2-4
Average Award	\$0.525	\$0.525	\$0.525
Range of Awards	\$0.450–\$0.749	\$0.450–\$0.749	\$0.450–\$0.749
Number of New Awards	0	0	2
Number of Continuing Awards	4	4	0-4
Total Grant Award	\$2.100	\$2.100	\$2.100

In FY 2014, CDC will provide support and scientific and programmatic expertise to two to four awardees. The current four FOAs supporting two public health departments (Colorado and New York) and two universities (Arizona and Iowa) expire in 2014. A new FOA will be competed to determine the new awardees. Awardees will continue to conduct population-based surveillance of nine muscular dystrophies. The goal is to determine prevalence, demographics, healthcare coverage, and types of clinics where patients receive care. These grants enhance research efforts to understand healthcare transition and other life stage issues for people who have Duchenne/Becker Muscular Dystrophy (DBMD) and ongoing analysis and dissemination of DBMD data collected previously.

Spina Bifida Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	17	17	8-17
Average Award	\$0.065	\$0.070	\$0.070
Range of Awards	\$0.042–\$0.070	\$0.050–\$0.070	\$0.060–\$0.070
Number of New Awards	0	0	8
Number of Continuing Awards	17	17	0-17
Total Grant Award	\$1.105	\$1.190	\$1.190

In FY 2014, CDC will fund eight to 17 awards supporting spina bifida clinics that collect and maintain longitudinal data (including demographics, interventions, and outcomes for persons with spina bifida) in a central National Spina Bifida Patient Registry. The current 17 awards support 19 spina bifida clinics and are funded under two FOAs that expire in 2014. A new FOA will be competed to fund eight to 17 awards that will support spina bifida clinics. These grants enhance research used to identify measures to develop national standards of care for patients with spina bifida, and assess progress toward those standards.

Congenital Heart Defects (CHD) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	4
Average Award	\$0.351	\$0.351	\$0.351
Range of Awards	\$0.045–\$0.450	\$0.045–\$0.450	\$0.045–\$0.450
Number of New Awards	3	0	1
Number of Continuing Awards	1	4	3
Total Grant Award	\$1.404	\$1.404	\$1.404

In FY 2014, CDC will fund three CHD awards to two state health departments and one academic site 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. In addition, one new competitive grant will be awarded in FY 2014 to promote awareness of congenital heart defects as a public health issue and improve understanding of the survival, healthcare utilization, and longer-term outcomes of those living with congenital heart defects.

PUBLIC HEALTH APPROACH TO BLOOD DISORDERS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$20.596	\$20.728	\$20.672	+\$0.076

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates.

Program Overview: CDC prevents blood disorders, and protects people who have them from complications, by using information gathered on risk factors, causes, and impacts of bleeding, clotting, and red blood cell disorders (hemoglobinopathies).

In FY2012, utilizing competitively awarded cooperative agreements for clotting disorders, two pilot projects were supported to evaluate the effectiveness of multiple approaches for venous thromboembolism (VTE) surveillance. In FY 2012, CDC also brought together healthcare practitioners and representatives from federal agencies, professional associations, and advocacy groups to provide input that will help frame CDC's development of a hospital-associated venous thromboembolism (VTE) surveillance system that will measure the substantial burden of VTE in hospitalized patients and gather information needed to bring about effective interventions, to not only protect patients but to support Healthy People 2020 VTE objectives.

In FY 2012, CDC translated science into action for bleeding disorders through the Universal Data Collection (UDC) surveillance system, providing quality data on the risks, causes, and impacts of bleeding disorders and inhibitors. Inhibitors are antibodies to products used by people with hemophilia to prevent bleeding; however, these products make treatment ineffective and can cause costs of care to skyrocket. Through four competitively awarded cooperative agreements, CDC supported the establishment of the Blood Safety Surveillance among People with Blood Disorders project.

In FY 2012, CDC utilized lessons learned from the joint CDC/National Institutes of Health (NIH) seven state pilot surveillance program, Registry and Surveillance for Hemoglobinopathies, that examined disorders such as sickle cell disease and thalassemia, and is disseminating *Strategies from the Field: Data Collection* and *Strategies from the Field: Health Promotion*. These field notes showcase the methods used by the pilot states, providing summaries of the resources needed, benefits, outcomes and lessons learned.

Budget Proposal: CDC's FY 2014 request of \$20,672,000 for Public Health Approach to Blood Disorders is an increase of \$76,000 above the FY 2012 level. This funding will allow CDC to improve health outcomes and limit complications for those who are at risk or currently have blood disorders, by

promoting a comprehensive care model; identifying and evaluating effective prevention strategies; and increasing public and healthcare provider awareness of bleeding, clotting, and red blood cell disorders.

For clotting disorders, in FY 2014 CDC will fund pilot data collection systems to provide the framework for a VTE event reporting module in the Patient Safety Component of the National Healthcare Safety Network and will continue educating about the signs, symptoms, and risks of VTE, which claims up to 100,000 American lives each year. Because of its profound impacts, preventing death and disability associated with VTE is one of CDC's strategic priorities. CDC will continue work with the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) to disseminate information on tools and practices that can protect patients from hospital-associated VTE, in follow-up to the FY 2012 VTE expert panel.

For bleeding disorders, the FY 2014 budget request will enable CDC to continue vital work of the Universal Data Collection (UDC) system to address risks, causes, and impacts, including essential information on the development of inhibitors. This will include testing people with hemophilia for inhibitors to identify potential genetic and environmental risk and protective factors for inhibitor development.

To address bleeding and clotting disorders in FY 2014, CDC will continue its partnership with the American Thrombosis Hemostasis Network. Through this and other alliances, CDC is conducting a project (initiated in FY 2011) titled Public Health Surveillance for the Prevention of Complications of Bleeding and Clotting Disorders. Approximately 128 hemophilia treatment centers participate in this project, which will be completed in FY 2014 and will begin supplying actionable information in 2015. The project will provide critical insight on the demographics, diagnoses, and health service utilization practices of people with bleeding and clotting disorders to assess trends over time, understand the risk factors for complications, and identify high-risk populations for prevention programs. CDC's work on the Blood Safety Surveillance among People with Blood Disorders project will identify complications and infectious transmissions in heavily transfused populations.

As a major objective in FY 2014, CDC will continue work to prevent and control complications from hemoglobinopathies. To enhance hemoglobinopathy screening and diagnosis, CDC will work with laboratories to develop standardized laboratory methods and identify training standards and competency outcomes. CDC will maintain its support of the Blood Safety Surveillance among People with Blood Disorders project to identify complications and infectious transmissions in heavily transfused populations. Blood transfusions are the foundation of care for patients with severe thalassemia, who are at higher risk for transfusion-related infections and complications such as iron overload and acute lung injury, which can result in organ failure and early death.

In addition, CDC will support a study to identify gaps in knowledge and information resources for red blood cell disorders related to three Healthy People 2020 Objectives, and will develop or adapt health education materials and self-care tools on sickle cell disease and thalassemia for patients, families, and healthcare providers. CDC will provide scientific and programmatic expertise to states for development of state-specific, population-based data collection systems to protect and improve the lives of people with sickle cell disease and thalassemia.

Public Health Approach to Blood Disorders Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	19	16	4-16
Average Award	\$0.470	\$0.530	\$0.419
Range of Awards	\$0.100–\$4.000	\$0.150–\$4.000	\$0.108–\$4.000
Number of New Awards	7	0	0
Number of Continuing Awards	12	16	4-16

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Total Grant Award	\$8.930	\$8.480	\$8.480

In FY 2014 CDC will fund four to 16 blood disorder competitive cooperative agreements primarily to professional organizations, 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.

PERFORMANCE

Child Health and Development

Performance Measures for Long-Term Objective: Prevent birth defects and developmental disabilities

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- 2012 Target
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 (per 10,000 live births) ¹ (Outcome)	FY 2008: 5.8 (Target Not Met)	4.4	N/A	N/A
5.1.5a: Increase the proportion of all children with autism spectrum disorders (ASDs) who receive a first evaluation by 36 months of age ² (Outcome)	FY 2011: 41.8% (Historical Actual)	N/A	N/A	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	N/A	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 ² (Outcome)	FY 2011: 35.9% (Historical Actual)	N/A	N/A	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 ² (Outcome)	FY 2011: 36.3% (Historical Actual)	N/A	N/A	N/A
5.1.6: Among the medications most frequently used during pregnancy, increase the number with sufficient evidence to determine the fetal risk ² (Output)	FY 2012: 2 (Baseline)	N/A	3	N/A

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- 2012 Target
5.1.7: Increase the proportion of CDC-funded, state-based birth defects surveillance programs that disseminate surveillance data on the 12 core conditions within 2 years of data collection (Outcome)	FY 2012: 50% (Baseline)	N/A	52.5%	N/A
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)	FY 2012: a) 36% (Baseline) b) 32% (Baseline)	N/A	a) 40% b) 36%	N/A
5.C: Number of model state-based fetal alcohol syndrome surveillance systems and regional training centers (Output)	FY 2012: 8 (Target Met)	8	8	Maintain
5.D: Number of states participating in monitoring for autism and other developmental disabilities (Output)	FY 2012: 12 (Target Met)	12	12	Maintain
5.K: Number of countries conducting surveillance of neural tube defects and/or monitoring blood folates among countries with a CDC presence (Output)	FY 2012: 17 (Baseline)	N/A	19	N/A

¹Unable to set targets; CDC is working on a replacement for FY 2015; please see narrative.

²Targets and results are set and reported biennially.

Performance Trends: CDC did not meet its target in FY 2008 (most recent data) to reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly among Hispanic women. CDC was unable to implement state/national level interventions, and birth prevalence data are limited to the state/national level making it difficult to assess impact at a local level (Measure 5.1.2). Program evaluations indicated that the small scale interventions supported by CDC increased awareness of folic acid, knowledge about how to prevent birth defects, and consumption of folic acid. The program, however, was unable to apply these positive results broadly enough to measurably affect state and national levels of folic acid-preventable diseases, and local data were unavailable. Recognizing the need for enhanced surveillance and epidemiology to support neural tube defect prevention efforts, CDC recently developed an output measure monitoring the number of countries with a CDC presence that conduct surveillance of neural tube defects and/or monitor blood folates. In FY 2012 (baseline year), this consisted of 17 countries (surveillance of neural tube defects in 10 and monitoring blood folates in 7) (Measure 5.K).

CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network sites monitor the prevalence of Autism Spectrum Disorders (ASDs) and other developmental disabilities in various geographic regions throughout the United States. The study focuses on eight-year-old children and has also begun conducting surveillance among four-year-old children in some sites. The most recent ASD prevalence estimates from ADDM were published in 2012, identifying one in 88 children with ASDs living in the ADDM Network communities during 2008. This marked a 78 percent increase in the identified prevalence of ASDs between 2002 and 2008. Some of the increase is due to the way children are identified, diagnosed, and served in their local communities. CDC plays a critical role in addressing autism by monitoring and tracking rates, researching causes and risk factors, and educating families and

providers about the importance of monitoring developmental milestones. 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).

For FY 2014, CDC developed three new measures that reflect efforts to enhance surveillance, increase the evidence base for effective interventions, and increase screening and provider-based interventions for risky alcohol use among women of reproductive age (Measures 5.1.6, 5.1.7, 5.1.8). In FY 2014, CDC will increase the number of current medications to three (one over FY 2012 baseline), for those medications most commonly used during pregnancy that have sufficient evidence to determine fetal risk. (Measure 5.1.6). CDC will increase to 52.5 percent (two-and-a-half percentage points over the FY 2012 baseline) the proportion of funded surveillance programs that report quality data in a timely manner (Measure 5.1.7). To help prevent alcohol-exposed pregnancies, CDC will gradually increase the percentage of primary care providers who screen women of reproductive age for risky alcohol use to 40 percent (four percentage points above the FY 2012 baseline) and increase the percentage of primary care providers who provide appropriate, evidence-based interventions to reduce alcohol-exposed pregnancy for those at-risk to 36 percent (four percentage points above the FY 2012 baseline) (Measure 5.1.8).

CDC supports activities to prevent fetal alcohol syndrome (FAS) and other fetal alcohol spectrum disorders (FASD) with focused efforts to increase alcohol screening and evidence-based interventions in healthcare settings serving women of reproductive age. There are currently eight model state-based fetal alcohol syndrome surveillance systems and Regional Training Centers (RTCs) (Measure 5.C). Within five 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. Additionally, three of the five RTCs received supplemental funding in FY 2013 to support implementation of alcohol screening and brief intervention within primary care systems in their regions. In FY2012, the RTCs conducted 286 trainings/events (792 hours of training) reaching 2,874 students/residents and 5,040 healthcare professionals.

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 2012 Target	FY 2014 Target	FY 2014 +/- 2012 Target
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 2010: 43.1% (Target Met)	51%	59%	+8%

Performance Trends: CDC's support for state- and territorial-based early hearing detection and intervention (EHDI) programs ensures that infants are screened for hearing loss and those who do not pass the screenings receive timely follow-up for diagnostic tests which are key to ensuring age-appropriate academic and social advancement. Early identification and intervention programs for hearing can save approximately \$200 million in additional education costs each year. In FY 2010, 43.1 percent of jurisdictions collected, reported and utilized EDHI data, compared with 36.3 percent in 2009 (baseline year) (Measure 5.2.5), and CDC documented that more than 97 percent of children born in the United States were screened for hearing loss. In FY 2014, CDC will increase the target to 59 percent for the percentage of jurisdictions using data to reduce the number of infants not receiving follow up.

Public Health Approach to Blood Disorders

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- 2012 Target
5.3.1: Increase the percentage of hemophilia patients enrolled in the Universal Data Collection system who are routinely screened for inhibitors (Outcome)	FY 2011: 37.4% (Baseline)	41.1%	46.8%	+5.7%

Performance Trends: Approximately 15-20 percent of people with hemophilia (PWH) develop an inhibitor, causing the immune system to destroy the clotting factor replacement (CFR) proteins used to prevent bleeds making typical CFR treatments ineffective. Medical providers typically treat PWH with higher and more frequent doses of CFR, exacerbating the inhibitor. This approach can result in significant treatment costs reaching up to \$1,000,000 per person each year and can increase hospitalizations and compromise physical functioning.

Although it is widely accepted by hemophilia care providers that the development of an inhibitor is a serious complication of treatment, routine screening is not the standard of care. CDC's Universal Data Collection (UDC) system provides population-level information that informs research to identify risk factors and evidence-based prevention practices for effective treatments. CDC uses the UDC to monitor inhibitor screening trends from the FY 2011 baseline of 37.4 percent of hemophilia patients enrolled in the UDC who are routinely screened for inhibitors (Measure 5.3.1).

STATE TABLES

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH			
	Early Hearing and Detection and Intervention		
STATE/TERRITORY	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Alabama	\$147,030	\$147,030	\$147,030
Alaska	\$156,933	\$156,933	\$156,933
Arizona	\$163,933	\$163,933	\$163,933
Arkansas	\$154,440	\$154,440	\$154,440
California	\$148,800	\$148,800	\$0
Colorado	\$157,297	\$157,297	\$157,297
Connecticut	\$170,000	\$170,000	\$170,000
Delaware	\$137,047	\$137,047	\$137,047
District of Columbia	-	-	-
Florida	\$145,689	\$145,689	\$0
Georgia	\$159,909	\$159,909	\$159,909
Hawaii	-	-	-
Idaho	\$137,801	\$137,801	\$137,801
Illinois	\$169,060	\$169,060	\$169,060
Indiana	\$170,000	\$170,000	\$170,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH			
	Early Hearing and Detection and Intervention		
STATE/TERRITORY	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Iowa	\$190,000	\$190,000	\$190,000
Kansas	-	-	-
Kentucky	\$166,920	\$166,920	\$166,920
Louisiana	\$166,072	\$166,072	\$166,072
Maine	\$157,334	\$157,334	\$157,334
Maryland	\$146,651	\$146,651	\$146,651
Massachusetts	\$156,470	\$156,470	\$156,470
Michigan	\$175,000	\$175,000	\$175,000
Minnesota	\$130,144	\$130,144	\$130,144
Mississippi	\$153,265	\$153,265	\$153,265
Missouri	\$140,255	\$140,255	\$140,255
Montana	\$154,998	\$154,998	\$154,998
Nebraska	\$142,682	\$142,682	\$142,682
Nevada	\$132,985	\$132,985	\$132,985
New Hampshire	\$164,000	\$164,000	\$164,000
New Jersey	\$172,000	\$172,000	\$172,000
New Mexico	\$134,144	\$134,144	\$134,144
New York	\$156,338	\$156,338	\$156,338
North Carolina	\$163,392	\$163,392	\$163,392
North Dakota	\$155,703	\$155,703	\$155,703
Ohio	\$130,782	\$130,782	\$130,782
Oklahoma	\$142,750	\$142,750	\$142,750
Oregon	\$162,365	\$162,365	\$162,365
Pennsylvania	-	-	-
Rhode Island	\$146,000	\$146,000	\$146,000
South Carolina	\$138,804	\$138,804	\$138,804
South Dakota	\$138,972	\$138,972	\$138,972
Tennessee	\$156,873	\$156,873	\$156,873
Texas	\$161,352	\$161,352	\$0
Utah	\$154,950	\$154,950	\$154,950
Vermont	\$150,000	\$150,000	\$150,000
Virginia	\$156,274	\$156,274	\$156,274
Washington	\$173,602	\$173,602	\$173,602
West Virginia	-	-	-
Wisconsin	\$170,791	\$170,791	\$170,791
Wyoming	\$141,924	\$141,924	\$141,924
State Sub-Total	\$7,101,731	\$7,101,731	\$6,645,890
America Samoa	\$144,414	\$144,414	\$144,414
Guam	\$141,000	\$141,000	\$141,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH			
	Early Hearing and Detection and Intervention		
STATE/TERRITORY	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Marshall Islands	\$89,333	\$89,333	\$89,333
Micronesia	\$83,056	\$83,056	\$83,056
Northern Marianas	\$122,350	\$122,350	\$122,350
Puerto Rico	-	-	-
Palau	\$91,229	\$91,229	\$91,229
Virgin Islands	-	-	-
Territory Sub-Total	\$671,382	\$671,382	\$671,382
Total	\$7,773,113	\$7,773,113	\$7,317,272

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH			
	State Disability Grants		
STATE/TERRITORY	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Alabama	\$300,000	\$300,000	\$300,000
Alaska	\$300,000	\$300,000	\$300,000
Arizona	-	-	-
Arkansas	\$299,943	\$299,943	\$299,943
California	-	-	-
Colorado	-	-	-
Connecticut	-	-	-
Delaware	\$299,992	\$299,992	\$299,992
District of Columbia	-	-	-
Florida	\$300,000	\$300,000	\$300,000
Georgia	-	-	-
Hawaii	-	-	-
Idaho	-	-	-
Illinois	\$300,000	\$300,000	\$300,000
Indiana	-	-	-
Iowa	\$300,000	\$300,000	\$300,000
Kansas	-	-	-
Kentucky	-	-	-
Louisiana	-	-	-
Maine	-	-	-
Maryland	-	-	-
Massachusetts	\$300,000	\$300,000	\$300,000
Michigan	\$300,000	\$300,000	\$300,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.184 BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES AND HEALTH			
	State Disability Grants		
STATE/TERRITORY	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate
Minnesota	-	-	-
Mississippi	-	-	-
Missouri	-	-	-
Montana	\$300,000	\$300,000	\$300,000
Nebraska	-	-	-
Nevada	-	-	-
New Hampshire	\$300,000	\$300,000	\$300,000
New Jersey	-	-	-
New Mexico	-	-	-
New York	\$300,000	\$300,000	\$300,000
North Carolina	\$300,000	\$300,000	\$300,000
North Dakota	\$300,000	\$300,000	\$300,000
Ohio	\$300,000	\$300,000	\$300,000
Oklahoma	-	-	-
Oregon	\$300,000	\$300,000	\$300,000
Pennsylvania	-	-	-
Rhode Island	\$300,000	\$300,000	\$300,000
South Carolina	\$299,930	\$299,930	\$299,930
South Dakota	-	-	-
Tennessee	-	-	-
Texas	-	-	-
Utah	-	-	-
Vermont	-	-	-
Virginia	-	-	-
Washington	-	-	-
West Virginia	-	-	-
Wisconsin	-	-	-
Wyoming	-	-	-
Total	\$5,399,865	\$5,399,865	\$5,399,865

ENVIRONMENTAL HEALTH

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$123.233	\$124.018	\$126.126	+\$2.893
ACA/PPHF	\$35.000	N/A	\$29.000	-\$6.000
Total	\$158.233	\$124.018	155.126	-\$3.107
FTEs	438	436	436	-2

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: PHS Act Title II §§ 301, 307, 310, 311, 317*, 317A*, 317B*, 317I*, 327, 352, 361, 366, 1102; Title XVII*; Toxic Substances Control Act § 405(c) (15 U.S.C. 2685)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$155,126,000 for Environmental Health, including \$29,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall decrease of \$3,107,000 below the FY 2012 level. The FY 2014 request includes an increase of \$2,468,000 for the Healthy Homes/Childhood Lead Poisoning activities and a decrease of \$6,000,000 for the Environmental Health Tracking Network.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Environmental Health Laboratory	\$50.406	\$50.726	\$50.607	+\$0.201
Environmental Health Activities	\$41.935	\$42.203	\$42.096	+\$0.161
Asthma	\$28.372	\$28.553	\$28.435	+\$0.063
Healthy Homes/Childhood Lead Poisoning	\$2.520	\$2.536	\$4.988	+\$2.468
Environmental Health Tracking Network (ACA/PPHF)	\$35.000	N/A	\$29.000	-\$6.000
Total	\$158.233	\$124.018	\$155.126	-\$3.107

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Environmental factors contribute to more than 25 percent of diseases worldwide, including cancer, asthma, and heart disease. CDC's environmental health efforts prevent illness, disabilities, and premature death caused by environmental exposures. Long-established expertise in laboratory science, medical toxicology, environmental epidemiology, and environmental public health practice enable CDC to address complex public health threats and respond to natural disasters and human-initiated events. CDC's environmental health programs serve all Americans, with special focus on the health of vulnerable populations, such as children and older Americans.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$185.415
2010	\$181.004
2011	\$134.855
2011 (ACA/PPHF)	\$35.000
2012	\$123.233
2012 (ACA/PPHF)	\$35.000
2013	\$124.018
2013 (ACA/PPHF) ²	N/A

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

ENVIRONMENTAL HEALTH LABORATORY BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$50.406	\$50.726	\$50.607	+\$0.201

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's Environmental Health Laboratory is recognized globally as the most advanced, state-of-the-art environmental public health laboratory. Its function is to improve the detection, diagnosis, treatment, and prevention of diseases resulting from exposure to toxic chemicals in the environment and of diseases that need advanced laboratory measurement for accurate diagnosis. The lab develops and applies innovative methods to respond to emergencies and to diagnose and assess risk for disease. The lab assures the quality of selected diagnostic tests for early disease detection, such as nationwide newborn screening for treatable diseases that cause malformation, mental retardation, and death. It also standardizes cholesterol tests and selected other diagnostic tests for chronic diseases so that results are sufficiently accurate for clinical use.

Budget Proposal: CDC's FY 2014 request of \$50,607,000 for the Environmental Health Laboratory is an increase of \$201,000 above the FY 2012 level. This amount will help achieve key performance targets, such as increasing the number of environmental chemicals assessed for exposure in the U.S. population by 5 percent.

The Environmental Health Laboratory uses biomonitoring—measurements in human blood and urine—to identify unsafe exposures or nutritional deficiencies in the U.S. population. CDC measures more than 350 chemicals and nutritional indicators and publishes findings in the most comprehensive, ongoing assessments of the nation's exposure to environmental chemicals and nutritional status. The agency is the sole or primary source for high-quality laboratory tests for numerous priority environmental chemicals, such as bisphenol A (BPA), speciated arsenic, uranium, speciated mercury, volatile organic compounds (VOCs), phthalates, triclosan, and select radionuclides (including polonium-210, cesium-134, cesium-137, and iodine-131), and many others. In FY 2014, CDC expects to publish new biomonitoring results, adding to new biomonitoring data for 66 chemicals and 58 nutritional indicators published last year.

CDC's high-quality exposure measurements help identify safe and unsafe levels of exposure to avoid unnecessary regulation, identify true hazards, and assess the effectiveness of interventions to reduce harmful exposures. For example, measurement of human urine showed daily consumption of canned soup compared to fresh soup increased exposure to BPA—a compound associated with adverse health outcomes—by more than tenfold. Within a few months of the results, a major canned soup manufacturer

eliminated BPA from its canned food packaging. CDC expects to collaborate on more than 50 studies in FY 2014 to assess environmental exposures in vulnerable population groups or investigate the relationship between environmental exposures and adverse health effects.

CDC's expertise also ensures greater accuracy of laboratory measurements for environmental chemicals, nutritional indicators, heart disease, stroke, and newborn screening. The agency operates the nation's only quality assurance program for dried blood spot tests for newborn screening. CDC provides quality assurance, conducts training, and transfers laboratory testing methods to state, local, research, and clinical laboratories. CDC's efforts reach more than 1,000 domestic and international laboratories, including newborn screening laboratories in all 50 states.

Grant Tables:

State-based Laboratory Biomonitoring Programs

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	3	3	3
Average Award	\$1.667	\$1.667	\$1.667
Range of Awards	\$1.000–\$2.652	\$1.000–\$2.652	\$1.000–\$2.652
Number of New Awards	0	0	3
Number of Continuing Awards	3	3	0
Total Grant Award	\$5.000	\$5.000	\$5.000

Biomonitoring grants help states assess environmental factors that can make people sick. Grantees are chosen competitively based on laboratory expertise, facilities, and local support for biomonitoring. 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. As a result of CDC funding, grantees can make timely and appropriate health decisions. CDC's five-year grants with California, New York, and Washington ended in FY 2013, but CDC will support three states through a new competitive award process in FY 2014.

Program to Expand State Newborn Screening for Severe Combined Immunodeficiency

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	2	3	3
Average Award	\$0.427	\$0.300	\$0.300
Range of Awards	\$0.416–\$0.437	\$0.200–\$0.600	\$0.200–\$0.600
Number of New Awards	0	3	0
Number of Continuing Awards	2	0	3
Total Grant Award	\$0.854	\$0.900	\$0.900

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's two-year grants with Michigan and Minnesota ended in FY 2012, but CDC plans to support up to three states beginning in FY 2013 depending on the strength of applicants and funding levels. Eligible state or territorial newborn screening programs are those that have not previously conducted state-wide SCID newborn screening and that demonstrate sufficient laboratory expertise, facilities, and legal authority to conduct screening.

ENVIRONMENTAL HEALTH ACTIVITIES BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Environmental Health Activities	\$41.935	\$42.203	\$42.096	+\$0.161
Environmental Health Tracking Network (ACA/PPHF)	\$35.000	N/A	\$29.000	-\$6.000
Total	\$76.935	\$42.203	\$71.096	-\$5.839

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: Each day, people everywhere are exposed to chemicals in their food, in the water they drink, and in the air they breathe. Some exposures are the result of accidents, disasters, or intentional attempts to cause harm. The side effects of chemical exposures can be costly. For example, CDC estimates that pesticide-related illnesses cost the United States at least \$800 million each year in healthcare costs, lost wages, and deaths. Non-chemical environmental exposures account for 90,000 hospitalizations for waterborne-related disease in the United States costing up to \$970 million.

Environmental Health Activities at CDC identify:

- the contaminants and toxins that make people sick
- how environmental systems transmit contaminants and toxins
- ways to eliminate the threat to people's health

Through this process, CDC helps communities ensure that food and water are free of environmental contaminants and that appropriate sanitation is available nationwide, saving lives and reducing medical costs. Environmental health experts at CDC, in coordination with CDC preparedness activities, respond to emergency events, providing scientific and programmatic advice, such as with the nuclear crisis in Japan, the cholera epidemic in Haiti, the Deep Water Horizon oil spill in the Gulf of Mexico, and Superstorm Sandy. Federal, state, and local entities are more adept at addressing environmental health hazards and responding to public health needs with CDC funding and expertise.

Budget Proposal: CDC's FY 2014 request of \$71,096,000 for Environmental Health Activities, including \$29,000,000 from the Affordable Care Act Prevention and Public Health Fund, is a decrease of \$5,839,000 below the FY 2012 level. With the \$6,000,000 decrease for the Environmental Health Tracking Network, CDC is discontinuing studies on the environmental causes of disease in order to focus on the application of study results in tools and methods that states can use to respond community environmental concerns.

CDC's Environmental Health Activities include an expansive range of programs and services that provide significant public health benefits to the American people:

Amyotrophic Lateral Sclerosis (ALS)—The National ALS Registry is an important resource for scientists to understand, cure, and prevent the disease. It was launched two years ago as a joint effort between CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). A web-based portal (<http://wwwn.cdc.gov/als/>) allows people with ALS to join the registry through self-registration, contains brief risk factor surveys, and features a Geographic Information System component for patients to locate nearby ALS clinics and support groups. Because the exact cause of ALS is largely unknown, ATSDR is publishing a funding opportunity announcement for research to increase risk factor knowledge of the disease. In addition, ATSDR is releasing the first national prevalence estimate of ALS.

Built Environment and Health Initiative—Personal health depends on many environmental factors, such as access to nutritious food, clean air and water, and safe and secure environments that facilitate regular

physical activity. When these are easily available in the communities where we live, work, and play, they can reduce leading public health challenges like asthma, transportation-related injuries and deaths, physical inactivity, obesity, heart disease, and stroke. CDC's Built Environment and Health Initiative supports the use of research, Health Impact Assessments, public health surveillance, program development, and evaluation to improve community environments and integrate health strategies into community planning, transportation, and land-use decisions. The program also supports the National Prevention Strategy and Healthy People 2020. Since 2005, with CDC funding and technical support, more than 20 states and communities have conducted over 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 2014, CDC is supporting the completion of over 20 Health Impact Assessments and at least five studies by 10 state and local health departments. CDC is also training over 500 people on health community design, availing scientific expertise, and continuing its work with the U.S. Department of Transportation and other partners to link community design and health metrics.

Climate and Health—Extreme weather events and changing climate conditions impact human health. People are susceptible to diseases that emerge in new areas, to stronger and longer heat waves, and to more frequent and severe droughts. CDC identifies the locations and people most at risk—a group including older Americans, those shut-in, chronically ill, and the underserved—and prepares communities for the health effects of climate change. In addition, CDC provides national health expertise during long-term weather events, such as droughts and heat waves. In FY 2014, public health officials will use CDC data and maps for extreme heat events to quickly identify risks and initiate actions that save lives and prevent illness.

Core Environmental Health Services—Environmental health staff comprises a quarter of the public health workforce in the United States. CDC prepares these professionals to better anticipate, identify, and respond to adverse environmental exposures that compromise human health. As result, we can avoid vector-borne disease outbreaks from failures in environmental services, ensure food and water is safe to consume, and foster effective sanitation. CDC accomplishes these aims by conducting surveillance, training environmental health staff, availing scientific expertise, and funding health departments.

As natural disasters and emergency events impact human health, experts at CDC are called upon by federal and state entities to assist in emergencies and conduct surveillance on disease, injury, and death. CDC's data analysis quickly identifies at-risk people. CDC's preparedness role save lives and prevents people from getting sick by assuring adequate planning and a rapid response. CDC's experts issue public health guidance and create surveillance methods, which will be updated based on the response to Superstorm Sandy, to help state and local health departments prepare for emergencies and respond appropriately. At the Environmental Health Training in Emergency Response (EHTER) center in Alabama, CDC teaches state and local officials how to restore clean drinking water, dispose of sewage properly, ensure food safety, and prevent the spread of diseases. CDC is expanding the intermediate level course at EHTER to include more public health concepts and exercises, and transitioning the awareness level course to an online platform to train more people.

CDC addresses environmental health threats from non-infectious agents through its epidemiological, toxicological, and clinical expertise. Non-infectious agents are chemicals or toxins that appear in greater concentration than is safe. These agents can be ingested accidentally or end up in locations or products where they do not belong. CDC must respond rapidly as acute toxic poisonings can result in severe or fatal illnesses. In recent years, CDC conducted 15 responses annually, but the number and diversity of requests is increasing because of reduced environmental health expertise at the state level. CDC expects to respond to 25 or more requests in FY 2014.

Safe Water—Drinking and recreational water qualities have a major influence on public health. Even in the United States, clean water is not always assured. Today, forty-five million Americans use water sources not protected by the Safe Drinking Water Act—such as wells, cisterns, and springs—putting them

at risk for exposure to environmental hazards. CDC provides scientific expertise, conducts trainings, investigates the root causes of waterborne illness outbreaks, characterizes the health burden, and funds public health actions to reduce exposure and disease from these water sources.

Radiation Studies—For over 20 years, CDC has served as the federal government’s radiation health expertise. Building on CDC’s response to the radiological incident in Fukushima, Japan and its analysis of radiological safety in the United States, CDC is releasing guidance on how to prevent and mitigate potential exposure to radiation. The agency is also creating an online training about personal protective equipment that is used in radiological incidents. CDC’s radiation expertise is not limited to emergency events. The agency is studying the health implications of radiation exposure from medical diagnostic imaging, which may increase cancer risk if at high enough levels. CDC is identifying the best practices that reduce radiation doses from medical diagnostic imaging exposures while balancing the need for medical imaging as part of quality medical care.

Grant Tables:

Built Environment and Health Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President’s Budget
Number of Awards	6	6	6
Average Award	\$0.154	\$0.154	\$0.154
Range of Awards	\$0.114–\$0.176	\$0.114–\$0.176	\$0.114–\$0.176
Number of New Awards	0	0	6
Number of Continuing Awards	6	6	0
Total Grant Award	\$0.924	\$0.924	\$0.924

CDC’s Built Environment and Health Initiative funded six state and local entities to conduct at least three Health Impact Assessments a year between 2011 and 2014. Grantees were selected competitively based on the robustness of their plan, the feasibility of their timeline, the ability to build on collaborations, access to data and resources, how they measure success, and the opportunity to continue activities once funding ends. Utilizing the capacities developed during the period of CDC-supported activity, many communities continue Health Impact Assessment activities even after direct CDC support ends, demonstrating the sustainability of CDC’s approach. In FY 2014, CDC expects to fund six entities to each conduct at least three Health Impact Assessments.

Climate and Health Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President’s Budget
Number of Awards	18	16	16
Average Award	\$0.211	\$0.249	\$0.249
Range of Awards	\$0.106–\$0.250	\$0.106–\$0.250	\$0.106–\$0.250
Number of New Awards	8	8	8
Number of Continuing Awards	10	8	8
Total Grant Award	\$3.804	\$3.998	\$3.998

Climate and health cooperative agreements prepare communities to analyze and respond to public health hazards related to changing weather patterns. CDC awards funding competitively to state and local health departments based on their capability to develop and apply advanced epidemiological and meteorological techniques that forecast climate and weather sensitive disease patterns, as well as their ability to utilize forecasts for timely and cost-effective responses.

Environmental Health Specialists Network (EHS-Net) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	10	10	10
Average Award	\$0.216	\$0.216	\$0.216
Range of Awards	\$0.117–\$0.350	\$0.117–\$0.350	\$0.117–\$0.350
Number of New Awards	0	0	10
Number of Continuing Awards	10	10	0
Total Grant Award	\$2.160	\$2.160	\$2.160

EHS-Net cooperative agreements support state and local health departments in investigating the root causes of food and waterborne disease outbreaks. EHS-Net is a unique capability, as other public health efforts focus on identifying infectious agents and exposure media, not the circumstances that led to initial contamination. CDC's competitive awards support three localities and five states, two of which receive multiple awards for different focus areas, to collect data through EHS-Net and implement protective actions.

Safe Water Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	18	18	18
Average Award	\$0.100	\$0.117	\$0.117
Range of Awards	\$0.047–\$0.140	\$0.100–\$0.150	\$0.100–\$0.150
Number of New Awards	0	10	0
Number of Continuing Awards	18	8	13
Total Grant Award	\$1.807	\$2.107	\$2.107

Safe Water cooperative agreements support state and local health departments in investigating water-related exposure risks for people who use drinking water systems that do not have to be tested regularly. CDC awards funding competitively based on the capacity to implement prevention activities and address risks for exposure to unsafe levels of contaminants.

ASTHMA BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$28.372	\$28.553	\$28.435	+\$0.063

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: In the United States, nearly 26 million people, including seven million children, have asthma. 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 a 2012 analysis, CDC measured almost a 20 percent 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.

CDC's National Asthma Control Program works with state health departments to implement community-based interventions, build community-based coalitions, and track the disease burden. For more than 10 years, CDC has helped people control their asthma, stay out of the hospital, and miss less school and

work. For example, the asthma control program in Mississippi trained more than 200 day care and child care professionals to make sure they know how to help control the asthma of children in their care. In Rhode Island, after leaving the emergency room, families are learning how to avoid asthma triggers, manage medications, and connecting with community resources. Alabama's asthma control program gives free online training in asthma management to healthcare providers across seven states.

Budget Proposal: CDC's FY 2014 request of \$28,435,000 for the National Asthma Control Program is an increase of \$63,000 above the FY 2012 level. CDC's asthma control program ensures that healthcare providers give the right type of care, and that people learn how to manage their asthma. By monitoring and analyzing asthma data in the United States, CDC is able to estimate the prevalence of asthma among population groups, track progress in helping people control asthma, and uncover the most effective programs that improve health and reduce medical costs. CDC also provides funding to state health departments to support asthma surveillance through the Behavioral Risk Factor Surveillance System. CDC prioritizes surveillance, patient and provider education, environmental management, research translation and guidance, and community outreach training.

In FY 2014, CDC will fund up to 36 health departments through a new, competitive cooperative agreement. Many states use CDC funding to promote asthma-friendly schools. Interventions include school-based asthma management, self-management education for students, educational training for school personnel, and indoor air quality improvement and trigger reduction. CDC is measuring the effectiveness of such programs, and collaborating with non-governmental organizations and other federal agencies, to guide how school-related activities are incorporated into the FY 2014 cooperative agreement.

Grant Tables:

Asthma Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	40	40	40
Average Award	\$0.359	\$0.359	\$0.359
Range of Awards	\$0.011–\$0.528	\$0.011–\$0.528	\$0.011–\$0.528
Number of New Awards	0	0	40
Number of Continuing Awards	40	40	0
Total Grant Award	\$14.370	\$14.370	\$14.370

Asthma cooperative agreements fund state health departments and national non-governmental organizations to conduct asthma surveillance and implement asthma management programs. In FY 2012, CDC supported the health departments in 34 states, Washington, D.C., and Puerto Rico, as well as national non-governmental organizations. Grants were awarded through a competitive process based on disease burden and programmatic capabilities. Some states receive multiple awards that reflect different focus areas, such as surveillance, partnerships, interventions, and evaluation.

HEALTHY HOMES/CHILDHOOD LEAD POISONING PREVENTION BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$2.520	\$2.536	\$4.988	+\$2.468

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: Reduction of lead exposure in children is one of the greatest environmental health accomplishments in the past 20 years. The data that states provide to CDC help target resources to the most vulnerable populations living in homes with lead-based paint hazards. From 2007–2010, prevention

efforts reduced the number of children exposed to lead (blood lead levels $\geq 10\mu\text{g/dL}$) by almost three million, saving \$26–57 billion in lifetime productivity earnings. Despite success over the past few decades, at least 4.2 million houses continue to expose children to lead at levels that can harm their intellectual development. African American children are three times more likely than white children to have elevated blood lead levels. There is no known safe level of exposure to lead. Any exposure to lead can reduce brain development and children's IQs.

Budget Proposal: CDC's FY 2014 request \$4,988,000 for the Healthy Homes and Lead Poisoning Prevention program is an increase of \$2,468,000 above the FY 2012 level. Consistent with the FY 2012 Appropriations level, CDC is not able to fund extramural activities at the requested level. CDC remains a resource to federal, state, and local agencies on primary prevention and clinical interventions to prevent lead poisoning and other housing related diseases. With increased funding in FY 2014, CDC will provide scientific and software expertise to state and local health departments using the Healthy Homes and Lead Poisoning Surveillance System (HHPSS). This system facilitates data collection on lead poisoning and other health hazards in homes, initiating actions by federal, state, and local agencies to protect children from lead exposure. HHPSS ensures that limited resources are targeted to the highest-risk children. CDC will also use increased funding to train public health workers on reliable, low-cost methods for reducing lead and other risks through its National Healthy Homes Training Center and Network.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
ACA/PPHF	\$35.000	N/A	\$29.000	-\$6.000

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Environmental Health Tracking Network

Program Overview: Public health officials and policymakers need timely, integrated environmental and health data to decide where to intervene and how to focus resources. CDC is working to close this gap by improving surveillance through the Environmental Health Tracking Network. The Tracking Network helps scientists assess the connection between environmental exposures and health by integrating national, state, and local data via CDC's central website (www.cdc.gov/ephtracking). Programs then use information to plan, apply, and evaluate actions to prevent and control environmentally related diseases. In many states, the Tracking Network is more than just a surveillance system—it is the foundation of environmental health activities to protect communities.

In the past seven years, state and local health officials used the Tracking Network more than 160 times to prevent sickness and the loss of life. These public health actions required use of the Tracking Network to determine disease impacts and trends, recognize unusual disease patterns, and identify the most affected people and places. Before tracking, even simple questions about health and the environment could take months to answer. With the Tracking Network in place, public health officials can respond quickly, often within hours, to locate hazard sources or answer the concerns of citizens. In Louisiana, for example, the Tracking Network is ensuring women in New Orleans receive regular prenatal care after mapping low birth weights to see high risk areas.

Budget Proposal: CDC's FY 2014 request of \$29,000,000 for the National Environmental Public Health Tracking Network is a decrease of \$6,000,000 below the FY 2012 level. At the requested level, CDC will reduce the amount of funding to states and eliminate technical assistance to other health agencies. The number of public health actions undertaken using Tracking Network data will increase from 15 to 16 with CDC's focus on capacity building for existing grants, but CDC expects health departments to use Tracking Network data for approximately eight fewer public health actions than in FY 2012. CDC is

discontinuing studies on the environmental causes of disease in order to focus on the application of study results in tools and methods that states can use to respond community environmental concerns.

Success of the Tracking Network requires partnerships between health departments, non-governmental organizations, federal agencies, and technology companies. CDC ensures the Tracking Network functions properly among all involved and that best practices are identified and shared. CDC grants help states and cities set up tracking programs. In past years, CDC provided scientific guidance in how to develop tracking programs and initiate tracking-related activities for state and territory health agencies that do not receive direct funding. Twenty-three health departments benefited from such guidance to date, but funding will not be available in FY 2014 to continue the effort.

In collaboration with EPA and NASA, CDC is maintaining the capabilities of the Tracking Network to use environmental and atmospheric data to improve air quality estimates and to integrate geographic information.

Grant Table:

Environmental Health Tracking Network Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	26	N/A	24
Average Award	\$0.839	N/A	\$0.737
Range of Awards	\$0.100–\$1.100	N/A	\$0.400–\$0.902
Number of New Awards	0	N/A	24
Number of Continuing Awards	26	N/A	0
Total Grant Award	\$21.821	N/A	\$17.688

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Environmental Health Tracking Network grants support the information technology to bring health and environmental data together, as well as the people who use 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 funding to state and local health departments through a competitive process based on accomplishments in using tracking data to improve public health, and progress in identifying and sharing new data. In addition to funding 23 states and New York City, CDC also supports two professional associations representing stewards of large health data systems. In FY 2014, CDC will eliminate funding for non-governmental organizations and reduce the average award to states and cities.

PERFORMANCE

Program: Environmental Health Laboratory

Performance Measures for Program: Environmental Health Laboratory

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 PB Target
6.1.1: Number of environmental chemicals, including nutritional indicators that are assessed for exposure of the U.S. population (Output)	FY 2012: 334 (Target Exceeded)	323	340	+17

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 PB Target
6.1.3: Number of laboratories participating in CDC's Division of Lab Sciences Quality Assurance and Standardization Programs to improve the quality of their laboratory measurements (Output)	FY 2012: 1356 (Target Exceeded)	974	990	+16
6.A: Number of environmental chemicals for which methods were developed or improved (Output)	FY 2012: 12 (Target Exceeded)	9	11	+2
6.B: Number of laboratory studies conducted to measure levels of environmental chemicals in exposed populations (Output)	FY 2012: 108 (Target Exceeded)	52	55	+3
6.F: Number of states assisted with screening newborns for preventable diseases (Output)	FY 2012: 50 (Target Met)	50	50	Maintain

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 2012, CDC exceeded its target of 323 chemicals measured, reflecting an upward trend in the number of chemicals measured since 2005 (Measure 6.1.1). CDC published new biomonitoring results for 66 chemicals, including 34 newly reported chemicals, in the *Updated Tables to the Fourth National Report on Human Exposure to Environmental Chemicals*, February 2012. In addition, CDC released new information on 58 nutritional biomarkers in the Second National Report on Biochemical Indicators of Diet and Nutrition in the U.S. Population.

Additionally in FY 2012, CDC exceeded its target to develop nine new or improved methods to measure environmental chemicals in people (Measure 6.A). For example, CDC developed a unique method to detect a new biomarker enabling studies of environmental exposure to formaldehyde, a chemical known to cause cancer and which has other harmful health effects. CDC also exceeded its target of completing 52 laboratory studies to identify populations with unsafe exposures to chemicals (Measure 6.B). The number of studies conducted each year varies depending on opportunities with collaborators and the alignment of study proposals with the Environmental Health Laboratory's mission and budgetary goals. The number of studies conducted in FY 2012 was unusually high, but CDC will continue to monitor the program and adjust targets should this performance level become a trend.

CDC's Environmental Health Laboratory provides quality assurance and standardization programs for testing of chronic diseases, newborn screening disorders, nutritional status, and environmental exposures. CDC met or exceeded its target for the number of laboratories voluntarily participating in these programs since 2007 (Measure 6.1.3). In FY 2012, CDC provided services to an unusually high number of laboratories that voluntarily participated in its quality assurance and standardization programs. Targets are set based on historical trends in participation; CDC will continue to monitor the program and adjust targets should this performance level become a trend. CDC provides newborn screening quality assurance to all states and met its FY 2012 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).

Program: Environmental Health Activities

Performance Measures for Program: Environmental Health Activities

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
6.1.2: Number of completed studies to determine the harmful health effects from environmental hazards (Output)	FY 2012: 29 (Target Exceeded)	24	27	-3
6.C: Number of public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures ¹ (Output)	FY 2012: 24 (Target Exceeded)	15	16	+1
6.H: Number of emergency radiation preparedness toolkits provided to clinicians/ public health workers (Output)	FY 2012: 2,014 (Target Exceeded)	750	1,000	300

¹ Targets reflect ACA/PPHF funding.

Performance Trends: Since 2005, 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. Since FY 2005, state and local public health officials used the Environmental Health Tracking Network to implement more than 160 data-driven public health actions (an average of approximately 20 per year) to prevent adverse health effects from environmental exposures, including 24 public health actions in FY 2012 (Measure 6.C). Reductions in grant and technical assistance funding in FY 2014 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 should this performance level become a trend. These actions include monitoring and providing information to residents and workers related to the Deepwater Horizon incident, helping residents reduce their exposure to uranium from drinking water, and providing information to the public on bed bug infestations and prevention strategies. The Center for Plain Language recently recognized the program with its 2012 ClearMark Award for the best plain language website in the public sector.

Providing expertise in radiation health and exposure, CDC exceeded its target in FY 2012 for Measure 6.H by distributing 2,014 radiation toolkits. Due to the ongoing effects of Fukushima's radiation disaster in March 2011, CDC experienced an increase in requests for the clinician and public health Radiation Emergency Toolkits in FY 2012 from western states such as California, Washington, and Hawaii. In addition, international requests for the toolkits spiked in the year following the disaster. CDC expects to distribute fewer toolkits at exhibits and conferences in FY 2012 and beyond due to decreases in travel and other efforts to prioritize resources. Between FY 2005 and FY 2012, CDC distributed 13,870 radiation emergency preparedness toolkits for public health professionals and 13,064 tool kits for emergency services clinicians to improve their ability to identify and respond to radiological emergency incidents.

Program: Asthma

Performance Measure for Program: Asthma

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
6.2.4: Increase the proportion of those with current asthma who report they have received self-management training for asthma in populations served by CDC funded state asthma control programs (Outcome)	FY 2010: 43% (Target Not Met)	50%	50%	Maintain

Performance Trends: Measure 6.2.4 reports the proportion of individuals with current asthma who report receiving asthma self-management training from a doctor or other healthcare provider. 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 healthcare costs and lost productivity. The United States saved four billion dollars in medical costs in 2008 because 245,000 fewer people were hospitalized due to asthma as a result of increased self-management education.

CDC did not meet the 2010 target for delivering self-management training through its funded grantees (Measure 6.2.4), but results are within the margin of error. The 2010 results are consistent with the 2008 and 2009 results, indicating a trend of steady program performance over the past three years. Funded states are implementing comprehensive, evidence-based programs that target healthcare 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*.

Program: Healthy Homes/Childhood Lead Poisoning Prevention

Performance Measures for Program: Healthy Homes/Childhood Lead Poisoning Prevention

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
6.2.5a: Reduce health disparities associated with blood lead levels in children aged 1-5 in the U.S. such that: a. The gap in blood lead levels between black children and children of other races is reduced ¹ (Outcome)	FY 2010: 0.52 µg/dL (Baseline)	N/A	N/A	N/A
6.2.5b: The gap in blood lead levels between children living above the federal poverty level and those living below the poverty level is reduced ¹ (Outcome)	FY 2010: 0.54 µg/dL (Baseline)	N/A	N/A	N/A

¹This measure is for informational purposes only. See narrative for additional information

Performance Trends: These measures (6.2.5a and 6.2.5b) serve as valuable indicators of the success of lead interventions nationwide. These measures focus on health disparity gaps that exist between children on the basis of both race and household income. The present health disparity gaps are stark. 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), which is a significant disparity that needs continued attention. While overall U.S. child lead levels have fallen significantly in the last decade, reducing disparities is critical to furthering the decrease in the mean blood lead levels among all young children in the U.S.

As CDC is not currently funding interventions directly or through cooperative agreements, CDC cannot directly impact the achievement of the current measures. Therefore, CDC has not set FY 2014 targets. Beginning in FY 2013, these measures will be retained only as contextual indicators of the overall success of lead poisoning interventions nationwide. CDC will add a new performance measure for FY 2015 and beyond that is commensurate with current program resources and capabilities but still effectively evaluates CDC performance.

STATE TABLES

CENTERS FOR DISEASE CONTROL AND PREVENTION ENVIRONMENTAL HEALTH STATE FUNDING ^{1,2}			
STATE/TERRITORY	FY 2010	FY 2011	FY 2012
Alabama	\$350,000	\$164,043	\$215,945
Alaska	-	-	-
Arizona	\$228,091	\$537,316	\$143,949
Arkansas	-	-	\$90,000
California	\$7,413,015	\$6,721,893	\$5,458,088
Colorado	\$686,802	\$866,783	\$726,802
Connecticut	\$1,989,604	\$1,753,132	\$1,189,500
Delaware	\$287,805	-	-
District of Columbia	\$2,812,100	\$2,298,437	\$354,877
Florida	\$2,682,788	\$2,383,742	\$1,699,937
Georgia	\$1,899,292	\$1,957,271	\$475,770
Hawaii	\$625,000	\$700,887	\$585,514
Idaho	-	\$101,878	-
Illinois	\$2,571,186	\$1,178,012	\$698,295
Indiana	\$1,375,178	\$965,182	\$366,616
Iowa	\$1,864,687	\$1,221,780	\$755,465
Kansas	\$1,223,635	\$1,171,580	\$597,010
Kentucky	\$1,112,074	\$920,077	\$425,000
Louisiana	\$2,589,322	\$1,948,437	\$1,118,510
Maine	\$2,147,754	\$2,033,314	\$1,639,751
Maryland	\$4,051,027	\$3,710,641	\$3,184,276
Massachusetts	\$3,147,764	\$2,689,015	\$2,030,165
Michigan	\$2,758,737	\$1,695,947	\$1,216,609
Minnesota	\$3,515,262	\$3,042,963	\$2,384,717
Mississippi	\$921,315	\$918,241	\$522,241
Missouri	\$2,073,578	\$2,221,300	\$1,648,771
Montana	\$350,000	\$796,924	\$379,612
Nebraska	-	\$139,750	\$165,710
Nevada	\$576,666	\$591,697	\$10,000
New Hampshire	\$1,500,344	\$1,555,945	\$1,302,209

CENTERS FOR DISEASE CONTROL AND PREVENTION ENVIRONMENTAL HEALTH STATE FUNDING^{1,2}			
STATE/TERRITORY	FY 2010	FY 2011	FY 2012
New Jersey	\$2,090,851	\$1,761,740	\$1,165,371
New Mexico	\$1,382,202	\$2,325,836	\$1,639,420
New York	\$8,368,001	\$6,160,778	\$4,993,300
North Carolina	\$1,317,176	\$1,512,355	\$748,076
North Dakota	-	\$99,757	\$2,851
Ohio	\$1,861,007	\$1,174,929	\$568,674
Oklahoma	\$574,878	\$838,050	\$306,272
Oregon	\$2,061,124	\$3,028,125	\$2,222,574
Pennsylvania	\$3,108,278	\$1,910,437	\$1,240,804
Rhode Island	\$1,731,478	\$1,419,372	\$973,879
South Carolina	\$1,012,000	\$1,123,483	\$872,097
South Dakota	-	-	-
Tennessee	\$575,000	\$500,000	\$350,001
Texas	\$1,675,086	\$1,341,118	\$492,057
Utah	\$1,493,197	\$1,620,995	\$1,521,187
Vermont	\$1,290,098	\$1,669,146	\$1,241,206
Virginia	\$1,782,070	\$980,444	\$128,415
Washington	\$3,498,348	\$4,331,024	\$3,090,031
West Virginia	\$510,916	\$396,000	\$397,000
Wisconsin	\$3,717,098	\$2,699,909	\$1,918,705
Wyoming	-	-	-
Subtotal States	\$88,801,834	\$79,179,685	\$53,257,259
American Samoa	-	-	-
Guam	-	-	-
Marshall Islands	-	-	-
Micronesia	-	-	-
Northern Marianas	-	-	-
Puerto Rico	\$374,984	\$487,739	\$441,920
Palau	-	-	-
Virgin Islands	-	-	\$1,000
Subtotal Territories	\$374,984	\$487,739	\$442,920
Total States and Territories	\$89,176,818	\$79,667,424	\$53,700,179

¹ State funding in this table represents all grants under the Environmental Health account.

² State grant totals include funding to cities and non-governmental organizations located within that state.

INJURY PREVENTION AND CONTROL

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$146.304	\$147.238	\$176.585	+\$30.281
PHS Evaluation Transfer	\$0.000	\$0.000	\$5.000	+\$5.000
Total	\$146.304	\$147.238	\$181.585	+\$35.281
FTEs	221	220	220	-1

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Enabling Legislation Citation: 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)*

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$181,585,000 for injury prevention and control, including \$5,000,000 in Public Health Service (PHS) Evaluation Transfer funds, is an increase of \$35,281,000 above the FY 2012 level. This increase supports an evaluation of the Rape Prevention and Education program and the President's plan to reduce gun violence in America.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Intentional Injury	\$98.776	\$99.407	\$114.001	+\$15.225
Rape Prevention (non-add)	\$41.709	\$41.974	\$46.729	+\$5.020
Gun Violence Prevention Research (non-add)	\$0.000	\$0.000	\$10.000	+\$10.000
NVDRS	\$3.570	\$3.592	\$23.570	+\$20.000
Unintentional Injury	\$33.740	\$33.956	\$33.794	+\$0.054
Injury Control Research Centers	\$10.218	\$10.283	\$10.220	+\$0.002
Total	\$146.304	\$147.238	\$181.585	+\$35.281

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

One person in the United States dies every three minutes from an injury or violent act. In fact, under the age of 45, Americans are more likely to die from violence and injuries than from any other cause. As part of addressing our goal to prevent the leading causes of disease, disability, and death, CDC is the lead federal agency that focuses on preventing unintentional and intentional injuries that occur outside of the workplace. Activities address a wide range of topics including intimate partner violence, sexual violence, teen dating violence, youth violence, suicidal behavior, child maltreatment, motor vehicle crashes, falls, prescription drug overdoses, traumatic brain injuries, and sports-related injuries. To prevent these injuries and mitigate their consequences, CDC collects and disseminates key public health data, identifies risk factors and injury prevention strategies, and translates scientific findings into effective community programs. CDC's work in injury and violence prevention consists of three primary components: intentional injury, unintentional injury, and Injury Control Research Centers.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$145.242
2010	\$148.790
2011	\$143.714
2012	\$146.304
2013	\$147.238

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect proposed BSS realignment.

INTENTIONAL INJURY PREVENTION BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Rape Prevention – total (non-add)	\$41.709	\$41.974	\$46.729	+\$5.020
Rape Prevention – PHS Evaluation (non-add)	\$0.000	\$0.000	\$5.000	+\$5.000
Gun Violence Prevention Research (non-add)	\$0.000	\$0.000	\$10.000	+\$10.000
Budget Authority	\$98.776	\$99.407	\$109.001	+\$10.225
PHS Evaluation Transfer	\$0.000	\$0.000	\$5.000	+\$5.000
Total	\$98.776	\$99.407	\$114.001	+\$15.225

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment.

Program 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. CDC provides scientific and programmatic expertise and funding for the research, implementation and evaluation of violence prevention strategies to prevent violence-related injuries and deaths, which cost our nation approximately \$69 billion a year. CDC resources directly and indirectly support violence prevention activities in over 900 state and local public health agencies, universities, and non-governmental organizations.

The foundation of all of CDC's violence prevention work is a strong base of data collection and research. One CDC surveillance (reporting) system that tracks violence is the National Intimate Partner and Sexual Violence Survey (NISVS). NISVS is the only national population-based survey that captures information about intimate partner and sexual violence at the state level, allowing CDC and other researchers to track these trends over time and evaluate prevention program effectiveness. Released in late 2011, the *2010 NISVS Summary Report* captured the first national public health data on intimate partner and sexual violence in nearly 15 years. In January 2013, CDC released a special data report from NISVS, *The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation*.

To address intimate partner violence and sexual assault, CDC promotes healthy relationships and supports rape prevention in coordination with state and local partners. The Rape Prevention and Education program (RPE) funds 57 health departments in states, territories and Washington, D.C. to work with rape crisis centers, state sexual assault coalitions, and others. For example, Florida's RPE program is working with the University of South Florida to provide training for bar owners and servers to recognize and intervene at the earliest signs of risk of alcohol-involved sexual assault, rape, and violence. CDC's *Dating Matters™: Strategies to Promote Healthy Teen Relationships* is in its second year of an innovative, five-year demonstration program that supports four local health departments in building healthy relationships among 11- to 14- year-olds in high-risk urban communities. Finally, CDC's Domestic Violence Prevention Enhancements and Leadership through Alliances (DELTA) program supports state domestic

violence coalitions. For example, North Carolina's DELTA program is developing a web-based tool to demonstrate how activities intended to prevent intimate partner violence may also prevent other types of violence, such as child maltreatment. This project leverages limited resources and has the potential to enhance partnerships committed to the prevention of all types of violence.

In 2012, CDC enhanced its capability to collect child maltreatment mortality data in selected states by linking a CDC system with state Child Fatality Review records in order to more accurately determine the national incidence and prevalence of child maltreatment. Also in 2012, CDC developed a child maltreatment prevention guidance document called *Essentials for Childhood: Steps to Create Safe, Stable, and Nurturing Relationships*. The guide contains actions that parents, communities, and states can take to ensure child well-being and to prevent child maltreatment.

CDC also supports the development, implementation, and evaluation of youth violence prevention activities across the nation. CDC's Striving to Reduce Youth Violence Everywhere (STRYVE) works with funded cities to stop youth violence before it starts, by reducing factors such as substance use and poor social skills that place youth at risk for violence, as well as by strengthening the factors that protect them from violence, such as being connected to a caring adult. Additionally, CDC currently funds six Academic Centers for Excellence in Youth Violence Prevention to help develop, apply, and rigorously evaluate promising prevention strategies in communities. For example, the Clark-Hill Institute at Virginia Commonwealth University helped educate its community about the increased prevalence of youth violence around convenience stores selling inexpensive, single-serve alcoholic beverages. Residents presented this information to the local Alcoholic Beverage Control authority, which then restricted licenses to convenience stores in order to prohibit sales of single-serve alcoholic beverages. The community subsequently experienced a decrease in youth violence rates in those areas. A peer-reviewed article on this success is currently pending publication, and when released it will help shape other communities' youth violence prevention strategies.

In addition to all of the above, the Core Violence and Injury Prevention Program provides support to states to prevent all forms of violence. This program is discussed in the following Unintentional Injury Prevention Budget Request.

Budget Proposal: CDC's FY 2014 request of \$114,001,000 for intentional injury prevention, including \$5,000,000 in Public Health Service Evaluation transfers, is an increase of \$15,225,000 above the FY 2012 level. There are approximately 30,000 firearm-related homicides and suicides a year, a clear public health crisis. CDC will invest \$10 million to conduct research on the causes and prevention of gun violence, including the relationship between video games, media images, and violence. Violence is preventable and CDC's efforts in FY 2014 will continue to help prevent violent acts before they occur, saving lives and money. In addition to program funding, CDC will continue to build the evidence-base of violence prevention. CDC will invest an additional \$5 million in the Rape Prevention and Education program to evaluate interventions and strategies designed to prevent sexual violence.

Gun Violence Prevention Research

In addition to the approximately 30,000 firearm-related homicides and suicides a year, more than 58,000 non-fatal firearm injuries from assault or self-harm are treated in hospital emergency departments annually. Together, each year they account for more than \$35.3 billion in medical and lost productivity costs to the United States. The President's plan, *Now is the Time*, calls for public health research on gun violence to give all Americans the information they need. To address the numerous gaps in the evidence base for firearm injury prevention, CDC will use \$10 million to begin conducting research into the causes and prevention of gun violence. These activities will be informed by a research agenda being developed in 2013 and will ensure that accurate and timely data are available to describe the characteristics of firearm violence, monitor firearm trends, and determine those gun violence prevention strategies likely to have the greatest public health impact. Gun violence prevention research will include study of the risk and protective factors associated with firearm injuries, the effectiveness of strategies to prevent gun violence,

and the roles of violent video games and violent media content on behavior. CDC will make funds available to support research into the causes and prevention of gun violence through a competitive, peer-review process, funding approximately ten to fifteen grants and cooperative agreements for three to five years.

Rape Prevention and Education (RPE) and Evaluation of Sexual Violence Prevention Activities

With a \$5 million increase for RPE in FY 2014, CDC will fund evaluation activities with the goal of generating findings to improve sexual violence prevention nationwide. CDC plans to competitively award approximately five to seven academic or research institutions in FY 2014 for a four to five year period. Funded institutions will partner with existing RPE grantees and conduct systematic data collection and evaluation efforts to evaluate strategies to prevent sexual violence. These evaluations will build the evidence base in sexual violence prevention and lead to scaling up evidence-based efforts throughout the RPE program.

CDC will continue to fund every state and several territories for sexual violence prevention through RPE in FY 2014. Among other RPE activities, state health departments 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 unacceptable.

Domestic Violence Prevention Enhancements and Leadership through Alliances (DELTA)

In collaboration with the intimate partner violence prevention activities conducted by state health departments, CDC will support the Domestic Violence Prevention Enhancements and Leadership through Alliances (DELTA) program. Through DELTA, ten funded state domestic violence coalitions will conduct prevention activities such as working with schools to prevent teen dating violence, partnering with the faith community to support healthy relationship development, and working with men and boys to prevent first time violent acts against intimate partners. DELTA grantees receive training and technical assistance to develop and implement the multi-level change strategies that prevent intimate partner violence while acknowledging the unique needs of their communities.

Dating Matters™

Middle school youth in low-income, high-crime, urban environments are at increased risk for dating violence. However, there is little evidence about how to prevent dating violence with this population. CDC's ongoing *Dating Matters™* program will address gaps in research and practice, and develop strategies tailored to youth in these high-risk communities. In FY 2014, staff will continue to implement and evaluate the program in over 40 middle schools and neighborhoods across four cities while also monitoring the ongoing efficacy of *Dating Matters™* among middle school participants who have moved on to high school. CDC estimates that up to 100,000 students and adults will participate in *Dating Matters™*.

Essentials for Childhood: Actions to Create Safe, Stable, Nurturing Relationships

A recent CDC study found that the total lifetime estimated financial costs associated with one year of confirmed cases of child maltreatment—physical abuse, sexual abuse, psychological abuse, and neglect—to be \$124 billion. In FY 2014, CDC's new *Essentials for Childhood: Actions to Create Safe, Stable, Nurturing Relationships* initiative will support three to four state health departments to pilot and evaluate a comprehensive child maltreatment prevention package. With state health department leadership, communities will promote safe, stable, and nurturing relationships; implement and refine prevention activities; and spread best practices across their states to help children grow up to be healthy and productive citizens.

Striving to Reduce Youth Violence Everywhere (STRYVE)

CDC will fund four local health departments through the STRYVE program. STRYVE brings together organizations from multiple sectors—including public health, education, criminal justice, and business—to prevent youth violence in high-risk communities.

Academic Centers of Excellence in Youth Violence Prevention

In FY 2014, CDC will continue to work with the Academic Centers for Excellence in Youth Violence Prevention to build communities' capacity to put science into action to prevent youth violence. University-community partnerships provide a unique and important opportunity to support communities' efforts to prevent violence and create safer, healthier communities.

Grant Tables:

Rape Prevention and Education Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR¹	FY 2014 President's Budget^{1,2}
Number of Awards	57	57	57
Average Award	\$0.602	\$0.602	\$0.602
Range of Awards	\$0.008–\$4.067	\$0.008–\$4.067	\$0.008–\$4.067
Number of New Awards	0	57	57
Number of Continuing Awards	57	0	0
Total Grant Award Amount	\$34.315	\$34.315	\$34.315

¹Average award amounts and range of award estimated on current funding formula and are subject to change based on available funding, a new one-year funding opportunity announcement in FY 2013, and a new five-year funding opportunity announcement to be released in FY 2014.

²Not inclusive of separate FY 2014 awards for evaluation of Rape Prevention and Education activities.

CDC funds all states, Washington, D.C., and a number of territories through a population-based formula five-year cooperative agreement to conduct a range of activities related to rape prevention and education. Grantee activities include educational seminars, professional training, leveraging resources through partnerships, and changing social norms. Grantees operate state and community hotlines, develop statewide sexual violence prevention plans, and build state and local capacity for program planning and implementation. A new five-year funding cycle will begin in FY 2014.

Domestic Violence Prevention Enhancement and Leadership Through Alliances Focusing on Outcomes for Communities United with States (DELTA FOCUS) Grant Table¹

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR	FY 2014 President's Budget
Number of Awards	14	10	10
Average Award	\$0.295	\$0.391	\$0.391
Range of Awards	\$0.212–\$0.394	\$0.344–\$0.410	\$0.344–\$0.410
Number of New Awards	0	10	0
Number of Continuing Awards	14	0	10
Total Grant Award Amount	\$4.126	\$3.907	\$3.907

¹FY 2012 amounts reflect the last year of funding for the DELTA III program.

Through a five-year competitive cooperative agreement awarded in FY 2013, CDC is funding 10 state domestic violence coalitions to reduce the incidence of intimate partner violence in communities. Grantees receiving DELTA funds are preventing intimate partner violence before it starts. DELTA FOCUS builds on earlier versions of DELTA cooperative agreements, with a greater focus on evaluation, building the evidence base, training and mentoring, and emphasizing the role of local coalitions in preventing violence. DELTA FOCUS will enhance the spread of prevention strategies by ensuring that grantees are engaged with the larger national violence prevention field and are sharing their work and

products through a national resource center. Success, challenges, and lessons learned from these programs will inform how to develop and improve intimate partner violence primary prevention infrastructure.

Academic Centers for Excellence in Youth Violence Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	6	6	6
Average Award	\$1.073	\$1.040	\$1.040
Range of Awards	\$1.073	\$1.040	\$1.040
Number of New Awards	0	0	0
Number of Continuing Awards	6	6	6
Total Grant Award Amount	\$6.436	\$6.238	\$6.238

CDC funds Academic Centers for Excellence in Youth Violence Prevention (ACEs) through competitive five-year cooperative agreements in two funding cycles: FY 2010-FY 2014 and FY 2011-FY 2015. The current ACEs are six universities: Johns Hopkins University, the University of Chicago, the University of Colorado, the University of Michigan, the University of North Carolina, and Virginia Commonwealth University. These universities serve as local, regional, and national resources for developing and applying effective prevention strategies in communities. The ACEs connect academic and community resources to implement and evaluate comprehensive approaches to prevent youth violence. Each ACE implements and formally evaluates interventions in its local community. ACE-developed and evaluated strategies strengthen youths' ability to resist violence and promote thriving, safer, and more connected communities.

Dating Matters™ Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	4
Average Award	\$0.350	\$0.350	\$0.350
Range of Awards	\$0.350	\$0.350	\$0.350
Number of New Awards	0	0	0
Number of Continuing Awards	4	4	4
Total Grant Award Amount	\$1.400	\$1.400	\$1.400

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™*, a comprehensive public health approach to the primary prevention of teen dating violence. Communities focus prevention activities on 11- to 14-year-old youth in high-risk urban communities. Activities include school curricula for dating violence prevention, parent-directed programs targeting home risk factors for teen dating violence such as low parental monitoring, and a communications campaign to reinforce messages about healthy relationships. Funded communities will also work with CDC to conduct cross-site evaluations to improve the program. CDC estimates that up to 100,000 students and adults will participate in *Dating Matters™*.

Striving to Reduce Youth Violence Everywhere (STRYVE) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	4
Average Award	\$0.225	\$0.225	\$0.225
Range of Awards	\$0.225	\$0.225	\$0.225
Number of New Awards	0	0	0
Number of Continuing Awards	4	4	4

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Total Grant Award Amount	\$0.900	\$0.900	\$0.900

Through a competitive five-year (FY 2011–FY 2015) cooperative agreement, CDC funds four local health departments (the Boston, Massachusetts Public Health Commission; Monterey County in Salinas, California; Multnomah County Health Department in Portland, Oregon; and the 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 improvement in organizational and community capacity, developing evaluation plans, and determining the resources necessary for sustaining programs.

NATIONAL VIOLENT DEATH REPORTING SYSTEM BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$3.570	\$3.592	\$23.570	+\$20.000

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: The foundation of all of CDC's violence prevention work is a strong base of data collection and research. The National Violent Death Reporting System (NVDRS) is critical to CDC's efforts to prevent violence, and the system helps funded states better understand the circumstances surrounding violent deaths. NVDRS is the only state-based surveillance (reporting) system that pools information from multiple data sources. These sources include state and local medical examiners, coroners, law enforcement, crime labs, and vital statistics. Information is pooled into a usable, anonymous database. NVDRS covers all types of violent deaths—including homicides, suicides, and child maltreatment fatalities—in all settings and for all age groups.

States use NVDRS data for strategic planning, development and implementation of violence and suicide prevention programs, and better targeting violence prevention resources. Eighteen states are currently funded by NVDRS. Beyond the state level, NVDRS data support the research of CDC and other federal agencies. In 2012, CDC collaborated with the Department of Defense and Veteran's Administration to better understand the circumstances of current and former military personnel who take their own lives. And in 2013, CDC is releasing the first ever large-sample detailed analysis of youth suicides, titled "The Relationship between Youth Involvement in Bullying and Suicide-Related Behaviors" and to be published in a special issue of the *Journal of Adolescent Health*.

Budget Proposal: CDC's FY 2014 request of \$23,570,000 for the National Violent Death Reporting System is an increase of \$20,000,000 above the FY 2012 level. This increase will support the President's gun violence prevention plan, *Now is the Time*, 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.

While NVDRS is a useful system today, it only covers 18 states, representing a limited portion of the national population. With the FY 2014 \$20 million increase, CDC will expand NVDRS to become a nationally-representative system, funding all 50 states and Washington DC through a new five-year funding opportunity announcement. This increase, and increase in average per grantee funding, will allow CDC to adequately fund all the highly-populated states not currently funded for NVDRS. The increase will also 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. Moreover, the funding increase will 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 in special populations such as active duty military. CDC will also complete updating NVDRS to a web-based data collection system in FY 2014.

NVDRS is the foundation of CDC's violence and suicide prevention work. With the increase, NVDRS will provide comprehensive data and functionality that no other system could offer in a fast, efficient manner. Other systems, such as vital statistics, count deaths. However, there is no other public health or law enforcement reporting system that gathers and links different types of important information on violent deaths in the same amount of detail as NVDRS. NVDRS is the only database on homicide that has the capacity to link to hospital and other health records. NVDRS identifies mass shootings occurring in the same incident, and also identifies similar violent incidents that occur in neighboring states during a short period of time. As the most comprehensive database on circumstances surrounding suicide, NVDRS suicide data may include 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.

An enhanced NVDRS will deliver national, standardized, and integrated data that will provide states and communities with vital information to better understand the preventable characteristics of violent deaths. For the first time, prevention researchers, practitioners, and policymakers across the entire nation will be able to gauge the magnitude, trends, and characteristics of violent deaths at the national, state and local levels to inform the development, implementation, and evaluation of violence prevention strategies in order to save lives.

Grant Table:

National Violent Death Reporting System (NVDRS) Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	18	18	51
Average Award	\$0.207	\$0.207	\$0.362
Range of Awards	\$0.098–\$0.266	\$0.098–\$0.266	\$0.108–\$0.910
Number of New Awards	0	0	51
Number of Continuing Awards	18	18	0
Total Grant Award Amount	\$3.735	\$3.735	\$18.471

¹ Average 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 2012, CDC used 100% of the NVDRS appropriation to support NVDRS awards. Since NVDRS continues to be at the core of CDC's violence prevention program due to its relationship with every violence topic, CDC has also used a cost sharing approach with other intentional injury budget lines to maintain data quality and to maximize participation in the system through additional awards to states. CDC plans to use this cost sharing approach for FY 2013 as well.

CDC funds 18 states through a competitive five-year cooperative agreement to collect violent death surveillance data from different sources (such as death certificates, police reports, and coroner or medical examiner reports) to pool into a usable database. In 2014 CDC will expand NVDRS to all 50 states and Washington, D.C through a new five-year funding opportunity announcement. This will provide national standardized and integrated incident-based data from a variety of law enforcement and public health sources to enable data comparisons within and across states, thus providing a deeper understanding of the context of violent deaths.

UNINTENTIONAL INJURY PREVENTION BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$33.740	\$33.956	\$33.794	+\$0.054

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC promotes safety and develops recommendations for effective programs and policies in multiple areas of unintentional injury, including motor vehicle injury, prescription drug overdose, traumatic brain injury, child injury, and older adult falls. CDC's approach to preventing unintentional injuries focuses on the areas of greatest opportunity for public health impact, contributing to CDC's goal of preventing the leading causes of disease, disability, and death.

Motor vehicle-related fatalities are the leading cause of death for people ages 5-34 in the United States. To prevent motor vehicle-related injuries and death, CDC is working with a number of organizations, including the National Highway Traffic Safety Administration, other federal agencies, state health departments, American Indian tribes, and academic institutions. Strategies focus on three key areas: preventing alcohol-impaired driving, promoting seat belts and child safety seat use, and improving teen driver safety. CDC supports state health departments through program evaluation, analysis of crash-related injury data, and guidance on interventions such as breath alcohol ignition interlocks and graduated driver licensing systems. CDC is also funding a project with five state health departments to disseminate information about increasing seat belt use. CDC also funds eight American Indian tribes to prevent alcohol-impaired driving and improve the use of seat belts and child safety seats. Among these tribes, the Tohono O'odham Nation has increased their seatbelt use by 73% and the Ho-Chunk Nation has increased seat belt use by 38% for drivers and 94% for passengers.

To address the tremendous increase in prescription drug misuse, abuse, and overdose, CDC identifies effective overdose prevention strategies in collaboration with other federal agencies, states, and non-governmental organizations. CDC analyzes data to better understand the overdose epidemic and its risk factors, and develops innovative prevention solutions. For example, CDC is working with the Bureau of Justice Assistance, a component of the U.S. Department of Justice, to develop the Prescription Behavior Surveillance System. This system, based on prescription drug monitoring program data, will provide a means to track drug prescribing and use, and help evaluate the impact of national and selected state interventions. CDC is also evaluating the health and economic impacts of state policies, such as "pill mill" laws that seek to reduce illegitimate pain killer prescribing, clinical guidelines related to medication prescriptions, and Medicaid patient review and restriction programs. In addition, CDC worked with the American College of Emergency Physicians (ACEP) to develop guidelines for opioid prescribing in emergency departments. These guidelines were released in June 2012 and disseminated to ACEP members and published online. In July 2012, CDC released a *Vital Signs* publication that provided recommendations for states, health insurers, and healthcare providers to reduce the improper use of methadone prescribed for pain.

To reduce traumatic brain injuries (TBI), including concussions, CDC conducts surveillance, develops and disseminates educational materials and clinical guidelines, and supports interventions. In partnership with the National Football League (NFL), CDC launched *Heads Up to Clinicians: Addressing Concussion in Sports among Kids and Teens* in FY 2012. This free, online course provides healthcare professionals and clinicians with guidance on TBI diagnosis and management, and is required training for U.S. Olympic Team medical staff. In addition, CDC helped develop and disseminate more than 500,000 *Heads Up* TBI educational materials to schools, coaches, and athletes, including resources for sports governing bodies such as USA Soccer, US Lacrosse, and USA Hockey.

Falls are the leading cause of injury deaths among older adults and can also have major psychological and social consequences. CDC is identifying effective falls prevention programs and promoting their widespread adoption. One such intervention is the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) toolkit. This toolkit and pocket guide helps healthcare providers assess older adult falls risk and reduce identified risk factors through treatment or referrals to appropriate falls prevention programs, such as a Tai Chi class or referral to a physical therapist.

CDC's Core Violence and Injury Prevention Program, funded by both Unintentional and Intentional Injury Prevention budget lines, provides resources and scientific and programmatic expertise to 20 state health departments. All 20 funded states address motor vehicle injury prevention as a priority. In addition to motor vehicle injury prevention, 17 of these states work on older adult falls prevention (with one state focusing on childhood falls prevention), and 16 of the 20 states address prescription drug overdose prevention. A few states also focus on traumatic brain injury (including sports concussions), drowning prevention, and burn injuries.

Budget Proposal: CDC's FY 2014 request of \$33,794,000 for unintentional injury prevention activities is an increase of \$54,000 above the FY 2012 level.

In FY 2014, CDC will fund and provide programmatic scientific support for high-priority unintentional injury prevention activities, including prevention of older adult falls, motor vehicle injuries, prescription drug overdose, and traumatic brain injury. CDC will also continue to fund public health agencies, academic institutions, and national organizations to track unintentional injuries, develop prevention strategies, and disseminate evidence-based interventions.

Motor Vehicle Injuries and Deaths

To prevent motor vehicle injuries and deaths, CDC will assist states by helping develop and implement interventions to increase appropriate use of seat belts and child safety seats, improve teen driver safety and increase parental involvement in teen driving, and prevent alcohol-impaired driving using evidence-based strategies. CDC will also begin a focus on improving safe mobility for older adult road users. The agency will maintain its support for eight tribes for motor vehicle injury prevention and work with experts across the nation to provide the public with information and products that help prevent crashes and motor-vehicle injuries. The Tribal programs have reduced alcohol-impaired driving, strengthened tribal motor vehicle safety laws, and increased occupant restraint use.

Prescription Drug Overdose

Overdoses from prescription opioids (painkillers like oxycodone, hydrocodone, and methadone) have claimed the lives of over 100,000 people over the last ten years alone. CDC's key work in surveillance and evaluation provides a crucial foundation for improved clinical prescription practice and identifies new strategies to reduce the unprecedented rise in prescription drug overdose deaths and associated healthcare costs. In FY 2014, CDC will continue to address this epidemic by identifying at-risk populations, evaluating promising prevention practices, filling critical knowledge gaps around prescription drug overdose, and complementing other federal agencies' work. CDC will improve clinical practice around drug prescription by emphasizing evidence-based practices and concentrating on changing primary care providers' inappropriate prescribing behaviors. CDC will continue to evaluate the health and economic impact of state prescription policies, such as "pill mill" laws. CDC will also expand efforts to support states in planning and implementing comprehensive prescription drug overdose prevention strategies.

Traumatic Brain Injury (TBI) Prevention

CDC will support TBI prevention through surveillance, education, and guideline development. Activities will include supporting the 20 Core VIPP-funded states to conduct TBI surveillance and develop state-level estimates of TBI; providing guidance to ensure that 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. CDC is also collaborating in the development of new pediatric mild TBI guidelines to assist in proper TBI diagnosis and treatment, and is partnering 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.

Core Violence and Injury Prevention Program (Core VIPP)

As part of CDC's ongoing effort to build capacity at the state level to address injuries and violence, CDC will continue to provide resources, including scientific and programmatic expertise, to 20 states through the Core VIPP program. 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, and providing education. States will continue to focus on their state-identified priority injury and violence prevention areas, which for many states include motor vehicle injury prevention, older adult falls prevention, and prescription drug overdose.

Grant Tables:

Core Violence and Injury Prevention Program Grant Table¹

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	20	20	20
Average Award	\$0.343	\$0.343	\$0.343
Range of Awards	\$0.150–\$0.813	\$0.150–\$0.813	\$0.150–\$0.813
Number of New Awards	0	0	0
Number of Continuing Awards	20	20	20
Total Grant Award Amount	\$6.865	\$6.865	\$6.865

¹ All 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.

CDC funds 20 state health departments through a five-year (FY 2011–FY 2015) competitive cooperative agreement for the Core Violence and Injury Prevention Program (Core VIPP). All 20 states receive funding for the Base Integration Component, which allows states to tailor prevention activities based on state needs while including essential areas—such as surveillance and evaluation—to assure program effectiveness. States receiving Basic Integration Component funding were also eligible to compete for expanded Core VIPP components. Five states receive funding to serve as Regional Network Leaders, which provide expanded support to other funded and unfunded states within their regions to maximize sharing of information and strategies among states, and allow unfunded states to receive support. Four states receive funding for Surveillance Quality Improvement activities to improve the overall quality of injury data. Three states receive funding for prevention of falls in older adults to integrate and link clinical and community-based programs. Four states receive funding for Motor Vehicle Child Injury Prevention activities to reduce motor vehicle-related injuries among children and teens. These funds will allow states to implement evidence-based strategies using the best available data and work to reduce the burden of injuries in our nation.

INJURY CONTROL RESEARCH CENTERS

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$10.218	\$10.283	\$10.220	+\$0.002

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: 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. ICRCs are conducting 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 Centers provide a high caliber of scientific competency, regional leadership in the field, and training for future injury researchers and the broader public health community.

To develop and disseminate interventions, ICRCs collaborate with state and local health agencies (including Core Violence and Injury Prevention Program grantees), community partners, and other non-governmental organizations. Decision-makers across the United States use ICRC research to shape federal, state, and local programs and policies. For example, the ICRC at Nationwide Children's Hospital in Columbus, Ohio, provided valuable research to the National Federation of High School Associations (NFHS) on the placement of the high school kickoff point. Based on their findings, the NFHS decided not to change the high school football kickoff point from the 40 yard line to the 35 yard line, due to the likelihood of an increase in injury risk to the players. In addition, the University of Iowa's ICRC recently worked with the Iowa Department of Public Health and a partner to analyze the full cost of sexual violence in their state. The April 2012 findings are being used to guide future sexual violence prevention program directions.

Budget Proposal: CDC's FY 2014 request of \$10,220,000 for Injury Control Research Centers is an increase of \$2,000 above the FY 2012 level.

In FY 2014, CDC will support 11 ICRCs, including four ICRCs awarded new or continuing funding. ICRCs will continue to conduct research and evaluation activities related to health and economic impacts of injury and violence as well as the improvement of injury prevention practices. For example, the University of Iowa's ICRC plans to evaluate the effectiveness of programs related to anti-bullying and reducing domestic violence, to investigate the causes of the growth of unintentional poisoning incidents, and to implement a parent-based teen driving safety program.

The results of ICRC research provide public health practitioners with innovative injury and violence prevention strategies to put into practice and fill gaps in the research base for risk factors and interventions. CDC will provide strategic direction to the ICRCs and to the field of injury prevention research, including priority injury topics such as traumatic brain injury, violence against children and youth, motor vehicle injuries, and prescription drug overdose. CDC will disseminate key findings from injury and violence prevention research from the ICRCs to the public health community. When implemented in states and communities, the program and policy efforts built from the ICRC research and evaluation findings will lead to reductions in injuries and violence.

Grant Table:

Injury Control Research Centers Program Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	11	11	11
Average Award	\$0.836	\$0.836	\$0.836
Range of Awards	\$0.836	\$0.836	\$0.836
Number of New Awards	7	0	4
Number of Continuing Awards	4	11	7
Total Grant Award Amount	\$9.202	\$9.202	\$9.202

CDC's Injury Control Research Center (ICRC) program funds 11 universities through multi-year competitive research grants to develop centers that conduct high-quality multidisciplinary extramural research to build the scientific base for injury prevention and translate scientific discoveries into practice. ICRCs are funded in two separate and overlapping funding cycles. Seven grantees were awarded new

five-year cooperative agreements in FY 2012; an estimated four institutions will be competitively awarded new multi-year cooperative agreements in FY 2014.

PERFORMANCE

Program: Intentional Injury Prevention

Performance Measure for Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from intentional injuries for people at all life stages.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
7.1.2b: Reduce victimization of youth enrolled in grades 9-12 as measured by the 12-month incidence of dating violence. ¹ (Outcome)	FY 2011: 9.4% (Target Met)	N/A	N/A	N/A
7.2.5: Increase the percentage of Core Violence and Injury Prevention Program (VIPP) funded states (N=20) that use surveillance data to assess outcomes and impact of unintentional injury and violence prevention strategies. (Intermediate Outcome)	CY 2012: 60% (Target Not Met) ²	75%	95%	+20

¹ Targets are set and data is reported biennially

² Due to budget constraints, the number of Core VIPP states was reduced to 20 starting in FY 2012. The baseline and 2012 target were computed using 28 states while the 2013 and 2014 targets are computed using the 20 states currently funded. The 2012 result data was computed using the 20 currently funded states.

Performance Trends: Violence-related injuries and deaths cost approximately \$69 billion a year in medical and work loss costs. Teen dating violence is one area of growing concern in violence prevention. In 2011, almost one in 10 high school students reported experiencing physical violence from a dating partner (Measure 7.1.2b). 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. Teens who are victims in high school are at higher risk for victimization during college. Current science demonstrates it is most effective to begin working with teens at a younger age to stop dating violence before it starts. CDC is actively identifying effective programmatic strategies and will work to further implement programs that are based on the best available science.

The Dating Matters™ initiative is an evidence based prevention program that supports local communities. The initiative promotes respectful, nonviolent dating relationships among youth ages 11–14 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 2011-2015). During this time, CDC estimates that up to 100,000 students, parents, and educators will participate in Dating Matters™. 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 3) Parents Matter, a community-level, family prevention program that enhances protective parenting practices.

The Core Violence and Injury Prevention Program (VIPP) is cross cutting and 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

Performance Measures for Long Term Objective: Achieve reductions in the burden of injuries, disability, or death from unintentional injuries for people at all life stages.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
7.2.4: Reduce motor vehicle deaths per 100M miles traveled ¹ (Outcome)	CY 2011: 1.10 (Target Not Met but Improved)	1.03	0.97	-0.06
7.2.5: Increase the percentage of Core Violence and Injury Prevention Program (VIPP) funded states (N=20) that use surveillance data to assess outcomes and impact of unintentional injury and violence prevention strategies. (Intermediate Outcome)	CY 2012: 60% ^{1,2} (Target Not Met)	75%	95%	+20

¹Results are reported based on Calendar year.

²Due to budget constraints, the number of Core VIPP states was reduced to 20 starting in FY 2012. The baseline and 2012 target were computed using 28 states while the 2013 and 2014 targets are computed using the 20 states currently funded. The 2012 result data was computed using the 20 currently funded states.

Performance Trends: Unintentional injuries are the leading cause of death for individuals ages 1–44 in the United States. In 2010, unintentional injury cost more than \$81 billion in medical costs. CDC works in multiple areas across unintentional injury; including transportation safety and elderly falls. 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).

The rate of traffic fatalities per 100 million vehicle miles traveled (VMT) has steadily declined between 2008 and 2011 (Measure 7.2.4), although CDC narrowly missed the 2011 target of 1.06 fatalities per 100 million VMT. These declines are likely attributable to prevention strategies that increase seat belt usage, create safer motor vehicles, and improve driving behaviors. Although reductions are a sign that motor vehicle safety efforts are effective, the dramatic rates of decline experienced between 2008 and 2011 are likely unsustainable as historical trends show repeated instances of large declines followed by a multi-year leveling off period. CDC provides rigorous surveillance to identify areas where additional safety gains are possible. Some of these areas where improvements can be realized include alcohol-impaired driving, seat belt and child safety seat use, and vulnerable populations including older adult road users, teens, and Alaska Natives/American Indians. By promoting the widespread use of proven approaches to road safety, and supporting the evaluation and implementation of evidence-based strategies; further increases in the safety of all road users can be achieved. For example, the “Parents Are the Key” communications campaign toolkit provides resources to support graduated driver licensing systems and parental involvement in teen driving. In addition, CDC’s Tribal Motor Vehicle Injury Prevention Program has significantly impacted communities through culturally appropriate, effective interventions implemented in eight tribal communities across the United States.

In 2011, CDC entered into a new five-year cooperative agreement period for the Core VIPP. This 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 2012, grantees engaged in their first full year of program implementation which was designed to largely be a planning year. As a result, 60 percent of grantees reported using data to assess outcomes and impact of injury and violence prevention strategies (Measure 7.2.5), indicating maintenance of the baseline number of grantees using surveillance data and retention of existing evaluation capacity.

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 the health department to receive the data. By adding NAS as a reportable condition, the health department can ascertain current incident rates. This will allow for more rapid determination of the success of various policy activities related to reducing prescription drug misuse in Tennessee.

STATE TABLES

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 Core State Injury Program^{1,2}				
State/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$0	\$0	\$0	\$0
Alaska	\$0	\$0	\$0	\$0
Arizona	\$180,621	\$180,621	\$180,621	\$0
Arkansas	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0
Colorado	\$813,029 ^{b,c,d}	\$813,029 ^{b,c,d}	\$813,029 ^{b,c,d}	\$0
Connecticut	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0
Florida	\$250,000	\$250,000	\$250,000	\$0
Georgia	\$0	\$0	\$0	\$0
Hawaii	\$150,000	\$150,000	\$150,000	\$0
Idaho	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0
Kansas	\$278,623 ^a	\$278,623 ^a	\$278,623 ^a	\$0
Kentucky	\$247,814	\$247,814	\$247,814	\$0
Louisiana	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0
Maryland	\$294,057 ^a	\$294,057 ^a	\$294,057 ^a	\$0
Massachusetts	\$427,388 ^{a,b}	\$427,388 ^{a,b}	\$427,388 ^{a,b}	\$0
Michigan	\$0	\$0	\$0	\$0
Minnesota	\$246,454	\$246,454	\$246,454	\$0
Mississippi	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0
Nebraska	\$299,693 ^d	\$299,693 ^d	\$299,693 ^d	\$0
Nevada	\$0	\$0	\$0	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 Core State Injury Program^{1,2}				
State/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
New Hampshire	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$0
New York	\$685,000 ^{c,d}	\$685,000 ^{c,d}	\$685,000 ^{c,d}	\$0
North Carolina	\$428,062 ^{a,b}	\$428,062 ^{a,b}	\$428,062 ^{a,b}	\$0
North Dakota	\$0	\$0	\$0	\$0
Ohio	\$250,000	\$250,000	\$250,000	\$0
Oklahoma	\$250,000	\$250,000	\$250,000	\$0
Oregon	\$534,975 ^c	\$534,975 ^c	\$534,975 ^c	\$0
Pennsylvania	\$250,000	\$250,000	\$250,000	\$0
Rhode Island	\$250,000	\$250,000	\$250,000	\$0
South Carolina	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0
Tennessee	\$247,686	\$247,686	\$247,686	\$0
Texas	\$0	\$0	\$0	\$0
Utah	\$332,422 ^b	\$332,422 ^b	\$332,422 ^b	\$0
Vermont	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0
Washington	\$449,114 ^{a,d}	\$449,114 ^{a,d}	\$449,114 ^{a,d}	\$0
West Virginia	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0
Total	\$6,864,938	\$6,864,938	\$6,864,938	\$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/>

²Note 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>

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 Rape Prevention and Education¹				
State/Territory	FY 2012 Enacted	FY 2013 CR ²	FY 2014 President's Budget ^{2,3}	FY 2014 +/- FY 2012
Alabama	\$534,004	\$534,004	\$534,004	\$0
Alaska	\$75,282	\$75,282	\$75,282	\$0
Arizona	\$616,082	\$616,082	\$616,082	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 Rape Prevention and Education¹				
State/Territory	FY 2012 Enacted	FY 2013 CR²	FY 2014 President's Budget^{2,3}	FY 2014 +/- FY 2012
Arkansas	\$321,020	\$321,020	\$321,020	\$0
California	\$4,067,279	\$4,067,279	\$4,067,279	\$0
Colorado	\$516,492	\$516,492	\$516,492	\$0
Connecticut	\$408,938	\$408,938	\$408,938	\$0
Delaware	\$94,094	\$94,094	\$94,094	\$0
District of Columbia	\$68,693	\$68,693	\$68,693	\$0
Florida	\$1,919,151	\$1,919,151	\$1,919,151	\$0
Georgia	\$983,022	\$983,022	\$983,022	\$0
Hawaii	\$145,481	\$145,481	\$145,481	\$0
Idaho	\$155,377	\$155,377	\$155,377	\$0
Illinois	\$1,491,299	\$1,491,299	\$1,491,299	\$0
Indiana	\$730,140	\$730,140	\$730,140	\$0
Iowa	\$351,390	\$351,390	\$351,390	\$0
Kansas	\$322,823	\$322,823	\$322,823	\$0
Kentucky	\$485,332	\$485,332	\$485,332	\$0
Louisiana	\$536,631	\$536,631	\$536,631	\$0
Maine	\$153,092	\$153,092	\$153,092	\$0
Maryland	\$635,997	\$635,997	\$635,997	\$0
Massachusetts	\$762,394	\$762,394	\$762,394	\$0
Michigan	\$1,193,401	\$1,193,401	\$1,193,401	\$0
Minnesota	\$590,727	\$590,727	\$590,727	\$0
Mississippi	\$341,584	\$341,584	\$341,584	\$0
Missouri	\$671,868	\$671,868	\$671,868	\$0
Montana	\$108,335	\$108,335	\$108,335	\$0
Nebraska	\$205,487	\$205,487	\$205,487	\$0
Nevada	\$239,949	\$239,949	\$239,949	\$0
New Hampshire	\$148,392	\$148,392	\$148,392	\$0
New Jersey	\$1,010,388	\$1,010,388	\$1,010,388	\$0
New Mexico	\$218,429	\$218,429	\$218,429	\$0
New York	\$2,278,678	\$2,278,678	\$2,278,678	\$0
North Carolina	\$966,555	\$966,555	\$966,555	\$0
North Dakota	\$77,115	\$77,115	\$77,115	\$0
Ohio	\$1,363,276	\$1,363,276	\$1,363,276	\$0
Oklahoma	\$414,351	\$414,351	\$414,351	\$0
Oregon	\$410,839	\$410,839	\$410,839	\$0
Pennsylvania	\$1,474,699	\$1,474,699	\$1,474,699	\$0
Rhode Island	\$125,882	\$125,882	\$125,882	\$0
South Carolina	\$481,759	\$481,759	\$481,759	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 Rape Prevention and Education¹				
State/Territory	FY 2012 Enacted	FY 2013 CR ²	FY 2014 President's Budget ^{2,3}	FY 2014 +/- FY 2012
South Dakota	\$90,641	\$90,641	\$90,641	\$0
Tennessee	\$683,165	\$683,165	\$683,165	\$0
Texas	\$2,503,869	\$2,503,869	\$2,503,869	\$0
Utah	\$268,157	\$268,157	\$268,157	\$0
Vermont	\$73,108	\$73,108	\$73,108	\$0
Virginia	\$849,982	\$849,982	\$849,982	\$0
Washington	\$707,761	\$707,761	\$707,761	\$0
West Virginia	\$217,144	\$217,144	\$217,144	\$0
Wisconsin	\$644,066	\$644,066	\$644,066	\$0
Wyoming	\$59,293	\$59,293	\$59,293	\$0
State Sub-Total	\$33,792,913	\$33,792,913	\$33,792,913	\$0
America Samoa	\$0	\$0	\$0	\$0
Guam	\$18,567	\$18,567	\$18,567	\$0
Marshall Islands	\$8,181	\$8,181	\$8,181	\$0
Micronesia	\$14,866	\$14,866	\$14,866	\$0
Northern Marianas	\$8,635	\$8,635	\$8,635	\$0
Puerto Rico	\$457,335	\$457,335	\$457,335	\$0
Palau	\$0	\$0	\$0	\$0
Virgin Islands	\$14,520	\$14,520	\$14,520	\$0
Territory Sub-Total	\$522,104	\$522,104	\$522,104	\$0
Total	\$34,315,017	\$34,315,017	\$34,315,017	\$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/>

²FY 2013 and FY 2014 award amounts are subject to change based on available funding, a new one-year funding opportunity announcement in FY 2013, and a new five-year funding opportunity announcement to be released in FY 2014.

³These FY 2014 totals exclude separate funding for evaluation of Rape Prevention and Education activities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 National Violent Death Reporting System¹				
State/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget ²	FY 2014 +/- FY 2012
Alabama	\$0	\$0	\$TBD	N/A
Alaska	\$155,761	\$155,761	\$155,761	\$0
Arizona	\$0	\$0	\$TBD	N/A
Arkansas	\$0	\$0	\$TBD	N/A
California	\$0	\$0	\$TBD	N/A
Colorado	\$209,546	\$209,546	\$209,546	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93.136 National Violent Death Reporting System¹				
State/Territory	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget²	FY 2014 +/- FY 2012
Connecticut	\$0	\$0	\$TBD	N/A
Delaware	\$0	\$0	\$TBD	N/A
District of Columbia	\$0	\$0	\$TBD	N/A
Florida	\$0	\$0	\$TBD	N/A
Georgia	\$249,834	\$249,834	\$249,834	\$0
Hawaii	\$0	\$0	\$TBD	N/A
Idaho	\$0	\$0	\$TBD	N/A
Illinois	\$0	\$0	\$TBD	N/A
Indiana	\$0	\$0	\$TBD	N/A
Iowa	\$0	\$0	\$TBD	N/A
Kansas	\$0	\$0	\$TBD	N/A
Kentucky	\$212,974	\$212,974	\$212,974	\$0
Louisiana	\$0	\$0	\$TBD	N/A
Maine	\$0	\$0	\$TBD	N/A
Maryland	\$244,439	\$244,439	\$244,439	\$0
Massachusetts	\$232,217	\$232,217	\$232,217	\$0
Michigan	\$256,257	\$256,257	\$256,257	\$0
Minnesota	\$0	\$0	\$TBD	N/A
Mississippi	\$0	\$0	\$TBD	N/A
Missouri	\$0	\$0	\$TBD	N/A
Montana	\$0	\$0	\$TBD	N/A
Nebraska	\$0	\$0	\$TBD	N/A
Nevada	\$0	\$0	\$TBD	N/A
New Hampshire	\$0	\$0	\$TBD	N/A
New Jersey	\$98,264	\$98,264	\$98,264	\$0
New Mexico	\$180,488	\$180,488	\$180,488	\$0
New York	\$0	\$0	\$TBD	N/A
North Carolina	\$249,865	\$249,865	\$249,865	\$0
North Dakota	\$0	\$0	\$TBD	N/A
Ohio	\$265,516	\$265,516	\$265,516	\$0
Oklahoma	\$201,488	\$201,488	\$201,488	\$0
Oregon	\$193,342	\$193,342	\$193,342	\$0
Pennsylvania	\$0	\$0	\$TBD	N/A
Rhode Island	\$127,038	\$127,038	\$127,038	\$0
South Carolina	\$209,452	\$209,452	\$209,452	\$0
South Dakota	\$0	\$0	\$TBD	N/A
Tennessee	\$0	\$0	\$TBD	N/A
Texas	\$0	\$0	\$TBD	N/A
Utah	\$200,582	\$200,582	\$200,582	\$0

NARRATIVE BY ACTIVITY
INJURY PREVENTION AND CONTROL
BUDGET REQUEST

Vermont	\$0	\$0	\$0	N/A
Virginia	\$235,403	\$235,403	\$235,403	\$0
Washington	\$0	\$0	\$TBD	N/A
West Virginia	\$0	\$0	\$TBD	N/A
Wisconsin	\$212,125	\$212,125	\$212,125	\$0
Wyoming	\$0	\$0	\$TBD	N/A
Total	\$3,734,591	\$3,734,591	\$18,471,000	+\$14,736,409

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

² New FOA will be recompeted in FY 2014. Award amounts for newly-funded states are to be determined (TBD); amounts for currently-funded states are estimated as staying the same but are subject to change.

PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$199.693	\$200.946	\$144.416	-\$55.277
PHS Evaluation Transfer	\$247.769	\$249.286	\$324.889	+\$77.120
ACA/PPHF	\$70.000	N/A	\$70.000	\$0.000
Total	\$517.462	\$450.232	\$539.305	+\$21.843
FTEs	1,069	1,066	1,066	-3

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: PHS Act Title II §§ 241, 301, 304, 306*, 307, 308(d), 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)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$539,305,000 for Public Health Scientific Services, including \$70,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of \$21,843,000 above the FY 2012 level. This increase allows CDC to expand death data from the vital registration jurisdictions. The increase will also support development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Health Statistics	\$159.062	\$160.036	\$181.475	+\$22.413
Surveillance, Epidemiology, and Public Health Informatics	\$246.712	\$248.253	\$245.799	-\$0.913
Public Health Workforce and Career Development	\$41.688	\$41.943	\$42.031	+\$0.343
ACA/PPHF	\$70.000	N/A	\$70.000	\$0.000
Public Health Research (non-add)	\$0.000	\$0.000	\$5.000	+\$5.000
Total	\$517.462	\$450.232	\$539.305	+\$21.843

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Public health scientific services are the foundation of CDC's efforts to protect the U.S. public's health by supporting CDC's goal of monitoring health and ensuring laboratory excellence. These services lead the development, adoption, and integration of sound public health surveillance and epidemiological practices, and are based on advances in epidemiology, informatics, laboratory science, and surveillance. Investment at the local, state, and national levels is essential to create a public health system in which limited resources can be used most effectively; interventions can be targeted to those most in need; and public

health programs can be well-designed. Public health scientific services support efforts across the agency through five main components: (1) health statistics; (2) laboratory science, policy, and practice; (3) surveillance and informatics; (4) epidemiology and analysis; and (5) professional development.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	N/A
2010	\$408.351
2010 (ACA/PPHF)	\$32.358
2011	\$395.564
2011 (ACA/PPHF)	\$72.000
2012	\$447.462
2012 (ACA/PPHF)	\$70.000
2013	\$450.232
2013 (ACA/PPHF) ²	N/A

¹The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

HEALTH STATISTICS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
PHS Evaluation Transfer	\$159.062	\$160.036	\$181.475	+\$22.413

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: The National Center for Health Statistics (NCHS) is a designated Federal Statistics Agency and the nation's principal health statistics agency, and as such, is accepted as providing impartial and trustworthy information. NCHS collects data on births and deaths, health status, and healthcare through four main mechanisms: the National Health Care Surveys, the National Health Interview Survey (NHIS), the National Health and Nutrition Examination Survey (NHANES), and the National Vital Statistics System (NVSS).

NHIS, the principal source of information on the health of the civilian, non-institutionalized population of the United States since 1957, has added key content to monitor changes in health and healthcare. HHS uses NHIS data to monitor trends in illness and disability, and to track progress toward achieving national health objectives as outlined in *Healthy People* from 1990 to 2020.

NHANES is a population-based survey designed to collect information on the health and nutrition of the U.S. household population. Since the early 1960s, NHANES data have been used to inform policy and improve the health of the U.S. population in many ways. Examples include removing lead from gasoline, creating the pediatric growth charts, and establishing national baseline estimates for cholesterol, blood pressure, and Hepatitis C in the United States.

The National Health Care Surveys provide information about the organizations and providers that supply healthcare, the services rendered, and the patients they serve to study healthcare use, patient care quality, clinical management of specific conditions, disparities in use and quality of care, diffusion of healthcare technologies, and policy change effects. NCHS has conducted a major redesign of the healthcare surveys included integrating multiple surveys into the new National Health Care Survey (NHCS).

NVSS, the oldest and most successful example of inter-governmental data sharing in public health, is the mechanism by which NCHS collects vital records, through contract, from 57 vital registration jurisdictions to create the nation's official vital statistics. This partnership allows NCHS to document

emerging trends such as the increase in prescription drug-related deaths and the decrease in teen births. . NVSS is the source of information that the United States reports to the United Nations Statistics Division and the World Health Organization. The U.S. Census Bureau relies on information from the NVSS on births and deaths to create yearly population estimates used by state and local governments and to allocate funding.

Budget Proposal: CDC's FY 2014 request of \$181,475,000 for health statistics is an increase of \$22,413,000 above the FY 2012 level. The increase prioritizes and supports the expansion of vital statistics to gradually phase in electronic death records in the 21 remaining jurisdictions over four years. The increase will also support development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods. This investment will expand CDC's capability to monitor key health indicators at the national, state, and community level.

The FY 2014 budget request maintains NCHS's capacity to support its ongoing seminal health and healthcare surveys and data collection systems in FY 2014, using personal interviews, healthcare records, physical examinations, diagnostic procedures, lab tests, and vital event registrations. The Budget also allows CDC to purchase 12 months of birth and death data from the vital registration jurisdictions and to fully implement electronic birth records in the two remaining jurisdictions.

National Health Care Survey

In 2011, NCHS replaced the National Hospital Discharge Survey with the National Health Care Survey (NHCS). In FY 2014, NHCS will continue to obtain information on inpatient discharges but will expand the information obtained on the characteristics of the hospital, and will rely more on administrative data for information on inpatient stays. In addition, the sampled hospitals will provide data on visits to their emergency and outpatient departments, and ambulatory surgery locations. NCHS will also collect data from a new sample of freestanding ambulatory surgery centers. Data collected by the Drug Abuse Warning Network survey, previously conducted by the Substance Abuse and Mental Health Services Administration, will be obtained from the emergency department component of NHCS.

In FY 2014, NCHS will release the first data from the National Study of Long-Term Care Providers, which will provide nationally representative statistical information about the supply and use of paid, regulated, long-term care providers, including for the first time, data on care received and provided in Adult Day Care Centers.

National Health Interview Survey

To improve monitoring the effects of health initiatives, NCHS expanded the sample size of the NHIS in FY 2011 and FY 2012, improving precision of national estimates and doubling the number of states for which we have key data. Data for approximately 40 states are now available to monitor the impact of changes in health and healthcare in order to evaluate, target, and improve programs to keep Americans safe and healthy. In FY 2014, NCHS will launch a web-based follow-back where previous NHIS participants are contacted to track changes in their health behaviors resulting from the Affordable Care Act (ACA) changes in access to health services. NCHS plans to pilot test procedures that would allow for collection of biomeasures such as height, weight, and blood pressure. NCHS will test collection of dried blood spots as part of the household interview, as a means of capturing clinical level data on heart disease, stroke, and diabetes risk.

National Health and Nutrition Examination Survey

NCHS implemented the NHANES Youth Fitness Survey in 2012, collecting the first national data on physical activity levels of children and teens in the United States. Results from this study will help researchers and policymakers better understand factors affecting childhood obesity. The 2013–2014 NHANES will increase focus on tooth fluorosis and exposure to fluoride in children, including specially

enhanced digital photography and measures of fluoride in the blood and from the participant's water supply. In addition, NHANES will provide the first measurement of current human papillomavirus (HPV) infection in males on a national survey.

National Vital Statistics System

In FY 2014, NCHS will phase in full implementation of electronic death records, moving as many jurisdictions as possible (initial target 15–17 states) from outdated systems. The web-based systems will integrate with other public health information systems, allowing improved data quality and more rapid compilation and use of these critical data sources. NCHS will work with the remaining vital registration jurisdictions to implement electronic birth record systems and the 2003 revision of the U.S. Standard Birth Certificate. Vital registration data purchased for NVSS will provide complete and ongoing data of births and deaths.

Survey Design, Data Analysis and Dissemination

In FY 2014, NCHS will evaluate and improve its processes for collecting data through the Questionnaire Design Research Laboratory, a laboratory that develops and tests survey instruments, improving the quality and usefulness of federal statistics by improving the reliability and validity of health statistics survey instruments.

In order to facilitate access to NCHS data for as wide a range of users as possible, NCHS is developing access tools that allow users to more easily obtain analytic results of interest without using statistical software. These systems will allow users to promptly access data needed for research and decision-making. The first of these systems is an on-line data query system that allows users to access public use data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) Emergency Department component. After completing the pilot test, NCHS will release a beta test version in FY 2013. If successful, NCHS will add data from the Outpatient Department component of the NHAMCS and from physician offices from the National Ambulatory Medical Care Survey over the next year. A second tool under development in FY 2014 will allow users to access both public use data as well as data that cannot be released due to confidentiality constraints (notably state identifiers) from the National Health Interview Survey. This on-line system will include state-of-the-art methods to ensure that respondent confidentiality is protected as required by law. Users will perform selected analyses of the rich multivariate NHIS core data from 1997 to the present in real time at no charge. In particular, they will be able to produce selected state-level estimates, addressing the need for more data at the state level for public health planning and evaluation.

NCHS conducts statistical research on small-area estimation. Most NCHS surveys provide data at the national, regional, or state level. There is growing interest among public health officials in obtaining information for smaller geographic areas, but it is not possible to produce estimates of sufficient reliability for these areas. Statistical models and auxiliary data can be used to produce better estimates (small-area estimates) for the areas of interest. In FY 2014, NCHS will continue to develop and evaluate models for small-area estimation, methods for incorporating auxiliary data, and methods for determining in advance whether a characteristic of interest would benefit from the application of “small-area estimation” techniques. Improved methods for small-area estimation will enhance the availability of state and local level data for planning and evaluation of public health efforts.

NCHS will continue to support data access and dissemination by making data more easily accessible to health professionals, researchers and policy makers. *Health, United States*, the Secretary's yearly report to Congress on the health of the nation, provides a timely overview of health, healthcare, and health insurance information to researchers, public health professionals, and policymakers. The Research Data Center provides access to confidential aggregate NCHS data, allowing researchers to conduct analyses that build on information presented in standard health statistics reports. NCHS will continue to improve the usability of data through the development of tools such as tutorials and on-line access systems, which

are made available to the public on the NCHS website. For example, NHANES is completing the tutorial on *NHANES-CMS* linked data (by August 2012), and plans to finish the *Physical Activity and Cardiovascular* fitness tutorial in 2013.

SURVEILLANCE, EPIDEMIOLOGY, INFORMATICS, AND LABORATORY SCIENCE BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$137.626	\$138.499	\$102.385	-\$35.241
PHS Evaluation Transfer	\$109.086	\$109.754	\$143.414	+\$34.328
ACA/PPHF	\$45.000	N/A	\$45.000	\$0.000
Public Health Research (non-add)	\$0.000	\$0.000	\$5.000	+\$5.000
Total	\$291.712	\$248.253	\$290.799	-\$0.913

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the WCF narrative for FY 2012 detailed realignment data.

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program Overview: CDC's public health scientific support services provide expertise in surveillance systems, epidemiologic analysis, informatics, public health workforce development, and laboratory policy and practice. CDC advances surveillance science and practice by managing various surveillance systems used across CDC, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Notifiable Diseases Surveillance System (NNDSS) and by establishing and sharing best practices that can be used by CDC programs and the public health community. Protecting and promoting public health requires reliable, timely, and constant information; CDC's informatics program supports public health surveillance by bridging the gap between the changing world of information technology and electronic health information with the public health community. CDC advances these efforts through supporting the adoption of Electronic Health Records-Meaningful Use (EHR-MU); deploying an innovative applied public health informatics laboratory and research cloud; and providing data management and information exchange services to CDC programs and the public health community. CDC provides expertise in scientific publication and systematic reviews to establish the evidence base for interventions. CDC puts epidemiology to work with products and services such as the *Morbidity and Mortality Weekly Report (MMWR)*, *CDC Vital Signs*, the *Guide to Community Preventive Services*, Epi Info™ and *Science Clips*. CDC's laboratory science, policy, and practice program provides leadership and training services to strengthen the quality of laboratory science at CDC, in the United States, and globally by providing guidelines and recommendations for public health laboratories. These services support CDC's national efforts to promote health; prevent disease, injury and disability; and prepare for emerging health threats.

Behavioral Risk Factor Surveillance System (BRFSS)

CDC's BRFSS was developed in 1984 and is the world's largest ongoing telephone health survey system. Every year, 50 states and seven territories work with CDC to design customized BRFSS questionnaires and collect and process data from adults on the health status, preventive health practices, and health risk behaviors associated with many of the most costly chronic conditions. These conditions—such as diabetes, high blood pressure, and cancer—are among the leading causes of death and disability in the United States. Flexibility in the BRFSS questionnaire design accommodates changing priorities, as well as public health emergencies, making it an optimal choice for gathering state-specific information such as the misuse of opioid prescription drugs in Utah and Montana, or information on national issues such as healthcare reform. Because the BRFSS is a state-based rather than national surveillance system, it is in a unique position to provide data specific to every state as well as community-level data for over 150 metropolitan statistical areas (MSAs) and the counties within those MSAs. Community data are essential for health departments to develop targeted public health interventions, address health disparities within their states, and allocate resources more efficiently. For many states and localities, the BRFSS is the only

source for this type of timely information. CDC programs, policymakers, and health researchers also rely on BRFSS data to track health trends and inform the development and evaluation of public health programs and policies to improve health.

National Notifiable Diseases Surveillance System (NNDSS)

In operation since 1951, CDC's NNDSS is the only public health surveillance system that monitors nationally reported cases of diseases posing the greatest threat to human health, including those that are of bioterrorism concern, including anthrax, botulism, plague, and smallpox, among others. The NNDSS also monitors many other foodborne, waterborne, and airborne diseases. In total, NNDSS monitors 77 nationally notifiable diseases for CDC programs through a centralized national system. Rather than conducting surveillance separately for each disease, states use NNDSS to report these diseases to CDC. To this end, CDC currently provides direct assistance to 50 states, eight territories, and five large local health departments through cooperative agreements. CDC sends approximately 50 percent of the NNDSS program funds to the jurisdictions to improve their ability to conduct these surveillance activities. The other 50 percent is used to provide oversight and standards development or national data management and technology improvements for public health reporting. Currently within a day of diagnosis, jurisdictions can notify the CDC Emergency Operations Center of disease cases. Regional and national notifiable disease data also are available to states for their disease prevention and control efforts. Within CDC, the NNDSS program provides disease-specific data to programs whose job is to identify and monitor disease outbreaks, develop policies and public health programs to prevent and control the spread of disease, and to evaluate the effectiveness of those interventions on a national level. Through new technical approaches, the NNDSS aims to improve the accessibility and usability of notifiable disease data for public health program planning and evaluation. Enhancing the timeliness of data and efficiencies in surveillance operations at local, state, and national levels is an additional goal. Success will be evident as the overall utility of notifiable diseases data for local and state health agencies and national public health programs increases.

Epidemiology

CDC collaborates with state and local public health partners to create and promote high quality, timely, and useful scientific products and services to strengthen and improve public health science and decision-making. These crosscutting products and services include: *Morbidity and Mortality Weekly Report*; *CDC Vital Signs*, systematic review methodology for the *Guide to Community Preventive Services* (Community Guide); innovative methods to collect, analyze, and communicate public health surveillance information through Epi Info™ software; analytic methods development; and access to scientific literature through the Public Health Library and Information Center and *Science Clips*.

CDC and public health partners employ the scientific products and services to inform decisions affecting public health. For example, the Community Guide builds the scientific evidence base for recommendations of an independent Task Force by conducting systematic reviews to address significant high-priority public health problems such as obesity, emergency preparedness, tobacco use, and worksite health promotion. The recommendations empower decision makers to optimize resources to: (1) protect and improve health, (2) reduce demand for future healthcare spending driven by preventable disease and disability, and (3) increase the U.S. workforce's productivity and economic competitiveness. The *MMWR* reports events of public health importance and prevention strategies to state and local health departments as quickly as possible to inform public health decision-making. *CDC Vital Signs*, a monthly feature including an *MMWR* report and supporting multimedia materials, extends the reach of the *MMWR* data through TV, print, broadcast, and internet media to deliver critical health information to the general public. Epi Info™ provides essential, free software to domestic and international public health partners for rapid assessment of disease outbreaks, cost-effective surveillance and monitoring, and customization of community surveys and reports, and supports epidemiologic and analytic standards for best practices in outbreak investigations and surveillance.

Informatics

Since its inception in 1997, CDC's informatics program has applied the powerful capabilities of information science and technology to help CDC programs prevent disease, disability, and early death. Program goals are: (1) strengthening the ability of public health agencies to benefit from and manage advances in electronic health information; and (2) fostering innovation, identifying best practices, sharing knowledge, and serving as the primary resource for issues in public health informatics. Through this program, CDC translates public health needs into information processes that are valued, strategic, and consistent with the larger health information technology (IT) world. This involves processing approximately 1.5 billion electronic messages exchanging public health information per year on behalf of CDC programs and state health departments. Informatics-based solutions improve public health information exchange in the areas of surveillance, emergency preparedness, laboratory services, and other public health activities. CDC strives to improve electronic data exchange across organizational and jurisdictional boundaries among state and local health departments and CDC programs.

The CDC informatics program supports the national "Electronic Health Records-Meaningful Use" (EHR-MU) initiative by engaging public health partners at federal, state, and local levels, as well as across CDC programs. CDC engages with federal partners to support the public health components of the electronic exchange of health information to improve the quality of care. Within CDC, the informatics program works closely with immunization services and the Epidemiology and Laboratory Capacity programs to prepare grantees to meet "Meaningful Use" requirements. Further, CDC provides direct assistance to state public health agencies to support electronic health information systems that receive data from providers: (1) reportable laboratory results, (2) immunization data submitted to immunization registries or immunization information systems, and (3) syndromic surveillance data. Success is measured by the number of public health agencies that are capable of accepting this information electronically. As of June 30, 2012, 48 out of 50 state health departments are capable of receiving meaningful use immunization data. In addition, 85 percent of jurisdictions (44 States and two local jurisdictions) can receive immunization data from the immunization registry.

CDC also supports the applied public health informatics laboratory and research cloud, which is a new service that significantly improves the evaluation and use of technology. The laboratory applies novel informatics techniques to further develop new informatics technology, and works with the appropriate CDC programs for deployment and implementation into public health programs. Recently, the lab improved physician decision-making capabilities through a new smartphone application, "PTT Advisor," which provides clinical guidelines and recommendations to physicians at the point of care, at no cost to them, related to an abnormal partial thromboplastin time (PTT) laboratory result. The program's success is defined by annual growth in the number of CDC programs and projects using this service application. The public health laboratory provides a frequently used service that displays success by monitoring the continual growth of CDC program engagement in the exploration of new techniques and solutions.

CDC supports a variety of surveillance systems and health information technology initiatives, including NNDSS, BioSense 2.0, electronic laboratory reporting, immunization reporting, and unstructured data (i.e. social media, etc.). Support includes providing data management information exchange support, data analysis tools, and other services as deemed necessary by CDC and the public health community. To explore the expansion of this support, CDC is creating a public health platform that engages members at all levels of the public health community to develop a useful and sustainable environment. Using an innovative design, this public health platform will support analytic tools and data services crucial to assisting public health officials in decision-making at the state and local level. This public health platform is housed in one environment, while integrating multiple programs and software platforms to increase utility and reduce redundancy in public health surveillance systems. The public health platform development is iterative and agile, allowing it to be flexible to meet the ever-changing needs of CDC and the public health community, and accommodate new advances in health information technology, surveillance, and public health practices.

Laboratory Science, Policy, and Practice

CDC's laboratory science, policy, and practice program strengthens state and local public health laboratories' ability to perform their critical role in protecting the public's health. The program helps public health laboratory leaders and professionals by developing and providing science-based recommendations for best practices and higher efficiency; creating a national database of public health laboratories' test services to encourage sharing of services across states; and delivering training in cutting-edge testing methods to thousands of public health laboratory professionals each year, both in laboratories and using distance-based methods. Within CDC, the program coordinates development of policies for CDC laboratories. One example is the Select Agents and Toxins Compliance Policy, the first uniform policy for possession, use, and transfer of dangerous select agents and toxins for all CDC laboratories in the United States. The program also delivers training and consultation to assist CDC laboratories to comply with federal regulatory mandates related to select agents, scientific specimen collections, and dual-use research.

In addition, CDC serves the nation's more than 230,000 clinical laboratories by working with the Centers for Medicare and Medicaid Services (CMS), through an interagency agreement, to develop science-based regulatory standards. Through this collaborative effort, the agencies conduct quality improvement research to assure the accuracy and reliability of clinical laboratory testing. Recently, the American Society for Microbiologists adopted CDC methods for systematic evidence reviews of laboratory quality improvement practices. CDC also contributes to the development of voluntary practice standards and guidelines to improve laboratory testing in support of quality healthcare. In addition, CDC develops and distributes companion educational products to improve practitioners' understanding and use of laboratory standards and guidelines.

Budget Proposal: CDC's FY 2014 request of \$290,799,000 for surveillance, epidemiology, informatics, and laboratory science, including \$143,414,000 in Public Health Service (PHS) Evaluation Transfer funds and \$45,000,000 from the Affordable Care Act Prevention and Public Health Fund is a decrease of \$913,000 below the FY 2012 level. The budget request maintains CDC's capacity to support the ongoing quality, timeliness, and accessibility of public health data for decision-making; support development of methods to improve quality; and support access to information from electronic health records. The FY 2014 Budget includes \$5,000,000 for public health systems research as authorized by Section 4301 of the Affordable Care Act. CDC will undertake research that seeks to identify the economic and budgetary impacts of public health interventions; expand data on healthcare utilization and effectiveness; and inform how public health should evolve and public health and healthcare should collaborate as the healthcare delivery system transforms.

Behavioral Risk Factor Surveillance System (BRFSS)

In FY 2014, CDC will fund states to improve population coverage of the BRFSS by increasing the average percentage of completed cell phone interviews to 25 percent. CDC will continue to explore the use of innovative, cost-effective ways to administer the BRFSS questionnaire—such as the use of internet-based panel surveys—to access hard-to-reach populations. The provision of community-level data will continue to be a priority in FY 2014, as CDC will utilize small area estimation modeling techniques to produce BRFSS estimates for every county in the United States. CDC will improve access to analytic tools to increase utility among BRFSS data users. These activities will build upon the recent successes of the BRFSS. For example, recently, CDC released the first BRFSS data set that combined data from both landline and cellular telephone survey respondents using a new advanced statistical weighting method. By including data from the adult population with only a cell phone and no landline phone (about 30 percent of all adults nationwide), BRFSS estimates now better capture health-risk behaviors and chronic disease prevalence among adults, especially among younger and lower-income adults who were previously under-represented in the BRFSS. Two new pilot projects that will test novel data collection methods are currently in their early stages. One of these innovative pilots will examine the

feasibility of collecting self-reported health data using electronic tools and comparing the reported data with the respondent's electronic health record data. CDC will use the results of these pilots, as well as a recent evaluation of BRFSS, to ensure the BRFSS is maintained as a timely, efficient, and agile state-of-the-art surveillance system.

National Notifiable Diseases Surveillance System (NNDSS)

In FY 2014, CDC's NNDSS will continue to fund 50 states, seven territories, Washington, D.C and five large health departments 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 to evaluate the effectiveness of those interventions within their states. For example, CDC support of NNDSS allowed Washington, D.C. to efficiently manage cases for people who lived, worked or used providers in other states within the greater metropolitan area, which improved the accuracy of reporting for Maryland, Washington, D.C. and Virginia. CDC continues to focus on improving efficiency of technology by completing a two-part evaluation of NNDSS. Phase I, completed December 2011, focused on CDC stakeholders who process, validate, and use NNDSS data. Phase II, launched at a public health conference in June 2012, focused on state-level users. On the basis of the evaluation results so far, CDC made further data-quality improvements and increased data processing efficiency. Reporting will be easier by adopting more intuitive visual displays. Interactive systems will allow users, both at CDC and at state and local levels, to use their own data to create need-specific charts, maps, and trend lines. In FY 2014, CDC will continue to make recommended improvements to data quality and completeness, and provide users with better visual analysis tools.

Epidemiology

In FY 2014, CDC will extend the readership of MMWR and CDC Vital Signs by partnering with constituents in state and local health departments; international colleagues; clinical medicine counterparts; print, broadcast, and online media; to make both publications more readily available through current and emerging technology in academic, research, and clinical settings. In FY 2012, CDC provided high quality, timely and useful scientific products and services to strengthen and improve public health science and decision-making. The Public Health Library and Information Center use in key areas such as article downloads, literature searches, reference questions, and training increased from 28 to 54 percent from FY 2011 levels, depending on the service. In the last six months of FY 2012 alone, *MMWR* published over 150 reports and summaries, and increased electronic subscribers by 20 percent. The *CDC Vital Signs* reached more than 1.8 million communication channels through www.cdc.gov/vitalsigns, social media, and subscribers to CDC information subscriptions services.

In FY 2014, CDC will continue to provide administrative, research and technical support to the Community Preventive Services Task Force. CDC provided scientific input to the Task Force in developing recommendations regarding tobacco use, skin cancer, health equity, alcohol and motor vehicle-related injury; provided technical assistance to seven states to increase awareness and use of the Guide; and increased by 125 percent the number of people receiving updates through GovDelivery e-mail service in the last six months of FY 2012. Across the nation, communities will continue to use recommendations to improve health and save money; for example, the Mount Prospect, Illinois school system saved \$66,657 annually on busing and doubled the number of students walking to school after implementing Task Force-recommended "street-scale infrastructure improvements" (e.g. sidewalks, marked crossings) to increase student activity levels.

In FY 2012, CDC released Epi Info™ version 7.1, an update with new mobile and web survey components; conducted 15 instructor-led training courses to 370 participants through collaboration with various public health partners; provided training to 81 new EIS officers; and conducted 15 Epi Info™ demonstrations for various public health partners. In FY 2014, CDC will continue these activities and expand efforts to maximize the impact of Epi Info™, including providing 20 demonstrations and 21 instructor-led training courses to various public health partners. In addition, CDC will maximize the

impact of Epi Info™ by developing special studies and investigations for domestic and international partners, and customer-requested services that allow access via handheld devices and the internet.

Informatics

In FY 2014, CDC will increase the public health usability of Electronic Health Records–Meaningful Use (EHR-MU), automated laboratory information systems, and health information exchanges by developing standard informatics guidelines and tools in collaboration with other CDC programs. These standards will streamline important public health activities such as emergency outbreak alerting, laboratory science practices, and clinician decision support. Current accomplishments include CDC’s pilot project with Chicago Department of Public Health and a network of Chicago Community Health Centers to deliver electronic public health outbreak alerts through electronic medical record (EMR) systems to clinicians. The alerts allow clinicians to react more quickly and effectively against a public health threat, by utilizing CDC-provided clinical guidelines and patient education information.

CDC informatics efforts will improve and increase the quality and quantity of data it provides to public health officials for interventions and decision-making. 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. In FY 2014, CDC will continue to explore innovative technology options using the applied public health informatics laboratory and research cloud. Since FY 2011, the laboratory has tested and supported 55 projects, representing 25 CDC programs. With level funding, the public health informatics laboratory plans to have an additional 31 engagements with 20 programs in FY 2014.

CDC will continue developing a public health platform that will enhance the mechanisms of collecting, processing, analyzing, and disseminating collected electronic health data. The platform will serve current and future public health needs, and will be designed with the potential to easily accommodate ever-changing technology.

Laboratory Science, Policy, and Practice

In FY 2014, CDC will implement new agency-wide policies for specimen collection management and ensure that CDC laboratories, which work with select agents and toxins, comply with federal regulatory requirements. In FY 2011, CDC developed and adopted the new Select Agents and Toxins Compliance Policy, the first uniform policy for possession, use, and transfer of dangerous select agents and toxins for all CDC laboratories in the United States. CDC also managed a unique and invaluable repository of biological specimens for use by researchers.

CDC will also ensure and track CDC compliance with federal dual-use research of concern requirements, and implement its five-year technology transfer plan. In FY 2012, CDC developed the first-ever, five-year plan to intensify and accelerate the commercialization of inventions developed by CDC laboratory scientists. This will lead to rapid translation of CDC scientific findings into new diagnostic tests, vaccines, and other products that public health departments and healthcare providers will use to prevent disease, identify disease cases, and treat patients.

CDC will create additional practical resources and provide scientific and programmatic expertise in FY 2014 to improve public health laboratories’ efficiency, effectiveness, and sustainability. Public health laboratories provide support to the nation’s health preparedness efforts. In FY 2012, CDC and partners launched the Laboratory Efficiencies Initiative (LEI) to help public health laboratories maintain critical testing protocols and build long-term sustainability. CDC implements high-efficiency management practices such as sharing test services among states, standardizing testing platforms, adopting interoperable informatics systems, and reducing procurement costs. Among other practical achievements, CDC led development and national dissemination of an evidence-based guide that laboratory directors can use to assess and plan implementation of such practices.

CDC will develop and deliver a minimum of 60 training courses in advanced public health laboratory practice to state and local public health professionals. Training needs assessments show there will be a large exodus of experienced staff from public health laboratories by 2020. New entrants into the public health laboratory workforce will require extensive training in basic, intermediate, and advanced microbiology; in molecular biology skills; and in such overarching skillsets as biosafety, biosecurity, and quality management systems. CDC will develop a new curriculum on core laboratory skills to address this critical need. In FY 2012, CDC conducted more than 96 training courses, reaching more than 6,000 laboratory professionals on topics such as biosecurity and biosafety best practices, influenza testing, tuberculosis, vaccine-preventable diseases, newborn screening, and parasitology. Evaluations from the training workshops indicated that: (1) 58 percent of training course participants implemented new or modified testing protocols and (2) 63 percent of the public health and clinical laboratory professionals who participated in training workshops will improve their laboratories' policies or practices.

Grant Tables:

Behavioral Risk Factor Surveillance System (BRFSS) Grant Table'

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	57	57	57
Average Award	\$0.247	\$0.247	\$0.247
Range of Awards	\$0.048–\$0.458	\$0.048–\$0.458	\$0.048–\$0.458
Number of New Awards ²	2	0	0
Number of Continuing Awards	55	57	57
Total Grant Award	\$14.100	\$14.100	\$14.100

¹The 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 2012. Non-core funding from other CDC programs and PPHF dollars are not reflected in this table.

²In FY 2011, two new territories joined the BRFSS, bringing the total to 57 grantees.

CDC works in partnership with state and territorial health departments through cooperative agreements to administer the BRFSS. Grant 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.). In FY 2014, CDC will fund 57 grantees to complete approximately 500,000 BRFSS surveys.

National Notifiable Diseases Surveillance System (NNDSS) Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	63	64	64
Average Award	\$0.163	\$0.162	\$0.162
Range of Awards	\$0.010–\$0.373	\$0.010–\$0.373	\$0.010–\$0.373
Number of New Awards ¹	7	1	1
Number of Continuing Awards	56	64	64
Total Grant Award	\$10.343	\$10.659	\$10.259

¹New funding opportunity announcement was recompeted in FY 2012.

In FY 2012, the beginning of a new five-year cooperative agreement period, all 50 states, five large local health departments, the Commonwealth of Puerto Rico, Washington D.C., and an additional six United States Affiliated Pacific Island territories were funded. These cooperative agreement awards are competitive, based on grantee request, and subject to the availability of funds. In FY 2013, the U.S. Virgin Islands will begin to receive funding for electronic disease reporting. CDC's NNDSS funding provides local and state public health agencies with the means to track, report, and respond to notifiable diseases. Funding is used to assist states to increase capacity (i.e. IT upgrades, personnel etc.) to provide

notifiable disease information to CDC in a timely manner. Because diseases do not respect borders, every major country in the world has a nationally notifiable disease surveillance system.

PUBLIC HEALTH WORKFORCE AND CAREER DEVELOPMENT BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$41.688	\$41.943	\$42.031	+\$0.343
ACA/PPHF	\$25.000	N/A	\$25.000	\$0.000
Total	\$66.688	\$41.943	\$67.031	+\$0.343

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Program 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 ensures a prepared, diverse, and sustainable public health workforce through programs that recruit new talent through experiential fellowships and provide high-quality workplace training, including e-learning. CDC’s fellowships and student programs develop skilled public health workers, serve state and local health departments, and fill gaps in key public health areas. CDC's fellowships include: (1) Epidemic Intelligence Service (EIS), (2) Presidential Management Fellows Program, (3) Prevention Effectiveness Fellowship Program, (4) Preventive Medicine Residency/Fellowship, (5) Public Health Associate Program, (6) Public Health Informatics Fellowship Program, and (7) Public Health Prevention Service (PHPS). CDC fellows provide a range of services to global, federal, state, tribal, local, and territorial partners. Fellows provide critical assistance with ongoing public health challenges, such as foodborne outbreak responses, reducing healthcare-associated infections, obesity prevention, tobacco use reduction, and injury prevention,. Fellows also provide surge capacity during public health emergencies, such as natural disasters and outbreaks of influenza, polio, and cholera. Placement of some fellows in the field also fills critical public health workforce gaps throughout the country. In addition to bringing new talent into public health, CDC trains the current workforce. CDC's centralized learning management system, CDC TRAIN, is accessible to all members of the public to pursue e-learning on a wide range of public health topics.

Budget Proposal: CDC’s FY 2014 request of \$67,031,000 for Public Health Workforce and Career Development, including \$25,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an increase of \$343,000 above the FY 2012 level.

As of September 30, 2012, CDC supported 546 fellows; 339 (62%) of those fellows were in state, tribal, local, and territorial field assignments in 45 states, Washington, D.C., American Samoa, Puerto Rico, and five tribal locations. The remaining fellows, 207 (38%), were assigned to CDC. CDC’s “disease detectives” from the Epidemic Intelligence Service (EIS) were on the ground early in the nationwide response to the 2012 fungal meningitis outbreak, playing a key role in extending CDC’s response and providing assistance to state and local public health officials. Over 80 EIS officers were marshaled for the response, providing 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. In FY 2014, CDC will maintain capacity to support fellowship programs, including EIS, which provide robust experiential learning while filling critical gaps in the public health workforce, and provide continuing education and training for the existing health professional workforce. In FY 2014, CDC will provide additional public health e-learning opportunities, enhance scientific and programmatic expertise provided by fellows, and increase its efforts to retain fellows in the public health system.

In FY 2014, CDC’s cooperative agreements with academic partners will initiate the placement of fellows in community-based public health assignments, while continuing to support approximately 17 fellows in

assignments at CDC. The cooperative agreements also will support the integration of population health concepts into curricula at medical, nursing, and public health schools.

Recognizing a need in the public health community, CDC is currently developing a new core curriculum for entry-level staff to enhance crosscutting skills in the basic public health sciences, including epidemiology, surveillance, informatics, prevention effectiveness, and laboratory practice. Since the launch of the CDC TRAIN learning management system in August 2011, over 36,000 learners have registered, giving them access to over 4,900 high-quality, technology-based learning products. In FY 2014, CDC plans to continue to expand access to public health e-learning products and training for the health professional workforce by including more learning products in CDC TRAIN, promoting the core public health curriculum, and connecting partner learning management systems.

CDC will reduce recruiting costs for its fellowships through social media; webinars; use of local, virtual career fairs; and videoconferencing. CDC will seek additional ways to achieve cost savings in the recruitment and training of fellows. CDC also will retain more fellowship graduates in state and local assignments through contracts, direct assistance, and increasing awareness of field assignment positions available across the agency.

Grant Table:

Academic Partners Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	4
Average Award	\$0.325	\$0.325	\$0.325
Range of Awards	\$0.265–\$0.385	\$0.265–\$0.385	\$0.265–\$0.385
Number of New Awards ¹	4	0	0
Number of Continuing Awards	0	4	4
Total Grant Award²	\$1.300	\$1.300	\$1.300

¹New funding opportunity announcement was recomputed in FY 2012.

²Total grant award represent the core award; other CDC offices can choose to fund supplemental awards using this cooperative agreement.

CDC funds four awardees through a competitive cooperative agreement program. The purpose of the cooperative agreement is to foster collaboration between academia and public health in order to make education more practical, and align academia with ground-level public health priorities as a strategy to improve population health. This cooperative agreement provides financial assistance for professional associations that represent domestic schools and programs that educate 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 of Public Health, and American Association of Colleges of Nursing. The collaborative facilitates interprofessional exchange and partnerships essential in enhancing professional education and improving public health. At the end of five years, awardees are expected to expand by 25 percent the number of medical and nursing schools that integrate population health concepts into their curriculum.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
ACA/PPHF	\$70.000	N/A	\$70.000	\$0.000

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The following activities are included:

- Healthcare Surveillance/Health Statistics – \$30,000,000

- Public Health Research - \$5,000,000
- Public Health Workforce Capacity – \$25,000,000 (included in the Public Health Workforce narrative)
- Community Guide – \$10,000,000

Healthcare Surveillance/Health Statistics

In FY 2014, CDC will target the \$30,000,000 request in Prevention and Public Health Fund investments toward tracking the effects of the Affordable Care Act on the healthcare system and on health outcomes. CDC will also direct \$5,000,000 for public health systems research as authorized by Section 4301 of the Affordable Care Act. The National Health Interview Survey (NHIS), National Ambulatory Medical Care Survey (NAMCS), and National Hospital Ambulatory Medical Care Survey (NHAMCS) are the core data systems used to monitor the effects of the Affordable Care Act. The NHIS will track the Affordable Care Act impact on care access and utilization. The increase in the NHIS sample will provide stable estimates for targeted populations. The NAMCS sample of physicians will expand to permit greater precision for estimates related to care that different population groups and groups with different conditions receive.

Surveys of ambulatory care through NAMCS, and hospital outpatient departments through NHAMCS, will expand the data collected on clinical management and on patient's risk factors for those with heart disease and stroke during the 12 months before the sampled visit. These data and resulting analysis will permit monitoring and evaluating goals to increase prevention through healthcare programs and expanded insurance coverage.

CDC will provide funding to the two states and territories that have not implemented the re-engineered, web-based electronic birth record systems and 2003 U.S. Standard Birth Certificate. Re-engineering the states' electronic infrastructure for registering birth and death certificates will improve the timeliness, quality, and security of the National Vital Statistics System. This will allow for faster reporting of birth data that is important to public health planning and evaluation. The computerization of birth as well as death certificates is crucial to improve security and effectively cross-match birth and death records to reduce birth certificate fraud. This funding will build on \$2,500,000 provided in FY 2012 to implement electronic birth record systems in four states.

CDC will use the Behavioral Risk Factor Surveillance System (BRFSS) to collect more detailed state-specific data for state- and sub-state adult populations on health insurance coverage, access to healthcare, and use of clinical preventive services than is currently available in the BRFSS. This funding will provide an additional year of data that state and local health departments can use to: (1) monitor the impacts of the Affordable Care Act on state healthcare access and utilization; and (2) 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.

CDC will undertake research that seeks to identify the economic and budgetary impacts of public health interventions; expand data on healthcare utilization and effectiveness; and inform how public health should evolve and public health and healthcare should collaborate as the healthcare delivery system transforms.

Community Guide

The Community Preventive Services Task Force (Task Force) findings and recommendations identify programs, services, and policies proven effective in a variety of real-world settings, such as communities, worksites, schools, and health plans. Demand for Task Force findings and recommendations are stronger now than ever before. In FY 2014, CDC will continue to provide ongoing administrative, research, and technical support for the operations of the Task Force by:

- Increasing the number of Community Guide systematic reviews that support Task Force findings and recommendations to address high-priority public health needs and identifying evidence gaps.
- Building dissemination and implementation support to assist policymakers, practitioners, and other decision makers in accessing and using Task Force recommendations.
- Increasing efficiency of Task Force operations to include supporting Task Force and committee meetings and the Task Force Annual Report to Congress.

PERFORMANCE

Program: Health Statistics

Performance Measures for Long Term Objective: Monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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)	9.4	7.5	-1.9
8.A.1.1a: Sustain the percentage of NCHS website users that are satisfied with data quality and relevance (Outcome)	FY 2012: 77.4% (Target Exceeded)	75.2%	77.4%	+2.2
8.A.1.1b: Sustain the percentage of Federal Power Users (key federal officials involved in health and healthcare policy or programs) that indicate that data quality is good or excellent (Outcome)	FY 2012: 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 ¹ (Output)	FY 2012: 8.2 Million (Target Not Met)	8.5 Million	10.6 Million	+2.1
8.F: Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey (Output)	FY 2012: 15 (Target Met)	15	15	Maintain
8.G: Number of households interviewed in the National Health Interview Survey ^{2,3} (Output)	FY 2012: 51,000 ⁴ (Target Exceeded)	46,500	55,000	+8,500
8.H.1: Number of physicians surveyed in the National Ambulatory Medical Care Survey ^{2,3} (Output)	FY 2012: 18,741 (Target Exceeded)	10,200	14,500	+4,300
8.H.2: Number of patient visit records surveyed in the National Ambulatory Medical Care Survey ^{2,3} (Output)	FY 2012: 170,543 (Target Exceeded)	90,000	132,000	+42,000

¹For FY 2013 onward, targets and actual results reflect an improved method for calculating web visits.

²FY 2012 targets and results reflect ACA/PPHF funding.

³The increase in NHIS and NAMCS sample size will vary depending on when funds are received.

⁴This is an estimate. Final data will be available June 30, 2013.

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 and improving efficiency while maintaining data quality (Measure 8.A.E.1). To drive program improvements, CDC 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 10 percentage points since 2008 (Measure 8.A.1.1a). Similarly, in 2012 CDC interviewed Federal Power Users (key federal officials involved in health and healthcare 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 percent Good or Excellent ratings for the fifth consecutive year in FY 2012 (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 decreased by 0.5 million in FY 2012 compared to 2010, although still up from 6.8 million in FY 2008 (Measure 8.A.1.3). A more accurate system for verifying web visits will be used beginning in FY 2013. CDC anticipates this system will reflect higher use of the NCHS web site than could be captured previously.

In addition to data quality, CDC also monitors the implementation of its national surveys. The number of communities visited by the mobile examination centers for the National Health and Nutrition Examination Survey remained stable at 15 (Measure 8.F). Since 2010, CDC has increased the number of interviews for two of its surveys. The sample size of the National Health Interview Survey increased by approximately 23 percent in FY 2012 compared to 2011 and 33 percent compared to 2010 (Measure 8.G). For the National Ambulatory Medical Care Survey, the number of physicians interviewed and patient records surveyed increased, by 367 percent and 414 percent, respectively over FY 2011 (Measures 8.H.1 and 8.H.2). The increases were due largely to funding received from the Prevention and Public Health Fund to monitor health reform efforts. Better data on expanded access to care, prevention, management of chronic conditions, and ultimately, improved health outcomes will result from the expansions. The Prevention and Public Health Funds for the National Ambulatory Medical Care Survey allowed for an increase in the sample; the timing of the receipt of those funds resulted in an even greater increase in the 2012 calendar year sample than had been anticipated. CDC anticipates the sample size will stabilize at a lower level in future survey years and has set the FY 2014 target accordingly. FY 2014 targets for the National Health Interview Survey and National Ambulatory Care Survey are set assuming comparable Prevention and Public Health Fund dollars. If funding is not comparable, the targets will need to be adjusted.

CDC also provides funding and programmatic expertise to states for the development, implementation, and adoption of electronic birth records. CDC continues a longstanding collaboration with the National Association for Public Health Statistics and Information Systems to improve the timeliness and quality of information derived from vital records and vital registration systems operated by cities, states, and territories. By the end of FY 2012, 47 of the 57 registration jurisdictions had re-engineered their birth registration systems. At the end of FY 2012, CDC funded six jurisdictions to complete the re-engineering of their birth systems and have an operational system in place by January 2014. In addition, 36 jurisdictions re-engineered death registration systems by the end of FY 2012, but a substantial number of jurisdictions had not fully implemented their systems.

Program: Surveillance, Epidemiology, and Laboratory Services (SELS)

Performance Measures for Long Term Objective: Lower barriers to data exchange across jurisdictions for public health surveillance and response.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 18% (Baseline)	N/A	54%	N/A
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 2012: 85% (Baseline)	N/A	65%	N/A
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 2012: 2% (Baseline)	N/A	63%	N/A
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 2012: 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 System (BRFSS) (Output)	FY 2011: 14.1% (Baseline)	N/A	25%	N/A

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.

Performance Measures for Long Term Objective: Improve access to and reach CDC's scientific health information among key audiences to maximize health impact

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 164,324 (Target Exceeded)	145,648	179,737	+34,089
8.B.2.2: Increase the electronic media reach of CDC Vital Signs through the 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 2012: 1,829,111 (Target Exceeded)	1,169,208	1,959,343	+790,135
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 2012: 1,220,956 (Target Exceeded)	973,724	1,220,956	+247,232

¹ FY 2012 targets and results reflect ACA/PPHF funding.

Performance Measures for Long Term Objective: Prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 58% (Baseline)	N/A	60%	N/A

Informatics Performance Trends: CDC developed new measures for FY 2014 to reflect the contribution of the informatics program and CDC program partners to the “Electronic Health Records – Meaningful Use” (EHR-MU) initiative. CDC is strengthening its capacity 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 need to test their capability to receive data in Meaningful Use-compliant format (i.e., Health Level 7 (HL7) 2.5.1 and 2.3.1 standards) from eligible hospitals, i.e. those hospitals with certified EHRs participating in the Centers for Medicare and Medicaid Services' Meaningful Use program. In FY 2014, Meaningful Use stage two requires all Immunization Information Systems providers to use HL7 version 2.5.1 format only. While providers currently using HL7 version 2.3.1 format are likely to be grandfathered in, CDC still anticipates a drop in capability with the transition to HL7 version 2.5.1, and has set a reduced target for FY 2014 (Measure 8.B.1.3b). CDC expects significant capability gains in FY 2013 and FY 2014 for Electronic Laboratory Reporting and Syndromic Surveillance as healthcare and public health agencies strive to meet the Meaningful Use program's stage one and two requirements identified for FY 2014 (Measures 8.B.1.3a and 8.B.1.3c). Public health agencies are not currently required to develop the ability to send messages to eligible providers and hospitals. The Office of National Coordinator for Health Information Technology is considering whether sending information to EHRs from public health agencies will be a stage three measure which would begin in FY 2016. However, it would likely only apply to Immunization Information Systems.

Surveillance Performance Trends: The National Notifiable Disease Surveillance System (NNDSS) monitors nationally reported cases of 77 diseases and funds 63 state and local jurisdictions to conduct disease detection and reporting. National data allows CDC to monitor trends, evaluate the effectiveness of prevention and control activities, conduct program planning and evaluation, develop public health policy, and conduct research. Currently, 18 states and Washington, D.C. use the CDC-developed National Electronic Disease Surveillance System (NEDSS)-Base System to transmit data to NNDSS. Another 28 states use a NEDSS-compatible system, and four states are implementing a NEDSS-compatible system. The remaining state, local, and territorial health departments provide data to CDC using other electronic and telephonic systems. 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. Jurisdictions have improved their ability to exchange data electronically with partners for surveillance purposes (Measure 8.K). For instance, 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 initially established the Behavioral Risk Factor Surveillance System (BRFSS) as a landline telephone-based health survey system conducted by states and territories. However, advances in telecommunications, most notably the development of cell phones, have impacted the ability of the BRFSS to operate as originally designed. 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 adults 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 cell phone interviews conducted from 4.5 percent in FY 2009 to 14.1 percent in FY 2011 (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—that are more common among younger respondents who were under-represented in the landline-only survey.

Epidemiology Performance Trends: In FY 2012 CDC delivered critical epidemiological data and recommendations for solving public health problems to over 160,000 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 115 percent since 2008, exceeding the target for four consecutive years (Measure 8.B.2.1). CDC anticipates the number of subscribers will continue to increase over the next two years. Similarly, the electronic media reach of CDC Vital Signs—a monthly program that targets the public, healthcare professionals, and policymakers through, fact sheets, social media, a website (<http://www.cdc.gov/vitalsigns>) and a linked issue of the MMWR—grew to over 1.9 million communications channels due to print, broadcast and cable media interest (Measure 8.B.2.2). CDC exceeded the FY 2011 and FY 2012 targets, but anticipates slower growth in the future, as media saturation is likely.

Community Guide findings and recommendations help decision makers, practitioners, and researchers select prevention strategies best suited to their settings and populations. In FY 2011 CDC established a performance measure to track access to and awareness of Community Guide findings and recommendations using page views of the Community Guide website (<http://www.thecommunityguide.org>) as a proxy for use (Measure 8.B.2.5). In FY 2012 CDC experienced 1,220,956 page views on the Community Guide website, exceeding the FY 2012 target by 25 percent. CDC will maintain this level of performance in FY 2014. A new measure to track use of the Community Guide's evidence-based findings and recommendations is in development. Additionally, in FY 2012, the Community Guide completed 14 systematic reviews in the following areas: tobacco use, cardiovascular disease, skin cancer, mental health, health equity, alcohol, and motor vehicle-related injury.

Laboratory Science Performance Trends: CDC developed a new, expanded measure for FY 2014 that tracks improvements to laboratory practices and policies resulting from CDC trainings (Measure 8.B.3.2). The new measure tracks “positive training outcomes” or improvements made in laboratory practice and policy as a result of all CDC laboratory workshops, providing more comprehensive data on outcomes of CDC laboratory workshops. Improvements include more accurate and timely test results for better community and patient health as well as safer and more secure laboratories, thereby protecting both laboratory professionals and the community at large. CDC calculates results by dividing the number of training participants who report making improvements by the total number of participants who respond to a survey conducted three to six months following training or who participate in a post-training proficiency testing challenge. CDC considers participants who successfully complete proficiency-testing challenges to have made a positive change based on their demonstrated ability to apply the skills learned in training in their own laboratory environment.

Program: Public Health Workforce and Career Development¹

Performance Measures for Long Term Objective: CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management. ² (Output)	FY 2012: 230 (Target Exceeded)	200	230	+30
8.B.4.2: Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies. ³ (Output)	FY 2012: 335 (Target Exceeded)	237	298	+61
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: 243 (Target Exceeded)	176	212	+36

¹ FY 2012 targets and results for 8.B.4.1, 8.B.4.2 and 8.B.4.3 reflect some ACA/PPHF funding.

² 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).

³ 8.B.4.2 includes ALL (new and continuing) CDC-funded trainees in EIS, PHPS, PMR/F, Public Health Informatics Fellowship Program (PHIFP), Public Health Associate Program (PHAP), Emerging Infectious Diseases (EID) Laboratory Fellowship, CDC/CSTE Applied Epidemiology Fellowship, Health Systems Integration Program (HSIP), and Applied Public Health Informatics Fellowship (APHIF).

⁴ 8.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, helping to fill a critical need, as the public health workforce has decreased by at least 57,000 jobs since 2008. In 2012, 84 percent of CDC’s fellowship program graduates pursued careers in public health practice, while less than 25 percent of graduates of schools of public health did so. CDC met or exceeded its target for four of the past five years for the number of new and continuing trainees in three long-standing CDC fellowship programs: the Epidemic Intelligence Service (EIS), Public Health

Prevention Service (PHPS), and Preventive Medicine Residency/Fellowship (PMR/F) (Measure 8.B.4.1). In FY 2014 CDC will support 230 trainees in these programs, maintaining current performance. Over the past two years, CDC exceeded the targets for its other 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. In FYs 2010, 2011, and 2012, CDC leveraged resources from other CDC programs and the Prevention and Public Health Fund (PPHF) to support an increase in the number of trainees. Fellowship programs tracked by Measures 8.B.4.2 and 8.B.4.3 are not proposed to receive additional PPHF funding in FY 2014, and therefore, CDC has set targets that are greater than the FY 2012 targets, but more modest than the FY 2012 results.

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 2012, CDC increased the number of trainees in STLT public health agencies from 119 trainees in 2009 to 335 (Measure 8.B.4.2) by targeting funding to fellowship programs that place fellows in STLT public health agencies. This strengthened workforce capacity in several critical disciplines, such as applied epidemiology, public health management, and informatics. As of September 30, 2012, CDC supported 546 fellows, 339 (62 percent) of whom were in state, tribal, local and territorial field assignments in 45 states, the District of Columbia, American Samoa, Puerto Rico, and five tribal locations. CDC assigned the remainder to headquarters. In FY 2012, PPHF supported 251 (74 percent) of CDC's 339 fellows in STLT public health agencies.

STATE TABLES^{1,2}

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$234,352	\$234,352	\$234,352	\$0
Alaska	\$305,941	\$305,941	\$305,941	\$0
Arizona	\$267,044	\$267,044	\$267,044	\$0
Arkansas	\$238,182	\$238,182	\$238,182	\$0
California	\$303,492	\$303,492	\$303,492	\$0
Colorado	\$353,797	\$353,797	\$353,797	\$0
Connecticut	\$275,295	\$275,295	\$275,295	\$0
Delaware	\$166,481	\$166,481	\$166,481	\$0
District of Columbia	\$285,977	\$285,977	\$285,977	\$0
Florida	\$192,018	\$192,018	\$192,018	\$0
Georgia	\$201,334	\$201,334	\$201,334	\$0
Hawaii	\$269,849	\$269,849	\$269,849	\$0
Idaho	\$247,486	\$247,486	\$247,486	\$0
Illinois	\$235,567	\$235,567	\$235,567	\$0
Indiana	\$212,414	\$212,414	\$212,414	\$0
Iowa	\$241,797	\$241,797	\$241,797	\$0
Kansas	\$458,586	\$458,586	\$458,586	\$0
Kentucky	\$202,186	\$202,186	\$202,186	\$0
Louisiana	\$238,182	\$238,182	\$238,182	\$0
Maine	\$240,456	\$240,456	\$240,456	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Maryland	\$282,377	\$282,377	\$282,377	\$0
Massachusetts	\$294,372	\$294,372	\$294,372	\$0
Michigan	\$318,839	\$318,839	\$318,839	\$0
Minnesota	\$259,564	\$259,564	\$259,564	\$0
Mississippi	\$220,776	\$220,776	\$220,776	\$0
Missouri	\$224,592	\$224,592	\$224,592	\$0
Montana	\$307,527	\$307,527	\$307,527	\$0
Nebraska	\$225,437	\$225,437	\$225,437	\$0
Nevada	\$273,818	\$273,818	\$273,818	\$0
New Hampshire	\$296,221	\$296,221	\$296,221	\$0
New Jersey	\$309,314	\$309,314	\$309,314	\$0
New Mexico	\$274,316	\$274,316	\$274,316	\$0
New York	\$306,258	\$306,258	\$306,258	\$0
North Carolina	\$350,422	\$350,422	\$350,422	\$0
North Dakota	\$212,281	\$212,281	\$212,281	\$0
Ohio	\$207,637	\$207,637	\$207,637	\$0
Oklahoma	\$221,855	\$221,855	\$221,855	\$0
Oregon	\$320,444	\$320,444	\$320,444	\$0
Pennsylvania	\$199,648	\$199,648	\$199,648	\$0
Rhode Island	\$214,006	\$214,006	\$214,006	\$0
South Carolina	\$295,111	\$295,111	\$295,111	\$0
South Dakota	\$170,951	\$170,951	\$170,951	\$0
Tennessee	\$165,783	\$165,783	\$165,783	\$0
Texas	\$252,566	\$252,566	\$252,566	\$0
Utah	\$322,040	\$322,040	\$322,040	\$0
Vermont	\$170,964	\$170,964	\$170,964	\$0
Virginia	\$189,660	\$189,660	\$189,660	\$0
Washington	\$326,535	\$326,535	\$326,535	\$0
West Virginia	\$282,377	\$282,377	\$282,377	\$0
Wisconsin	\$286,800	\$286,800	\$286,800	\$0
Wyoming	\$290,785	\$290,785	\$290,785	\$0
State Sub-Total	\$13,243,712	\$13,243,712	\$13,243,712	\$0
America Samoa	\$77,190	\$77,190	\$77,190	\$0
Guam	\$146,792	\$146,792	\$146,792	\$0
Micronesia	\$48,466	\$48,466	\$48,466	\$0
Puerto Rico	\$190,913	\$190,913	\$190,913	\$0
Palau	\$127,192	\$127,192	\$127,192	\$0
Virgin Islands	\$234,198	\$234,198	\$234,198	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Territory Sub-Total	\$824,751	\$824,751	\$824,751	\$0
Total States/Territories	\$14,068,463	\$14,068,463	\$14,068,463	\$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/>.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM (NNDSS)				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$240,108	\$240,108	\$240,108	\$0
Alaska	\$224,698	\$224,698	\$224,698	\$0
American Samoa	\$57,801	\$57,801	\$57,801	\$0
Arizona	\$99,973	\$99,973	\$99,973	\$0
Arkansas	\$109,699	\$109,699	\$109,699	\$0
California	\$300,191	\$300,191	\$300,191	\$0
Chicago	\$136,789	\$136,789	\$136,789	\$0
Colorado	\$232,876	\$232,876	\$232,876	\$0
Commonwealth of Puerto Rico	\$80,214	\$80,214	\$80,214	\$0
Commonwealth of Northern Mariana Islands	\$24,210	\$24,210	\$24,210	\$0
Connecticut	\$180,491	\$180,491	\$180,491	\$0
Delaware	\$77,496	\$77,496	\$77,496	\$0
Federated States of Micronesia	\$9,580	\$9,580	\$9,580	\$0
Florida	\$128,120	\$128,120	\$128,120	\$0
Georgia	\$124,080	\$124,080	\$124,080	\$0
Guam	\$172,978	\$108,488	\$108,488	-\$64,490
Hawaii	\$181,493	\$181,493	\$181,493	\$0
Houston	\$146,533	\$146,533	\$146,533	\$0
Idaho	\$108,118	\$108,118	\$108,118	\$0
Illinois	\$141,188	\$141,188	\$141,188	\$0
Indiana	\$97,366	\$97,366	\$97,366	\$0
Iowa	\$202,571	\$202,571	\$202,571	\$0
Kansas	\$159,205	\$159,205	\$159,205	\$0
Kentucky	\$71,521	\$71,521	\$71,521	\$0
Los Angeles	\$280,649	\$280,649	\$280,649	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM (NNDSS)				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Louisiana	\$257,449	\$257,449	\$257,449	\$0
Maine	\$125,200	\$125,200	\$125,200	\$0
Maryland	\$323,770	\$323,770	\$323,770	\$0
Massachusetts	\$149,344	\$149,344	\$149,344	\$0
Michigan	\$94,580	\$94,580	\$94,580	\$0
Minnesota	\$264,192	\$264,192	\$264,192	\$0
Mississippi	\$86,954	\$86,954	\$86,954	\$0
Missouri	\$182,327	\$182,327	\$182,327	\$0
Montana	\$136,460	\$136,460	\$136,460	\$0
Nebraska	\$235,433	\$235,433	\$235,433	\$0
Nevada	\$198,903	\$198,903	\$198,903	\$0
New Hampshire	\$142,655	\$142,655	\$142,655	\$0
New Jersey	\$199,650	\$199,650	\$199,650	\$0
New Mexico	\$111,944	\$111,944	\$111,944	\$0
New York	\$373,484	\$373,484	\$373,484	\$0
New York City	\$210,574	\$210,574	\$210,574	\$0
North Carolina	\$98,407	\$98,407	\$98,407	\$0
North Dakota	\$108,574	\$108,574	\$108,574	\$0
Ohio	\$332,561	\$332,561	\$332,561	\$0
Oklahoma	\$135,941	\$135,941	\$135,941	\$0
Oregon	\$252,640	\$252,640	\$252,640	\$0
Pennsylvania	\$263,963	\$263,963	\$263,963	\$0
Philadelphia	\$92,037	\$92,037	\$92,037	\$0
Republic of Marshall Islands	\$24,610	\$24,610	\$24,610	\$0
Republic of Palau	\$45,508	\$45,508	\$45,508	\$0
Rhode Island	\$216,631	\$216,631	\$216,631	\$0
South Carolina	\$159,325	\$159,325	\$159,325	\$0
South Dakota	\$58,827	\$58,827	\$58,827	\$0
Tennessee	\$164,572	\$164,572	\$164,572	\$0
Texas	\$74,256	\$74,256	\$74,256	\$0
Utah	\$124,969	\$124,969	\$124,969	\$0
Vermont	\$205,040	\$205,040	\$205,040	\$0
Virginia	\$350,727	\$350,727	\$350,727	\$0
Virgin Islands	\$0	\$79,880	\$79,880	\$79,880
Washington	\$264,765	\$264,765	\$264,765	\$0
Washington, District of Columbia	\$151,644	\$151,644	\$151,644	\$0
West Virginia	\$182,844	\$182,844	\$182,844	\$0
Wisconsin	\$184,210	\$184,210	\$184,210	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM (NNDSS)				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Wyoming	\$171,035	\$171,035	\$171,035	\$0
Total States/Territories	\$10,343,953	\$10,359,343	\$10,359,343	\$15,390

OCCUPATIONAL SAFETY AND HEALTH

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
NIOSH – Discretionary Total	\$325.281	\$327.327	\$271.911	-\$53.370
Budget Authority	\$214.557	\$215.925	\$0.000	-\$214.557
PHS Evaluation Transfer	\$110.724	\$111.402	\$271.911	+\$161.187
EEOICPA– Mandatory	\$55.358	\$55.358	\$55.358	\$0.000
World Trade Center – Mandatory	\$187.560	\$239.230	\$241.000	+\$53.440
Total	\$568.199	\$621.915	\$568.269	+\$0.070
FTEs	1,158	1,153	1,153	-5

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Enabling Legislation Citation: PHS Act 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. 95-164 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 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

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite

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

SUMMARY

CDC's FY 2014 request of \$568,269,000 for Occupational Safety and Health is an overall increase of \$70,000 above the FY 2012 level. This request includes an increase of \$53,440,000 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. There is a \$53,370,000 decrease in the FY 2014 budget due to the proposed elimination of the Agriculture, Forestry, and Fishing Sector (AgFF), and the Education and Research Centers (ERCs). The FY 2014 request includes \$55,358,000 in mandatory funding for the Energy Employees Occupational Illness Compensation Program Act, and \$241,000,000 in mandatory funding for the World Trade Center Health Program. The Budget does not include funding for AgFF or the ERCs.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
National Occupational Research Agenda	\$124.346	\$125.107	\$98.926	-\$25.420
<i>Agriculture, Forestry and Fishing Sector Research Program (non-add)</i>	\$25.681	\$25.838	\$0.000	-\$25.681
All Other Occupational Safety and Health	\$200.935	\$202.220	\$172.985	-\$27.950

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
<i>Education and Research Centers (non-add)</i>	\$28.775	\$28.959	\$0.000	-\$28.775
EEOICPA– Mandatory	\$55.358	\$55.358	\$55.358	\$0.000
World Trade Center – Mandatory	\$187.560	\$239.230	\$241.000	+\$53.440
Total	\$568.199	\$621.915	\$568.269	+\$0.070

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

The mission of CDC's National Institute for Occupational Safety and Health (NIOSH) is to generate new knowledge in the field of occupational safety and health through collaborations with diverse partners, and to transfer that knowledge into workplace practice to prevent work-related injury, illness, and death. This work is a core element of CDC's goal to keep Americans safe from environmental and work-related hazards. CDC's work in this area protects the safety and health of the nation's 153 million workers and provides 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, which uses partnerships to maximize the impact of occupational safety and health research. CDC's Other Occupational Safety and Health activities involve areas such as surveillance, Health Hazard Evaluations, and basic laboratory research. The CDC activities described here lead to safer worksites and reduced exposure to workplace hazards. CDC also receives mandatory funding for the Energy Employees Occupational Illness Compensation Program Act and the World Trade Center Health Program.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$360.059
2010	\$429.965
2011	\$442.437
2012	\$568.199
2013	\$621.915

¹ Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

NATIONAL OCCUPATIONAL RESEARCH AGENDA (NORA) BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Budget Authority	\$13.622	\$13.705	\$0.000	-\$13.622
PHS Evaluation Transfer	\$110.724	\$111.402	\$98.926	-\$11.798
<i>AgFF Program (non-add)</i>	<i>\$25.681</i>	<i>\$25.838</i>	<i>\$0.000</i>	<i>-\$25.681</i>
Total	\$124.346	\$125.107	\$98.926	-\$25.420

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: The National Occupational Research Agenda (NORA) provides guidance to the occupational safety and health community on research priorities within ten 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 that 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 interventions to market; transferring knowledge and products to employers, workers, and policymakers; and evaluating programs using qualitative or quantitative data.

NORA research has made critical contributions to the occupational safety and health evidence base by identifying and quantifying risks and recommending potential prevention measures. For example, in FY 2012, NORA research identified preventable work-related health risks, including:

- A greater-than-expected risk of miscarriages among nurses with occupational exposures to hazardous drugs.
- Continued high risk for acute pesticide-related illness among U.S. farmworkers, with rates twice as high among female farmworkers as male farmworkers.
- An inhalation health hazard for worker exposure to crystalline silica in hydraulic fracturing or “fracking” operations.

Other recent NORA accomplishments demonstrate the translation of research into practice. For example, CDC developed an award-winning light-emitting diode (LED) cap lamp, which enhances illumination of underground mines and associated hazards, such as areas of unstable rock and large equipment, to prevent injuries to miners. CDC also worked with transportation, warehousing, and utilities industry partners to measure truck drivers’ body measurements, and found significant differences between the current truck driver workforce and truck drivers of 30 years ago. CDC disseminated these results, and subsequently four truck manufacturers and three parts suppliers used the data to create truck cabs with increased visibility, better fitting seat belts, and easier entry. In addition, in FY 2012, CDC completed 434 certified respirator decisions, including 275 new approvals, and 155 complete respirator audits, improving the quality and quantity of respiratory protection for workers in multiple industries.

Budget Proposal: CDC’s FY 2014 request of \$98,926,000 for NORA is \$25,420,000 below the FY 2012 level, and includes elimination of the Agriculture, Forestry and Fishing (AgFF) sector research program (-\$25,681,000). 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. The nine remaining research sectors employ over 136.9 million Americans—the majority of working adults—and CDC will focus on the needs of this significant group. CDC will use FY 2014 funds to address high priority occupational hazards in the other nine industry sectors listed above, as well as emerging issues that may require new approaches to prevention, such as nanotechnology. Examples of high-priority occupational hazards include 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.

In FY 2014, NORA will provide funding for Personal Protective Technology (PPT) Program activities that support PPT research 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 issued in FY 2012 and FY 2013. These new standards update the agency’s requirements for testing and certification of respiratory protective devices including closed-circuit escape respirators. The revised rules strengthen respiratory protection for workers including those escaping from toxic concentrations of fumes, gases, or smoke, or from confined areas, such as mines, where there is insufficient oxygen.

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 collaborates with partners in industry, labor, academia, and government, allowing researchers to conduct full-scale experiments before testing interventions at working mines. This capability helps evaluate and diffuse technologies that can prevent mine disasters, improve miners' likelihood of survival if trapped inside a mine after an explosion or collapse, increase the safety and effectiveness of mine rescue teams, and reduce exposure to hazardous conditions in the mining environment.

One of the emerging issues that CDC will address with FY 2014 funds is worker exposure to nanoparticles and nanomaterials. CDC provides national and international leadership in investigating the health implications of exposure to nanoparticles and nanomaterials, and makes major scientific contributions to the National Nanotechnology Initiative, a multi-agency U.S. government program that coordinates federal efforts in nanotechnology. In FY 2014, CDC will focus on developing and distributing guidance materials for businesses and government agencies to develop effective risk-management programs. CDC's Nanotechnology Research Center will 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.

Grant Table:

NORA Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	130	113	82
Average Award	\$0.442	\$0.508	\$0.469
Range of Awards	\$0.057–\$5.750	\$0.057–\$5.750	\$0.057–\$5.750
Number of New Awards	25	25	16
Number of Continuing Awards	105	88	66
Total Grant Award Amount	\$57.492	\$57.492	\$38.492

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.

ALL OTHER OCCUPATIONAL SAFETY AND HEALTH BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$200.935	\$202.220	\$0.000	-\$200.935
PHS Evaluation Transfer	\$0.000	\$0.000	\$172.985	+\$172.985
<i>ERCs (non-add)</i>	<i>\$28.775</i>	<i>\$28.959</i>	<i>\$0.000</i>	<i>-\$28.775</i>
Total	\$200.935	\$202.220	\$172.985	-\$27.950

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's 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. CDC's exposure assessment activities use multi-disciplinary research to identify and characterize workplace exposures, develop estimates of specific exposures to use in risk assessment studies, and evaluate the significance of exposure and effectiveness of intervention strategies.

Other occupational safety and health activities also include CDC's efforts to conduct and support occupational safety and health surveillance. CDC's Sentinel Event Notification System for Occupational Risk (SENSOR) program provides programmatic expertise and funding to state health departments to conduct surveillance on occupational illnesses or injuries. For example, in FY 2012, CDC scientists assessed the frequency of illness from insecticides used to control bed bugs. Relevant cases from 2003–2010 were sought from the SENSOR-Pesticides program and the New York City Department of Health and Mental Hygiene. CDC scientists provided recommendations on preventing future illness from bed bug-related insecticides by educating the public about effective bed bug management.

Other accomplishments of public health activities in this program include the FY 2011 development of an improved method for collecting samples to detect infectious airborne influenza virus. This new method could expedite the identification and collection of samples in studies of the transmission and spread of influenza, particularly among healthcare workers. In FY 2012, the CDC-funded Michigan Fatality Assessment and Control Evaluation program (which investigates work-related fatalities), in conjunction with CDC and the Occupational Safety and Health Administration (OSHA), reported deaths among bathtub finishers using methylene chloride-based stripping agents. Although the hazards of methylene chloride are known, this was the first time the hazard to workers in the bathtub refinishing industry had been recognized. Subsequently Michigan, CDC, and OSHA disseminated prevention information to employers, workers, and others, preventing further deaths.

Budget Proposal: CDC's FY 2014 request of \$172,985,000 for All Other Occupational Safety and Health is \$27,950,000 below the FY 2012 level, and includes elimination of funding for the Education and Research Centers (ERCs) (-\$28,775,000). 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 2014 funding to support public health tools, such as state-based surveillance, Health Hazard Evaluations, and exposure assessment research.

CDC will provide funding, and scientific and programmatic support 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, and temporary-worker health.

With the funds requested for FY 2014, 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 2012, CDC conducted 268 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.

Grant Table:

All Other Occupational Safety and Health Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	69	65	45
Average Award	\$0.542	\$0.575	\$0.292
Range of Awards	\$0.011-\$1.921	\$0.020-\$1.746	\$0.020-\$0.440
Number of New Awards	20	12	7
Number of Continuing Awards	49	53	38
Total Grant Award Amount	\$37.396	\$37.396	\$13.128

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.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT (EEOICPA)
BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Mandatory Funding	\$55.358	\$55.358	\$55.358	\$0.000

Program Overview: 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 2012, CDC completed 2,911 dose reconstructions and submitted them to the Department of Labor; received 13 SEC petitions; and supported 49 meetings of the ABRWH, its Subcommittees, and Work Groups. Based on the recommendations of the ABRWH, the HHS Secretary has added 94 classes of employees to the SEC as of December 4, 2012.

Budget Proposal: CDC's FY 2014 estimate of \$55,358,000 in mandatory funding for EEOICPA is level with FY 2012. As mandated by EEOICPA, CDC will use this funding for activities that support the completion of an estimated 3,000 radiation dose reconstructions to support the Department of Labor's adjudication of claims; evaluation of an estimated 12 petitions to add classes of employees to the SEC; and provide administrative and technical support for the ABRWH. CDC will 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 2014 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 trend downward toward an estimate of 3,000 in 2014 as claims are adjudicated or claimants receive compensation as members of the SEC.

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 BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Mandatory Funding	\$187.560	\$239.230	\$241.000	+\$53.440

Program Overview: The September 11, 2001 terrorist attacks in New York City, 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 physiological trauma. The James Zadroga 9/11 Health and Compensation Act of 2010 (P.L. 111-347) provided health benefits to eligible responders and survivors beginning on July 1, 2011. Pursuant to this statute, the World Trade Center Health Program (WTCHP) 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 June 2012, the WTCHP had enrolled a total of 64,000 eligible responders and survivors. Since the beginning of FY 2012, the WTCHP has received claims for eligible treatment or medication for more than 13,000 of these responders and survivors.

Budget Proposal: CDC's FY 2014 estimate of \$241,000,000 in mandatory funding for the WTCHP is an increase of \$53,440,000 above the FY 2012 level. This increase provides funding for the addition of cancer to the List of WTC-Related Health Conditions, which became effective in October 2012. The increase also includes funding for responders from the Shanksville, Pennsylvania and Pentagon sites, who will be eligible to enroll in the WTCHP in 2013. Funding will support:

- Monitoring and treatment services for responders and survivors in the WTCHP.
- Infrastructure costs for the Clinical Centers of Excellence (CCE) and the National Program to support clinical activities.
- Extramural research projects.

- Data Centers.
- The WTC Health Registry.

The WTCHP provides monitoring and treatment services via a fee-for-service model of delivery. In FY 2014, CDC will renew the intra-agency agreement with the Centers for Medicare and Medicaid Services (CMS) to reimburse the CCEs and the National Program for clinical services provided to the WTCHP members. The CCEs work as a clinical consortium with standardized medical monitoring protocols, clinical presentations, and programmatic decision-making across the practice sites. This standardization and the fee-for-service model enable the WTCHP to track claims-level data for monitoring and treatment, analyze the data for program compliance, and report on spending at a more detailed level across the WTCHP. The CCEs also engage with labor representatives and members of the New York City community to discuss program policies and ensure awareness of emerging issues.

In FY 2014, CDC will continue contracts with seven CCEs and the National Program to provide administrative and member services, and three contracts with Data Centers to provide uniform data collection and analysis. Additionally, CDC will use FY 2014 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 2014 funds will continue the cooperative agreement with the New York City Department of Health and Mental Hygiene for the WTC Health Registry data collection activities. The WTC Health Registry will continue to provide a central, unified database to help assess health effects among persons exposed to the WTC disaster.

FY 2014 funds will support the WTCHP Scientific/Technical Advisory Committee (STAC). 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 WTCHP, as evidenced by the addition of cancers to the List of WTC-Related Health Conditions. Upon request from the Administrator, the STAC convened public meetings to discuss the available scientific information and then submitted a recommendation for the addition of certain groups of cancers to the list. The WTCHP Administrator reviewed the STAC's recommendation and other available information, and issued a notice of proposed rulemaking in June 2012 recommending the addition of 50 types of cancers. The Rule became final on September 12, 2012, and went into effect on October 12, 2012.

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
9.1.1: Increase the effectiveness of the implementation of the recommendations from the National Academies reviews ¹ (Outcome)	FY 2010: Develop implementation plans in response to National Academies recommendations (Target Met)	50% of the [8] evaluated CDC NIOSH programs will receive a score of 2 out of 5 or better, and 50% of these will receive a score of 4 out of 5 or better based on an external review of their progress implementing recommendations from their National Academies reviews	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	N/A

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
9.2.3b: Reduce the number of construction workers killed in roadway construction work zones due to being struck by construction vehicles or equipment ² (Outcome)	FY 2010: 15 (Historical Actual)	N/A	9	N/A

¹This is a biennial measure, and targets are established for FY 2012 and FY 2014.

²This is a long term outcome measure, and final data will be collected in 2015.

Performance Trends: For the past 10 years, the National Occupational Research Agenda (NORA) has served as a framework to guide occupational safety and health research not only for CDC but for the entire occupational safety and health (OSH) community. NORA has resulted in concentrated efforts between government, academia, labor unions, and industry that lead to faster, more effective implementation of OSH-related workplace solutions. CDC is now in the second decade of NORA, building on past successes while preparing for new challenges in designing research to address the 21st century workplace.

NORA encompasses activities across 10 occupational sectors. In the construction sector, roadway workers risk fatal and serious non-fatal injuries in work zones when in close proximity to construction equipment. Measure 9.2.3b tracks results of a unique research project initially funded through NORA. It is also indicative of a larger population of workers at risk of being struck by operating equipment within the construction industry as well as in the mining, transportation, and warehousing industries. Using the average number of annual fatalities from 1992-1998, CDC set baseline at 22 deaths per year. Data since 2003 indicate that the number of fatalities peaked in 2005 at 32 deaths and dropped annually thereafter to 15 deaths in 2010, a 32 percent decrease over baseline. The productive partnerships between NIOSH and the Occupational Safety and Health Administration, labor unions, state agencies, and industry trade associations have contributed to raising the bar on work zone safety and keeping worker safety in the forefront of national discussions. However if risk remains constant over time, the annual number of fatalities can be expected to rise and fall relative to roadway construction activity.

CDC contracted with the National Academies (NA) to review its occupational safety and health research program portfolio, assess the impact and relevance of each program, and identify emerging issues. The NA evaluation committees reported favorable scores for program relevance and impact for all seven of the CDC programs evaluated, including hearing loss; mining; respiratory diseases; traumatic injuries; construction; personal protective technology; and health hazard evaluations. CDC is currently measuring its progress toward implementing the recommendations made by the NA review committees. In FY 2014 CDC anticipates that 100 percent of reviewed programs will score at least four out of five on an external review of their progress (Measure 9.1.1).

Program: Other Occupational Safety and Health Research

Performance Measures for Long Term Objective: Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; measure the success of implemented intervention strategies

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
9.1.2a: Increase the number of research and intervention projects that were based on surveillance information (Output)	FY 2011: 121 (Target Met)	Evaluate the role that tracking information had in designing research and intervention projects	130	N/A

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
9.1.2b: Increase the number of projects that use surveillance information to demonstrate the success of NIOSH research (Output)	FY 2011: 57 (Target Met)	Identify the role that follow-up tracking information can have in assessing the success of interventions.	57	N/A
9.1.2c: Reduce the prevalence rate of elevated blood lead levels in adults (per 100,000) due to work exposure (Output)	FY 2011: 6.40 (Target Exceeded)	Reduce the prevalence rate of elevated blood lead levels in adults by 3% (from the previous year value)	6.20	N/A

Performance Measures for Long Term Objective: Reduce workplace illness, injury, and mortality in targeted sectors

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
9.2.2a: Reduce rate of non-fatal workplace injuries (per 100 FTE) among youth ages 15–17 (Outcome)	FY 2012: 3.7 (Target Exceeded)	4.2	3.7	-0.5
9.2.2c: Maintain $\geq 95\%$ of active underground coal mines in the U.S. that possesses NIOSH-approved plans to perform x-ray surveillance for pneumoconiosis (Outcome)	FY 2012: 97% (Target Exceeded)	90%	90%	Maintain
9.2.3a: Percent reduction in respirable coal dust overexposure ¹ (Outcome)	FY 2009: 30% (Historical Actual)	N/A	50%	N/A
9.2.3c: Ensure the quality of NIOSH certified respirators by increasing the number of audit activities completed (Outcome)	FY 2012: 155 (Target Exceeded)	66	171	+105
9.A: Number of safety and health patent filings (Output)	FY 2012: 6 (Target Exceeded)	5	5	Maintain
9.B: Number of certification decisions issued for personal protective equipment (Output)	FY 2012: 434 (Target Exceeded)	300	300	Maintain
9.D: Number of health hazard evaluations/fatality assessment and control evaluations (Output)	FY 2012: 331 (Target Not Met but Improved)	350	290	-60
9.E: Number of research articles published in peer-review publications (Output)	FY 2012: 380 (Target Exceeded)	250	350	+100

¹ This is a long term outcome measure, and final data will be collected in 2014. Annual trend data will be available by FY 2013

Performance Trends: CDC continues to meet its performance targets by using surveillance information to develop and evaluate projects. In FY 2011, CDC based 121 research and intervention projects on surveillance information and 57 intervention programs used surveillance information to demonstrate the effectiveness of the program's strategies (Measures 9.1.2a, 9.1.2b). The Adult Blood Lead Epidemiology & Surveillance program (ABLES) has maintained the surveillance of work-related lead exposures among adults in 41 states (Measure 9.1.2c). To address the slight uptick in prevalence seen in FY 2010, CDC

funded 40 state ABLES programs and provided programmatic expertise to one unfunded program, published the ABLES Impact Card and initiated a Public Health Practice NORA project to reduce lead exposures in the battery manufacturing industry. ABLES state interventions led to a reduction in the prevalence of elevated blood lead levels due to work exposure by eight percent compared to FY 2010, restoring the downward trend.

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 3.7 per 100 FTE in FY 2012, 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," 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 U.S. to develop plans to perform x-ray surveillance for pneumoconiosis. Since 2008, at least 97 percent of active U.S. mines in the Coal Workers Health Surveillance Program have possessed a CDC-approved plan, well exceeding the 90 percent target (Measure 9.2.2c). A new regulation for digital chest imaging adopted in FY 2012 may bring additional mines into the program that do not have a CDC-approved plan. The FY 2014 target remains level as CDC works with these new mines to develop plans. By 2014, CDC expects Mining Sector interventions to achieve a 50 percent reduction in occupational illnesses due to respirable coal dust overexposure. Recent data from 2009 indicate a 30 percent reduction in coal dust exposure, more than double the initial 13.7 percent 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 155 respirator audit activities in 2012, exceeding expectations for the second year in a row (Measure 9.2.3c). CDC set the FY 2014 target at 171 to remain ambitious. Manufacturing sites are projected to grow slowly and the type of respirator audited will take longer to test, impacting the length of time required to complete the testing. Additionally, FY 2012 data demonstrate improvements in the inventory and quality of respiratory protection for workers in all industry sectors through 434 certified respirator decisions, exceeding the target but down from FY 2010 and FY 2011 (Measure 9.B). The FY 2014 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 2012, CDC filed six safety and health patents, exceeding the target and surpassing the FY 2011 results (Measure 9.A). The FY 2014 target is set more modestly 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 200 in 2008 to 380 in 2012. Due to high performance, CDC revised the FY 2014 target upward from 250 to 350 (Measure 9.E). These publications represent a substantial contribution to the scientific literature regarding occupational health and safety. For example, in 2009, NIOSH published *Approaches to Safe Nanotechnology: Managing the Health and Safety Concerns Associated with Engineering Nanomaterials*. This document presents guidelines for the use of engineering controls and personal protective equipment to minimize worker exposures. It has been widely cited and used around the world.

PUBLIC HEALTH PREPAREDNESS AND RESPONSE

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$1,351.817	\$1,360.463	\$1,334.316	-\$17.501
Pandemic Flu balances from P.L. 111-32	\$30.000	\$0.000	\$0.000	-\$30.000
Total	\$1,381.817	\$1,360.463	\$1,334.316	-\$47.501
FTEs	560	557	557	-3

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Enabling Legislation Citation: PHSA Title II §§ 301, 307, 310, 311, 317*, 319, 319C-1*, 319D*, 319F*, 319F-2*, 319G*, 351A*, 352, 361, Title XVII*, 2801, 2812*

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$1,334,316,000 for Public Health Preparedness and Response is a decrease of \$47,501,000 below the FY 2012 level for State and Local Preparedness and Response Capability, CDC Preparedness and Response Capability, and the Strategic National Stockpile.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
State and Local Preparedness and Response Capability	\$666.245	\$670.513	\$658.026	-\$8.219
CDC Preparedness and Response Capability	\$167.104	\$168.165	\$166.012	-\$1.092
Strategic National Stockpile	\$518.468	\$521.786	\$510.278	-\$8.190
Pandemic Flu balances from P.L. 111-32	\$30.000	\$0.000	\$0.000	-\$30.000
Total	\$1,381.817	\$1,360.463	\$1,334.316	-\$47.501

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

CDC's Public Health Preparedness and Response appropriation addresses the overarching goal of protecting Americans from natural and bioterrorism threats. CDC works 24/7/365 to ensure the security, safety, and health of the United States from threats, 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 through grants and training.
- Overseeing and regulating deadly toxins to ensure they are safeguarded.
- Providing comprehensive situational awareness by overseeing a national laboratory network and building national tracking and surveillance systems.
- Preparing for emergency response and recovery by maintaining the Strategic National Stockpile.

FUNDING HISTORY^{1,2}

Public Health Preparedness and Response	
Fiscal Year	Dollars (in millions)
2009	\$1,514.657
2010	\$1,522.339
2011	\$1,405.416
2011(ACA/PPHF)	\$10.000
2012	\$1,381.817
2013	\$1,360.463

Strategic National Stockpile	
Fiscal Year	Dollars (in millions)
2003	\$298.050
2004	\$397.640
2005	\$466.700
2006	\$524.339
2007	\$496.348
2008	\$551.509
2009	\$570.307
2010	\$595.749
2011	\$591.001
2012	\$548.468
2013	\$521.786

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²Includes all funding sources (including Public Health Social Services Emergency Fund, Pandemic Influenza balances from P.L. 111-32).

STATE AND LOCAL PREPAREDNESS AND RESPONSE CAPABILITY BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$666.245	\$670.513	\$658.026	-\$8.219

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's State and Local Preparedness and Response Capability supports preparedness activities nationwide by providing scientific and programmatic expertise and funding to state, local, and territorial public health agencies through the Public Health Emergency Preparedness (PHEP) cooperative agreement. CDC is responsible for establishing operational standards for awardees receiving PHEP funds. Approximately 94 percent of the appropriation provides funding for three areas of public health preparedness: (1) Preparedness base funding for 50 states, eight territories, and four directly funded localities; (2) Cities Readiness Initiative (CRI) funding for 72 metropolitan statistical areas; and (3) Preparedness funding for 10 Level 1 chemical laboratories (LRN-C).

Public health threats are always present, and a key goal of CDC is to protect Americans from natural and bioterrorism threats. Whether caused by natural, accidental, or intentional means, these threats can lead to the onset of public health incidents. Being prepared to prevent, respond to, and rapidly recover from public health threats is critical for protecting and securing our nation's public health.

CDC implemented the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* to ensure federal preparedness funds are directed to priority areas as identified through state,

local, and territorial strategic planning efforts. These capabilities create national standards for public health preparedness capability-based planning, and assist state and local planners in identifying gaps in preparedness, determining specific jurisdictional priorities, and developing plans for building and sustaining capabilities. These standards further promote interagency synergy with Presidential Policy Directives, accelerate state and local preparedness planning, and ensure safer, more resilient, and better prepared communities. The standards better prepare state and local health departments for responding to public health emergencies and incidents, encouraging health departments to develop annual and long-term preparedness strategies and investments.

PHEP cooperative agreement funding builds and sustains public health preparedness capabilities within state, local, and territorial jurisdictions. Awardees must demonstrate measurable and sustainable progress toward achieving all preparedness capabilities over the PHEP cooperative agreement's five-year project period. Vital activities that prepare communities to respond and recover from public health threats and emergencies also contribute to building sustainable healthcare and public health systems used every day, including programs designed for vulnerable, special needs or at-risk populations as described under the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006.

The goal of the 2012-2017 Hospital Preparedness Program (HPP)-PHEP cooperative agreement program is to provide scientific and programmatic expertise and resources that support public health departments and healthcare systems/organizations in demonstrating measurable and sustainable progress toward preparedness capabilities for prepared and resilient communities. In addition to funding, PHEP awardees receive customized consultation services provided by CDC project officers and subject matter experts who helped develop the 15 public health preparedness capabilities and are well versed in current preparedness issues. Subject matter experts provide targeted interventions for awardee-identified needs. This support may include tools, resources, and expertise that focus on understanding the required capability and demonstrating performance; developing strategies to accomplish performance measures; providing scientifically sound evidence to show effectiveness of strategies in terms of outcomes and return on investment; and monitoring awardee progress. This transfer of CDC's knowledge and best practices supports awardees in the building and maintenance of public health preparedness capabilities.

Budget Proposal: CDC's FY 2014 request of \$658,026,000 for State and Local Preparedness and Response Capability is a decrease of \$8,219,000 below the FY 2012 level. The decrease will reduce the amount of funding awarded to state and local health departments through the PHEP and CRI programs.

Specifically, reductions in funding may:

- Reduce exercising of capability-based plans that are essential for ensuring operational readiness and ongoing program development
- Slow the development of risk reduction strategies for vulnerable and at-risk populations that align with overarching state and local emergency management response plans
- Decrease state and local partners' capabilities in information sharing, disease surveillance and detection, public health workforce and other core infrastructure, which may affect the duration and severity of outbreaks

In FY 2014, CDC will provide support to key public health preparedness areas including biosurveillance, laboratory response, community resilience, countermeasure planning and mitigation, incident management, information management, and surge management, thereby complying with provisions in PAHPA. CDC will strengthen state and local health departments' capabilities to protect the health security of the United States by adhering to national standards described within *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. Public health departments will prioritize capability development based on their current ability to prepare for, and respond to, public health threats and emergencies. CDC will continue pursuing additional opportunities to align the PHEP cooperative agreement with other federally funded preparedness programs to increase efficiency,

eliminate potential redundancy, and reduce grantee administrative burdens. Additionally, the PHEP cooperative agreement program will continue to facilitate development of a long-term IT solution by partnering with the Administration for Children and Families (ACF) Center of Excellence for Grants Management to advance program and performance management and enable further scientific analysis of national public health preparedness capability development investments. This partnership will standardize IT systems, promote shared services, and improve customer service.

In FY 2011, CDC defined 15 national standards for state and local public health preparedness capabilities. These standards, based on evidence-informed documents, relevant preparedness literature, and subject matter expertise gathered from across the federal government and the state and local practice community, allowed CDC to reengineer the PHEP cooperative agreement into a capabilities-based model funding program that aligns with the National Preparedness Goal, Presidential Policy Directive-8 (PPD-8), and the National Response Framework (NRF). The PHEP capabilities represent a national public health standard for state and local preparedness that better prepares state and local health departments for responding to public health emergencies and incidents. These capabilities align with the National Preparedness Guidelines, the National Health Security Strategy, and HHS 10 Essential Public Health Services model.

The PHEP capabilities-based model enables state and local public health agencies to identify which preparedness capabilities are sufficient and which aspects need additional support. CDC also enhanced PHEP grants management to improve program review and awardee accountability and to strengthen tracking of deliverables, costs, performance measures, and awardee progress toward achieving the capabilities. The standards, which will be refined over time as emerging evidence becomes available to advance preparedness knowledge, are being integrated with the National Preparedness Goal's national core capabilities to improve coordination between public health and emergency management programs at the federal, state, and local levels.

Grant Tables:

Public Health Emergency Preparedness (All PHEP awards combined) ^{1,2}

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	62	62	62
Average Award	\$10.005	\$9.877	\$9.877
Range of Awards	\$0.328–\$42.839	\$0.325–\$41.853	\$0.325–\$41.853
Number of New Awards	0	0	0
Number of Continuing Awards	62	62	62
Total Grant Award	\$619.448	\$612.400	\$612.400

¹Funding includes direct assistance to grantees provided through the Career Epidemiology Field Officer Program (CEFO). CEFO personnel are assigned to states by request and are funded by the PHEP. As of January 2012, there were 32 CEFOs in 24 states. States must agree to an initial two-year placement, with the option to renew the request annually.

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.

In FY 2014, CDC will fund 62 state, territorial, and local public health departments through a noncompetitive, formula-based, joint HPP-PHEP cooperative agreement. The purpose of the 2012-2017 PHEP cooperative agreement is to provide financial assistance and programmatic and scientific expertise to states, territories, and local governments to improve their capacity and ability to respond to public health emergencies thereby enhancing the overall public health security of the United States. The HPP and PHEP cooperative agreements represent a critical source of funding and support to our nation's public health and healthcare preparedness systems, and HPP-PHEP grant alignment is founded upon the following goals:

- Increase program impact and advance preparedness

- Reduce awardee burden and enhance customer service provided to states and localities
- Improve federal efficiencies
- Promote innovation with program implementation
- Demonstrate a clear return on investment and communicate preparedness accomplishments to help ensure sustainability of the PHEP and HPP cooperative agreements

Public Health Emergency Preparedness (Base PHEP funding Subtotal) ^{2,3}

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	62	62	62
Average Award	\$8.948	\$8.948	\$8.948
Range of Awards	\$0.325–\$36.176	\$0.325–\$36.224	\$0.325–\$36.224
Number of New Awards	0	0	0
Number of Continuing Awards	62	62	62
Total Grant Award	\$554.803	\$555.654	\$555.654

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.

³Included in 'All PHEP awards combined' grant table.

In FY 2014, preparedness cooperative agreement base funding will provide a critical source of funding, guidance, and programmatic expertise for the 62 PHEP awardees. Through targeted activities, the PHEP cooperative agreement ensures public health departments are emergency-ready. These efforts support the NRF, which guides how the nation responds to all types of hazards, including public health security threats and emergencies, such as infectious disease outbreaks; natural disasters; biological, chemical, and radiological incidents; and explosions. Whether caused by natural, unintentional, or intentional means, these threats can rapidly overwhelm state and local public health systems. As mandated by PAHPA, CDC allocates funding according to a population-based formula, due to the increased potential for mass casualties in jurisdictions with higher population density. The program demonstrates increased preparedness using performance measures and related evaluation and assessment data, as well as PAHPA accountability provisions or evidence-based benchmarks.

Public Health Emergency Preparedness (CRI Subtotal) ^{2,3}

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	54	54	54
Average Award	\$1.006	\$0.859	\$0.859
Range of Awards	\$0.170–\$5.612	\$0.170–\$4.578	\$0.170–\$4.578
Number of New Awards	0	0	0
Number of Continuing Awards	54	54	54
Total Grant Award	\$54.299	\$46.401	\$46.401

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.

³Included in 'All PHEP awards combined' grant table.

CRI, created in 2004, supports local medical countermeasure distribution and dispensing planning in the nation's largest cities that contain approximately 57 percent of the U.S. population. In FY 2014, the PHEP cooperative agreement will fund CRI cities using a population-based formula to strengthen their ability to effectively distribute and dispense medical countermeasures from the Strategic National Stockpile to their entire population within 48 hours of the decision to do so in response to public health emergencies. A total of 54 PHEP awardees, 50 states, and four directly funded localities receive CRI funding as a

designated part of their PHEP award for distribution to 72 targeted metropolitan statistical areas in their jurisdictions.

***Public Health Emergency Preparedness (Level 1 Chemical Labs Subtotal)*^{2,3}**

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	10	10	10
Average Award	\$1.035	\$1.035	\$1.035
Range of Awards	\$0.808–\$1.603	\$0.808–\$1.603	\$0.808–\$1.603
Number of New Awards	0	0	0
Number of Continuing Awards	10	10	10
Total Grant Award	\$10.345	\$10.345	\$10.345

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.

³Included in 'All PHEP awards combined' grant table.

In FY 2014, the PHEP cooperative agreement will fund 10 Level 1 chemical testing laboratories that improve the ability of states to detect and respond to toxic chemical agents, including mustard agents, nerve agents, and other toxic industrial chemicals. These laboratories also serve as surge capacity laboratories for CDC during a major public health security event and use PHEP funding to address objectives related to chemical emergency response surge capacity, including staffing and equipping the lab, maintaining critical instrumentation in a state of readiness, training and proficiency testing for staff; and participating in local, state, and national exercises. Using high-throughput analysis capabilities to detect threat agents, these labs expand CDC's ability to analyze large numbers of patient samples when responding to large-scale exposure incidents, decreasing the time needed to provide appropriate, life-saving countermeasures. CDC allocates funding based on Level 1 membership in the Laboratory Response Network-Chemical (LRN-C). This funding helps reduce the time for Level 1 LRN labs to test, process, and report samples, as demonstrated during a yearly LRN surge capacity exercise.

CDC PREPAREDNESS AND RESPONSE CAPABILITY BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$167.104	\$168.165	\$166.012	-\$1.092

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: Saving lives depends on rapid detection and response to public health threats and emergencies. CDC's Preparedness and Response Capability supports the agency's comprehensive Emergency Management Program (EMP), the intersection where emergency management practice and public health programs meet. The agency's core capabilities, epidemiology, laboratory, and surveillance protect Americans against health threats and emergencies. CDC's Preparedness and Response Capability supports cross-cutting research and critical infrastructure to be able to respond to public health emergencies.

CDC coordinates and executes preparedness and response activities 24/7/365 to protect public health. CDC:

1. Develops tests to rapidly detect biological, chemical, and radiological agents;
2. Creates emergency response plans and exercises those plans to assess and improve response;
3. Conducts health hazard evaluations and hazardous substance assessments;

4. Develops risk and emergency communication systems to ensure state, local, tribal, territorial, and federal officials have vital, timely information during a response; and
5. Regulates laboratories handling the most dangerous infectious agents and toxins to ensure the safety of lab workers and the American public, while sharing scientific expertise for advanced laboratory and surveillance systems.

CDC also supports research to help improve function and capabilities in the preparedness and response system by increasing knowledge for effectively detecting and responding to public health threats. This investment yields cross-cutting benefits that keep public health infrastructure strong throughout the United States. Examples include:

- CDC-funded research in North Carolina demonstrated that nationally accredited health departments performed at a higher level than non-accredited health departments during a public health emergency, based on capabilities outlined by a national accreditation board. This research highlights the need for health departments to pursue national accreditation, thereby increasing preparedness across the nation.
- Research to increase tribal and other communities' ability to prepare for, respond to, and recover from disasters in Southern California provided ancillary benefits by strengthening relationships to address other concerns such as environmental health issues.

When a public health emergency occurs, critical elements of CDC work together to mount an appropriate response. CDC also conducts preparedness and response activities through partnerships with other federal, state, local, and international agencies, combining the necessary expertise the public health system, communities, and individuals to protect against health threats. Whether responding to a foodborne disease outbreak or a natural or intentional disaster, these programs save lives.

Over the next 5 years, CDC will strengthen partnerships with other federal partners, state/local health departments, medical professionals, and other non-governmental stakeholders to apply tenets of emergency management to public health-related emergencies, facilitating successful accomplishment of CDC's mission by using science combined with emergency management principles by:

- Supporting World Health Organization International Health Regulations (IHR) implementation.
- Developing and strengthening CDC's emergency management workforce.
- Gaining Emergency Management Accreditation Program (EMAP) accreditation.

CDC improves domestic health security through IHR implementation by enhancing public health emergency management capacities and sharing best practices in priority countries focused on preparedness, process for response, and risk communication.

CDC will seek assessment of its Emergency Management Program through EMAP. EMAP is an independent, non-profit organization that fosters excellence and accountability in emergency management and homeland security programs by establishing credible standards applied in a peer review accreditation process. EMAP accreditation will demonstrate CDC's commitment to uphold the same preparedness standards as its stakeholders.

CDC's Select Agent Program greatly increases the federal government's oversight of the safety and security of dangerous biological agents and toxins. Many entities registered to possess select agents and toxins have improved and strengthened their biosafety practices and procedures. The Select Agent Program ensures compliance with safety and security standards by:

- Inspecting entities that possess, use, or transfer select agents.

- Providing guidance to the regulated community.
- Developing and enforcing select agent regulations.

The Laboratory Response Network (LRN) is a collection of over 150 state, local, federal, and international laboratories that provide rapid testing capability to identify and respond to biological, chemical, limited radiological and nuclear threats, and other public health emergencies. CDC supports LRN by:

- Providing grants for lab equipment, training programs, technology transfer, and quality assurance programs.
- Encouraging LRN members to adopt standardized laboratory information management systems (LIMS) to improve the speed and accuracy of data exchange between CDC and member laboratories.
- Partnering with LIMS vendors to develop standard biological- and chemical-threats LIMS modules to reduce costs for labs and speed implementation.

Through BioSense 2.0, CDC provides innovative and reliable ways to develop accurate, comprehensive, nationwide and regional situation awareness views for all-hazard health threats, including bioterrorism. BioSense 2.0 will continue to develop tools and analytics that empower jurisdictions with advanced surveillance capabilities. Through its cloud-computing platform, BioSense 2.0 will give users the ability to share health data and analysis seamlessly with each other and with CDC. BioSense 2.0 also will continue to align and expand with Centers for Medicare & Medicaid Services (CMS), as well as provide participating jurisdictions the means to receive and validate electronic health record data/information from emergency departments, and to work toward accommodating other types of public health data, including Meaningful Use data, as the stages are refined. By 2014, BioSense 2.0 will capture more than 65 percent of the nation's hospital emergency-department data, plus data from other healthcare sources. This will give decision makers timely and accurate situation-awareness information about the public's health at local, state, regional, and national levels.

BioSense 2.0 provides federal, state, and local partners an all-hazards surveillance platform to monitor outbreaks and harmful health effects of hazardous agents throughout a public health emergency. BioSense 2.0 was designed to address shortcomings in previous systems as identified by CDC partners. The new system collects surveillance data from state and local health departments' existing surveillance systems. In the coming years, CDC aims to extend the usefulness of BioSense 2.0 by expanding the amount and type of data beyond emergency department data, supporting state and local needs by providing relevant analytic tools and training, and providing direct support to state and local jurisdictions for tracking population health at multiple levels.

Budget Proposal: CDC's FY 2014 request of \$166,012,000 for CDC Preparedness and Response Capabilities is a decrease of \$1,092,000 below the FY 2012 level. At this funding level CDC will maintain its highest priority programs including existing laboratory networks. Development of new training and exercise materials and new research programs will not be initiated.

In FY 2014, CDC will work to expand its EMP by focusing and building on existing public health infrastructure, sustainability, and increased health security. CDC's EMP coordinates programs across the agency to rapidly analyze situations and determine if there is a national public health threat, based on available information. Critical components of the EMP include the CDC Emergency Operations Center (EOC) and a dedicated incident command structure allowing better coordination of subject matter experts in response to large- and small-scale public health events. Without this vital resource, CDC's response would likely be delayed or ineffective.

In FY 2014, CDC will work to improve the ability to detect a number of biological agents by developing and deploying improved assays for detection of *Yersinia pestis* (Plague) and *Variola major* (smallpox) and bolstering CDC's testing capability for unknown emerging pathogens through the implementation of advanced technologies, such as high-throughput sequencing and microarrays. In addition, CDC's fully implemented Quality Management System will support the deployment 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). Current groundwork should allow the *Rickettsia* and other LRN assays to achieve Food and Drug Administration (FDA) clearance and approval by FY 2014.

In response to the Fukushima nuclear power plant incident in March 2011, CDC will update population monitoring guidance, particularly incorporating needs identified for the public health community. CDC will develop a radiation training curriculum that is specifically designed to meet the information and operational needs of local public health and emergency management professionals. CDC's emergency management program coordinates expertise across CDC to rapidly analyze situations and determine if there is a national public health threat.

CDC protects public health by responding to at least 15,000 calls per year in the EOC. These calls range from requests for botulinum antitoxin and medications for malaria, to requests for consultation in regard to rabies, and for consultation with the Agency for Toxic Substances and Disease Registry. CDC understands the unusual patterns a public health crisis may take and has developed guidelines on how to anticipate problems, track progress of events globally, and prepare for and respond to these events efficiently and effectively. In FY 2012, CDC provided emergency deployment support for more than 250 staff during a number of public health emergencies, including outbreaks of typhoid fever in Zimbabwe and Legionnaire's disease in U.S. Virgin Islands.

The Select Agent Program currently maintains and inspects 347 entities as active registrants, processing select agents and toxins in the United States. In addition, CDC regulates the importation of agents that cause disease, through the Etiologic Agent Import Permit Program (EAIPP). The EAIPP processes over 2,000 permits annually to allow for the importation of etiologic agents, hosts, and vectors of human disease into the United States. The FY 2014 request allows CDC to continue this important work at similar levels to FY 2012, when the Select Agent Program:

- Promoted confidence in the U.S. biodefense enterprise by regulating the safe and secure possession, use, and transfer of biological select agents and toxins (232 inspections and 2,137 registration amendments), and permitted the importation of etiological agents and vectors (1,238 Import Permits). The low incidence in calendar year 2012 of confirmed thefts (0), confirmed losses (0), and confirmed releases (3) of exposures resulting in occupational illness demonstrates the effectiveness of these programs.
- Contacted registered entities to verify the security of select agents and toxins during natural disasters and man-made incidents to ensure that these agents and toxins were protected against theft, loss, or release.
- Developed a Geographic Information System tool that tracks and monitors the potential impact of natural hazards and man-made disasters for entities registered with the Select Agent Program.
- Published Final Rules in collaboration with CDC's partner, the U.S. Department of Agriculture's Animal and Plant Health Inspection Service (APHIS), as directed by Executive Order 13546, "Optimizing the Security of Biological Select Agents and Toxins in the United States."
- Published a notice seeking public comment regarding the classification of highly pathogenic avian influenza (HPAI).

CDC is committed to providing timely surveillance of health problems as they evolve. This gives public health officials the data, information, and tools they need to better prepare for and coordinate responses to public health events, thereby safeguarding and improving the health of the public.

BioSense 2.0, launched in November 2011, is the first HHS system to adopt a cutting-edge and cost-effective cloud-computing environment. This approach provides a secure platform for state, local, tribal, and territorial public health departments, as well as other federal agencies, to send, store, analyze, and share data that signal alerts for potential health problems before they become epidemics. The collection of hospital emergency department data in near-real time provides public health officials at all levels and across jurisdictions with vital information to improve illness detection, assessment, and response. BioSense 2.0 provides the foundation, formerly unavailable, for local, regional, and national pictures of population health in near real-time situations. In FY 2014, CDC proposes to continue building surveillance capacity by providing training on use of analytic tools; the technical expertise necessary to add data feeds from participating jurisdictions to BioSense 2.0; and financial assistance to 35 jurisdictions to increase their ability to practice and enhance situation awareness. BioSense 2.0 monitors many events and outbreaks, both routine and unforeseen, and can be quickly scaled up to accommodate a significant influx of data and analysis activity during pandemics and other major public health events.

The BioSense 2.0 program realized a 44 percent increase in the participation of state and local health departments since its inception. The system is increasingly used to monitor potential all-hazards events including the 2012 presidential conventions, Super Bowl, NCAA Tournament, and NATO summit, as well as outbreaks such as dengue infection in the United States, the 2011 Heat Wave, and the Japanese Tsunami and Nuclear Disaster.

CDC's Biosurveillance Coordination Activity (funded through the BioSense Program) leads efforts to integrate human health data into a national biosurveillance enterprise. This national security imperative provides essential information for the early detection, rapid response, management, and mitigation of potentially catastrophic emerging infectious disease outbreaks, pandemics, and other public health emergencies whether they originate domestically or abroad. CDC leads the coordination of strategic partnerships in health surveillance and informatics with a diverse set of federal, state, local, tribal, and private sector stakeholders (such as the White House National Security Staff, Department of Defense (DOD), Department of Homeland Security, the Council of State and Territorial Epidemiologists, and state and local health departments).

Grant Table:

BioSense Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	35	35	35
Average Award	\$0.200	\$0.200	\$0.200
Range of Awards	\$0.100–\$0.300	\$0.100–\$0.300	\$0.100–\$0.300
Number of New Awards	35	0	0
Number of Continuing Awards	0	35	35
Total Grant Award	\$7.084	\$7.084	\$7.084

In FY 2014, CDC will support 35 awardees to improve local, state, regional, and national syndromic surveillance by incorporating automated, timely data submissions to allow for earlier alerts and warnings. The award provides financial assistance for these public health departments to have an individual surveillance system in the BioSense 2.0 Federal Information Security Management Act (FISMA) moderate GovCloud environment, as well as participate in the shared space with all other jurisdictions in BioSense 2.0 at their discretion. Through this funding, CDC will gain access to syndromic surveillance data from all jurisdictions awarded and continue to strengthen partnerships with local and state health

representatives, as well as other federal and private partners (e.g., Veterans Affairs, DOD, hospitals, electronic health record vendors).

STRATEGIC NATIONAL STOCKPILE BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$518.468	\$521.786	\$510.278	-\$8.190
Pandemic Flu balances from P.L. 111-32	\$30.000	\$0.000	\$0.000	-\$30.000
Total	\$548.468	\$521.786	\$510.278	-\$38.190

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: The Strategic National Stockpile (SNS), created in 1999, is designed to stockpile and deliver life-saving medical countermeasures (MCMs) during a national emergency. It serves as the largest public repository of pharmaceuticals, critical medical supplies, Federal Medical Stations (FMS), and equipment available for rapid delivery to support public health security threats. Nearly 80 percent of the funding received to support the stockpile goes toward purchasing and maintaining MCMs designed to help the public respond to and recover from major natural disasters; infectious disease outbreaks; bioterrorism; and chemical, radiological, or nuclear events. The remaining 20 percent of this funding supports science and research activities, programmatic expertise, response operations, and oversight functions.

CDC manages the science, acquisition, storage, and logistical operations of the SNS for use during a public health security threat, and works to improve the healthcare delivery system's all-hazards preparedness response. CDC also provides training and programmatic expertise to support state, local, tribal, and territorial health departments' ability to receive, stage, store, distribute, and dispense federal medical supplies based on the National Standards for Public Health Emergency Preparedness and Response. SNS funding supports extensive work across CDC as well, including smallpox activities, laboratory capacities, anthrax management, hospital preparedness and surge capabilities, terrorism preparedness, and medication access for chronic conditions before, during, and after disasters.

In pursuit of the long term Strategic Plan for the Division of Strategic National Stockpile, CDC continues to invest in improving preparedness for MCM responses. To ensure government and private sector partners are fully prepared to utilize SNS assets, CDC expanded the partner base of private sector entities prepared to dispense MCM and increase community resilience, while continually training public health staff to ensure a ready and capable workforce at state and local levels. Raising the standard for preparedness of SNS staff, CDC continues to define and refine core capabilities for responders, train and test staff against established standards, and validate storage and readiness levels of SNS assets. Continuing recent trends, CDC is exploring cost reduction and efficiency measures to ensure good stewardship of appropriated funds through development and implementation of internal cost savings guidance and contract management guidance, enhancement of existing resource management systems and innovation and exploration of knowledge and technology systems for more efficient operations. Finally, CDC continues to support preparedness and response needs at the federal, state, and local levels, engaging existing and potential MCM response stakeholders, and advancing communication capabilities across the nation. Through these activities, CDC is advancing the MCM response capability of the nation and increasing efficiency of SNS management.

Budget Proposal: CDC's FY 2014 request of \$510,278,000 for the SNS is a decrease of \$38,190,000 below the FY 2012 level. This will be implemented by not replacing expiring items that rank lower on formulary priorities, based on an annual review of the SNS.

Reductions in funding could result in:

- Fewer people receiving treatment during an influenza pandemic
- Fewer people receiving post-exposure prophylaxis following anthrax release

CDC collaborates with the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) to adjust the SNS formulary based on current 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 lifecycles. CDC delivers annual reports to PHEMCE on the status of SNS materiel to ensure tracking of identified priorities.

Timely procurement of new and replacement MCMs is necessary to achieve established PHEMCE goals and protect the public from health security threats. CDC will coordinate with PHEMCE to prioritize and identify which expiring products need to be replaced to maintain current capabilities.

In addition, state and local public health jurisdictions are challenged with declining funding and tax bases. CDC is working to help alleviate that burden by fostering partnerships with private entities. For example, CDC is helping establish community partnerships to fill staffing requirements for dispensing during an emergency, because the need often exceeds the number of local public health staff and volunteers on hand. CDC also is working with the private sector to develop innovative, cost-effective solutions for MCM distribution and is exploring other cost-saving initiatives, such as dose sparing and further warehouse consolidation that will save money without compromising public health security.

CDC uses over \$35 million to support research and science activities across CDC to expand the knowledge base and develop updated utilization guidance for MCMs stockpiled in the SNS. These activities directly support the ability to utilize SNS MCMs effectively during a response, but are funded for completion by scientists and subject matter experts in other parts of CDC. These activities include extensive research on smallpox vaccine effectiveness under varying scenarios and in varying populations. The data from this research inform ongoing projects to develop and update CDC's guidance to practitioners on the effective utilization of these vaccines during an outbreak, and are also used to refine CDC response plans for the deployment of stockpiled smallpox vaccines.

In addition to smallpox threats, CDC also addresses the high priority threat of inhalation anthrax exposure. CDC funding for SNS supports the activities of CDC's cross-functional Anthrax Management Team, focused on improving the agency's capabilities to respond to an anthrax attack in the United States. The Anthrax Management Team is staffed and supported by subject matter experts from across CDC to incorporate SNS capabilities and deployment experience, CDC research data and resources, and current scientific findings into cohesive planning and guidance development. The Anthrax Management Team's work results in ongoing improvement in the understanding of requirements and constraints governing a large-scale MCM response to an anthrax release with improved agency guidance to state and local partners on effective utilization of anthrax MCMs and MCM distribution and dispensing requirements.

State and local technical assistance reviews identify successes and areas for improvement both in state and local SNS planning and in CDC's guidance and assistance on SNS-related issues as funded by the PHEP cooperative agreement. Results of these reviews demonstrate increasing preparedness at the state and local level.

SNS assets total nearly \$5 billion in lifesaving countermeasures, so efficient overhead and inventory management is critical. CDC implemented cost-saving activities that saved over \$100 million in FY 2012. These measures include:

- Discontinuing Shelf Life Extension Program relabeling and eliminating bifurcated needles from the formulary resulting in \$37 million in savings.

- Combining three warehouses into one, saving approximately \$1 million per year.
- Saving \$8 million from the operation support contracts over a two-year period.
- Reducing annual travel and personnel requirements by \$791,000.
- Allowing the dedicated aircraft contract to expire, saving \$1.8 million in FY 2012.
- Negotiating \$408 million price reduction for anthrax vaccine replacement over five years.

Other major CDC accomplishments related to SNS include the evaluation and enhancement of the nation's capability to utilize SNS assets. In FY 2012, CDC provided direct support for 13 exercises at the federal, state, and local levels, and trained 1,371 individuals supporting all levels of emergency MCM response. CDC has seen benefits from this investment through successful exercises, such as a full-scale anthrax exercise conducted over three days in May 2012. This exercise involved staff from CDC, HHS, Alabama, Kentucky, North Carolina, and Tennessee. It validated, through real and simulated deployment of CDC staff and MCM assets, the capability to respond to two simultaneous anthrax releases in the United States.

PERFORMANCE

Program: State and Local Preparedness and Response Capability

Performance Measures for Long Term Objective: Enhance and sustain preparedness and response capability across state, local, and territorial health departments.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
13.5.2: 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 2011:95% (Target Exceeded) ¹	65%	74%	9
13.5.3: 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 2011:87% (Target Exceeded) ²	91%	95%	+4

¹ Data for this measure is now aligned to better reflect fiscal years. Therefore, CDC updated results reported in the FY 2013 PB from 76% to 74% for FY 2010.

² In order to account for varying data lags, this measure was adjusted in FY 2014 to more accurately reflect outcomes for the corresponding funding period. This adjustment resulted in an update of 2010 results from 92% to 89%.

Performance Trends: CDC utilizes Public Health Emergency Preparedness (PHEP) awardee-reported data to aid jurisdictions in identifying preparedness gaps and developing targeted strategies to improve performance across operations. In FY 2011, 95 percent of PHEP-funded public health laboratories that correctly subtyped *E. coli* submitted results within four working days (Measure 13.5.2). CDC exceeded the target by 27 percentage points, in part, because it improved its data quality assurance process. This

result continues a trend of annual improvement in accurate *E.coli* subtyping and reporting which began in 2007. The FY 2014 target remains conservative because CDC will transition to a new data collection system in FY 2013, re-baseline the data, and re-establish the FY 2014 target accordingly. 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 the duration of exposure to consumers and cases of illness. In FY 2012, CDC traced a Shiga toxin-producing *E. coli* in five states linked to organic spinach and pre-packed leafy greens.

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. To ensure timeliness and effectiveness, awardees must demonstrate the ability to rapidly assemble key incident management leadership empowered to make response decisions. In FY 2011, CDC exceeded the target with 87 percent of PHEP-funded public health agencies convening trained staff within 60 minutes of notification to make decisions regarding partner interaction and incident response (Measure 13.5.3). This is a significant increase of 19 percentage points over the 2009 baseline. In April 2012, Union County, Iowa successfully mobilized members of the incident management structure and initiated a plan of action within 60 minutes of a tornado's impact on a local hospital, resulting in the successful and safe evacuation of patients, staff, and records to another nearby hospital.

Program: CDC Preparedness and Response Capability

Performance Measures for Long Term Objective: Integrate and enhance existing surveillance systems at the local, state, national, and international levels to detect, monitor, report, and evaluate public health threats.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 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 2012: 16 (Target Exceeded)	15	30	+15
13.1.1a: Increase the proportion of jurisdictions contributing data into BioSense 2.0 to improve the national picture of population health. (Output)	FY 2012: 57% (Historical Actual)	38%	71%	+33%

Performance Trends: Since FY 2009, CDC has steadily increased LRN-specific electronic data exchange capacity of member labs, growing from three labs in 2010 to 16 labs in FY 2012 and exceeding the FY 2012 target (Measure 13.1.3). While close to 100 percent of the approximately 150 LRN labs are capable of exchanging data through the LRN Results Messenger, Laboratory Information Management System Integration (LIMS_i) enables laboratories to share LRN data within the network utilizing their current systems. LIMS_i allows labs to respond quickly to public health threats by providing an integrated solution that builds on a lab's current systems and workflow, rather than utilizing additional CDC software. CDC incorporated feedback from participating laboratories to improve and streamline the LIMS_i implementation process and engaged vendors to create standard bioterrorism modules to reduce costs and provide more timely implementations. CDC estimates total LRN LIMS_i implementations will grow to at least 30 labs by the end of FY 2014.

BioSense 2.0 provides the rapid scalability of gathering and providing human health data to prepare for and respond to bioterrorist incidents, national disasters, or epidemics. This includes the identification of public health threats and improved, appropriate, and timely responses. Jurisdictions are supplied with near

real time emergency department data, allowing communities to respond quickly with appropriate prevention and intervention strategies. Furthermore, BioSense 2.0 facilitates the integration, interpretation, and sharing of information across jurisdictions and federal agencies. The enhanced system expands state and local infrastructure allowing the collection and analysis of patient symptom data from emergency rooms and hospitals to monitor outbreaks and their impact during an emergency BioSense 2.0 also allows for the detection of the origin and geographic scope of outbreaks, enabling local authorities to rapidly mobilize responses. As of December 2012, 57 percent of jurisdictions have joined the program by completing Data Use Agreements (DUAs), and over 15 additional jurisdictions are pending. The number of signed DUAs illustrates strides in state and local involvement and acceptance, exceeding expectations for this measure (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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
13.3.1: Sustain the percentage of Laboratory Response Network (LRN) laboratories that have demonstrated ability to rapidly detect select biological threat agents	FY 2012:93% (Target Exceeded)	92%	92%	Maintain

Performance Trends: LRN proficiency testing ensures laboratories within the Laboratory Response Network (LRN) have the ability to rapidly identify biological threat agents by performing LRN assays using agent-specific testing algorithms and available electronic resources to submit results. CDC 2012 proficiency testing results indicate that 93 percent of LRN laboratories are able to meet standards. This is consistent with past performance of meeting or exceeding targets since 2008 for Measure 13.3.1. Future targets remain steady at 92 percent due to various factors, including increasing complexity for future proficiency testing and the planned release of new assays that will challenge continuation of public health labs' historical passing rates.

Program: Strategic National Stockpile

Performance Measures for Long-Term Objective: Assure an integrated, sustainable, nationwide response and recover capacity to limit morbidity and mortality from public health threats.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
13.4.2: 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 2012:100% (Target Met)	100%	100%	Maintain
13.4.5: Number of trained and ready preparedness and response teams available for response to multiple events (Output)	FY 2012:17 (Target Not Met) ⁷	19	15	-4

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
13.4.6: Percentage of inventory accuracies attained by using quality inventory management systems ⁸ (Outcome)	FY 2012: 99.13% (Target Exceeded)	95%	97%	+2

⁷ Data year and result were aligned in FY 2014

⁸ CDC revised this measure in FY 2014 to track inventory accuracies rather than inaccuracies. Therefore, there is no change in the substance of the measure compared to the FY 2013 PB

Performance Trends: CDC improves the management and distribution of Strategic National Stockpile (SNS) materiel by utilizing systems derived from proven practices and innovative solutions. These systems aid in the acquisition, flexible storage, and configuration of materiel for emergency response support. This includes the provision of program expertise and the coordination of emergency response exercises. Since FY 2009, CDC has successfully and consistently delivered SNS materiel within 12 to 48 hours of adverse events to mitigate loss of life. CDC met its targets for increasing preparedness for dispensing countermeasures at the local level between FY 2008 and FY 2011. In FY 2012, CDC developed a medical countermeasure distribution and dispensing (MCMDD) composite score to serve as a collective indicator of MCMDD preparedness and operational capability within PHEP awardees and City Readiness Initiative (CRI) areas. CDC derived the composite measure from the results of technical assistance reviews (TARs), drill submissions, full-scale exercises, and compliance with programmatic standards. Even with this more robust measure, CDC met its FY 2012 target to sustain local level preparedness for dispensing countermeasures (Measure 13.4.2).

CDC improved operational efficiency in FY 2012 by consolidating several inventory warehouses effectively reducing the targeted need for 19 response teams to adequately respond to a public health threat. As a result, CDC only supported 17 teams, two below the target (Measure 13.4.5). CDC reduced the target in FY 2014 to 15 responder teams to further align the new structure and operational improvements. This includes the implementation of a responder-pool, replacing the designated response team approach utilized previously.

CDC maintains internal tracking systems to monitor its ability to deliver critical medical countermeasures in a national emergency. While continuously exceeding the inventory accuracy target of 95 percent since 2009, future targets remain conservative as enhancements in inventory management systems are expected to challenge inventory accuracy during implementation stages through FY 2014 (Measure 13.4.6). CDC provided technical expertise and conducted 14 exercises with state and local public health representatives and emergency response personnel to enhance the ability of PHEP-funded jurisdictions to receive, stage, store, distribute, and dispense SNS assets.

STATE TABLES¹

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93-069 PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM				
State/Territory/Grantee	FY 2012 Actual	FY 2013 Estimate ²	FY 2014 Estimate ²	FY 2014 +/- FY 2012
Alabama	\$9,103,210	\$9,051,891	\$9,051,891	-\$51,319
Alaska	\$4,197,971	\$4,256,787	\$4,256,787	\$58,816
Arizona	\$11,931,236	\$11,720,782	\$11,720,782	-\$210,454
Arkansas	\$6,741,223	\$6,706,614	\$6,706,614	-\$34,609

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93-069 PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM				
State/Territory/Grantee	FY 2012 Actual	FY 2013 Estimate²	FY 2014 Estimate²	FY 2014 +/- FY 2012
California	\$42,839,937	\$41,852,852	\$41,852,852	-\$987,085
Colorado	\$9,810,527	\$9,684,857	\$9,684,857	-\$125,670
Connecticut	\$7,916,637	\$7,813,206	\$7,813,206	-\$103,431
Delaware	\$4,409,756	\$4,382,862	\$4,382,862	-\$26,894
Florida	\$29,547,908	\$29,026,658	\$29,026,658	-\$521,250
Georgia	\$16,224,868	\$15,963,275	\$15,963,275	-\$261,593
Hawaii	\$4,918,135	\$4,870,129	\$4,870,129	-\$48,006
Idaho	\$5,072,309	\$5,042,450	\$5,042,450	-\$29,859
Illinois	\$17,315,437	\$16,984,571	\$16,984,571	-\$330,866
Indiana	\$11,641,890	\$11,505,398	\$11,505,398	-\$136,492
Iowa	\$6,888,712	\$6,887,483	\$6,887,483	-\$1,229
Kansas	\$6,871,271	\$6,798,579	\$6,798,579	-\$72,692
Kentucky	\$8,664,857	\$8,595,416	\$8,595,416	-\$69,441
Louisiana	\$9,046,664	\$8,950,422	\$8,950,422	-\$96,242
Maine	\$4,775,927	\$4,778,228	\$4,778,228	\$2,301
Maryland	\$11,447,761	\$11,187,492	\$11,187,492	-\$260,269
Massachusetts	\$13,215,674	\$12,979,630	\$12,979,630	-\$236,044
Michigan	\$17,122,558	\$16,912,692	\$16,912,692	-\$209,866
Minnesota	\$11,303,489	\$11,142,898	\$11,142,898	-\$160,591
Mississippi	\$6,826,045	\$6,818,608	\$6,818,608	-\$7,437
Missouri	\$11,189,315	\$11,025,077	\$11,025,077	-\$164,238
Montana	\$4,366,055	\$4,367,769	\$4,367,769	\$1,714
Nebraska	\$5,421,224	\$5,385,174	\$5,385,174	-\$36,050
Nevada	\$6,824,877	\$6,726,462	\$6,726,462	-\$98,415
New Hampshire	\$4,881,449	\$4,861,625	\$4,861,625	-\$19,824
New Jersey	\$16,033,232	\$15,636,993	\$15,636,993	-\$396,239
New Mexico	\$6,716,529	\$6,673,229	\$6,673,229	-\$43,300
New York	\$19,926,605	\$19,618,462	\$19,618,462	-\$308,143
North Carolina	\$14,976,630	\$14,910,965	\$14,910,965	-\$65,665
North Dakota	\$4,197,971	\$4,256,787	\$4,256,787	\$58,816
Ohio	\$18,538,073	\$18,265,400	\$18,265,400	-\$272,673
Oklahoma	\$7,895,438	\$7,835,737	\$7,835,737	-\$59,701
Oregon	\$8,145,629	\$8,057,715	\$8,057,715	-\$87,914
Pennsylvania	\$20,201,109	\$19,883,780	\$19,883,780	-\$317,329
Rhode Island	\$4,574,482	\$4,520,693	\$4,520,693	-\$53,789
South Carolina	\$9,764,874	\$9,720,387	\$9,720,387	-\$44,487
South Dakota	\$4,197,971	\$4,256,787	\$4,256,787	\$58,816

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE GRANTS CFDA NUMBER: 93-069 PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM				
State/Territory/Grantee	FY 2012 Actual	FY 2013 Estimate²	FY 2014 Estimate²	FY 2014 +/- FY 2012
Tennessee	\$11,424,097	\$11,296,820	\$11,296,820	-\$127,277
Texas	\$37,551,857	\$36,831,382	\$36,831,382	-\$720,475
Utah	\$6,664,430	\$6,609,822	\$6,609,822	-\$54,608
Vermont	\$4,197,971	\$4,256,787	\$4,256,787	\$58,816
Virginia	\$15,098,787	\$14,820,503	\$14,820,503	-\$278,284
Washington	\$12,242,591	\$12,049,443	\$12,049,443	-\$193,148
West Virginia	\$5,425,674	\$5,426,058	\$5,426,058	\$384
Wisconsin	\$11,727,640	\$11,639,872	\$11,639,872	-\$87,768
Wyoming	\$4,197,971	\$4,256,787	\$4,256,787	\$58,816
Chicago	\$9,847,147	\$9,854,475	\$9,854,475	\$7,328
Los Angeles County	\$20,059,493	\$20,086,182	\$20,086,182	\$26,689
New York City	\$18,657,853	\$18,680,075	\$18,680,075	\$22,222
Washington, D.C.	\$6,336,749	\$6,337,792	\$6,337,792	\$1,043
American Samoa	\$380,333	\$380,448	\$380,448	\$115
Guam	\$518,712	\$519,025	\$519,025	\$313
Marshall Islands	\$379,640	\$379,754	\$379,754	\$114
Micronesia	\$429,576	\$429,762	\$429,762	\$186
Northern Mariana Islands	\$358,428	\$358,511	\$358,511	\$83
Palau	\$325,248	\$325,284	\$325,284	\$36
Puerto Rico	\$7,505,428	\$7,511,883	\$7,511,883	\$6,455
Virgin Islands	\$432,716	\$432,906	\$432,906	\$190
Total States/Cities/Territories	\$619,447,806	\$612,400,393	\$612,400,393	-\$7,047,413

¹ This state table is a snapshot of selected programs that fund all 50 states (and in some cases local, tribal, and territorial grantees).

² 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.

GLOBAL HEALTH

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Budget Authority	\$376.608	\$378.979	\$393.024	+\$16.416
Total	\$376.608	\$378.979	\$393.024	+\$16.416
FTEs	910	906	906	-4

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Enabling Legislation Citation: PHS Act Title II §§ 301, 304, 307, 310, 319*, 327, 340C, 361–369*, Title VVII*, 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); Section 212 of the Consolidated Appropriations Act, 2012 (P.L. 112-74, Division F)

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$393,024,000 for global health is an increase of \$16,416,000 above the FY 2012 level to stop all wild poliovirus transmission and any new vaccine-derived polioviruses by the end of 2014.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Global HIV/AIDS	\$131.190	\$131.993	\$131.942	+\$0.752
Global Immunization	\$167.744	\$168.815	\$183.003	+\$15.259
Polio Eradication	\$115.904	\$116.644	\$131.053	+\$15.149
Global measles and other vaccine-preventable diseases	\$51.840	\$52.171	\$51.950	+\$0.110
Global Disease Detection and Emergency Response	\$45.386	\$45.676	\$45.580	+\$0.194
Parasitic Diseases and Malaria	\$22.069	\$22.211	\$22.231	+\$0.162
Global Public Health Capacity Development	\$10.219	\$10.284	\$10.268	+\$0.049
Total	\$376.608	\$378.979	\$393.024	+\$16.416

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

In service of CDC's overall goal to ensure global disease protection, CDC improves health globally and protects the American people 24/7 from global health, safety, and security threats that cross international borders. With scientists and health experts embedded in countries around the globe, CDC uses its expertise in translating and adapting scientific evidence into policies and public health action to strengthen public health capacity in partner countries, leading to public health impact. Working with partners, CDC builds strong national programs and sustainable public health systems that can respond effectively to the global HIV/AIDS epidemic and to other diseases that threaten the health and prosperity of the global community at large. CDC uses scientific expertise to prevent disease, disability, and death through immunizations and prevention, treatment and control of infectious diseases that threaten the health of individuals at home and abroad. Through research and science-based public health action and

partnerships, CDC addresses health issues, ensures global health security, and achieves safer, healthier, and longer lives worldwide.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$308.824
2010	\$346.614
2011	\$340.265
2012	\$376.608
2013	\$378.979

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates.

GLOBAL HIV/AIDS BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget¹	FY 2014 +/- FY 2012
Budget Authority	\$131.190	\$131.993	\$131.942	+\$0.752

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC, a principal United States Government (USG) agency implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), strengthens national HIV/AIDS programs and enhances health systems to ensure local capacity for a comprehensive and self-sufficient response. CDC works through its long-standing partnerships with Ministries of Health (MOHs) and global partners to implement and expand high-quality integrated HIV/AIDS care and treatment services; expand effective prevention programs to halt new infections; strengthen and expand high-quality laboratory services; conduct research; and provide epidemiologic science support to develop sustainable public health systems in resource-constrained countries. 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: (1) increase numbers of HIV-positive patients on antiretroviral therapy, (2) prevent mother-to-child HIV transmission, and (3) increase numbers of males medically circumcised.

To accomplish these program activities and priorities, CDC provides on-site scientific and programmatic support and mentoring through its headquarters in Atlanta and its 45 offices around the world. CDC staffing dedicated to the implementation of PEPFAR includes over 380 staff in Atlanta and more than 1,400 staff overseas—1,200 of whom are local host-country nationals. This workforce of highly trained medical officers, epidemiologists, public health advisors, statisticians, health economists, data management analysts, behavioral scientists, and laboratory scientists support PEPFAR efforts in Africa, Asia, Central and South America, and the Caribbean.

To optimize PEPFAR programming, CDC has led groundbreaking operational research and economic analysis to improve the quality and efficiency of PEPFAR programs and identify interventions and best practices that improve cost-effectiveness and maximize health impact. CDC has also led treatment costing efforts that have been instrumental in PEPFAR program decision-making. These activities, in tandem with expanding the use of surveillance and health information systems, have allowed CDC to promote data-driven, evidence-based programming for greater health impact and operational efficiency throughout PEPFAR.

Other CDC contributions to PEPFAR include collaboration and technical input to the World Health Organization (WHO) in the development of international guidelines for HIV prevention, care, and

treatment programs. For example, CDC provided scientific input to WHO to develop the April 2012 guidance identifying more effective treatment options for HIV-infected pregnant and breastfeeding women, and how to optimize and integrate programs to prevent mother-to-child transmission of HIV.

Budget Proposal: CDC's FY 2014 request of \$131,942,000 for global HIV/AIDS is an increase of \$752,000 above the FY 2012 level. In addition to funding requested through the base appropriation, CDC receives interagency funding transfers from the Department of State Global Public Health Programs appropriation to implement PEPFAR.

In FY 2014, CDC will continue to work closely with all USG PEPFAR-implementing agencies to ensure program activities are well coordinated, which is accomplished in part through the development of a unified Country Operational Plan that reflects the complementary programming of all agencies. CDC's unique contributions are scientific, data-driven programs that ensure the greatest health impact and most efficient use of available resources.

Scaling-Up Treatment for People Living with HIV/AIDS while Working to Transition Programs to Country Ownership

Antiretroviral therapy (ART) reduces an HIV positive person's viral load, thereby reducing the risk of sexual transmission to a partner by up to 96 percent. In FY 2012, CDC-supported partners provided ART to 2.62 million adults and children, 679,000 more than in FY 2011 (baseline year). In FY 2014, CDC plans to provide ART to 3.3 million adults and children, an increase of 496,934 over the FY 2013 target of 2.8 million.

Scale-up efforts will leverage pre-existing clinical service platforms and will target high-risk populations through HIV testing and counseling approaches designed to be accessible and acceptable to these populations. CDC will provide on-site assistance and mentoring to MOHs and other indigenous partners to:

- help ensure that HIV/AIDS care and treatment services are efficient and of high quality;
- continue to develop and disseminate protocols, tool kits, and training curricula to accelerate and improve care and treatment service delivery; and
- develop and evaluate innovative approaches that are low cost and high impact to reach HIV-positive populations, especially high-risk populations for contracting HIV.

CDC has worked with MOHs to build their capacity to lead, manage, and implement self-sustaining national HIV programs. CDC has successfully transitioned all of its PEPFAR-supported blood safety programs and is now transitioning antiretroviral clinical services from U.S.-based implementing partners to MOHs and other indigenous organizations. To date, CDC has transitioned over half of the antiretroviral clinical services with the remainder scheduled for transition by FY 2017.

CDC partner countries for this activity include: Botswana, Cambodia, China, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guyana, Haiti, Kenya, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Vietnam, and Zambia.

Preventing Mother-to-Child Transmission (PMTCT) of HIV

The use of appropriate antiretroviral medication during pregnancy and breastfeeding can reduce the risk of mother-to-child transmission to less than five percent. In FY 2012, CDC-supported partners provided ART to 370,000 HIV-positive pregnant women, an increase of almost 80,000 compared to FY 2011 (baseline year). In FY 2014, CDC plans to provide antiretroviral medication to 467,599 HIV-positive pregnant women, an increase of 41,926 over the FY 2013 target of 425,673.

CDC will provide on-site leadership, guidance, training, and mentoring needed for PMTCT scale-up and will leverage pre-existing PMTCT facilities, as well as establish linkages to other healthcare services and

platforms. CDC will develop and disseminate training, planning, and implementation tools for adaptation to country-specific context. Finally, CDC will conduct operational research to identify and implement efficient and effective models of service delivery adapted to district, regional, sub-national and national contexts in CDC priority countries.

CDC priority countries for PMTCT of HIV include: Cambodia, Cameroon, China, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guyana, Haiti, Kenya, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, South Sudan, Tanzania, Uganda, Vietnam, and Zambia.

Expanding Voluntary Medical Male Circumcision (VMMC)

Conclusive scientific evidence shows that circumcision reduces men's risk of HIV acquisition from heterosexual exposure by at least 60 percent. VMMC programs offer unprecedented opportunities for HIV counseling and testing and the referral of HIV positive men for HIV care and treatment, thereby broadening the benefit of community-level HIV prevention interventions.

In FY 2012, CDC-supported partners performed 540,622 VMMCs, an increase of almost 250,000 compared to FY 2011 (baseline year). In FY 2014, CDC plans to provide 941,521 million males age 15 years and over with voluntary medical circumcision, an increase of 191,521 over the FY 2013 target of 750,000. CDC will focus scale-up efforts in 10 priority countries (see below), and will provide guidance, training, and oversight to assist MOHs and other implementing partners to use surgical and non-surgical procedures to increase service delivery capacity.

CDC priority countries for VMMC include: Botswana, Ethiopia, Kenya, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, and Zambia.

Health Systems Strengthening

CDC supports three areas of health-systems strengthening for HIV/AIDS: high quality laboratory services and systems, surveillance and health information systems, and MOH and workforce capacity development.

CDC establishes high-quality laboratory networks and systems that are essential to epidemic surveillance and assessing program impact for HIV/AIDS, and that serve as early detection sentinels for emerging health threats of global significance. In FY 2014, this support will expand training and strengthen proficiency testing centers to ensure sustained, high quality diagnostic capacity, and will leverage the involvement of key partners such as the African Society of Laboratory Medicine (ASLM) and the Clinton Health Access Initiative.

CDC provides on-site assistance in the design, implementation, and use of public health surveillance and information systems for HIV/AIDS, and will work with MOHs and other indigenous partners to establish and strengthen those systems. In FY 2014, CDC will provide on-site assistance in over 60 countries. This creates sustainable, locally owned systems that provide high quality data needed to monitor and evaluate program impact, and to enable program planning and course correction.

CDC provides guidance, tools, and mentoring to MOHs to build their capacity to manage a national-level response to HIV/AIDS and other health threats, as well as provide countries with assistance to plan, monitor, and evaluate human resources for health investments. In FY 2014, this includes building a trained local workforce through pre-service and in-service training, as well as daily mentoring, to over 1,200 locally employed staff. An example of this is CDC's Strengthening Laboratory Management Toward Accreditation (SLMTA) initiative, which was launched in 2009 and has trained 865 laboratorians from around the world. This comprehensive training program teaches 66 management tasks and routines required to operate a laboratory effectively and efficiently, and to deliver quality and reliable results.

Public Health Research and Analysis

Through economic analysis, operational research, and assessments, CDC will identify cost-effective interventions and best practices. For example, CDC has pioneered the use of outcome-linked expenditure analysis using data from prevention, care, and treatment activities, and is working to integrate this analysis quickly as a routine component of program planning. Outcome-linked expenditure analysis will help ensure more efficient program implementation, the identification of efficient program models, and will enable rapid course corrections to improve program effectiveness. In FY 2012, CDC led the implementation of this initiative in nine countries (Ethiopia, Kenya, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Uganda, and Zambia). In FY 2013, Phase II will expand to cover most of the PEPFAR countries in Sub-Saharan Africa and Vietnam; by the end of FY 2014, all countries supported by PEPFAR will have launched outcome-linked expenditure analysis.

GLOBAL IMMUNIZATION BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Budget Authority	\$167.744	\$168.815	\$183.003	+\$15.259
Polio Eradication	\$115.904	\$116.644	\$131.053	+\$15.149
Measles and other vaccine-preventable diseases	\$51.840	\$52.171	\$51.950	+\$0.110

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's global immunization program protects the health of Americans and global citizens by preventing disease, disability, and death through immunization. The number of children dying each year has fallen below 10 million for the first time in documented history, due to introduction of new and underutilized vaccines and strengthened systems to deliver vaccines around the world. CDC and other U.S. agencies, national governments, and partners support global immunization goals to reduce deaths due to vaccine preventable diseases (VPDs). Polio cases have dropped by more than 99 percent since 1988, measles deaths declined by 74 percent from 2000 through 2010, and more than 2.5 million VPD deaths are prevented each year through routine immunization.¹¹ CDC works to achieve and sustain several global immunization initiatives:

- Eradicating polio
- Achieving a global reduction of deaths resulting 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.

CDC acts on these goals through: (1) epidemiological and laboratory surveillance expertise for VPDs; (2) expertise for immunization policy development; (3) immunization campaign planning, implementation, monitoring, and evaluation; (4) outbreak preparedness and response for VPDs; (5) immunization system strengthening; (6) introduction of new vaccines; and (7) training to build national capacity for disease response for vaccine preventable diseases.

¹¹Simons E, et al. Assessment of the 2010 global measles mortality reduction goal: results from a model of surveillance data. *Lancet*. 2012; 379(9832): 2173-8.

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 VPDs. Although the United States has reduced its VPD burden through its strong immunization programs, the nation remains at risk for VPDs due to their continued occurrence in other countries. CDC supports global efforts to reduce VPDs as a founding partner of initiatives such as the Global Polio Eradication Initiative (GPEI) and the Measles and Rubella Initiative (MR Initiative). These efforts provide an umbrella of protection for the U.S. public's health and contribute to the overall improvement in global maternal and child health.

Childhood immunization is one of the most cost-effective public health interventions. 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.¹² Immunization programs also boost economies by reducing disease burden. 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, in 2008 one hospital outbreak in the United States with 34 cases resulted in costs up to \$800,000.¹³

Vaccines save lives, prevent disease, and are much more cost effective than hospitalizations. Working closely with public health partners, CDC can continue to reduce health disparities and work toward creating a world without vaccine-preventable disease, disability, and death.

Polio

As the lead scientific agency for USG efforts toward global polio eradication, CDC has contributed significantly to the more than 99 percent decline in global polio cases from more than 350,000 cases reported annually in 1988 to 650 cases reported in 2011. India, one of the four remaining endemic countries in 2010, achieved a major milestone by reaching one year without polio transmission in January 2012. CDC works with national counterparts on short- and long-term assignments through WHO or UNICEF country offices, establishing and jointly coordinating the Stop the Transmission of Polio (STOP) program. This effort has trained and deployed more than 1,800 public health professionals to work on polio surveillance, data management, campaign planning and implementation, program management, and communications in high-risk countries. Building on the success of the STOP program, in 2010, CDC created enhanced STOP teams in Angola, Democratic Republic of Congo, Nigeria, and South Sudan to increase the amount of time health professionals spent in high-risk districts. Additionally, in 2011, CDC worked with the field epidemiology and laboratory training program to create a national STOP (NSTOP) team in Pakistan; these professionals now serve as leaders in the ministry of health and oversee the new governance structure for the Pakistani polio program. In 2012, CDC developed a NSTOP program in Nigeria as well. CDC scientists provide recommendations to country authorities to guide their eradication efforts, develop guidance and strategies to interrupt circulation of wild poliovirus, strengthen polio surveillance and laboratory systems, assist in implementing strategies in the field with local health officials and community leaders, and integrate polio eradication activities within existing immunization systems.

Measles and Rubella (MR), New Vaccine Introduction, and Immunization System Strengthening

CDC provides vaccine funding and on-the-ground expertise to reduce deaths from measles, building on a 74 percent decline from 2000–2010 and the estimated 9.6 million measles deaths averted through vaccination during that same timeframe. CDC is the lead USG scientific agency for the MR Initiative. Through the MR Initiative, CDC builds local capacity for immunization campaigns, enhances

¹²Duintjer Tebbens RJ, et al. Economic Analysis of the Global Polio Eradication Initiative. *Vaccine*. 2010; 29(2):334-43

¹³Chen S, et al. Health Care–Associated Measles Outbreak in the United States After an Importation: Challenges and Economic Impact. *Journal of Infectious Diseases*. 2011; 203(11):1517-1525

immunization delivery systems, and builds the human capacity and infrastructure for laboratory-based detection and diagnosis. These activities are essential for improving global surveillance toward more timely detection and response to cases imported into the United States. By the end of 2011, 185 countries were reporting monthly surveillance data. CDC houses one of the world's three specialized global laboratories in the global network of national and WHO regional laboratories testing for both measles and rubella. These specialized laboratories standardize procedures and protocols, develop and validate new techniques, and train other laboratorians. This Global Measles and Rubella Laboratory Network was established in 2001 following the successful multi-tiered model provided by the Global Polio Laboratory Network. Today, the global network includes more than 690 laboratories and provides the foundation for expansion and support to other VPDs such as rotavirus, Japanese encephalitis, yellow fever, human papilloma virus (HPV), and invasive bacterial diseases.

CDC provides scientific expertise and consultation to WHO, UNICEF, and MOHs to strengthen immunization systems and prepare for new vaccine introduction. For example, routine immunization systems were strengthened to facilitate the introduction of a pentavalent vaccine in Haiti in mid-2012 (a vaccine containing diphtheria, pertussis, tetanus, Hib, and hepatitis B). Successful introduction of new vaccines in developing countries requires strong immunization programs that deliver high quality, effective vaccines. Strong immunization programs are in a better position to sustain the gains of polio and measles initiatives and effectively partner with other public health interventions (e.g., insecticide treated bed nets, screening and treatment for HIV). CDC identifies high-impact, cost-effective interventions by developing and testing interventions in high-risk countries with largest numbers of unimmunized children.

CDC is committed to building on the successes of the GPEI and MR Initiatives to achieve global polio eradication, measles elimination, and sustain the gains made by these programs.

Budget Proposal: CDC's FY 2014 request of \$183,003,000 for global immunization is an increase of \$15,259,000 above the FY 2012 level. This increase supports the Global Polio Eradication Initiative (GPEI) and partner efforts towards the goal of stopping all WPV transmission and any new vaccine-derived polioviruses by the end of 2014. Lessons learned from the successes in India will be the focus of the increased efforts, which include maintaining sensitive surveillance, improving the quality of supplemental immunization activities, intensifying routine immunization programs in high-risk areas and populations, aggressively mopping-up polio outbreaks, and introducing the use of bivalent oral polio vaccine. CDC and GPEI partner efforts will align with the Polio Eradication and Endgame Strategy from 2013–2018.

In coordination with WHO, UNICEF, Rotary International, Bill and Melinda Gates Foundation, other USG agencies, and MOHs, CDC will improve national ownership, oversight, and accountability of programs; sustain supplementary immunization activities; and improve performance quality and monitoring of immunization programs. CDC will enhance epidemiologic, laboratory, and programmatic support to WHO and UNICEF to develop, monitor, and evaluate programs and strengthen national level surveillance capacity, including serving as the global polio reference laboratory in a network of 145 national laboratories. CDC will continue to provide expertise in virology, diagnostics, and laboratory procedures. In addition, CDC will ensure quality assurance, diagnostic confirmation, and genomic sequencing of samples obtained worldwide. These efforts are critical to achieving the interruption of wild poliovirus, maintaining surveillance and vaccination activities until the world is certified polio-free, and implementing the Polio Eradication and Endgame Strategy from 2013–2018. CDC will continue its programmatic emergency response, providing rapid, intensive deployments of scientific experts to monitor immunization activities and acute flaccid paralysis surveillance in any remaining polio-endemic countries (currently Afghanistan, Nigeria, and Pakistan); reinfected countries (currently Chad); and countries at risk for polio infection or transmission in accordance to the USG-endorsed Global Polio Emergency Action Plan.

As the world nears polio eradication, CDC will provide expertise, recommendations, and implementation guidance for the comprehensive Polio Eradication and Endgame Strategy from 2013–2018. This strategy was prepared during fall 2012 with full input of the implementing partners of GPEI, including CDC, and a draft was released at the January 2013 WHO Executive Board meeting. This strategy will build on successes, evidenced by the 2011 interruption of polio transmission in India, by focusing on the challenges to interrupt wild poliovirus transmission in the three remaining polio-endemic countries and other countries at risk for polio infection or transmission. CDC will continue to provide recommendations within the GPEI partnership to develop a timeline for the following improvements:

1. the 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 2014,
2. the introduction of inactivated poliovirus vaccine into the routine childhood vaccination schedule,
3. eventual cessation of the use of oral polio vaccine,
4. completion of the plans and procedures for laboratory containment of wild polioviruses and eventual global eradication. CDC has reduced the time for laboratories to detect and confirm the presence of poliovirus in samples from 42 to 21 days. CDC continues to support global labs to sustain this standard.

CDC, a partner of the MR Initiative along with WHO, UNICEF, American Red Cross, United Nations Foundation, and Global Alliance for Vaccines and Immunization (GAVI) Alliance, remains committed 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 56,925 in FY 2014 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, guiding countries' 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 vaccines through social mobilization campaigns and will conduct research needed to support cost-effective and improved vaccination and diagnostic tools.

Supplemental, disease-specific immunization campaigns have played an important role in reaching targeted goals such as polio eradication and measles mortality reduction. However, these gains could not have been achieved without concomitant efforts through routine immunization delivery systems for all recommended vaccines. Progress in polio eradication and measles elimination is fragile; without further sustainable improvements in immunization systems, large outbreaks undoubtedly will occur and cases and deaths will increase. To improve vaccination coverage in priority countries and introduce new vaccines, CDC will conduct pre-vaccine introduction assessments and post-introduction evaluations, train national immunization technical advisory groups, and assist countries in making decisions to introduce new and underutilized vaccines. In addition, CDC will design and evaluate strategies to enhance disease surveillance systems, including laboratory networks, to monitor data quality and the impact of new vaccine introduction on reducing VPD occurrence.

Grant Table:

Global Immunizations Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	5	5	4
Average Award	\$22.398	\$16.896	\$24.000
Range of Awards	\$0.425–\$55.081	\$0.400–\$36.058	\$5.000–\$45.000
Number of New Awards	1	2	0
Number of Continuing Awards	4	3	4

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Total Grant Award	\$112.000	\$84.480	\$96.000

In FY 2014, CDC will fund four awards through single eligibility, competitive cooperative agreements to UN agencies. Some examples of current grantees include WHO, UNICEF, United Nations Foundation, Pan American Health Organization, and KidsRisk. The purpose of these cooperative agreements is to direct polio eradication, reduce measles and rubella mortality, and strengthen immunization systems. The five-year goals of the program include providing global leadership and expert scientific analysis for vaccine-preventable disease eradication and elimination initiatives and other targeted vaccine preventable disease control goals, with a particular focus on reaching the goal of polio eradication. Other five-year goals include strengthening the capacity of health systems to deliver routine immunization services, strengthening vaccine-preventable disease health and information systems, increasing the appropriate development, introduction, and use of new and underused vaccines, and promoting synergies between immunization and other public health interventions to strengthen health systems.

Partnerships will work to improve national ownership, oversight, and accountability; sustain supplementary immunization activities; and improve performance quality and monitoring of immunization programs. Grants will support achievement of global polio and measles goals, strategies for controlling rubella and congenital rubella syndrome, strengthening routine immunization and disease surveillance systems; and linking measles control activities with other health interventions.

GLOBAL DISEASE DETECTION AND EMERGENCY RESPONSE BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Budget Authority	\$45.386	\$45.676	\$45.580	+\$0.194

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC's Global Disease Detection (GDD) and Emergency Response programs protect Americans and the global community from urgent public health threats. CDC's work contributes to the full emergency continuum that includes building capacity before an outbreak or emergency strikes, monitoring and detecting disease threats, responding to outbreaks or international emergencies before they affect the United States, and aiding in health system reconstruction so the affected country can respond to future incidents.

CDC's portfolio of global disease detection activities leverages agency-wide public health expertise to ensure adequate capacity in field epidemiology and surveillance; zoonotic disease investigation and control; public health information technology systems; and laboratory diagnostics, biosafety, systems development, and biosecurity practices for extremely dangerous pathogens.

Capacity building allows CDC to monitor, detect, and assess disease threats. CDC maintains surveillance and laboratory diagnostics in order to protect the world from new infectious disease threats. In FY 2011, CDC discovered 12 new disease threats. The GDD program is comprised of strategically positioned GDD Regional Centers in eight countries where disease outbreaks are most likely to occur, the GDD Operations Center based at CDC headquarters, and international partner networks that support global disease detection activities.

Building capacity for a country to respond to a potential outbreak or emergency before an event occurs helps contain dangerous pathogens as they emerge, which saves lives and prevents the spread of disease to the United States. CDC provides outbreak response to countries requesting CDC assistance for diseases

on the list of international concern.¹⁴ In FY 2011, CDC responded to 247 disease outbreaks via the GDD Regional Centers and through coordination with the GDD Operations Center and other CDC programs. These outbreaks included febrile encephalitis, human H5N1 influenza, viral hemorrhagic fever, and cholera.

CDC's international emergency response activities reduce illness and death, and improve the health of populations affected by emergencies through public health action, operational research, and emergency public health policy development. CDC provides humanitarian assistance based on requests for assistance from other USG agencies, United Nations agencies, and non-governmental organization (NGO) partners. In FY 2011, CDC provided assistance to over 63 humanitarian missions in 10 countries.

CDC's capacity building work in Haiti after the January 2010 earthquake allowed a rapid response to the cholera outbreak that began in October 2010. CDC training of Haitian MOH staff, and establishing and improving surveillance systems resulted in identifying and genetically typing cholera, and launching a full-scale emergency response operation within three days of reported increases of watery diarrhea. Previously, Haiti had a poorly functioning National Sentinel Site Surveillance System (NSSS). CDC strengthened that system and established an Internally Displaced Persons Surveillance System and a Cholera Surveillance System that feed data into the strengthened NSSS, which now provides more accurate, real-time data on disease in Haiti.

Budget Proposal: CDC's FY 2014 request of \$45,580,000 for GDD and Emergency Response is an increase of \$194,000 above the FY 2012 level.

The GDD and emergency response programs at CDC will build upon program accomplishments to continue to fulfill CDC's mission of protecting the health of U.S. citizens and the global community from urgent public health threats. CDC's GDD and Emergency Response programs will provide rapid response, similar to previous years, to at least 100 disease outbreaks and public health emergencies, likely to include febrile encephalitis, human H5N1 influenza, viral hemorrhagic fever, and cholera.

To provide necessary coverage for disease detection, 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 eight GDD Regional Centers currently located in Bangladesh, China, Egypt, Guatemala, India, Kenya, South Africa, and Thailand and two GDD Regional Centers under development in Georgia and Kazakhstan. The GDD Regional Centers in China, Egypt, Guatemala, Kenya, and Thailand will detect dangerous pathogens through focused population-based surveillance covering approximately 108 million people. The GDD Centers in Bangladesh, India, and South Africa are strengthening their national surveillance and laboratory systems to conduct population-based surveillance.

Growing concerns with global health security require strengthening USG interagency partnerships (i.e. with Department of Defense, Department of State, United States Agency for International Development, and National Security staff) to promote coherent, coordinated policies and programs.

CDC will continue to provide rapid health and nutrition assessment, public health surveillance, epidemic investigation, disease prevention and control, program evaluation, and emergency preparedness to assist MOH, USG partners, and non-governmental partners. Through these collaborations, CDC will establish dozens of new in-country laboratory diagnostic tests through training and technology transfer, enabling host countries to detect emerging health threats locally.

¹⁴The International Health Regulations (IHR) require all countries to report immediately to WHO any occurrence of smallpox, polio, Severe Acute Respiratory Syndrome (SARS), and new strains of human influenza. In addition, the IHR provides a decision algorithm for declaring other incidents of a biological, chemical, radiological, or nuclear nature to be declared a potential Public Health Emergency of International Concern. A current list of diseases under the WHO Global Alert and Response network is at <http://www.who.int/csr/disease/en/>.

CDC collaborates with international, bilateral, and non-governmental relief organizations to provide data-driven, evidence-based public health interventions during humanitarian emergencies. CDC will maintain and strengthen these strategic relationships.

Grant Table:

Global Disease Detection and Emergency Response Grant Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	36	40	39
Average Award	\$0.252	\$0.218	\$0.224
Range of Awards	\$0.002–\$1.993	\$0.002–\$1.993	\$0.002–\$1.993
Number of New Awards	6	4	2
Number of Continuing Awards	30	36	37
Total Grant Award	\$9.085	\$8.732	\$8.732

In FY 2014, CDC will fund 34 awards through both competitive grants and non-competitive agreements. The five-year goals of the program are to increase capacity to detect and control emerging infectious disease outbreaks and to prevent or reduce illness, injury, and death related to humanitarian emergencies.

The grants provide financial assistance for academic institutions and NGOs. CDC awards grants 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 grantees include: Emory University, Georgia Institute of Technology, iMMAP, International Rescue Committee, UNICEF, United Nations High Commissioner on Refugees, WHO, Antares, Herzog Hospital, Columbia University, Association of Schools of Public Health, and American Society of Microbiology.

The cooperative agreements provide financial assistance to MOHs to: (1) build epidemiologic and laboratory capacity through trainings with the local ministries of health to detect and control emerging infectious diseases; (2) provide support in the fields of reproductive health, water, and sanitation, and health information to populations affected by war and humanitarian emergencies; and (3) increase the public health capacity of the United Nations and international NGOs mandated with addressing and coordinating responses to and prevention of war-related injuries in less-developed countries.

PARASITIC DISEASES AND MALARIA BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ¹	FY 2014 President's Budget ¹	FY 2014 +/- FY 2012
Budget Authority	\$22.069	\$22.211	\$22.231	+\$0.162

¹ FY 2012 and FY 2013 are comparable to FY 2014 to reflect proposed BSS realignment. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC—a key implementing partner for the President's Malaria Initiative (PMI)—supports prevention, control, diagnosis, and treatment of a wide range of parasitic diseases that threaten the health of individuals in the United States and globally. Parasitic diseases have tremendous impact on global mortality and morbidity, and are a significant U.S. health concern due to increases in global travel, importations, and domestically acquired infections. CDC has more than 150 highly trained medical officers, epidemiologists, public health advisors/analysts, statisticians, health scientists, entomologists, and laboratory scientists based at headquarters and in the field, working on laboratory support, reference diagnostics, operations research, surveillance, monitoring and evaluation, case management, capacity building, and providing expert knowledge and leadership on parasitic diseases.

In 2011, CDC national reference labs tested more than 10,000 specimens from U.S. residents and government overseas staff for parasitic diseases. CDC's labs also responded to 549 telediagnosis inquiries

and released investigational new drugs to hospitals and clinicians to treat approximately 150 U.S. residents with potentially life-threatening infections. CDC also conducted studies to better understand the transmission cycle for and risk posed by Chagas disease in the United States, as well as developed and improved tests for monitoring cases of neurocysticercosis (the most common cause of adult onset epilepsy globally), baylisascariasis (an infection with the roundworm found in raccoons, acquired through contact with infected raccoon feces), and leishmaniasis (a parasitic infection spread by the bite of infected sand flies).

CDC also conducts activities to prevent, treat, and monitor malaria among U.S. travelers and visitors; last year the agency responded via its 24/7 hotline to over 8,000 inquiries, many of them urgent requests related to life-saving diagnosis and treatment. Additionally, CDC develops the Health Information for International Travel guideline—an annual reference guide for U.S. citizens traveling to malaria-endemic countries.

Globally, CDC provides scientific and programmatic expertise in surveillance, monitoring, and evaluation to USG, global, and MOH programs working to control and eliminate Neglected Tropical Diseases (NTDs). CDC also conducts critical research to identify best practices guidance for these programs. CDC has worked in close collaboration with Haiti's MOH to continue progress toward elimination of lymphatic filariasis, which resulted in the treatment of more than 2.3 million individuals during Haiti's mass drug administration campaign from 2011 to 2012. CDC assisted with a crucial step towards the elimination of onchocerciasis (an infection caused by parasitic worms transmitted from person-to-person by black flies) in Guatemala by determining infection rates in the black fly vectors during peak transmission season. CDC also evaluated a new diagnostic test for schistosomiasis that will enable easier and faster diagnosis and treatment.

CDC also enhances vector control, case management, surveillance, monitoring and evaluation, and capacity building for PMI. CDC works with MOHs and other partners to conduct vital research to optimize existing tools and strategies, and to develop new ones to prevent and control malaria. For example, CDC developed and evaluated standard methods for Insecticide Treated Net (ITN) physical durability. ITNs, when used correctly and consistently, are a highly effective method of providing individual protection from malaria infection and are now a cornerstone intervention in malaria prevention efforts worldwide. Research shows that high ownership and use of ITNs reduce deaths from all causes in children under five by about 20 percent, and reduce malarial infections among pregnant women and children under five by up to 50 percent. In addition, high ITN coverage can reduce populations of mosquitoes that transmit malaria, providing a protective community effect that reduces the risk of malaria even among those not using an ITN.

In collaboration with WHO and the Foundation for Innovative New Diagnostics, CDC established international standards for rapid diagnostic test performance and reliability that have improved malaria diagnoses. CDC recently published positive results from a study evaluating the combined use of ITNs and indoor residual spraying in areas of low malaria transmission, and assisted with the release of the first country-specific impact report in Tanzania. To date, scale-up of these interventions through PMI and other program efforts has reduced deaths from all causes in children less than five years of age by 16–50 percent in PMI countries surveyed—contributing to saving more than 200,000 lives over the past decade.

Budget Proposal: CDC's FY 2014 request of \$22,231,000 for parasitic diseases and malaria is an increase of \$162,000 above the FY 2012 level. Within this total, \$10,660,000 is provided for malaria.

CDC will continue to maintain the national parasitic disease reference laboratories and national surveillance for notifiable parasitic diseases, both created to build capacity and assist states and counties to monitor, accurately diagnose, and enable prompt and effective treatment of parasitic diseases. Since the initiation of the national surveillance for babesiosis (a tick-borne parasitic disease) on January 1, 2011, more than 1,000 cases have been reported to CDC. CDC completed the first summary of national surveillance for babesiosis and published the results in July 2012. CDC will improve diagnosis and

knowledge of parasitic diseases by providing 24/7 expert consultation on these diseases to physicians, hospitals, and laboratories working to treat individuals who may be infected. CDC will also engage in studies to better understand the populations most at risk for parasitic infections in the United States and how to prevent infections. CDC continues to supply otherwise unavailable drugs to treat parasitic infections among individuals in the United States.

CDC will also maintain ongoing malaria surveillance in the United States. There were 1,691 cases (mostly imported) of malaria in the United States in 2010 (most recent year for which data are available). CDC will assess and regularly update malaria prevention guidelines for U.S. travelers and guidelines for protecting recipients of blood transfusions from transfusion-transmitted malaria.

Globally, CDC will continue to provide leadership and expertise in preventing and controlling parasitic diseases, including malaria. Malaria prevention and treatment tools (e.g., indoor residual spraying, insecticide-treated nets, anti-malaria drug therapies, and intermittent preventive treatment in pregnancy) and mass drug administration for NTDs are among the most cost-effective interventions available to improve maternal and child survival and health. CDC will support U.S. and global initiatives to decrease the rate of deaths from all causes in children under five in PMI target countries, and to reduce the enormous illness and disability associated with NTDs in the USG NTD target countries. CDC will measure success by both the number and outcome of scientific and programmatic assistance consultations provided, laboratory tests conducted, monitoring and evaluation activities accomplished, and progress reached on research project.

CDC will support effective prevention and elimination programs to control or eliminate NTDs—particularly lymphatic filariasis (elephantiasis), onchocerciasis (river blindness), trachoma, schistosomiasis, and the soil-transmitted helminthes—and eradication of Guinea worm through CDC's technical support of U.S. and global programs. CDC's technical support includes training, diagnostic tool development, implementation, monitoring, evaluation, and integration of NTD programs. Building on CDC's development of a training curriculum for a Transmission Assessment Survey that documents interruption of transmission of lymphatic filariasis, CDC will assist countries in Africa and elsewhere to conduct the survey.

CDC will monitor improvements in child survival in PMI countries, including assisting additional countries in documenting program impacts. To support achieving PMI targets related to intervention coverage and reductions in malaria-related mortality, CDC will provide scientific leadership and advice to the USG Malaria Coordinator, and will be a key implementer of monitoring and evaluation, surveillance, and operations research activities in the 19 PMI-focus African countries and in the Greater Mekong Sub-region. Global malaria prevention and control programs will continue to scale up and implement cost-effective interventions: intermittent preventive treatment in pregnancy, insecticide-treated bed nets and indoor residual spraying, and artemisinin combination therapy.

CDC will also provide scientific and programmatic expertise and support related to strategic information, diagnostics, case management, and vector control to 15 malaria-endemic, non-PMI countries, to help reduce the risk of malaria in these countries and to reduce the number of cases imported to the United States. CDC will conduct laboratory-based research and development, and epidemiological evaluations in support of malaria control interventions. These interventions include long-lasting, insecticide-treated nets; indoor residual spraying; durable wall linings; continuing to assess malaria in pregnancy; novel drugs; insecticides; vaccines; and delivery systems. Interventions also include case management (e.g., diagnosis, treatment, and antimalarial drug resistance) to develop evidence-based guidance, new tools, and innovative approaches.

CDC will maintain the global reference insectary—an unparalleled resource for research—to better understand mosquito vectors, manage and mitigate insecticide resistance, and facilitate successful field implementation of vector-control interventions. 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 PMI countries, and assess new vector control methods and insecticides. CDC also will develop and evaluate new rapid and simple field methods to test the quality of malarial drugs.

GLOBAL PUBLIC HEALTH CAPACITY DEVELOPMENT BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget¹	FY 2014 +/- FY 2012
Budget Authority	\$10.219	\$10.284	\$10.268	+\$0.049

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: CDC builds the self-reliant workforce and systems needed to detect and respond to public health threats and emergencies and to reduce illnesses that together cause the largest burden of disease globally. This approach reduces the need for external intervention (including CDC) and the risk of international spread of disease, including transmission to the United States. CDC provides scientific and programmatic leadership to and collaborates with local and international organizations to help MOHs develop Field Epidemiology Training Programs (FETPs). These programs assist countries as they develop the workforce and systems necessary to detect and respond to disease outbreaks; track health patterns; and improve laboratory management, applied research, program evaluation, communications, and program management. 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 is no longer present.

The Sustainable Management Development Program (SMDP) helps MOHs improve organizational performance and governance, creates more effective use of limited resources, strengthens stewardship, and advances best practices through applied research and evaluation. Through these and other global health programs, CDC provides strategic direction and technical support to MOHs to build sustainable public health capacity around the world.

FETP increasingly focuses on national and international public health priorities and provides specific concentration on immunization, laboratory practice, malaria, polio eradication, tobacco control, non-communicable diseases, and tuberculosis. Through planned investigations and evaluations to understand disease burden and prevention in FY 2011, FETP residents conducted more than 300 confirmed outbreak investigations, strengthened over 550 surveillance systems, and provided specific recommendations for improvements. Both FETP and SMDP are working with the polio eradication STOP program and deploying FETP residents in difficult-to-reach areas of Nigeria and Pakistan. In support of polio eradication efforts, the Pakistan FETP has accessed 58 new areas including 33 high-risk districts, helped vaccinate 5,360 children originally missed during vaccination campaigns, and identified and vaccinated 2,781 previous refusals. CDC conducted the Epidemiology Laboratory Surveillance and Response Workforce Mapping project in four countries as part of strategic efforts to identify gaps and address capacity development needs, which will help countries address requirements under the International Health Regulations (2005).

Budget Proposal: CDC's FY 2014 request of \$10,268,000 for global public health capacity development is an increase of \$49,000 above the FY 2012 level.

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 data in-country. The data provide evidence of outbreaks and identify opportunities to reduce spread of diseases to the United States and other nations. The FETP tiered training model with beginner (six months), intermediate (nine months) and advanced (two years) programs has proven successful for ensuring that epidemiologists are available at all public health workforce levels. CDC will build on this success by expanding the reach of the FETP to sub-national levels in up to 10 countries, and

linking workforce capacity development with CDC's National Public Health Institute activities, which is helping countries consolidate public health functions and create a systematic use of evidence for decision-making. CDC also will strengthen the capabilities of all FETP graduates to respond to national and global priorities such as emerging new diseases, polio, immunization, and tobacco control, and will expand distance learning and self-based training modules to reach more residents. Regional networks have proven essential for sharing lessons learned and providing a platform for CDC and countries to support one another to improve health. CDC will expand partnerships with four regional FETP networks in areas of strategic importance, such as the Middle East, Africa, or Central Asia, to provide shared training and capacity building opportunities, staff multi-country outbreak response teams, and expand the partnership and collaboration capacity of individual country programs.

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; graduates from the Jordan FETP returned home to start a 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 which a FETP does not exist. CDC also will strengthen partnerships with other USG agencies, private foundations, universities, and others to improve health impact among workforce capacity and systems-strengthening programs. In addition, CDC will strengthen partnerships with other USG agencies, private foundations, universities, and others to improve health impact among the public health workforce through SMDP's focus on helping countries improve their health program's efficiency and effectiveness.

CDC will continue to reduce specific diseases and risk factors by enhancing country planning and management capacity, as well as by increasing knowledge and evidence through data collection, program evaluation, and research. Building upon experience developing and implementing electronic disease reporting systems in Central Asia, Saudi Arabia, China, and elsewhere, CDC will enhance the health information system capacity of partner countries, particularly for surveillance, and will translate the data obtained into strategic approaches that improve people's 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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
10.A.1.5: Increase the number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (Output)	FY 2012: 2,620,177 (Baseline)	N/A	3,310,618	N/A
10.A.1.6: Increase the number of HIV+ pregnant women receiving antiretroviral medications, to reduce mother-to-child HIV transmission (Output)	FY 2012: 370,000 (Baseline)	N/A	467,599	N/A

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
10.A.1.7: 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 2012: 540,622 (Baseline)	N/A	941,521	N/A

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 now a policy priority for the U.S. and preventing new HIV infections is critical to stem the global HIV/AIDS pandemic in the absence of an HIV vaccine. To achieve this, CDC focuses on three pivotal evidence-based interventions: preventive antiretroviral therapy (ART), preventing mother-to-child transmission (PMTCT), and voluntary medical male circumcision (VMMC). ART reduces an HIV positive person's viral load, thereby reducing the risk of sexual transmission to a partner by up to 96 percent. 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 percent, with numerous 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.

In FY 2014, CDC will report CDC-specific measures that represent contributions to achieving PEPFAR targets rather than reflecting aggregate efforts under PEPFAR for all USG partners. In FY 2011, CDC-supported partners in 20 PEPFAR countries provided antiretroviral treatment to 1,941,177 adults and children (Measure 10.A.1.5). In FY 2012, more than 2.62 million adults and children with advanced HIV infection received ART, 679,000 more than in FY 2011. CDC is on track to meet or exceed its target of providing ART to 3.3 million children and adults by the end of FY 2014.

In FY 2011, 20 CDC-supported partner countries provided antiretroviral medication to 291,180 HIV-positive pregnant women, reducing the risk of passing the virus on to their children (Measure 10.A.1.6). In FY 2012, 370,000 HIV-positive pregnant women received ART, an increase of almost 80,000. CDC is on track to meet its target for FY 2014 of providing 467,599 HIV-positive pregnant women with ART.

In FY 2011, 291,863 males age 15 and older voluntarily received circumcision by a qualified healthcare provider (Measure 10.A.1.7). In FY 2012, CDC-supported partners in 10 high priority PEPFAR countries performed 540,622 VMMCs, an increase of almost 250,000. Though VMMC is not a new prevention program, rapidly scaling up VMMC is a new initiative, unlike the more established ART and PMTCT programs. Therefore, CDC is assisting country teams to overcome implementation challenges, in part by identifying and disseminating potential solutions and lessons learned to all countries implementing VMMC. CDC is also expanding training, increasing the number of dedicated VMMC teams, supporting mobile services and conducting outreach to mobilize the eligible male population. FY 2014 targets are ambitious, but achievable, in light of the challenges encountered.

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 but Improved)	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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 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 2011: 31,483,738 (Target Not Met but Improved)	51,400,000	55,000,000	3,600,000

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 Exceeded)	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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 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 (Historical Actual)	136	141	+5

Efficiency measure for Global Immunization

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
10.B.E.1: Increase the percentage of the annual budget that directly supports the program purpose in the field. (Efficiency)	FY 2012: 81% (Target Not Met)	≥90%	≥90%	Maintain

Performance Trends: Global immunization funding supports global polio eradication and global measles mortality-reduction efforts. CDC is the lead technical monitoring agency for the Independent Monitoring Board of the Global Polio Eradication Initiative (GPEI). The number of countries reporting endemic wild

poliovirus (WPV) remained stable at four from 2008-2010 and then declined to three countries — Pakistan, Afghanistan and Nigeria— from 2010-2011 (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 within and outside its borders, as well as continued circulation along the Afghanistan-Pakistan border, prevented the achievement of the FY 2012 target and compounds the challenge of interrupting residual WPV transmission.

Eradicating WPV cases among the three remaining countries is vital to preventing re-infection among polio-free countries and will require intensive operational efforts to reach children in isolated areas, including more resources per child. In early 2011, CDC faced concerns regarding achieving sufficient progress towards the OPV target, but through additional resources, purchased 289,000,000 doses of OPV and vaccinated approximately 31 million children, 2 million more than in 2010 (10.B.1.2). In resource poor countries, especially those with inadequate sanitation, multiple doses of OPV must be administered to achieve immunity.

Many of the re-infected countries suffered substantial and recurrent polio outbreaks due to low routine immunization coverage levels (less than 80 percent), suboptimal outbreak response, and weak health systems—together constituting a “WPV importation belt” that stretched from West Africa to Central Africa to the Horn of Africa. 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 2013. 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 2011 to scale up its activities and rapidly expand expertise for 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 allocate resources effectively.

Reducing cumulative global measles-related mortality by 95 percent compared with CY 2000 estimates presents unique challenges. The global measles mortality data released in late 2011 showed measles outbreaks from 2009 through 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 2002 (10.B.2.1). Additionally, in 2011, WHO documented 1,310 measles cases in Europe, posing a severe public health challenge to the Western Hemisphere. Since 2008, CDC’s collaboration with the Pan American Health Organization (PAHO) has helped ensure that these cases do not spur an endemic (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 indicator to reflect the strength of national immunization program performance. More countries achieving this target reflect progress in the global effort to strengthen immunization systems, with expected declines in the number of vaccine preventable diseases. The number of countries achieving 90 percent immunization coverage for DTP3 has steadily increased from 125 in 2008 to 133 in 2011 (Measure 10.B.2.3).

Increased staffing costs associated with activating the Emergency Operations Center (EOC) for polio eradication and rising administrative and travel costs reduced the percentage of the annual budget used to directly support program operations (Measure 10.B.E.1). However, EOC expenditures are expected to be a one-time expense, and hired staff are currently spending more time in the field which should improve the program’s performance in FY 2013 for this measure. CDC continues to review options for reducing costs on a monthly basis to minimize administrative overhead while maximizing direct spending for field

related activities. Plans to achieve the 90 percent threshold in FY 2014 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: Global Disease Detection (GDD) and Emergency Response

Performance measure for Long Term Objective: The Division of Global Disease Detection (GDD) and Emergency response will work with Ministries of Health, other USG Agencies, and international partners to build outbreak detection and response public health capacity in support of the International Health Regulations (2005).

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 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)	79%	80%	+1

Performance Trends: The GDD Monitoring and Evaluation framework captures quarterly data to monitor progress and assess program impact of GDD Regional Centers. CDC increased the percentage 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. Handling of these request dropped to 72 percent in FY 2012 (Measure 10.E.1). Although CDC did not meet its target, the performance improvement from baseline to FY 2012 reflects improved in-country capacity to detect emerging outbreaks resulting from GDD Regional Centers efforts. Furthermore, CDC added one additional Regional Center in Bangladesh in FY 2012. As newly added GDD Regional Centers improve capacity to quickly respond to outbreaks, the average response time for all centers will improve in FY 2014. Recent outbreak responses have included H5N1 avian influenza in the Middle East and Southeast Asia, cholera in east Africa and Haiti, and anthrax in southern Africa.

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.¹

Contextual Indicators	Most Recent Result	FY 2015 Target
10.C.1: 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 2011: 42.8% (Target Not Met)	N/A
10.C.3: 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 2011: 24.5% (Target Not Met)	N/A

¹ Due to data reporting timeframes, there is a two-year gap between the baseline for the third set of countries and the actual data for the first set of countries in 2011. Therefore, 2014 - 2015 targets cannot be established

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
10.C.A: The number of CDC authored publications that inform the global evidence for malaria control and prevention programs (Output)	FY 2011: 45 (Baseline)	N/A	57	N/A

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
10.C.4: The percentage of laboratory test results reported within the expected turn-around time (two weeks) upon receipt by CDC labs (Outcome)	FY 2011: 85.2% (Baseline)	87%	90%	+3

Performance Trends: Parasitic diseases have a tremendous impact on global mortality and morbidity and are a significant health concern in the U.S. due to increased global 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 2011 (baseline year), CDC analyzed and reported 85.2 percent of specimens in a timely manner (approximately two weeks from the time of receipt by CDC labs, Measure 10.C.4).

Malaria prevention and treatment tools are among the most cost-effective interventions available to improve global maternal and child survival and health. CDC's research directly enhances the development of new tools to manage and mitigate threats from drug and insecticide resistance, informs future program and policy decisions, and equips host country governments through collaboration with partners, such as the Ifakara Health Institute in Tanzania.

Based on evidence from CDC research over the last two decades, global malaria prevention and control programs continue to scale up and implement cost-effective interventions. This includes (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 (ACTs) to treat individuals infected with malaria.

While CDC and its partners did not meet FY 2011 PMI performance targets for Measures 10.C.1 and 10.C.3, PMI countries expanded their use of malaria prevention and treatment tools as compared to the baseline set in 2006. The percent of children under five years old who slept under an insecticide-treated net the night before more than doubled from 16 percent to 43 percent. Additionally, the percent of women who received at least two doses of IPTp increased from 18 percent to 25 percent. The shortfalls in meeting the targets reflect procurement inefficiencies and delays in national distribution systems, and the efficacy of the IPTp intervention. 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 regarding IPTp use. 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 percent in surveyed PMI countries. Country results vary widely as unique contextual factors influence outcomes. These efforts have also contributed to saving more than 200,000 lives over the past ten years (World Malaria Report, 2011).

In 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. CDC published an average of 45 peer-reviewed papers annually between 2009-2011 for malaria prevention and control efforts (Measure 10.C.A). From 2011-2012, 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. 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. In clinical trials, it was the first to demonstrate that it can protect young children and infants in malaria-endemic areas against infection and clinical disease caused by *Plasmodium falciparum*, the most deadly species of the malaria parasite (GlaxoSmithKline Factsheet 21, April 2010).

FY 2012 data for all parasitic diseases and malaria measures will be available in April 2013.

Program: Global Public Health Capacity Development

Performance measures for Long Term Objective: To increase the number of skilled Epidemiologists providing sustained public health capacity in low and middle-income countries.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
10.F.1a: Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology Training Program (FETP). New Residents (Outcome)	FY 2011: 351 (Target Exceeded)	179	430	+251
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 2011: 2,678 (Target Exceeded)	2,660	3,101	+441

Performance Trends: Since 1980, CDC developed 46 international Field Epidemiology Training Programs (FETP) serving 64 countries and graduated over 2,600 epidemiologists. In FY 2011, CDC exceeded targets for new residents and total graduates (Measures 10.F.1a and 10.F.1b). The FY 2011 results show a substantial increase in the number of new residents participating in FETP. This is primarily due to launching several new FETPs in 2011 as well as expanding existing programs to include more residents. FETP and Sustainable Management Development Program graduates go on to serve in key public health positions within MOHs in their respective countries. Approximately 80 percent of FETP graduates remain within their respective MOH after graduation and many are assigned to key leadership positions, such as the National Director of TB 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. Their presence enhances sustainable public health capacity in these countries, which is critical in transitioning U.S. government global health investments to long-term host-country ownership. FETP graduates and residents conducted more than 320 outbreak investigations, over 200 planned investigations, and approximately 350 surveillance system evaluations. This enabled recommendations for programmatic improvement and implementation of concepts and techniques learned throughout the training.

CDC-WIDE ACTIVITIES AND PROGRAM SUPPORT

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$219.295	\$220.822	\$131.403	-\$87.892
PHS Evaluation Transfer	\$0.000	\$0.000	\$0.000	\$0.000
ACA/PPHF	\$41.200	N/A	\$41.200	\$0.000
Total	\$260.495	\$220.822	\$172.603	-\$87.892
FTEs	1,994	1,981	1,981	-13

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Enabling Legislation Citation: PHS Act Title II §§ 301, 304, 306*, 307, 308, 310, 311, 317, 317F*, 319, 319A, 319D*, 322, 325, 327, 352, 361–369, 391*, Title XVII*, 2821*

Enabling Legislation Status: Permanent

Authorization of Appropriations for FY 2014: Indefinite; Expired/Expiring noted with *

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

SUMMARY

CDC's FY 2014 request of \$172,603,000 for CDC-Wide Activities and Program Support is an overall decrease of \$87,892,000 below the FY 2012 level which includes the elimination of the Preventive Health and Health Services Block Grant. These funds support a range of infrastructure and services for mission-critical activities and programs to function.

(dollars in millions)	FY 2012 Enacted ¹	FY 2013 CR ^{1,2}	FY 2014 President's Budget	FY 2014 +/- FY 2012
Buildings and Facilities	\$24.946	\$25.106	\$14.591	-\$10.355
Public Health Leadership and Support ³	\$114.804	\$115.661	\$116.812	+\$2.008
Preventive Health Block Grant Program	\$79.545	\$80.055	\$0.000	-\$79.545
ACA/PPHF	\$41.200	N/A	\$41.200	\$0.000
Total	\$260.495	\$220.822	\$172.603	-\$87.892

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

³Funding is being realigned to programs as part of CDC's transition to a Working Capital Fund financing structure for business services support activities.

FUNDING HISTORY¹

Fiscal Year	Dollars (in millions)
2009	\$822.513
2010	\$680.324
2010 (ACA/PPHF)	\$50.142
2011	\$563.539
2011 (ACA/PPHF)	\$41.200
2012	\$219.295
2012 (ACA/PPHF)	\$41.200
2013	\$220.822
2013 (ACA/PPHF) ²	N/A

¹Funding level for FY 2009 has not been made comparable to reflect the FY 2010 budget realignment. The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates.

²The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

BUILDINGS AND FACILITIES BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$24.946	\$25.106	\$14.591	-\$10.355

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program 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.

B&F indirectly supports all program activities that take place in CDC-controlled space, such as laboratory research (infectious diseases, environmental health, occupational safety and health, and mine safety), data and information system centers, and non-laboratory based public health research.

Current activities focus on repair and improvement (R&I) projects to restore or improve a failed or failing primary building system or real property component to effective use, including roofs, chillers, boilers, water and air conditioning systems, elevators, foundations, windows, and built-in laboratory equipment. The R&I program has three focus areas:

- 1) adherence and compliance with national and local codes and standards (e.g. Fire & Life Safety Codes);
- 2) engineering and facility condition index sustainment/improvement (e.g. electrical distribution system upgrades, roof replacements, chiller/boiler replacements, etc.); and
- 3) urgent program requirements (laboratory upgrades, critical equipment replacement such as autoclaves, walk-in freezers, specimen storage upgrades, etc.).

B&F incorporates sustainable design principles and effective operations and maintenance to reduce resource consumption (including energy, water, and capital resources) and maintain the facilities in good condition.

CDC also funds new construction projects, including additions or major improvements (renovations or alterations) to existing buildings in CDC's owned inventory. CDC completed and occupied Building 24 at its Roybal Campus in July 2011 and relocated approximately 700 persons from leased space, allowing CDC to terminate two existing operating leases. In 2012, CDC continued the construction of Building 107

and Parking Deck 161A at its Chamblee campus. The completion of this building, anticipated in May 2013, is expected to allow CDC to eliminate additional operating leases.

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. CDC conducts on-going building assessments and the commissioning of its existing buildings, with emphasis on energy and water conservation, to meet the challenges required by the Energy Independence and Security Act (EISA), the Guiding Principles for High Performance and Sustainable Federal Buildings, Executive Order 13514, and Executive Order 13423. Potential projects generated by the building assessments are incorporated into the annual facilities business plans. 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. One additional project is registered with USGBC with the goal of achieving LEED certification.

CDC maintains a transportation management program through its B&F program. CDC maintains a transportation choices website and hosts alternative-commute educational programs. CDC's Fare Share program provides ridership opportunities through planned commuter programs at all Atlanta area campuses. As an active member of the Clifton Corridor Transportation Management Association, CDC works with transportation management associations such as the Clean Air Campaign, Atlanta Regional Commission's Ride Smart Program, and other related organizations to address common transportation concerns, improve accessibility and mobility, share services, improve air quality, and mitigate traffic congestion by promoting alternative forms of transportation.

Budget Proposal: CDC's FY 2014 request of \$14,591,000 for B&F is a decrease of \$10,355,000 below the FY 2012 level. This 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 through new budgetary resources and carryover funds. CDC will also continue planning 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 and Pittsburgh research campuses, R&I and capital needs are expected to increase.

The FY 2014 request includes funding for R&I projects in existing, owned facilities sufficient to maintain CDC's portfolio Condition Index (CI) at 90 or higher for laboratory, laboratory support, and critical infrastructure assets, and fund additional, mission critical R&I projects. CDC is taking aggressive steps to make its R&I Program budget request more transparent in the budget formulation process.

For fiscal years 2012, 2013 and 2014, CDC has projected a prioritized R&I Program based on project categories. All categories except Program Support and Emergency are supported by a Facilities Condition Assessment, preparation of a Project Evaluation and Rating Tool for each proposed project, and review by an Asset Management Team to prioritize projects for sustaining and improving facilities conditions, addressing code and safety deficiencies, and ensuring physical and operational security. The Emergency category is a reserve fund. CDC's Investment Review Board will meet in 2013 to assess the final project list and make allocations among eligible program-requested projects. In FY 2013, CDC will support critical R&I with carryover funds to maintain the condition of CDC's portfolio of assets. The project categories are listed below.

- **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 (FLS): 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 (CI): The Federal Real Property Council (FRPC) 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 (FRV). 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.
- 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 Projects¹

Project Category	FY 2012 (# and estimated cost)	FY 2013 (# and estimated cost)	FY 2014 (# and estimated cost)
Emergency	9 projects; \$1,207,800	1 project; \$1,000,000	1 project; 1,000,000
Fire & Life Safety	9 projects; \$1,744,484	23 projects; \$3,578,865	8 projects; \$1,581,910
Security	4 project; \$412,000	7 project; \$1,297,000	13 projects; \$4,878,948
Condition Index	38 projects; \$13,196,694	70 projects; \$20,934,438	53 projects; \$16,813,858
Program Support	4 projects; \$1,872,089	10 projects; \$862,000	2 projects; \$30,000
Space Utilization	1 project; \$100,000	15 projects; \$1,573,500	N/A
Other	10 projects; \$1,078,000	1 project; \$500,000	1 project; \$500,000
Total	75 projects; \$19,611,067	127 projects; \$29,745,803	78 projects; \$24,804,716

¹ Data as of the third quarter in FY 2012.

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.

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	Impact	Explanation
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.

In addition to R&I projects, CDC will continue planning the consolidation of the NIOSH Cincinnati Research Facilities. The Lake Lynn Laboratory closed September 30, 2012, and CDC is exploring alternative ways to carryout important mine safety research. Research conducted at the Laboratory has resulted in new regulations, new practices, and new technologies to prevent or mitigate explosions and reduce their catastrophic consequences.

CDC will also proceed with the planning phase of consolidating the NIOSH Cincinnati Research Facilities (Taft, Taft North, and Hamilton buildings) into one central location with the intent of purchasing new property and making limited improvements to an existing facility. NIOSH Cincinnati is co-located on two campuses, eight miles apart. The facilities/buildings have significant deficiencies, in both space configuration and the condition of building systems due to the 60 year age of the facilities, negatively impacts critical research, impedes scientific collaboration, and also creates health and safety challenges for NIOSH laboratorians. One central location will reduce recurring costs associated with operating two separate campuses.

Activities include determining NIOSH's specific space requirements, adjacencies and equipment needs; preparing a project development study to fully articulate the criteria used to evaluate potential purchase candidates; conducting environmental condition and impact analyses of potential buildings/properties; conducting engineering and interior layout evaluations of potential buildings; developing cost estimates for design/renovation of potential buildings; and conducting appraisals and preliminary title evaluations.

BUSINESS SERVICES SUPPORT BUDGET REQUEST

The Business Services Support budget line is proposed for elimination in FY 2014 and the funds will be distributed to CDC's program budget lines based on FY 2011 consumption data. The Working Capital Fund will support agency business services. Please refer to the Working Capital Fund narrative for more information.

CDC BUILDINGS AND FACILITIES CARRYOVER TABLE

CDC Buildings and Facilities	Actual Carry-over/ Unobligated Balance 09/30/2009 End of FY 2009	Actual Carry-over/ Unobligated Balance 09/30/2010 End of FY 2010	Actual Carry-over/ Unobligated Balance 09/30/2011 End of FY 2011	Actual Carry-over/ Unobligated Balance 09/30/2012 End of FY 2012	Projected Carry-over/ Unobligated Balance 09/30/2013 End of FY 2013	Projected Carry-over/ Unobligated Balance 9/30/2014 End of FY 2014
Carryover by Fiscal Year						
Project						
Roybal, Emerging Infectious Disease Lab, Bldg #18	0	0	0		0	0
Roybal, Scientific Communications Center, Bldg #19	0	37,729	37,729	37,729	0	0
Roybal, Transshipment/Infrastructure Project, Bldg #20	1,030,045	1,721,404	1,721,404	1,744,385	0	0
Roybal, Headquarters & Emergency Operations Center, Bldg #21	63,665	63,665	121,414	169,847	0	0
Roybal, Blast-Resistant Glazing, Bldgs 1E, 2, and 16	25,805	25,805	25,805	25,805	0	0
Roybal, Entrance Security Modifications	20,817	54,685	95,142	95,142	0	0
Chamblee, Secure Entrance/Site work	0	0	0	0	0	0
Bldgs. #107	24,350,000	26,423,396	16,111,728	10,943,160	0	0
Bldgs. #108	26,350,000	0	0	0	0	0
Chamblee, Parasitic Disease Lab, Bldg #109	17,295	17,295	17,295	17,295	0	0
Roybal, East Campus Consolidated Lab Project, Bldg # 23	10,849,877	6,456,901	501,899	5,468,947	0	0
Chamblee, Environmental Health Facility, Bldg # 106	518,662	522,077	1,119	593,696	0	0
Adv Planning for Atlanta Projects in the Five Year Plan/Master plan	0	0	0	0	0	0
Chamblee, Environmental Toxicology Lab, Bldg # 110	1,219,744	1,219,744	0	1,235,410	0	0
All Campuses, Emergency Fire & Life Safety Initiative	270,563	270,563	0	280,124	0	0
Repairs and Improvement 1/	34,130,141	39,103,481	11,906,508	20,550,347	7,724,785	0
CCID Roybal, B24 Epi Tower	39,777,808	28,777,847	11,625,875	76,905	0	0
Data Center/Recovery Site	976,936	1,398,474	1,317	1,412,509	0	0
Cincinnati Lab Consolidation Project	0	62,423	0	62,423	0	0
Ft. Collins Laboratory	572,328	572,328	0	572,328	0	0
Fort Collins, DVBD Replacement Lab	77,047	88,296	154,498	154,498	0	0
Ft. Collins, DVBD Shell Space Project	1,060,149	513,972	22,193	596,682	0	0
Roybal, Bldg #17	0	0	0	0	0	0
Mine Safety Research	4,750,000	4,407,129	14,030,524	14,428,050	14,086,459	14,086,459
Arctic Investigation Program (AIP) Laboratory Renovation Addition	519,737	221,596	221,596	221,596	0	0
Totals	146,580,619	111,958,810	56,596,046	58,686,878	21,811,244	14,086,459

¹FY 12 Actual Carryover of \$20,550,347 includes: (1) \$1,583,089 of carryover from Symbol 75-X-0943 and (2) \$18,967,258 of carryover from Symbol 75-1216-0943.

PUBLIC HEALTH LEADERSHIP AND SUPPORT BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted¹	FY 2013 CR¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$114.804	\$115.661	\$116.812	+\$2.008

¹FY 2012 and FY 2013 are comparable to FY 2014 to reflect BSS realignment estimates. Refer to the Working Capital Fund narrative for FY 2012 detailed realignment data.

Program Overview: The public health leadership and support line funds the CDC's Office of the Director; Office for State, Tribal, Local, and Territorial Support; 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 supporting management of the agency on a day-to-day basis, these funds are used in two major ways to directly support health organizations and officials in the field.

In the past, these provided the CDC Director the capacity to respond to health emergencies not funded elsewhere in the agency before they become catastrophic. For example, in 2011, CDC used leadership and

support funds to expedite and expand testing of a new dengue vaccine developed by CDC in response to dengue outbreaks in Florida and Hawaii and a large outbreak in Puerto Rico. These funds also allowed CDC to improve overall data quality being reported to the National Healthcare Safety Network dialysis module and encouraged use of reported data for local quality improvement initiatives.

Budget Proposal: CDC's FY 2014 request of \$116,812,000 for public health leadership and support is an increase of \$2,008,000 above the FY 2012 level. This increase will support initiatives associated with urgent and emergent public health events as opportunities arise, without disrupting ongoing efforts. Activities envisioned are short in duration but lasting in impact, making a difference with a one-time investment. Examples of important initiatives that could be supported, depending on other emerging priorities, include:

- Development of point-of-care quality assurance tests to ensure that the malaria tests used in the field for rapid diagnosis (RDT) do not deteriorate when stored under the high temperature conditions typical of most malaria endemic regions. Ensuring RDT performance under such conditions is critical to quality patient care.
- Detection of healthcare-associated infections with emerging resistance: building surveillance capacity for multi-drug resistant organisms such as *Clostridium difficile*, Methicillin-resistant *Staphylococcus aureus* (MRSA), and Carbapenem-resistant Enterobacteriaceae (CRE) in the United States through the Emerging Infections program.
- Evaluation to identify cost-effective approaches for schools to link teenage young men who have sex with men to HIV testing.
- Use of medication sensors and mobile phone applications to engage and support patients in asthma management.

Office for State, Tribal, Local and Territorial Support (OSTLTS)

Within the funds requested for FY 2014, CDC's Office for State, Tribal, Local and Territorial Support will continue to 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; and working with internal and external stakeholders such as health departments and national public health organizations to identify and implement improvements in CDC's 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. OSTLTS also facilitates CDC's cross-cutting activities to collaborate with health officials in the field to inform CDC's public health activities, conduct joint problem-solving and decision making, and to identify and implement ways that CDC can increase and improve its services and support to improve public health at all levels.

Office of the Director

The funds requested in FY 2014 will continue to support CDC's efforts to provide efficient, transparent, and accountable public health leadership to the nation. At CDC, this is accomplished through a complement of offices that provide leadership and services agency-wide. These offices and their functions are described below.

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/Office of Inspector General engagements and recommendations
- HHS/Immediate Office of the Secretary Liaison
- Records management

Office of Communications

The Office of Communications 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. The communication office works to:

- Develop and produce communication campaigns, audio and video public service announcements, and related content.
- Ensure the media accurately represents CDC data, research, guidelines, and actions.
- Provide consultation on the effective and appropriate use of news and electronic media.
- Manage CDC's internet and intranet sites.
- Develop strategies to help CDC employees communicate more effectively with partners and the public.
- Produce broadcast, audio, and video material; writer editor services; and multi-lingual services.

Policy Office

The Policy Office includes the CDC-Washington office, advises CDC leadership, and provides the following support to the agency:

- Develop and implement the National Prevention Strategy.
- Monitor public health implications of ACA implementation at federal, state, and local levels and disseminate key information inside and outside CDC.
- Use tools to gain the maximum preventive benefit from the clinical system and to integrate clinical care with community health interventions.
- Build relationships with government agencies and other organizations to advance public health agendas, with a special emphasis on state and local agencies.

Appropriations, Legislation, and Formulation Office

The Appropriations, Legislation, and Formulation Office, within the Financial Management Office, prepares CDC's budget in accordance with the Department Health and Human Services (HHS), Office of Management and Budget (OMB), and Congressional requirements, policies, procedures, and regulations. This office provides broad support to the agency, for example:

- Oversight, direction, and guidance for all aspects of CDC's budget formulation processes
- Collaborate with other parts of CDC in the development and implementation of long-term financing plans and strategies

- Develop materials for, and participate in, budget reviews and hearings before HHS, OMB, and Congress
- Represent the agency before HHS, OMB, and Congress regarding budgetary policy and appropriations issues and requirements.

Program Office

The Office for Program supports all CDC programs with planning, accountability, and performance evaluation. The Office for Program will continue to:

- Provide analytic and advisory assistance to enable effective design/re-design of programs.
- Promote the integration of performance measurement, goal setting, and program evaluation in improving programs.
- Support and guide the use of performance measures in program monitoring (e.g., Healthy People 2020, PART/GPRA).
- Provide support for evaluation capacity-building across CDC programs.

Office of Minority Health and Health Equity

The Office of Minority Health and Health Equity (OMHHE) provides leadership for CDC-wide policies, strategies, action planning and evaluation to eliminate health disparities. OMHHE will continue to:

- 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.

In addition, the Office of Diversity Management and Equal Employment Opportunity and the Office of Safety, Health, and Environment have moved under the Working Capital Fund portfolio. As a result, approximately \$20 million will be transferred from PHLs, as part of the overall BSS realignment, to provide continued support for these services.

PHLS also supports program leadership for:

- The Office of Infectious Diseases (OID) leads, promotes, and facilitates 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.
- The Office of Non-communicable Diseases, Injury and Environmental Health (ONDIEH) provides the overall strategic direction and leadership for the prevention of non-communicable diseases, injury, disabilities, and environmental health hazards.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT BUDGET REQUEST

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$79.545	\$80.055	\$0.000	-\$79.545

Budget Proposal: The FY 2014 budget request reflects the elimination of the Preventive Health and Health Services Block Grant (PHHSBG) program. Through CDC's existing activities, there is sufficient funding to state health departments. When the PHHSBG was first authorized in 1981, there were minimal resources within CDC's budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity, and many states did not receive funding from CDC to support prevention of chronic disease. However, since 1981, categorical programs at CDC have grown to over \$1 billion annually and the PHHSBG now represents a much smaller percentage of state budgets when compared to total available CDC funding.

These activities may be more effectively and efficiently implemented through the Chronic Disease Prevention and Health Promotion Program's combined Funding Opportunity Announcement, 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 disease.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget	FY 2014 +/- FY 2012
ACA/PPHF	\$41.200	N/A	\$41.200	\$0.000

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The following activities are included:

- National Prevention Strategy – \$1,000,000
- National Public Health Improvement Initiative – \$40,200,000

National Prevention Strategy

The National Prevention Strategy outlines a series of priority recommendations and effective prevention efforts that public, private, and non-profit sectors at the national, state, local, tribal, and territorial levels can implement. The National Prevention Strategy focuses on improving the health of communities, in addition to promoting access to and use of expanded preventive care practices. This community-centered approach to prevention and wellness will provide the foundation for many of the Strategy's actions. Specific recommendations contained within the Strategy will be based on the recommendations from CDC's Community Guide and include the most effective and sustainable prevention efforts.

In FY 2014, CDC will provide scientific and technical support to the National Prevention Council, including facilitation, implementation, coordination, and alignment to the evidence-based recommendations among the 17 federal departments that make up the Council; ensure the ongoing engagement of the public and partners; and track the progress in implementing the National Prevention Strategy, such as collecting, analyzing, and refining data and measures to monitor and track the Strategy's implementation.

National Public Health Improvement Initiative (NPHII)

NPHII is increasing the capacity of state, tribal, local, and territorial (STLT) health agencies to utilize performance and quality improvement practices that lead to more efficient and effective public health services, systems, and organizations. CDC is funding directly, or through bona fide agents, a total of 48 states, four federally recognized tribes, three tribal organizations serving more than 280 federally recognized tribes, Washington, D.C., nine large local health departments, four U.S. territories, three U.S. Affiliated Pacific Islands (USAPI), and one USAPI bona fide agent that provides a regional voice for USAPIs.

In FY 2011, the initiative's first year, 93 percent of grantees increased their performance improvement capacity through dedicated staff implementing performance and quality improvement methods. CDC and grantees established the first nationwide collaboration network of state, tribal, local, and territorial health agency Performance Improvement Managers. In FY 2012, CDC and its grantees further aligned activities to accelerate their readiness to achieve national performance standards for the 12 domains of public health agency accreditation. These standards help officials ensure their agencies: (1) are more effective, well organized, and operating with less waste; (2) generate the objective information needed to make critical decisions about the future of programs and services in their communities; (3) improve service, value, performance, transparency, and accountability; and (4) have a solid foundation to deliver core public health functions and essential services. For example, grantees are integrating and aligning jurisdictional health assessments, health improvement and organizational strategic plans, and assessing their readiness to achieve accreditation (gap analysis).

Over the next two years, CDC will build health departments' capacity to more effectively manage and deliver their programs and services, meet national performance and accreditation standards, advance Healthy People 2020 objectives, and share successful practices to improve and protect the public's health. CDC and national partner organizations will provide training and targeted capacity building assistance to the 73 NPHII awardees to ensure program goals are achieved. In addition, CDC will leverage its nationwide Performance Improvement Managers Network to build a collaborative learning community where public health agencies share knowledge and expertise to establish and sustain an organization-wide culture of continuous performance and quality improvement.

In FY 2014, CDC will strengthen the public health system and establish the links necessary to support essential U.S. public health programs and increase the effective and efficient use of resources. CDC will achieve this by increasing the number of public health organizations focused on improving the quality and performance of programs, systems, and services within and across jurisdictions; and integrating with the healthcare sector which is the key to long-term cost savings and system transformation.

CDC will widely disseminate lessons learned from early grantee successes. For example, New Jersey implemented automated, electronic reporting of influenza test results from the state lab to CDC, enabling more rapid detection and response by drastically reducing reporting time from two to three weeks down to two to three days. In Tennessee, the state health department strengthened its public health data system to improve speed and accuracy of vital records tracking, enabling better health status access and monitoring. In Virginia the state health department consolidated critical metrics from 119 public health system databases into one dashboard system serving all offices, identifying at least \$1.2 million in potential annual savings in information technology costs to reinvest in programs and staffing. These achievements illustrate how NPHII funds leverage and improve the work and impact of other public health investments to protect health.

Grant Tables:

State, Local, Tribal and Territorial Health Departments (STLTs) Grants Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	73	N/A	73
Average Award	\$0.450	N/A	\$0.450
Range of Awards	\$0.100–\$1.093	N/A	\$0.100–\$1.093
Number of New Awards	0	N/A	0
Number of Continuing Awards	73	N/A	73
Total Grant Award	\$33.300	N/A	\$33.300

¹The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

In FY 2012, CDC funded 73 grantees to improve their capacity to utilize performance and quality improvement practices through a competitive, formula-based, discretionary cooperative agreement. NPHII grantees apply performance and quality improvement methods to generate objective information to design and/or redesign their programs, systems, and services; strategically invest in what works by adopting evidence-based policies and practices; increase the use of cross-jurisdictional collaboration for policies, programs, and services; and prepare for national public health department accreditation. More specific information on grantee projects is available at <http://www.cdc.gov/stltpublichealth/nphii>.

NPHII Grantee Capacity Building Grants Table

(dollars in millions)	FY 2012 Enacted	FY 2013 CR ¹	FY 2014 President's Budget
Number of Awards	6	N/A	6
Average Award	\$0.480	N/A	\$0.480
Range of Awards	\$0.464–\$0.600	N/A	\$0.464–\$0.600
Number of New Awards	0	N/A	0
Number of Continuing Awards	6	N/A	6
Total Grant Award	\$2.880	N/A	\$2.880

¹The final FY 2013 allocation of the Prevention and Public Health Fund was not available during the development of the FY 2014 CJ.

CDC funds five national public health organizations through competitive cooperative agreement supplements. These partners provide NPHII grantees with additional resources, expert consultation, training, and tools to build their organizational capacity and readiness to improve the quality and performance of their services, systems, and organizations, and to achieve accreditation. This effort leverages the existing knowledge, reach, and resources of these national partner organizations, enabling broader dissemination among U.S. public health agencies. An additional award to one of these partners supports accreditation readiness efforts in large metropolitan jurisdictions. The opportunity was limited to health departments serving populations of more than 1.5 million but not directly receiving funding through NPHII.

PERFORMANCE

Program Buildings and Facilities

Performance Measures Long Term Objective: Improve efficiency and sustainability of CDC Facilities²

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
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) ¹	CY 2012: 24.8% (Target Exceeded)	9%	13%	+4
12.E.1: Reduce energy (E) and water (W) consumption per square foot (Efficiency)	FY 2012: 23.3% (E) (Target Exceeded); +34.9% (W) (Target Not Met)	21%(E); 10%(W)	27% (E); 14% (W)	+6 (E); +4 (W)

¹ Per the HHS Sustainable Buildings Plan, this calculation is based on square footage

² Targets 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 performance³

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
12.1.1: Maintain Earned Value Management (EVM) index values of one for capital and repair/improvement projects based on scope, schedule, and cost ¹ (Output)	FY 2012: 1.02 (Target Exceeded)	1.00±0.08	1.00±0.08	Maintain
12.2.1a: Improve work order closure rates (Output)	FY 2012: 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 2012: 92.62 CI (Target Exceeded)	90 CI	90 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 2012: 0.36% (Target Exceeded)	2%	2%	Maintain
12.2.1e: Improve building utilization ² (Output)	FY 2012: 4.27% (O) (Target Exceeded); 1.42% (U) (Target Exceeded)	6.70% (O); 5.00% (U)	6.70% (O); 5.00% (U)	Maintain
12.2.1f: Improve buildings and facilities operating costs (Output)	FY 2012: \$13.18 /sq. ft. (Target Not Met)	\$10.29 /sq. ft.	\$10.29 /sq. ft.	Maintain

¹ The target and results for this measure are based on calendar year reporting

² Over-utilized (O); Under-utilized (U)

³ Targets are set by HHS and align to Executive Order 13327

Performance Trends: CDC's Buildings and Facilities Office equips CDC to carry out its mission in safe, sustainable, and efficient operating facilities. Since 2008, CDC has:

- Experienced unexpected increases to water and energy consumption, but continued to meet or exceed energy performance targets. However, CDC did not meet its CY 2012 water consumption target (Measure 12.E.1). Unusually warm weather is considered to be one of the drivers for the increase. Lack of individual building water meters prevent more thorough monitoring of consumption. However, CDC will install new water meters that provide water usage data for specific buildings/areas.
- Increased the percent of sustainable facilities (Measure 12.E.2), and increased overall Condition Index (CI) by demolishing assets with very low CI (Measure 12.2.1c).
- Improved building utilization by compressing office spaces to meet the new utilization rate (UR) standard of 170 usable square feet per occupant (Measure 12.2.1e).
- Improved 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).

In FY 2012, CDC once again met the performance targets for CI, mission dependency and utilization. To reduce non-mission dependency, CDC continually re-evaluates its assets. 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. CDC will demolish these buildings in FY 2013 and improve mission dependency.

CDC's operating costs fluctuated between FY 2008 and FY 2012. Although targets have not changed since FY 2010, CDC recommends HHS's operating cost metric be reviewed. It is not weighted to account for the extremely high costs of operating laboratory buildings. Therefore, assets with significant laboratory usage skew these costs beyond normal benchmarking standards for building operating costs. Because CDC's laboratories comprise approximately 44 percent of its total asset square footage, the inherently high laboratory operating costs increase CDC's overall operating cost performance compared to the non-weighted HHS target. To demonstrate this, CDC completed a collaborative study with the General Services Administration (GSA) to benchmark laboratory and office operating costs among similar private, institutional, and government laboratory-owning entities. The study found that CDC's operating costs were lower than the average (\$15.40/sq. ft.) of the laboratory owners surveyed. Yet the target has been less than \$11.00/sq. ft. since FY 2005 (currently at \$10.29/sq. ft.). This indicates that the operating cost metric for Measure 12.2.1f is too low and should be weighted or perhaps divided into discrete categories for laboratory assets vs. non-laboratory assets.

CDC continues to compress its office space (i.e., better floor layouts and smaller cubicles) to meet the new UR standards. CDC based the construction of Building 107 at the Chamblee campus on the new 170 UR standard, allowing CDC to consolidate several off-campus leases. In 2012, CDC terminated four leases from two major office buildings (Executive Park 12 and 57), saving over \$4,000,000 in recurring annual costs. CDC will terminate nine leases in FY 2013 (four in Ft. Collins, one in Hyattsville, and four in Atlanta) which will result in savings of over \$6,000,000 in recurring annual costs.

In 2012, CDC completed final development at the Roybal campus, concluding the existing 2000-2009 Master Plan for campus construction. CDC began developing a new 2015-2025 Master Plan and Environmental Impact Statement. CDC also completed an office compression and carrying capacity study 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.

Program: Working Capital Fund

Performance Measures for Working Capital Fund

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
15.2.2: Maintain the percent of invoices paid on time (Efficiency)	FY 2012: 98.8% (Target Exceeded)	98%	98%	Maintain
15.4.2: Reduce the percentage of high-risk contract types awarded (Efficiency) ¹	FY 2012: +4% (Target Not Met)	-10%	-10%	Maintain

¹Noncompetitive, competitive one-bid, cost reimbursement, time and material, or labor hour.

Performance Trends: CDC's Financial Management Office (FMO) actively supports CDC's goals and customers through fiscal stewardship and financial strategy by providing financial services, budgetary and legislative guidance, and quality assurance. 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 \$15.97 per \$1,000,000 in total payments in FY 2012, a 37 percent reduction over 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 its target of reducing awards in high risk categories in FY 2010, it did not meet its targets for FY 2011 or FY 2012 (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. However, in FY 2012, CDC performed extremely well in two of the four sub-categories, reducing non-competitive awards by 36 percent and cost reimbursements by 20 percent. To maintain these sub-category performance levels and improve performance levels for competitive one-bid awards and time and material, CDC is assessing current processes and identifying necessary changes to reduce the number of competitive one-bid awards. CDC will continue to work with programs to better define their requirements to facilitate the use/award of fixed priced contracts. This includes establishing fixed price contracts with competed task orders as the preferred contract type for CDC.

In FY 2014, CDC will begin implementing the Working Capital Fund (WCF), which will achieve greater efficiency and transparency in the provision of Agency-wide business services support. CDC will include WCF performance measures beginning in FY 2015.

Program: State, Tribal, Local and Territorial Support

Performance Measures for Long Term Objective: Improve the capacity and performance of State, Tribal, and local public health agencies to more efficiently and effectively manage and deliver high quality programs and services to protect the public's health

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- 2012 Target
11.B.4.1: Increase the percentage of nationally PHAB ¹ accredited State and local public health agencies (Intermediate Outcome)	FY 2013: 4% State Health Departments; 0.4% Local Health Departments (Preliminary)	15%	30% State Health Departments; 6% Local Health Departments	N/A
11.B.4.2: Increase the percentage of NPHII ² awardees that demonstrate increased efficiencies or improved program effectiveness through the implementation of performance or quality improvement projects (Intermediate Outcome)	FY 2011: 78% (Target Exceeded)	30%	80%	+50

¹Public Health Accreditation Board

²National Public Health Improvement Initiative

Performance Trends: In 2010, CDC developed measures to track efforts to increase 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 improves the health of the public at the lowest cost while increasing public health agency transparency and accountability to policymakers and the public.

The Public Health Accreditation Board (PHAB) launched its health department accreditation program in September 2011. As of March 2013, PHAB is assessing the accreditation readiness of 128 applicants: 15 states, 112 local health agencies, and one tribal health agency. These applicants comprise approximately 30 percent of state health agencies and five percent of the nation's local health agencies. CDC did not meet its FY 2012 target because the first round of accreditation did not occur until February 2013. This is the first national public health accreditation program, thus initial lessons learned demonstrate that targets set proved to be overly ambitious, as well as establishing a need to display State Health Department data and Local Health Department data separately. Preliminary data as of March 2013 demonstrate that four percent of State Health Departments and 0.4 percent of Local Health Departments achieved accreditation. The full first year of results will be available in September 2013.

As health agencies are developing their capacity and readiness to meet accreditation standards, PHAB is developing its capacity to work with an increasing number of applicants to verify conformity with the standards (11.B.4.1). To this end, CDC developed new accreditation tools and trainings, as well as expanded CDC's health department accreditation support initiatives. Data from measure 11.B.4.2 demonstrate that 78 percent of grantees reported undertaking a performance or quality improvement initiative, far exceeding FY 2011 targets. CDC will continue utilizing 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.

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 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012 Target
11.B.1.1c: Increase health behavior impact of CDC.gov (Outcome)	FY 2012: 89% (Target Exceeded)	71%	89%	+18

Performance Trends: The Pew Research Center's Internet & American Life Project estimates that 81 percent of adults used the internet in 2012, 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 help 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.

In FY 2012, 89 percent of visitors to CDC.gov indicated positive health impact and behavior change after visiting the site. This reflects CDC's refined 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 maintain the FY 2012 performance level in FY 2014.

WORKING CAPITAL FUND

INTRODUCTION

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 (WCF) to achieve greater efficiency and transparency in support of agency-wide business services. The WCF is a revolving fund with extended availability and serves as the sole funding mechanism to finance centralized business services support across CDC. Once fully operational, services rendered under the WCF are performed at pre-established rates that are used to cover the full cost of operations and future investments (i.e., capital expenses). The WCF operates on revenues collected for services, rather than Congressional appropriations, thereby creating market-like incentives for both customers and service providers to maximize efficiency and service.

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)

IMPLEMENTATION APPROACH

CDC is leveraging experience from implementation of the CDC Indirect Cost (IDC) methodology as the agency prepares to shift to a WCF. Throughout FY 2013, CDC will continue to design the infrastructure for WCF operations including developing the rate structure; training the WCF operations team; developing a five-year capital investment plan; designing the IT infrastructure to support billing and accounting functions; and, establishing the governance structure.

In a WCF environment, business service offices (BSOs) provide services to CDC programs and the WCF bills programs for business services consumed based on pre-established rates. CDC's WCF replaces the Business Services Support (BSS) direct appropriation, which was used in previous fiscal years to provide funding for CDC's BSOs such as the Procurement and Grants Office, Financial Management Office, and Information Technology Services Office. Human resources, equal employment opportunity, and some safety and health services will also be included in the working capital fund service portfolio. These services were historically funded by PHLS. As a result, additional funding will be transferred from PHLS, as part of the overall BSS realignment, to provide continued support for these services, and programs will be billed the same way they are billed for other business services (e.g., IT, Financial Services, Procurement and Grants, etc.).

In order for CDC to operationalize the WCF in FY 2014, this budget requests that the BSS appropriated amount from the prior fiscal year be distributed to the program budget lines based on historical consumption data

REALIGNMENT OF THE BSS BUDGET

The budget request realigns the BSS appropriation to the program budget lines based on historical business service consumption data. When the WCF is fully operational, programs will receive bills for services consumed, based on pre-established rates that encompass the full cost of service provision.

Table 1 below reflects the realignment of budget authority funding that support business services to each of the program budget lines. The amounts in this table were calculated using FY 2011 consumption data. FY 2012 consumption data will be available when the FY 2014 appropriation cycle begins and may result in minor adjustments to the distribution presented.

Table 1 - BSS Distribution

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ Working Capital Fund (WCF) Detail Table (Dollars in Thousands)					
Budget Activity/Description	FY 2012			2014	
	Enacted	BSS Realignment ¹	Enacted ² (Comparably Adjusted)	President's Budget	President's Budget +/- FY 2012 Enacted CA
Immunization and Respiratory Diseases	\$778,947	\$35,915	\$814,862	\$754,020	-\$60,842
Immunization and Respiratory Diseases - BA	\$576,083	\$35,915	\$611,998	\$668,696	\$56,698
Immunization and Respiratory Diseases - PHS Evaluation Transfer	\$12,864	\$0	\$12,864	\$12,864	\$0
Immunization and Respiratory Diseases - PPHF	\$190,000	\$0	\$190,000	\$72,460	-\$117,540
-- Section 317 Immunization Program	\$367,870	\$11,440	\$379,310	\$391,549	\$12,239
-- Immunization Program (PPHF)	\$190,000	\$0	\$190,000	\$72,460	-\$117,540
-- Program Implementation and Accountability	\$62,302	\$10,603	\$72,905	\$116,950	\$44,045
-- National Immunization Survey - PHS Evaluation Transfer (non-add)	\$12,864	\$0	\$12,864	\$12,864	\$0
-- Influenza/Influenza Planning and Response	\$158,775	\$13,872	\$172,647	\$173,061	\$414
-- Influenza Planning and Response	\$155,445	\$13,352	\$168,797	\$169,201	\$404
-- Seasonal Influenza	\$3,330	\$520	\$3,850	\$3,860	\$10
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	\$1,109,934	\$53,030	\$1,162,964	\$1,176,942	\$13,978
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - BA	\$1,099,934	\$53,030	\$1,152,964	\$1,173,942	\$20,978
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PHS Eval	\$0	\$0	\$0	\$3,000	\$3,000
HIV/AIDS, Viral Hepatitis, STI and TB Prevention - PPHF	\$10,000	\$0	\$10,000	\$0	-\$10,000
-- Domestic HIV/AIDS Prevention and Research -	\$786,176	\$36,457	\$822,633	\$836,124	\$13,491
-- HIV Prevention by Health Department ³	\$392,636	\$6,926	\$399,562	\$399,744	\$182
-- National Programs to Identify and Reach High Risk Populations ³	\$363,702	\$27,060	\$390,762	\$400,985	\$10,223
-- School Health - HIV BA	\$29,838	\$2,471	\$32,309	\$32,395	\$86
-- School Health - HIV PHS Evaluation Transfer	\$0	\$0	\$0	\$3,000	\$3,000
-- Viral Hepatitis	\$19,672	\$1,610	\$21,282	\$31,410	\$10,128
-- Viral Hepatitis (PPHF)	\$10,000	\$0	\$10,000	\$0	-\$10,000
-- Sexually Transmitted Infections (STIs)	\$153,788	\$7,909	\$161,697	\$161,710	\$13
-- Tuberculosis (TB)	\$140,298	\$7,054	\$147,352	\$147,698	\$346
Emerging and Zoonotic Infectious Diseases	\$304,226	\$57,917	\$362,143	\$432,414	\$70,271
Emerging and Zoonotic Infectious Diseases - BA	\$252,476	\$57,917	\$310,393	\$380,664	\$70,271
Emerging and Zoonotic Infectious Diseases - PPHF	\$51,750	\$0	\$51,750	\$51,750	\$0
-- Core Infectious Diseases ⁴	\$184,657	\$41,071	\$225,728	\$226,754	\$1,026
-- Food Safety (non-add)	\$27,113	\$5,505	\$32,618	\$49,223	\$16,605
-- National HealthCare Safety Network (non-add)	\$14,840	\$4,231	\$19,071	\$31,562	\$12,491
-- Quarantine (non-add)	\$25,866	\$7,110	\$32,976	\$33,125	\$149
-- Federal Isolation and Quarantine (non-add)	N/A	\$0	N/A	\$1,000	N/A
-- Advanced Molecular Detection (AMD)	\$0	\$0	\$0	\$40,000	\$40,000
-- Epi and Lab Capacity program (PPHF) (non-add)	\$40,000	\$0	\$40,000	\$40,000	\$0
-- Healthcare-Associated Infections (PPHF) (non-add)	\$11,750	\$0	\$11,750	\$11,750	\$0
Chronic Disease Prevention and Health Promotion	\$1,167,427	\$43,939	\$1,211,366	\$1,036,093	-\$175,273
Chronic Disease Prevention and Health Promotion - BA	\$756,377	\$43,939	\$800,316	\$620,189	-\$180,127
Chronic Disease Prevention and Health Promotion - PPHF	\$411,050	\$0	\$411,050	\$415,904	\$4,854
-- Tobacco	\$108,077	\$7,446	\$115,523	\$117,360	\$1,837
-- Tobacco (PPHF)	\$83,000	\$0	\$83,000	\$95,000	\$12,000
-- Nutrition, Physical Activity and Obesity	\$33,998	\$3,204	\$37,202	\$47,400	\$10,198
-- Nutrition, Physical Activity and Obesity (PPHF)	\$10,000	\$0	\$10,000	\$0	-\$10,000
-- School Health	\$13,522	\$1,159	\$14,681	\$14,703	\$22
-- Health Promotion	\$17,584	\$1,432	\$19,016	\$19,062	\$46
-- Prevention Research Centers	\$17,900	\$1,012	\$18,912	\$25,041	\$6,129
-- Prevention Research Centers (PPHF)	\$10,000	\$0	\$10,000	\$0	-\$10,000
-- Heart Disease and Stroke	\$54,975	\$3,787	\$58,762	\$58,870	\$108
-- Diabetes	\$64,434	\$4,686	\$69,120	\$69,260	\$140
-- National Diabetes Prevention Program	\$0	\$0	\$0	\$10,000	\$10,000
-- National Diabetes Prevention Program (PPHF)	\$10,000	\$0	\$10,000	\$0	-\$10,000
-- Cancer Prevention and Control	\$358,304	\$13,240	\$371,544	\$329,660	-\$41,884
-- Cancer Prevention and Control (PPHF)	\$10,000	\$0	\$10,000	\$173,064	\$163,064
-- Cancer Prevention and Control - BA	\$348,304	\$13,240	\$361,544	\$156,596	-\$204,948
-- Breast and Cervical Cancer (BA and PPHF)	\$214,779	\$7,784	\$222,563	\$184,560	-\$38,003
-- Breast and Cervical Cancer	\$204,779	\$7,784	\$212,563	\$110,249	-\$102,314
-- WISEWOMAN (non-add)	\$20,629	\$784	\$21,413	\$21,413	\$0
-- Breast and Cervical Cancer (PPHF) (non-add)	\$10,000	\$0	\$10,000	\$74,311	\$64,311
-- Colorectal Cancer	\$42,830	\$1,628	\$44,458	\$40,577	-\$3,881

NARRATIVE BY ACTIVITY
WORKING CAPITAL FUND
BUDGET REQUEST

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ Working Capital Fund (WCF) Detail Table (Dollars in Thousands)					
Budget Activity/Description	FY 2012			2014	
	Enacted	BSS Realignment ¹	Enacted ² (Comparably Adjusted)	President's Budget	President's Budget +/- FY 2012 Enacted CA
-- Oral Health	\$14,644	\$1,234	\$15,878	\$15,921	\$43
-- Safe Motherhood/Infant Health	\$43,803	\$5,321	\$49,124	\$49,322	\$198
-- Arthritis and Other Chronic Diseases	\$25,196	\$1,418	\$26,614	\$26,654	\$40
-- Community Grants	\$279,940	\$0	\$279,940	\$146,340	-\$133,600
-- Racial and Ethnic Approach to Community Health	\$13,940	\$0	\$13,940	\$0	-\$13,940
-- Racial and Ethnic Approach to Community Health (PPHF)	\$40,000	\$0	\$40,000	\$0	-\$40,000
-- Community Transformation Grants - BA	\$0	\$0	\$0	\$10,000	\$10,000
-- Community Transformation Grants (PPHF)	\$226,000	\$0	\$226,000	\$136,340	-\$89,660
-- Million Hearts (PPHF)	\$0	\$0	\$0	\$5,000	\$5,000
-- Workplace Wellness (PPHF)	\$10,000	\$0	\$10,000	\$0	-\$10,000
-- Healthy Weight Task Force Obesity Activities (PPHF)	\$5,000	\$0	\$5,000	\$4,000	-\$1,000
-- Hospitals Promoting Breastfeeding (PPHF)	\$7,050	\$0	\$7,050	\$2,500	-\$4,550
Birth Defects, Developmental Disabilities, Disability and Health	\$130,587	\$11,205	\$141,792	\$141,944	\$152
Birth Defects, Developmental Disabilities, Disability and Health - BA	\$130,587	\$11,205	\$141,792	\$67,148	-\$74,644
Birth Defects, Developmental Disabilities, Disability and Health - PPHF	N/A	N/A	N/A	\$74,796	N/A
-- Child Health and Development - BA	\$61,966	\$5,735	\$67,701	\$23,098	-\$44,603
-- Child Health and Development (PPHF)	N/A	N/A	N/A	\$44,646	N/A
-- Birth Defects (PPHF)	N/A	N/A	N/A	\$21,798	N/A
-- Fetal Alcohol Syndrome (PPHF)	N/A	N/A	N/A	\$10,789	N/A
-- Folic Acid (PPHF)	N/A	N/A	N/A	\$3,160	N/A
-- Infant Health (PPHF)	N/A	N/A	N/A	\$8,899	N/A
-- Autism	\$21,265	\$1,790	\$23,055	\$23,098	\$43
-- Health and Development with Disabilities - BA ⁵	\$49,874	\$3,621	\$53,495	\$23,378	-\$30,117
-- Health and Development with Disabilities (PPHF)	N/A	N/A	N/A	\$30,150	N/A
-- Disability and Health (includes Child Development Studies)	\$17,779	\$1,134	\$18,913	\$18,941	\$28
-- Limb Loss (PPHF)	N/A	N/A	N/A	\$3,095	N/A
-- Tourette Syndrome (PPHF)	N/A	N/A	N/A	\$1,842	N/A
-- Early Hearing Detection and Intervention	\$10,630	\$618	\$11,248	\$4,437	-\$6,811
-- Early Hearing Detection and Intervention (PPHF)	N/A	N/A	N/A	\$6,816	N/A
-- Muscular Dystrophy (PPHF)	N/A	N/A	N/A	\$6,364	N/A
-- Attention Deficit Hyperactivity Disorder (PPHF)	N/A	N/A	N/A	\$1,828	N/A
-- Fragile X (PPHF)	N/A	N/A	N/A	\$1,802	N/A
-- Spina Bifida (PPHF)	N/A	N/A	N/A	\$6,265	N/A
-- Congenital Heart Failure (PPHF)	N/A	N/A	N/A	\$2,138	N/A
-- Public Health Approach to Blood Disorders - BA	\$18,747	\$1,849	\$20,596	\$20,672	\$76
Environmental Health	\$139,998	\$18,235	\$158,233	\$155,126	-\$3,107
Environmental Health - BA	\$104,998	\$18,235	\$123,233	\$126,126	\$2,893
Environmental Health - PPHF	\$35,000	\$0	\$35,000	\$29,000	-\$6,000
-- Environmental Health Laboratory	\$42,383	\$8,023	\$50,406	\$50,607	\$201
-- Environmental Health Activities	\$35,322	\$6,613	\$41,935	\$42,096	\$161
-- Built Environment & Health Initiative (non-add)	\$2,628	\$492	\$3,120	\$3,132	\$12
-- Climate Change (non-add)	\$7,359	\$789	\$8,148	\$8,165	\$17
-- Environmental and Health Outcome Tracking Network (PPHF)	\$35,000	\$0	\$35,000	\$29,000	-\$6,000
-- Asthma	\$25,298	\$3,074	\$28,372	\$28,435	\$63
-- Healthy Homes/Childhood Lead Poisoning	\$1,995	\$525	\$2,520	\$4,988	\$2,468
-- Healthy Home and Community Environments	\$0	\$0	\$0	\$0	\$0
Injury Prevention and Control	\$137,693	\$8,611	\$146,304	\$181,585	\$35,281
Injury Prevention and Control - BA	\$137,693	\$8,611	\$146,304	\$176,585	\$30,281
Injury Prevention and Control - PHS Evaluation Transfer	\$0	\$0	\$0	\$5,000	\$5,000
-- Intentional Injury	\$93,282	\$5,494	\$98,776	\$114,001	\$15,225
-- Domestic Violence and Sexual Violence	\$31,042	\$1,418	\$32,460	\$32,611	\$151
-- Child Maltreatment (non-add)	\$6,959	\$410	\$7,369	\$7,392	\$23
-- Youth Violence Prevention - BA	\$14,968	\$882	\$15,850	\$15,890	\$40
-- Domestic Violence Community Projects	\$5,411	\$319	\$5,730	\$5,738	\$8
-- Rape Prevention - BA	\$39,389	\$2,320	\$41,709	\$41,729	\$20
-- Rape Prevention - PHS Evaluation Transfer	\$0	\$0	\$0	\$5,000	\$5,000
-- Gun Violence Prevention Research	\$0	\$0	\$0	\$10,000	\$10,000
-- All Other Intentional Injury	\$2,472	\$555	\$3,027	\$3,033	\$6
-- NVDRS - BA	\$3,471	\$99	\$3,570	\$23,570	\$20,000
-- Unintentional Injury	\$30,966	\$2,774	\$33,740	\$33,794	\$54

NARRATIVE BY ACTIVITY
WORKING CAPITAL FUND
BUDGET REQUEST

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ Working Capital Fund (WCF) Detail Table (Dollars in Thousands)					
Budget Activity/Description	FY 2012			2014	
	Enacted	BSS Realignment ¹	Enacted ² (Comparably Adjusted)	President's Budget	President's Budget +/- FY 2012 Enacted CA
-- Injury Control Research Centers	\$9,974	\$244	\$10,218	\$10,220	\$2
Public Health Scientific Services	\$461,741	\$55,721	\$517,462	\$539,305	\$21,843
Public Health Scientific Services - BA	\$143,972	\$55,721	\$199,693	\$144,416	-\$55,277
Public Health Scientific Services - PHS Evaluation Transfer	\$247,769	\$0	\$247,769	\$324,889	\$77,120
Public Health Scientific Services - PPHF	\$70,000	\$0	\$70,000	\$70,000	\$0
-- Health Statistics	\$138,683	\$20,379	\$159,062	\$181,475	\$22,413
-- Health Statistics - BA	\$0	\$20,379	\$20,379	\$0	-\$20,379
-- Health Statistics - PHS Evaluation Transfer	\$138,683	\$0	\$138,683	\$181,475	\$42,792
-- Surveillance, Epidemiology, and PH Informatics	\$262,129	\$29,583	\$291,712	\$290,799	-\$913
-- Surveillance, Epidemiology, and PH Informatics - BA	\$108,043	\$29,583	\$137,626	\$102,385	-\$35,241
-- Surveillance, Epidemiology, and PH Informatics - PHS Eval	\$109,086	\$0	\$109,086	\$143,414	\$34,328
-- Surveillance, Epidemiology, and PH Informatics - PPHF	\$45,000	\$0	\$45,000	\$45,000	\$0
-- Community Guide (PPHF)	\$10,000	\$0	\$10,000	\$10,000	\$0
-- Public Health Research (PPHF)	\$0	\$0	\$0	\$5,000	\$5,000
-- Healthcare Surveillance/Health Statistics (PPHF) ⁶	\$35,000	\$0	\$35,000	\$30,000	-\$5,000
-- Public Health Workforce and Career Development - BA	\$35,929	\$5,759	\$41,688	\$42,031	\$343
-- Public Health Workforce Capacity (PPHF)	\$25,000	\$0	\$25,000	\$25,000	\$0
Occupational Safety and Health	\$292,588	\$32,693	\$325,281	\$271,911	-\$53,370
Occupational Safety and Health - BA	\$181,864	\$32,693	\$214,557	\$0	-\$214,557
Occupational Safety and Health - PHS Evaluation Transfer	\$110,724	\$0	\$110,724	\$271,911	\$161,187
-- NORA - BA	\$642	\$12,980	\$13,622	\$0	-\$13,622
-- NORA - PHS Evaluation Transfers	\$110,724	\$0	\$110,724	\$98,926	-\$11,798
-- Education and Research Centers	\$24,268	\$4,507	\$28,775	\$0	-\$28,775
-- Personal Protective Technology	\$16,791	\$3,128	\$19,919	\$0	-\$19,919
-- Personal Protective Technology - PHS Evaluation Transfer	\$0	\$0	\$0	\$20,021	\$20,021
-- Healthier Workforce Center	\$5,016	\$415	\$5,431	\$0	-\$5,431
-- Healthier Workforce Center - PHS Evaluation Transfer	\$0	\$0	\$0	\$5,433	\$5,433
-- Mining Research - BA	\$52,363	\$9,764	\$62,127	\$0	-\$62,127
-- Mining Research - PHS Evaluation Transfer	\$0	\$0	\$0	\$62,374	\$62,374
-- Other Occupational Safety and Health Research - BA	\$82,784	\$1,899	\$84,683	\$0	-\$84,683
-- Other Occupational Safety and Health Research - PHS Evaluation Transfer	\$0	\$0	\$0	\$85,157	\$85,157
-- NanoTechnology (non-add)	\$9,500	\$1,761	\$11,261	\$11,150	-\$111
Global Health	\$347,594	\$29,014	\$376,608	\$393,024	\$16,416
-- Global AIDS Program	\$117,118	\$14,072	\$131,190	\$131,942	\$752
-- Global Immunization Program	\$160,287	\$7,457	\$167,744	\$183,003	\$15,259
-- Polio Eradication	\$111,286	\$4,618	\$115,904	\$131,053	\$15,149
-- Measles and Other Vaccine Preventable Diseases	\$49,001	\$2,839	\$51,840	\$51,950	\$110
-- Global Disease Detection and Emergency Response	\$41,601	\$3,785	\$45,386	\$45,580	\$194
-- Parasitic Diseases and Malaria	\$19,367	\$2,702	\$22,069	\$22,231	\$162
-- Global Public Health Capacity Development	\$9,221	\$998	\$10,219	\$10,268	\$49
Public Health Preparedness and Response	\$1,329,479	\$52,338	\$1,381,817	\$1,334,316	-\$47,501
Public Health Preparedness and Response - BA	\$1,299,479	\$52,338	\$1,351,817	\$1,334,316	-\$17,501
Public Health Preparedness and Response - PHSSEF	\$30,000	\$0	\$30,000	\$0	-\$30,000
-- State and Local Preparedness and Response Capability	\$657,418	\$8,827	\$666,245	\$658,026	-\$8,219
-- CDC Preparedness and Response Capability	\$138,269	\$28,835	\$167,104	\$166,012	-\$1,092
-- Strategic National Stockpile	\$533,792	\$14,676	\$548,468	\$510,278	-\$38,190
-- Strategic National Stockpile - BA	\$503,792	\$14,676	\$518,468	\$510,278	-\$8,190
-- PHSSEF Strategic National Stockpile Transfer	\$30,000	\$0	\$30,000	\$0	-\$30,000
Cross-Cutting Activities and Program Support	\$659,113	-\$398,618	\$260,495	\$172,603	-\$87,892
Cross-Cutting Activities and Program Support - BA	\$617,913	-\$398,618	\$219,295	\$131,403	-\$87,892
Cross-Cutting Activities and Program Support - PPHF	\$41,200	\$0	\$41,200	\$41,200	\$0
-- Preventive Health and Health Services Block Grants	\$79,545	\$0	\$79,545	\$0	-\$79,545
-- Business Services Support	\$394,682	-\$394,682	\$0	\$0	\$0
-- Building and facilities	\$24,946	\$0	\$24,946	\$14,591	-\$10,355
-- Public Health Leadership and Support	\$118,740	-\$3,936	\$114,804	\$116,812	\$2,008
-- National Prevention Strategy (PPHF) -	\$1,000	\$0	\$1,000	\$1,000	\$0
-- National Public Health Improvement Initiative (PPHF) -	\$40,200	\$0	\$40,200	\$40,200	\$0
Total CDC, BA (adjusted for proposed ACL transfer)	\$5,648,970	\$0	\$5,648,970	\$5,216,509	-\$432,461
Total CDC, Budget Authority -	\$5,655,670	\$0	\$5,655,670	\$5,216,509	-\$439,161
Total CDC, (adjusted for proposed ACL transfer)	\$6,020,327	\$0	\$6,020,327	\$5,834,173	-\$186,154

CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 CJ Working Capital Fund (WCF) Detail Table (Dollars in Thousands)					
Budget Activity/Description	FY 2012			2014	
	Enacted	BSS Realignment ¹	Enacted ² (Comparably Adjusted)	President's Budget	President's Budget +/- FY 2012 Enacted CA
Total CDC, (Budget Authority & PHS Evaluation Transfers) -	\$6,027,027	\$0	\$6,027,027	\$5,834,173	-\$192,854
Program Level, (adjusted for proposed ACL transfer)	\$6,859,327	\$0	\$6,859,327	\$6,589,283	-\$270,044
Program Level (includes BA, PHS Eval, PHSSEF & PPHF) -	\$6,866,027	\$0	\$6,866,027	\$6,589,283	-\$276,744
Agency for Toxic Substances and Disease Registry	\$76,215	\$0	\$76,215	\$76,215	\$0
Public Health and Social Services Emergency Fund (Transfer) (non-add)	\$30,000	\$0	\$30,000	\$0	-\$30,000
Affordable Care Act- Prevention and Public Health Fund Transfer (non-add)	\$809,000	\$0	\$809,000	\$755,110	-\$53,890
Vaccines for Children ⁷	\$4,005,941	\$0	\$4,005,941	\$4,293,383	\$287,442
Energy Employees Occupational Illness Compensation Program Act (EEOICPA)	\$55,358	\$0	\$55,358	\$55,358	\$0
World Trade Center (Mandatory) ⁸	\$187,560	\$0	\$187,560	\$241,000	\$53,440
PHS Evaluation Transfers (non-add)	\$371,357	\$0	\$371,357	\$617,664	\$246,307
Other User Fees	\$2,226	\$0	\$2,226	\$2,226	\$0
(Total CDC/ATSDR adjusted for proposed ACL transfer)	\$11,186,627	\$0	\$11,186,627	\$11,257,465	\$70,838
Total, CDC/ATSDR Program Level -	\$11,193,327	\$0	\$11,193,327	\$11,257,465	\$64,138

¹ The BSS Realignment estimates were calculated using FY 2011 consumption data. FY 2012 Consumption data will be available when the FY 2014 appropriations cycle begins and may result in minor changes.

² The FY 2012 and 2013 amounts have been made comparable to FY 2014 to reflect proposed BSS realignment.

³ FY 2012 Domestic HIV lines have been made comparable to FY 2013 PB to reflect the FY 2013 PB proposed structure.

⁴ The Core Infectious Disease line was proposed in FY 2013 PB. This consolidates multiple budget lines under the Emerging and Zoonotic Infectious Diseases budget line. The 2012 Core Infectious Disease amount has been comparably adjusted.

⁵ FY 2012 and 2013 Disabilities and Health line has been comparably adjusted to reflect the transfer of \$6.7 million for Paralysis Resource Center to ACL.

⁶ A portion of Healthcare Surveillance/Statistics funding supports NCHS activities.

⁷ The FY 2012 level reflects an estimated funding level. The FY 2013 level represents the anticipated transfer from Medicaid, and does not include \$0.656 million in prior year recoveries and refunds, for a total program level of \$3,607.256 million. The FY 2014 level represents the anticipated transfer from Medicaid.

⁸ The FY 2012 through FY 2014 amounts reflect the Federal government's estimated obligations.

FY 2014 WCF FUNDING LEVEL

The WCF total operating budget is built on a number of funding sources. In the first year, these include: PHLS funding (one-time permanent realignment to fold in business services that had been supported with these resources), the BSS budget realignment, and estimated overhead costs associated with other sources of funding for CDC. Estimated amounts for these other funding sources are based on the most current information and will likely change:

Other Funding Sources	Estimates (dollars in millions)
Agency for Toxic Substances & Disease Registry	\$11.034
Energy Employees Occupational Illness Compensation Program Act	\$4.300
Gifts and Donations	\$0.451
Prevention & Public Health Fund	\$23.058
Minority AIDS Initiative	\$0.100
President's Emergency Plan for AIDS Relief	\$33.663
Vaccines for Children	\$25.253
World Trade Center	\$3.675
Reimbursable Revenue	\$10.000
Other Supplemental Funding Sources	\$2.378

As stated above, these estimates are based on available information and will likely change.

The WCF Governance Board (described below) will approve 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, approved annually by the Board, will include the following:

- Service line operational budgets (e.g., financial management office, rent, utilities, etc.);
- Restricted reserves; and
- Unrestricted reserves.

Like most WCFs, CDC's WCF will have reserves (unobligated balances) that are not constrained by the fiscal year cycle. Restricted reserves include amounts that will be used for capital IT infrastructure investment financing and accrued annual leave, while unrestricted reserves include amounts that will be used to offset any unforeseen, one-time costs that the Fund may incur during the fiscal year. The WCF Governance Board will determine a target between 2 to 4 percent of WCF annual operating revenue to cover unrestricted reserves.

For planning purposes, the following are estimates for the total WCF operation budget in FY 2014. The final budget will be approved by the Board prior to the start of the fiscal year.

CDC Business Services Funding Sources	
Funding Type	FY 2014 Request
BSS Appropriation Realignment	\$394,682,000
PHLS Realignment (one-time)	\$20,667,779
Other Funding Sources	\$113,912,600
Total	\$529,262,379

Objectives

CDC identified the following objectives for its WCF:

- 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. A rate management process that includes both an annual management review and independent audit ensures that the rate methodology is transparent and equitable for customers and recovers the Agency's actual costs. CDC's WCF will be included as part of HHS' annual CFO audit.
- Allow CDC Center directors, as the majority-voting members on the WCF Governance Board (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 WCF operations and have the discretion to make necessary trade-off decisions to accommodate shifting priorities of the Agency.
- Increase awareness and accountability for usage of business services support resulting in a strong financial incentive for Centers to carefully consider their consumption. 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 enable business line managers to finance mission-critical investments and improvements over time. This will reduce the volatility of WCF rates and minimize the impact of drastic changes in funding levels.
- Improve the efficiency and effectiveness of CDC's business services support by refining and 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.

Benefits of the WCF

The WCF promotes more effective cost control and greater efficiency in the provision of administrative services to CDC programs. A WCF provides service owners with better information on the cost of individual services and customer demand for services. With this information, business services can target inefficient processes and performance issues and enhance overall resource planning. Services and their associated rates will be reviewed on an annual basis to ensure that programs receive services that are relevant to their missions and are cost effective for the Agency.

In a WCF environment, CDC programs plan for the cost of WCF services as part of their overall budgets, which will more accurately reflect the full level of resources required to carry out CDC's public health mission. In addition, by providing customers with visibility into the service costs, it will incentivize program managers to understand the factors that drive the costs of services programs and to exercise greater control over the incurred costs. Over time, CDC will drive operational efficiencies across service organizations and provide CDC program managers with greater control over how funds are allocated between support services and program-direct activities.

Governance Structure

CDC will establish a WCF Governance Board (Board) to provide a structured and effective governance process for all aspects of the operations of CDC's working capital fund. The Board will ensure senior level engagement and oversight and promote transparency. In accordance with FY 2012 conference report language, CDC Center directors will serve as voting members on the WCF governance board and will preside over the Fund's operations.

The Board will determine 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 will also approve key fund design decisions and approve any IT capital investments that support WCF service provision. The Board will establish various working groups to gather and analyze information related to operations and board decisions.

Scope

CDC's working capital fund will encompass a portfolio of business services support in the following major categories:

- *Human Resources:* Services include developing and managing the hiring, selection, and recruitment 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.

- *Buildings, Facilities, and Logistics Management Services:* Services include conducting real property and space management activities; operating, and maintaining CDC's facilities; managing operating and capital leases, utilities, operation and maintenance contracts, and the administrative costs of the Buildings and Facilities Office. Additional services include developing CDC policy and procedures for logistics management, including accountable property, supplies, transportation, and shipping. Repairs and improvements and B&F capital projects are not included in the WCF service portfolio and will continue to be funded from the B&F 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. Activities provided by FMO are coordinated with HHS, OMB, and Congress.
- *IT Services, Support, and Infrastructure Services:* 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.
- *Security and Safety Services:* 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.
- *Procurement 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.
- *Compliance Services:* Services include Agency policy development, management, and consultation activities; management of the internal controls program; management of EEO complaint processing and staff education; and, management of federal advisory committee activities. Additional compliance services include monitoring and oversight of Agency and program measures in the area of sustainability.
- *General Administrative Support Services:* Services encompass administrative services provided in support of CDC programs that are not aligned to specific service providers.

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 and efficiency of operations;
- Reliability of financial reporting; and
- Compliance with applicable laws and regulations.

CDC will monitor operational and financial performance of the Fund and individual service lines. 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. The WCF Fund Manager will report on the overall financial performance of the Fund on a quarterly basis. 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 business service delivery.

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 reserved retained earnings and unreserved retained earnings. The target range is two to four percent of operating revenue.

Reserved Retained Earnings

Reserved retained earnings include funding for capital investments and accrued annual leave for WCF employees. Each fiscal year, the WCF governance board will review and approve a five-year capital investment plan for the BSOs that are included in the Fund. In addition, as the WCF is not an appropriated account, the Fund will retain a sufficient amount of reserves to pay accrued annual leave for all employees of the WCF.

Unreserved Retained Earnings

Unreserved retained earnings include funding used to finance unforeseen, one-time costs. Examples include costs associated with providing enhanced service levels for new or existing services and costs associated with discontinuing services. In an effort to stabilize rates throughout the fiscal year, unreserved retained earnings may also be used to absorb the impact of unanticipated price fluctuations that service providers may experience during the year.

CDC will impose a restriction on the level of unreserved 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 unreserved earnings. Throughout the fiscal year, the WCF Governance Board and WCF Fund Manager will monitor the level of unreserved retained earnings to ensure that the level of reserves remains in compliance with the policy.

REIMBURSEMENTS AND TRUST FUNDS

(dollars in millions)	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Reimbursements and Trust Funds	\$765.559	\$948.086	\$948.086	+\$182.527
PHS Evaluation Transfer	\$0.000	\$0.000	\$0.000	\$0.000
ACA/PPHF	\$0.000	\$0.000	\$0.000	\$0.000
Total	\$765.559	\$948.086	\$948.086	+\$182.527

Authorizing Legislation: PHS Act §§ 214, 301, 306(b)(4), 311, 353; Consolidated Appropriations Act, 2012 (P.L. 112-74)

SUMMARY

CDC's FY 2014 request of \$948,086,000 for reimbursements and trust funds is an increase of \$182,527,000 from the FY 2012 level.

(dollars in millions)	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Reimbursements and Trust Funds	\$765.559	\$948.086	\$948.086	+\$182.527

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 thousands)	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate
Department of Agriculture 2 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.	\$8,397	\$8,460	\$8,460
Department of Commerce 4 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.	\$1,335	\$2,650	\$2,650
Department of Defense 1 Agreement: National Death Index. 14 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.	\$62,210	\$62,722	\$62,722
Department of Energy 9 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.	\$3,252	\$5,492	\$5,492
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.	\$574,063	\$662,955	\$662,955
Department of Homeland Security 16 Agreements for Design & Development of Rapid Methods for AMR Susceptibility Testing for Potential BT Agents.	\$9,121	\$11,036	\$11,036
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 1 Agreement to support the Prevention and Control of Viral Hepatitis Infection in the Pacific Region.	\$50	\$50	\$50

NARRATIVE BY ACTIVITY
REIMBURSEMENTS AND TRUST FUNDS
BUDGET REQUEST

(dollars in thousands)	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate
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.	\$740	\$1,222	\$1,222
Department of Labor 1 Agreement: Support for the Production of the America's Children Report and Other Related Publications. 4 Agreements to provide NIOSH responsibilities under the Energy Employees Occupational Illness Compensation Program Act.	\$2,155	\$4,150	\$4,150
Department of State 1 Agreement for Field Assignee to assist with various States: Delaware and Iowa and Laboratory Testing.	\$5,088	\$5,088	\$5,088
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.	\$534	\$2,718	\$2,718
Environmental Protection Agency 2 Agreements: Forum on Aging Statistics, Forum on Child and Family Statistics. 22 Agreements to Collaborate Studies Occupational and Environmental Risk; Waterborne Contaminant and Diseases.	\$6,333	\$6,619	\$6,619
Federal Emergency Management Agency 4 Agreements for Emergency Responses; and Public Health Assessment of Air Quality in Temporary Housing.	\$523	\$623	\$623
Food and Drug Administration 2 Agreements for Health & Nutrition Exam Survey, Resource Data Center	\$1,143	\$1,150	\$1,150
Social Security Administration 1 Agreement: Support for the Production of the Older Americans: Key Indicators of Well Being Report and Other Related Publications.	\$186	\$190	\$190
Non-Federal Agencies 2 Agreements: Oral HPV Testing with Ohio State University, Asthma Supplement to the National Ambulatory Medical Care Survey with MERCK.	\$750	\$750	\$750
Other 56 Agreements for surveillance and Standardization of Genetic Testing. Numerous agreements with other institutions such as USAID, WHO, UN, Peace Corps, Executive Office of the President, FBI, Department of Education, Department of Transportation, NASA, Census Bureau, Johns Hopkins, Coast Guard, Consumer Product Safety Commission, State of Oregon, National Cancer Institute, and State Departments of Health in Florida, Wisconsin, Wyoming, Iowa, Mississippi, Louisiana and Hawaii, etc. Further, agreements that provide funding for the President's Malaria Initiative and Emerging Pandemic Threats, as well work in tuberculosis; viral hepatitis, maternal and child health; immunization; neglected tropical diseases; and water, sanitation and hygiene.	\$79,032	\$158,064	\$158,064

NARRATIVE BY ACTIVITY
REIMBURSEMENTS AND TRUST FUNDS
BUDGET REQUEST

(dollars in thousands)	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate
Undefined/Unidentified Agreements			
None	\$3,642	\$3,642	\$3,642
User Fees	\$7,000	\$10,500	\$10,500
TOTAL	\$765,559	\$948,086	\$948,086

SUPPORTING INFORMATION

OBJECT CLASS TABLE - DIRECT

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION OBJECT CLASSIFICATION - DIRECT AMOUNTS (DOLLARS IN THOUSANDS)				
Object Class	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent (11.1)	\$746,632	\$750,492	\$758,599	\$11,967
Other than Full-Time Permanent (11.3)	\$101,223	\$101,746	\$102,436	\$1,213
Other Personnel Comp. (11.5)	\$31,718	\$31,882	\$31,859	\$141
Military Personnel (11.7)	\$70,671	\$71,036	\$72,252	\$1,581
Special Personal Service Comp. (11.8)	\$991	\$996	\$995	\$4
Total Personnel Compensation	\$951,235	\$956,153	\$966,142	\$14,907
Civilian personnel Benefits (12.1)	\$262,286	\$263,642	\$266,413	\$4,127
Military Personnel Benefits (12.2)	\$47,414	\$47,659	\$48,226	\$812
Benefits to Former Personnel (13.0)	\$288	\$289	\$292	\$4
SubTotal Pay Costs	\$1,261,223	\$1,267,744	\$1,281,074	\$19,851
Travel (21.0)	\$45,979	\$46,217	\$47,601	\$1,622
Transportation of Things (22.0)	\$18,210	\$18,304	\$18,520	\$310
Rental Payments to GSA (23.1)	\$8,499	\$8,543	\$8,643	\$144
Rental Payments to Others (23.2)	\$1,351	\$1,358	\$1,374	\$23
Communications, Utilities, and Misc. Charges (23.3)	\$42,000	\$42,217	\$42,714	\$714
NTWK Use Data TRANSM SVC (23.8)	\$537	\$540	\$546	\$9
Printing and Reproduction (24.0)	\$3,831	\$3,851	\$3,896	\$65
Other Contractual Services (25)	\$1,150,927	\$1,156,877	\$1,056,208	-\$94,719
<i>Advisory and Assistance Services (25.1)</i>	<i>\$401,160</i>	<i>\$403,234</i>	<i>\$384,004</i>	<i>-\$17,156</i>
<i>Other Services (25.2)</i>	<i>\$206,224</i>	<i>\$207,290</i>	<i>\$184,890</i>	<i>-\$21,334</i>
<i>Purchases from Government Accounts (25.3)</i>	<i>\$324,409</i>	<i>\$326,086</i>	<i>\$290,849</i>	<i>-\$33,560</i>
<i>Operation and Maintenance of Facilities (25.4)</i>	<i>\$71,389</i>	<i>\$71,758</i>	<i>\$64,004</i>	<i>-\$7,385</i>
<i>Research and Development Contracts (25.5)</i>	<i>\$66,505</i>	<i>\$66,849</i>	<i>\$59,625</i>	<i>-\$6,880</i>
<i>Medical Services (25.6)</i>	<i>\$28,331</i>	<i>\$28,477</i>	<i>\$25,400</i>	<i>-\$2,931</i>
<i>Operation and Maintenance of Equipment (25.7)</i>	<i>\$29,903</i>	<i>\$30,058</i>	<i>\$26,810</i>	<i>-\$3,093</i>
<i>Subsistence and Support of Persons (25.8)</i>	<i>\$674</i>	<i>\$677</i>	<i>\$604</i>	<i>-\$70</i>
<i>Consultants, other and misc (25.9)</i>	<i>\$22,332</i>	<i>\$22,447</i>	<i>\$20,022</i>	<i>-\$2,310</i>
Supplies and Materials (26.0)	\$515,338	\$518,002	\$535,222	\$19,884
Equipment (31.0)	\$67,054	\$67,401	\$78,194	\$11,140
Land and Structures (32.0)	\$15,073	\$15,151	\$15,073	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$2,525,473	\$2,538,521	\$2,127,270	-\$398,203
Insurance Claims and Indemnities (42.0)	\$89	\$89	\$89	\$0
Interest and Dividends (43.0)	\$86	\$86	\$86	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$4,394,447	\$4,417,157	\$3,935,435	-\$459,012
Total Budget Authority	\$5,655,670	\$5,684,901	\$5,216,509	-\$439,161
Average Cost per FTE				
Civilian FTEs	8,685	8,631	8,631	-1%
Civilian Average Salary and Benefits	\$132	\$133	\$134	\$3
Percent change	N/A	-4%	1%	N/A
Military FTEs	807	807	807	0%
Military Average Salary and Benefits	\$146	\$147	\$149	\$3
Percent change	N/A	2%	2%	N/A
Total FTEs	9,492	9,438	9,438	-54
Average Salary and Benefits	\$133	\$134	\$136	\$3
Percent change	N/A	1%	1%	N/A

OBJECT CLASS TABLE - REIMBURSABLE

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION OBJECT CLASSIFICATION - REIMBURSABLE AMOUNTS (DOLLARS IN THOUSANDS)				
Object Class	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent(11.1)	\$107,432	\$133,046	\$133,046	\$25,614
Other than Full-Time Permanent (11.3)	\$22,633	\$28,029	\$28,029	\$5,396
Other Personnel Comp. (11.5)	\$5,590	\$6,922	\$6,922	\$1,333
Military Personnel (11.7)	\$9,709	\$12,024	\$12,024	\$2,315
Special Personal Service Comp. (11.8)	\$259	\$320	\$320	\$62
Total Personnel Compensation	\$145,623	\$180,343	\$180,343	\$34,720
Civilian Personnel Benefits (12.1)	\$36,496	\$45,197	\$45,197	\$8,701
Military Personnel Benefits (12.2)	\$6,530	\$8,087	\$8,087	\$1,557
Benefits to Former Personnel (13.0)	\$0	\$0	\$0	\$0
SubTotal Pay Costs	\$188,649	\$233,628	\$233,628	\$44,978
Travel (21.0)	\$13,383	\$16,573	\$16,573	\$3,191
Transportation of Things (22.0)	\$669	\$828	\$828	\$159
Rental Payments to GSA (23.1)	\$910	\$1,127	\$1,127	\$217
Rental Payments to Others (23.2)	\$295	\$366	\$366	\$70
Communications, Utilities, and Misc. Charges (23.3)	\$1,585	\$1,962	\$1,962	\$378
Printing and Reproduction (24.0)	\$1,128	\$1,396	\$1,396	\$269
Other Contractual Services:				
Advisory and Assistance Services (25.1)	\$92,287	\$114,291	\$114,291	\$22,003
Other Services (25.2)	\$90,160	\$111,656	\$111,656	\$21,496
Purchases from Government Accounts (25.3)	\$70,338	\$87,108	\$87,108	\$16,770
Operation and Maintenance of Facilities (25.4)	\$3,144	\$3,894	\$3,894	\$750
Research and Development Contracts (25.5)	\$31,944	\$39,560	\$39,560	\$7,616
Medical Services (25.6)	\$30,123	\$37,305	\$37,305	\$7,182
Operation and Maintenance of Equipment (25.7)	\$2,694	\$3,336	\$3,336	\$642
Subsistence and Support of Persons (25.8)	\$3	\$4	\$4	\$1
Consultants, other and misc (25.9)	\$2,406	\$2,980	\$2,980	\$574
Subtotal Other Contractual Services	\$341,068	\$422,387	\$422,387	\$81,319
Supplies and Materials (26.0)	\$45,410	\$56,237	\$56,237	\$10,827
Equipment (31.0)	\$12,398	\$15,354	\$15,354	\$2,956
Land and Structures (32.0)	\$0	\$0	\$0	\$0
Investments and Loans (33.0)	\$0	\$0	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$177,953	\$220,382	\$220,382	\$42,428
Insurance Claims and Indemnities (42.0)	\$80	\$99	\$99	\$19
Interest and Dividends (43.0)	\$0	\$0	\$0	\$0
Refunds (44.0)	\$0	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$576,910	\$714,458	\$714,458	\$137,549
Total Budget Authority	\$765,559	\$948,086	\$948,086	\$182,527
Average Cost per FTE				
Reimbursable FTEs	1,018	1,018	1,018	0
Average Salary and Benefits	\$169,107	\$209,426	\$209,426	\$40,319
Percent change	NA	0.9%	0.0%	NA
Military FTEs	72	72	72	0
Military Average Salary and Benefits	\$225,552	\$279,329	\$279,329	\$0
Percent change	NA	23.8%	0.0%	NA
Total FTEs	1,090	1,090	1,090	0
Total Average Salary and Benefits	\$173,073	\$214,337	\$214,337	\$41,265
Percent change	NA	23.84%	0.00%	23.84%

OBJECT CLASS TABLE - AFFORDABLE CARE ACT

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION OBJECT CLASSIFICATION - PPHF (DOLLARS IN THOUSANDS)				
Object Class	FY 2012 Enacted¹	FY 2013 CR²	FY 2014 President's Budget	FY 2014 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent(11.1)	\$14,879	N/A	\$13,917	-\$961
Other than Full-Time Permanent (11.3)	\$5,047	N/A	\$4,720	-\$326
Other Personnel Comp. (11.5)	\$505	N/A	\$473	-\$33
Military Personnel (11.7)	\$1,803	N/A	\$1,686	-\$118
Special Personal Service Comp. (11.8)	\$0	N/A	\$0	\$0
Total Personnel Compensation	\$22,234	N/A	\$20,796	-\$1,438
Civilian personnel Benefits (12.1)	\$6,701	N/A	\$6,268	-\$432
Military Personnel Benefits (12.2)	\$1,286	N/A	\$1,203	-\$83
Benefits to Former Personnel (13.0)	\$0	N/A	\$0	\$0
SubTotal Pay Costs	\$30,222	N/A	\$28,267	-\$1,955
Travel (21.0)	\$950	N/A	\$889	-\$61
Transportation of Things (22.0)	\$553	N/A	\$517	-\$36
Rental Payments to GSA (23.1)	\$14,500	N/A	\$13,562	-\$938
Rental Payments to Others (23.2)	\$2	N/A	\$2	\$0
Communications, Utilities, and Misc.Charges (23.3)	\$3,253	N/A	\$3,042	-\$210
NTWK Use Data TRANSM SVC (23.8)	\$0	N/A	\$0	\$0
Printing and Reproduction (24.0)	\$16	N/A	\$15	-\$1
Other Contractual Services:				
Advisory and Assistance Services (25.1)	\$133,367	N/A	\$124,741	-\$8,626
Other Services (25.2)	\$6,747	N/A	\$6,311	-\$435
Purchases from Government Accounts (25.3)	\$38,935	N/A	\$36,416	-\$2,518
Operation and Maintenance of Facilities (25.4)	\$0	N/A	\$0	\$0
Research and Development Contracts (25.5)	\$5,258	N/A	\$4,918	-\$340
Medical Services (25.6)	\$2,502	N/A	\$2,340	-\$162
Operation and Maintenance of Equipment (25.7)	\$346	N/A	\$324	-\$22
Subsistence and Support of Persons (25.8)	\$0	N/A	\$0	\$0
Consultants, other and misc (25.9)	\$1,505	N/A	\$1,408	-\$97
Subtotal Other Contractual Services	\$188,660	N/A	\$176,458	-\$12,202
Supplies and Materials (26.0)	\$100,746	N/A	\$94,230	-\$6,516
Equipment (31.0)	\$454	N/A	\$424	-\$29
Land and Structures (32.0)	\$0	N/A	\$0	\$0
Investments and Loans (33.0)	\$0	N/A	\$0	\$0
Grants, Subsidies, and Contributions (41.0)	\$467,972	N/A	\$437,704	-\$30,269
Insurance Claims and Indemnities (42.0)	\$0	N/A	\$0	\$0
Interest and Dividends (43.0)	\$0	N/A	\$0	\$0
Refunds (44.0)	\$0	N/A	\$0	\$0
Subtotal Non-Pay Costs	\$777,105	N/A	\$726,843	-\$50,262
Total Budget Authority	\$807,327	N/A	\$755,110	-\$52,217
Average Cost per FTE³				
Civilian FTEs	63	N/A	73	10
Civilian Average Salary and Benefits	\$432.54	N/A	\$348.00	-\$84.53
Percent change	14%	N/A	N/A	NA
Military FTEs	30	N/A	35	5
Military Average Salary	\$102.14	N/A	\$82.13	-\$20.01
Percent change	14%	N/A	N/A	NA
Total FTEs	93	N/A	108	15
Total Average Salary⁴	\$325	N/A	\$261	-\$64
Percent change	N/A	N/A	N/A	NA

¹ Reflects FY 2012 actual obligations

² The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary

³ PPHF FTEs based on direct hire estimates

⁴ PPHF Civilian Avg. Salary only includes partial compensation

SALARIES AND EXPENSES

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SALARIES AND EXPENSES (DOLLARS IN THOUSANDS)				
	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Personnel Compensation:				
Full-Time Permanent (11.1)	\$746,632	\$750,492	\$758,599	\$11,967
Other than Full-Time Permanent (11.3)	\$101,223	\$101,746	\$102,436	\$1,213
Other Personnel Comp. (11.5)	\$31,718	\$31,882	\$31,859	\$141
Military Personnel (11.7)	\$70,671	\$71,036	\$72,252	\$1,581
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Total Personnel Compensation	\$951,235	\$956,153	\$966,142	\$14,907
Civilian personnel Benefits (12.1)	\$262,286	\$263,642	\$266,413	\$4,127
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Benefits to Former Personnel (13.0)	\$288	\$289	\$292	\$4
SubTotal Pay Costs	\$1,261,223	\$1,267,744	\$1,281,074	\$19,851
Travel (21.0)	\$45,979	\$46,217	\$47,601	\$1,622
Transportation of Things (22.0)	\$18,210	\$18,304	\$18,520	\$310
Communications, Utilities, and Misc. Charges (23.3)	\$42,000	\$42,217	\$42,714	\$714
Printing and Reproduction (24.0)	\$3,831	\$3,851	\$3,896	\$65
Other Contractual Services:	\$1,150,927	\$1,156,877	\$1,056,208	-\$94,719
Advisory and Assistance Services (25.1)	<i>\$401,160</i>	<i>\$403,234</i>	<i>\$384,004</i>	<i>-\$17,156</i>
Other Services (25.2)	<i>\$206,224</i>	<i>\$207,290</i>	<i>\$184,890</i>	<i>-\$21,334</i>
Purchases from Government Accounts (25.3)	<i>\$324,409</i>	<i>\$326,086</i>	<i>\$290,849</i>	<i>-\$33,560</i>
Operation and Maintenance of Facilities (25.4)	<i>\$71,389</i>	<i>\$71,758</i>	<i>\$64,004</i>	<i>-\$7,385</i>
Research and Development Contracts (25.5)	<i>\$66,505</i>	<i>\$66,849</i>	<i>\$59,625</i>	<i>-\$6,880</i>
Medical Services (25.6)	<i>\$28,331</i>	<i>\$28,477</i>	<i>\$25,400</i>	<i>-\$2,931</i>
Operation and Maintenance of Equipment (25.7)	<i>\$29,903</i>	<i>\$30,058</i>	<i>\$26,810</i>	<i>-\$3,093</i>
Subsistence and Support of Persons (25.8)	<i>\$674</i>	<i>\$677</i>	<i>\$604</i>	<i>-\$70</i>
Supplies and Materials (26.0)	\$515,338	\$518,002	\$535,222	\$19,884
Subtotal Non-Pay Costs	\$1,776,285	\$1,785,468	\$1,704,160	-\$72,125
Rental Payments to Others (23.2)	\$1,351	\$1,358	\$1,374	\$23
Total, Salaries & Expenses and Rent	\$3,038,859	\$3,054,570	\$2,986,608	-\$52,251
Direct FTE	9,492	9,438	9,438	-54

STATEMENT OF PERSONNEL RESOURCES

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)						
Direct FTE	FY 2012		FY 2013		FY 2014	
	Civilian	Comm Corp	Civilian	Comm Corp	Civilian	Comm Corp
Immunization and Respiratory Diseases	591	74	587	74	587	74
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	1,086	110	1,079	110	1,079	110
Emerging and Zoonotic Infectious Diseases	968	134	962	134	962	134
Chronic Disease Prevention and Health Promotion	892	84	887	84	887	84
Birth Defects, Developmental Disabilities, Disability and Health	226	11	225	11	225	11
Environmental Health	363	33	361	33	361	33
Injury Prevention and Control	208	13	207	13	207	13
Public Health Scientific Services	438	54	435	54	435	54
Occupational Safety and Health	839	63	834	63	834	63
Global Health	731	130	727	130	727	130
CDC-wide Cross-cutting Activities	1,845	41	1,832	41	1,832	41
<i>Public Health Leadership and Support</i>	494	14	491	14	491	14
<i>Business Services Support</i>	1,351	27	1,341	27	1,341	27
Public Health Preparedness and Response	498	60	495	60	495	60
Agency for Toxic Substances and Disease Registry	250	35	250	35	250	35
<i>Subtotal, Direct FTE</i>	8,935	842	8,881	842	8,881	842
Reimbursable FTE						
Immunization and Respiratory Diseases	8	0	8	0	8	0
HIV/AIDS, Viral Hepatitis, STD and TB Prevention	0	2	0	2	0	2
Emerging and Zoonotic Infectious Diseases	32	3	32	3	32	3
Chronic Disease Prevention and Health Promotion	8	0	8	0	8	0
Birth Defects, Developmental Disabilities, Disability and Health	3	0	3	0	3	0
Environmental Health	31	11	31	11	31	11
Injury Prevention and Control	0	0	0	0	0	0
Public Health Scientific Services	557	20	557	20	557	20
Occupational Safety and Health	234	22	234	22	234	22
Global Health	37	12	37	12	37	12
CDC-wide Cross-cutting Activities	107	1	107	1	107	1
<i>Public Health Leadership and Support</i>	103	0	103	0	103	0
<i>Business Services Support</i>	4	1	4	1	4	1
Public Health Preparedness and Response	1	1	1	1	1	1
Agency for Toxic Substances and Disease Registry	10	0	10	0	10	0
<i>Subtotal, Reimbursable FTE</i>	1,028	72	1,028	72	1,028	72
TOTAL, CDC/ATSDR FTE	9,963	914	9,909	914	9,909	914

DETAIL OF POSITIONS

FY 2014 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION PROGRAM ADMINISTRATION DETAIL OF POSITIONS^{1, 2, 3}			
	FY 2012 Actual	FY 2013 Base	FY 2014 Budget Estimate
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	36	32	29
Total - SES Salary	\$5,641,178	\$5,018,504	\$5,082,901
GS-15	638	617	609
GS-14	1,841	1,761	1,734
GS-13	2,704	2,582	2,537
GS-12	1,517	1,457	1,433
GS-11	882	848	834
GS-10	69	66	66
GS-9	475	467	458
GS-8	85	76	74
GS-7	351	318	294
GS-6	77	67	62
GS-5	73	62	57
GS-4	96	49	38
GS-3	38	17	15
GS-2	14	5	3
GS-1	5	3	0
Subtotal	8865	8395	8214
Total - GS Salary	\$765,334,293	\$826,283,488	\$821,169,198
Average ES level			
Average ES salary			
Average GS grade	12.0	12.0	12.0
Average GS salary	86,332	98,426	99,972
Average Special Pay Categories			
Average Comm. Corps Salary ³	85,065	92,972	97,077
Average Wage Grade Salary	54,447	58,530	59,709

¹ Includes special pays and allowances

² Totals do not include reimbursable FTEs

³ This table reflects "positions" not full-time equivalent(s) (FTEs)

PROGRAMS PROPOSED FOR ELIMINATION

The table below shows the programs proposed for elimination in the FY 2014 President's Budget Request. Following the table is the rationale for the elimination of each program.

PROGRAM	REDUCTION AMOUNT (dollars in millions)
Preparedness and Emergency Response Learning Centers and Research Centers	\$8.087
Education and Research Centers	\$28.775
National Occupational Research Agenda-AgFF	\$25.681
Preventive Health and Health Services Block Grant	\$79.545
Racial and Ethnic Approaches to Community Health	\$53.940
Workplace Wellness	\$10.000
Total	\$206.028

Program (-\$211.000 million)

Preparedness and Emergency Response Learning Centers and Research Centers (-\$8.087 million)

The FY 2014 budget request reflects the elimination of the Preparedness and Emergency Response Learning Centers and Research Centers (-\$8.087 million). CDC recognizes the important work conducted by the Preparedness and Emergency Response Learning Centers and Research Centers. These Centers have demonstrated impactful work products in support of preparedness and response scientific research and workforce development. Due to the reduced FY 2014 proposed budget, reductions were needed and the Academic Centers were included in the programs to be reduced.

Education and Research Centers (-\$28.775 million)

The FY 2014 budget request reflects elimination of funding for the Education and Research Centers (ERCs) (\$28.775 million). 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. As a result of limited resources, funding for the federal portion of these grants will be eliminated; however, CDC will continue to provide scientific and programmatic expertise to the ERCs as requested.

National Occupational Research Agenda Agricultural, Forestry and Fishing sector (-\$25.681 million)

The FY 2014 budget request reflects elimination of the Agricultural, Forestry and Fishing (AgFF) sector of the National Occupational Research Agenda (NORA) (\$25.681 million). Although this program has made positive contributions, it has been proposed for elimination in a limited-resource environment.

Preventive Health and Health Services Block Grant (-\$79.545 million)

The FY 2014 budget request reflects the elimination of the Preventive Health and Health Services Block Grant program. These activities may be more effectively and efficiently implemented through the Chronic Disease Prevention and Health Promotion Program's combined Funding Opportunity Announcement, which provides the ability for to states to coordinate activities across several related categorical funding streams. Resources to state health departments from PPHF investments may also help meet these needs. Elimination of this program provides an opportunity to find savings while expanding core public health

activities and CDC's winnable battles such as food safety, tobacco, and the reduction of healthcare-acquired infections.

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

The FY 2014 budget request eliminates funding for the Racial and Ethnic Approaches to Community Health (REACH) program. The Community Transformation Grants (CTG) program, which builds on past program successes and lessons learned, marks the next stage of CDC's community-based programs. The CTG program integrates best practices and lessons learned from the REACH program into its approach, amplifying the dissemination of these best practices and lessons learned to communities across the nation.

Workplace Wellness (-\$10.000 million)

The FY 2014 budget eliminates the Workplace Wellness program which received \$10 million in PPHF funding in FY 2012. 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.

SUMMARY OF CDC CONTRIBUTIONS TO THE FY 2014 HHS PERFORMANCE PLAN

The HHS Performance Plan includes a total of 23 CDC-associated measures: three FY 2012–2013 federal Agency Priority Goals, 12 HHS Strategic Plan Measures, and eight additional measures for key CDC program areas (below).

CDC CONTRIBUTIONS TO AGENCY PRIORITY GOALS, FY 2012- 2013¹

CDC Component	Program	Measure	HHS SP
National Center for Emerging and Zoonotic Infectious Diseases	Food Safety	By December 31, 2013, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 2.1 cases per 100,000.	3.E
National Center for Chronic Disease Prevention and Health Promotion	Tobacco	By December 31, 2013, reduce annual adults' cigarette consumption in the United States from 1,281 cigarettes per capita to 1,062 cigarettes per capita, which represents a 17.1% decrease from the baseline.	3.D
National Center for Emerging and Zoonotic Infectious Diseases	Healthcare Associated Infections/National Healthcare Safety Network	By September 30, 2013, reduce the national rate of healthcare-associated infections (HAIs) by demonstrating significant, quantitative and measurable reductions in hospital-acquired central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).	1.D

¹ CDC contributes to these shared goals but does not lead them

CDC CONTRIBUTIONS TO FY 2014 HHS STRATEGIC PLAN

CDC Component	Program	Measure	HHS SP
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)	1.C
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
National Center for Emerging and Zoonotic Infectious Diseases	National Health Care Safety Network and Healthcare-Associated Infections	Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (3.3.4)	1.B
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	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	Epidemiology	Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets (8.B.2.2)	4.C

CDC Component	Program	Measure	HHS SP
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
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)	5.C
Office of Surveillance, Epidemiology, and Laboratory Services	Public Health Workforce and Career Development	Maintain the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies (8.B.4.3).	5.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)	5.C
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

CDC CONTRIBUTIONS LIMITED TO THE FY 2014 HHS PERFORMANCE PLAN

CDC Component	Program	Measures	HHS SP
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	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)	5.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	Antibiotic Resistance	Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (3.2.1)	3.A
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

SUPPORTING INFORMATION

SUMMARY OF CDC CONTRIBUTIONS TO FY 2014 HHS PERFORMANCE PLAN

CDC Component	Program	Measures	HHS SP
National Center for Injury Prevention and Control	Unintentional Injury	Motor vehicle deaths per 100 million vehicle miles traveled (7.2.4)	3.D
Center for Global Health	Parasitic Diseases and Malaria	Increase the proportion of children under five years old who slept under an insecticide treated net the previous night in PMI target countries. (10.C.1)	3.E

DISCONTINUED MEASURES TABLE FOR FY 2014

The following discontinued measures cannot report more recent results because the data is unavailable. Either the data source changed with the development of a replacement measure or there is a problem with the data source itself: 1.3.1a, 1.3.2a, 1.6.2, 6.E.2, 8.A.1.1.c, 10.C.2, 13.5.E.1a-b, and 14.E.2

Measure 1.E.1: Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S. (Efficiency)

FY	Target	Result
2012	Maintain 98% reduction in inventory depots	98% reduction (Target Met)
2011	Maintain 98% reduction in inventory depots	98% reduction (Target Met)
2010	Maintain 98% reduction in inventory depots	98% reduction (Target Met)
2009	Reduce inventory depots by 98%.	98% reduction (Target Met)

Measure 1.3.1a: Increase the rate of influenza vaccination in persons 65 years of age and older (Intermediate Outcome)¹

FY	Target	Result
2011	72%	Jan 31, 2013
2010	90%	66% (Target Not Met)
2009	85%	66% (Target Not Met)

¹Replaced by Measure 1.3.3a

Measure 1.3.2a: Increase the rate of influenza vaccination among adults ages 18 to 64. (Intermediate Outcome)¹

FY	Target	Result
2011	33%	Jan 31, 2013
2010	30%	28% (Target Not Met but Improved)
2009	Set Baseline	27% (Baseline)

¹Replaced by Measure 1.3.3a

Measure 1.6.2: Increase the percentage of Public Health Emergency Preparedness (PHEP) Cooperative Agreement grantees (SLTTs) that meet the standard for surveillance and laboratory capability criteria. (Output)

FY	Target	Result
2011	50%	Jan 31, 2012
2010	Set Baseline	37% (Baseline)

Measure 2.1.4: Increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AS) (Outcome)

FY	Target	Result
2010	55.0%	55.9% (Target Exceeded)
2009	N/A	52.8% (Baseline)

Measure 3.E.1: Enhance detection and control of foodborne outbreaks by increasing the number of foodborne isolates identified, fingerprinted, and electronically submitted to CDC's computerized national database networks with annual level funding. (Efficiency)

FY	Target	Result
2012	40,000	46,919 (Target Exceeded)
2011	40,000	44,658 (Target Exceeded)
2010	35,276	42,162 (Target Exceeded)

Measure 3.3.2: Reduce the estimated number of cases of healthcare associated invasive Methicillin-resistant *Staphylococcus aureus* (MRSA) infections. (Outcome)

FY	Target	Result
2011	52,000 cases	62,600 (Target Not Met but Improved)
2010	N/A	64,158 cases (Historical Actual)
2009	N/A	71,828 cases (Historical Actual)

4.10.1a: Increase the proportion of adults over age 65 who are up to date on core clinical preventive services (men). (Intermediate Outcome)

FY	Target	Result
2010	N/A	46.3% (Historical Actual)
2008	Set Baseline	46.3% (Baseline)

4.10.1b: Increase the proportion of adults over age 65 who are up to date on core clinical preventive services (women). (Intermediate Outcome)

FY	Target	Result
2010	N/A	47.9% (Historical Actual)
2008	Set Baseline	47.9% (Baseline)

4.11.2: Increase the percentage of CDC-funded states that increase arthritis appropriate self-management education or physical activity course. (Output)

FY	Target	Result
2011	66.6%	66.6% (Target Met)

FY	Target	Result
2010	Set Baseline	58% (Baseline)

4.12.2: Increase the number of states with standards to improve the nutritional quality of competitive food in schools. (Intermediate Outcome)

FY	Target	Result
2012	41	40 (Target Not Met but Improved)
2011	40	39 (Target Not Met)
2010	N/A	39 (Historical Actual)
2009	Set Baseline	33 (Baseline)

Measure 5.1.1: Increase the evidence base on effective interventions to decrease the prevalence of modifiable risk factors for major birth defects.

FY	Target	Result
2012	Identify an intervention that can potentially decrease the prevalence of a modifiable risk factor for major birth defects OR understand the role of one effect modifier in reducing the impact of a modifiable risk factor for major birth defects	Published study results examining the relationship between periconceptional vitamins or supplements that contain folic ac and diabetes mellitus-associated birth defects
2011	Set Baseline	Published study results demonstrating the role of healthy diets in the prevention of neural tube defects and orofacial clefts (Baseline)

Measure 5.1.4: Improve the quality and usability of birth defects surveillance data. (Outcome)

FY	Target	Result
2012	Develop and promote the use of minimal standards for surveillance in 10 state-based birth defects programs	Yes (Target Met)
2011	Disseminate guidelines for incorporating surveillance of stillbirth into birth defects monitoring systems. Evaluate the feasibility of conducting population-based surveillance for fetal alcohol syndrome	Yes (Target Met)
2010	Estimate the prevalence of spina bifida by race and sex among children and adolescents in 10 regions of the U.S. Publish results of collaborative research projects on clubfoot and pyloric stenosis.	Yes (Target Met)
2009	Use a new data linkage software tool developed at CDC to evaluate the association of childhood cancer and birth defects.	No (Target Not Met)

Measure 6.E.2: Increase the percentage of cost savings each year for NCEH/ATSDR as a result of the Public Health Integrated Business Services High Performing Organization

FY	Target	Result
2012	30	Dec 31, 2012

FY	Target	Result
2011	30	Dec 31, 2011
2010	29	42 (Target Exceeded)
2009	28	38 (Target Exceeded)

Measure 8.A.1.1c: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: reimbursable customers (Outcome)

FY	Target	Result
2012	N/A	N/A
2011	Increase Excellent rating from 56% to 61%	100% Good or Excellent (Target Exceeded)
2010	N/A	N/A
2009	N/A	N/A

Measure 8.B.1.2: Increase the number of jurisdictions that can send at least one type of electronic message to CDC in compliance with published standards. (Output)

FY	Target	Result
2012	42	37 (Target Not Met but Improved)
2011	30	30 (Target Met)
2010	10	29 (Target Exceeded)
2009	5	22 (Target Exceeded)

Measure 8.B.3.1: Evaluate the impact of National Laboratory Training Network training programs on laboratory practices (Outcome)

FY	Target	Result
2012	More than 50% of public health and clinical laboratorians attending NLTN public health laboratory workshops either updated or improved laboratory policies or practices as a result of the training.	54% (Target Exceeded)
2011	More than 65% of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses who reported lacking practices for protection of individuals, security of assets and information, or training/practice drills added these practices or modified current practices as a result of the training.	66.2% (Target Met)
2010	More than 65% of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses who reported lacking practices for protection of individuals, security of assets and information, or training/practice drills added these practices or modified current practices as a result of the course.	70% (Target Met)

FY	Target	Result
2009	More than 40% of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses who reported lacking practices for protection of individuals, security of assets and information, or training/practice drills added these practices or modified current practices as a result of the course.	90% (Target Exceeded)

Measure 9.E.2: Reduce consumption of utilities (e.g., gas, electric, water). (Efficiency)

FY	Target	Result
2011	\$3.16 / sq. ft.	\$2.69/sq.f.t (Target Exceeded)
2010	\$3.16 / sq. ft.	\$2.66 / sq. ft. (Target Exceeded)
2009	\$3.19 / sq. ft.	\$2.79 / sq. ft. (Target Exceeded)

Measure 10.A.1.1: Number of people receiving HIV/AS treatment. (Output)

FY	Target	Result
2009	2,568,137 people	2,329,400 people (Target Not Met but Improved)
2008	1,668,800 people	2,007,800 people (Target Exceeded)
2007	1,200,000 people	1,358,375 people (Target Exceeded)

Measure 10.A.1.2: Number of individuals proved with general HIV-related care services. (Output)

FY	Target	Result
2009	7,693,971	6,855,300 (Target Not Met but Improved)
2008	4,970,650	5,734,800 (Target Exceeded)
2007	3,130,341	3,901,543 (Target Exceeded)

Measure 10.A.1.3: Number of pregnant women receiving PMTCT services, including counseling and testing. (Output)

FY	Target	Result
2009	7,134,086	6,565,800 (Target Not Met but Improved)
2008	5,406,208	5,850,100 (Target Exceeded)
2007	3,650,949	4,011,797 (Target Exceeded)

Measure 10.A.1.4: Number of individuals who received counseling and testing services for HIV and received their test results. (Output)

FY	Target	Result
2009	16,527,468	18,719,300 (Target Exceeded)

FY	Target	Result
2008	12,258,174	17,901,400 (Target Exceeded)
2007	7,671,789	10,580,699 (Target Exceeded)

Measure 10.C.2: Increase the percentage of children under five with fever in the previous two weeks that received treatment with antimalarials within 24 hours of onset of their symptoms in PMI target countries.

FY	Target	Result
2012	85% (median in 2007 countries)	Dec 31, 2012
2011	85% (median) in 2006 countries	26% (Target Not Met)
2008	3 rd 6 of 8 countries (Baseline)	29.5%

Measure 13.1.1: Increase number of outpatient and emergency department (ED) patient visits under surveillance in BioSense program per 1,000 population in United States. (Output)

FY	Target	Result
2011	454	430 (Target Not Met But Improved)
2010	413	424 (Target Exceeded)
2009	N/A	405 (Historical Actual)

Measure 13.5.E.1a: Decrease the amount of (A) time required for the Division of State and Local Readiness (DSLRL) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by proving appropriate tools and functionality in the DSLR System (Efficiency)

FY	Target	Result
2011	20 days	Dec 31, 2012
2010	20 days	19 days (Target Exceeded)
2009	21 days	17 days (Target Exceeded)

Measure 13.5.E.1b: Decrease the (B) dollars required for the Division of State and Local Readiness (DSLRL) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by proving appropriate tools and functionality in the DSLR System (Efficiency)

FY	Target	Result
2011	20.2% reduction	Dec 31, 2012
2010	23.3% reduction	60% reduction (Target Exceeded)
2009	22.9% reduction	56% reduction (Target Exceeded)

Measure 13.5.4: Percentage of public health agencies that directly receive CDC PHEP funding that can complete an After Action Report and Improvement Plan within 40 days of a real or simulated response. (Output)

FY	Target	Result
2011	73 %	47% (Preliminary)
2010	66 %	65 % (Target Not Met but Improved) ¹
2009	Set Baseline	60 % (Baseline)

¹ CDC adjusted this measure to accommodate data lag and accurately reflect results from the funding period. Reporting for this measure is now accurately aligned to fiscal years.

Measure 13.4.E.2: Dollars saved per \$1 invested in the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) for available projects. (Efficiency)

FY	Target	Result
2012	\$18	40.25 ²
2011	\$20	\$19 (Target Not Met but Improved)
2010	\$20	\$12 (Target Not Met)
2009	\$28	\$15 (Target Not Met but Improved)

² This measure previously included the expenditures required to relabel products that qualified for shelf-life extension. FY 2012 results do not include these expenditures, significantly inflating the savings. FY 2012 results cannot be directly compared to previous years' results

Measure 14.E.2: Increase the percentage of cost savings each year for NCEH/ATSDR as a result of the Public Health Integrated Business Services High Performing Organization.

FY	Target	Result
2012	30	Dec 31, 2012
2011	30	Dec 31, 2011
2010	29	42
2009	28	38

Measure 14.3.2: Prove services to mitigate the risks of health effects from exposure to hazards from disasters and other emergencies (Output)

FY	Target	Result
2012	Deploy staff as requested to emergency events in a timely manner 100% of the time	100% (Target Exceeded)
2011	Deploy staff as requested to emergency events in a timely manner 100% of the time	100% (Target Exceeded)
2010	Deploy staff as requested to emergency events in a timely manner 100% of the time	100% (Target Exceeded)
2009	Deploy staff as requested to emergency events in a timely manner 100% of the time	100% (Target Met)

BUDGET BY STRATEGIC OBJECTIVE

FY 2014 PRESIDENT'S BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION BUDGET BY STRATEGIC OBJECTIVE (Budgetary Resources in Millions)			
HHS Strategic Objectives	FY 2012 Enacted ¹	FY 2013 CR ²	FY 2014 PB ²
1 Strengthen Health Care	\$28.91	\$31.77	\$51.77
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety	\$28.91	\$31.77	\$51.77
1.C Emphasize primary and preventive care linked with community prevention services			
1.D Reduce the growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality, culturally competent care for vulnerable populations			
1.F Promote the adoption and meaningful use of health information technology			
2 Advance Scientific Knowledge and Innovation	\$125.69	\$176.67	\$152.47
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in the regulatory sciences to improve food and medical product safety			
2.D Increase our understanding of what works in public health and human service practice	\$125.69	\$176.67	\$152.47
3 Advance the Health, Safety, and Well-Being of the American People	\$4,888.45	\$5,173.87	\$4,977.61
3.A Promote the safety, well-being and healthy development of children and youth	\$148.84	\$147.55	\$107.55
3.B Promote economic and social well-being for individuals, families and communities	\$4.10		
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults	\$180.60	\$170.15	\$170.15
3.D Promote prevention and wellness	\$1,340.78	\$1,950.83	\$1,726.77
3.E Reduce the occurrence of infectious diseases	\$1,884.66	\$1,803.13	\$1,808.13
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	\$1,329.46	\$1,102.20	\$1,165.00
4 Increase Efficiency, Transparency, and Accountability of HHS Programs	\$459.74	\$154.56	\$189.56

**FY 2014 PRESIDENT'S BUDGET SUBMISSION
CENTERS FOR DISEASE CONTROL AND PREVENTION
BUDGET BY STRATEGIC OBJECTIVE**
(Budgetary Resources in Millions)

HHS Strategic Objectives	FY 2012 Enacted¹	FY 2013 CR²	FY 2014 PB²
4.A Ensure program integrity and responsible stewardship of resources			
4.B Fight fraud and work to eliminate improper payments			
4.C Use HHS data to improve the health and well-being of the American people	\$459.74	\$154.56	\$189.56
4.D Improve HHS environmental, energy, and economic performance to promote sustainability			
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce	\$524.19	\$521.60	\$462.70
5.A Invest in the HHS workforce to meet America's health and human services needs today and tomorrow			
5.B Ensure that the Nation's health care workforce can meet increased demands			
5.C Enhance the ability of the public health workforce to improve public health at home and abroad	\$61.78	\$69.30	\$40.40
5.D Strengthen the Nation's human services workforce			
5.E Improve national, state, and local surveillance and epidemiology capacity	\$462.41	\$452.30	\$422.30
Total	\$6,027.0	\$6,058.5	\$5,834.1

¹ Full cost estimates for FY 2012 are based on professional judgments for performance measures that were current for those years.

² To the extent possible, FY 2013 and FY 2014 estimates have been revised to account for budget changes. They do not reflect retired or developmental measures resulting from efforts to improve the state of CDC's performance measures.

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA) WORKSHEET

[Department: Component]

Table 1

	PY 2012 (Actual)	CY 2013 (Estimates)	BY 2014* (Estimates)
1) Number of Physicians Receiving PCAs	3	3	3
2) Number of Physicians with One-Year PCA Agreements	0	0	0
3) Number of Physicians with Multi-Year PCA Agreements	3	3	3
4) Average Annual PCA Physician Pay (without PCA payment)	179700	179700	179700
5) Average Annual PCA Payment	28667	28667	28667
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position		
	Category II Research Position	3	3
	Category III Occupational Health		
	Category IV-A Disability Evaluation		
	Category IV-B Health and Medical Admin.		

*FY 2013 data will be approved during the FY 2014 Budget cycle.

- 7) 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.

- 8) 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 three SES physicians for whom this PCA amount is appropriate and necessary.

- 9) 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.

- 10) 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.

- 11) 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.

SIGNIFICANT ITEMS

SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS - SENATE**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2014 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
SENATE REPORT
CENTERS FOR DISEASE CONTROL AND PREVENTION****HEALTHCARE WORKERS**

The Committee is aware that healthcare workers are at high risk during seasonal influenza epidemics and periodic influenza pandemics. Yet, this is when their work is most needed. The Committee recommends that CDC work in partnership with CMS to ensure that all healthcare workers receive the annual influenza vaccination.

Action taken or to be taken

CDC recognizes the importance of protecting healthcare workers and their patients against influenza. CDC, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) do recommend that all U.S. healthcare workers get vaccinated annually against influenza. Influenza is a serious disease that can lead to hospitalization and sometimes even death. Vaccination is the most effective strategy in preventing the spread of influenza. Vaccination levels among healthcare personnel (HCP) have increased in recent years—from 10 percent in the 1989 National Health Interview Survey (NHIS) to 49 percent in the 2008 NHIS. The most recent vaccination level estimates for HCP come from an internet panel survey conducted in November 2012. (<http://www.cdc.gov/flu/pdf/fluview/hcp-ips-nov2012.pdf>) This survey found coverage of over 80 percent among nurses, physicians, and pharmacists and 83 percent coverage among HCP working in hospitals. The lowest coverage was among HCP working in long term care facilities at 49 percent and 43 percent among assistants/aides.

The use of quality measures and tracking vaccination rates has been shown to be an effective strategy to increase overall vaccine coverage. In 2008, CDC began working with the National Quality Forum (NQF) and the Centers for Medicaid and Medicare Services (CMS) to develop a standardized measure for assessing influenza vaccination of healthcare workers that would be considered for inclusion in CMS' Hospital Inpatient Quality Reporting (IQR) Program, as well as programs for other healthcare venues. Later that year, CDC proposed a standardized measure for assessing influenza vaccination of HCP to the NQF. The measure was designed to ensure that reported HCP influenza vaccination rates were comprehensive within a single healthcare facility and comparable across facilities. This proposal received time-limited endorsement from the NQF, with full endorsement pending review of results of a pilot study to assess the feasibility and validity of the measure.

CMS published the final rule in August 2011. The final rule requires acute care hospitals to report HCP influenza vaccination rates through CDC's National Healthcare Safety Network (NHSN) system by May 2013 as part of CMS' Hospital IQR Program. A CMS rule requiring ambulatory surgical centers to report HCP influenza vaccination using the NQF measure goes into effect October 1, 2014 with a deadline of May 15, 2015 for submitting initial HCP influenza vaccination data to CMS via CDC's NHSN. The NQF fully endorsed the measure in May 2012.

IMMUNIZATION INFRASTRUCTURE

The Committee strongly supports investments in strengthening the systems around immunization delivery, and encourages CDC to develop further strategies 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; and (3) strengthen the evidence base to inform immunization policy and program monitoring.

Action taken or to be taken

CDC recognizes that a strong public health infrastructure is vital to ensuring high vaccination coverage levels and low incidence of vaccine-preventable diseases, as well as maintaining adequate public health preparedness for response to a vaccine-preventable national emergency, such as a pandemic or biologic attack. Regardless of whether a vaccine is publically or privately purchased, public health at the federal, state, and local levels plays a critical role in ensuring a safe and effective national immunization system.

CDC has been investing in several activities to transition, strengthen, and modernize the immunization infrastructure for the full implementation of health insurance reforms over the past several years. Section 317 vaccine is a precious national resource that is needed to continue to fill critical public health needs, such as providing routine vaccination for those with no health insurance, and responding to outbreaks of vaccine-preventable diseases and other urgent public health issues. To ensure Section 317 vaccine is being used for these most vulnerable populations, CDC implemented a new vaccine use policy beginning October 1, 2012. This policy clarifies that it is not appropriate for Section 317 vaccine to be used for routine vaccination of children, adolescents, and adults who are considered fully insured. CDC recognizes the role of immunization information system (IIS) in supporting the management and implementation of state and local programs to address vaccine-preventable diseases in all age groups. At present, CDC has taken steps to enhance or strengthen IISs with several initiatives including enhanced Electronic Health Record (EHR)-IIS interoperability and the use of 2 D barcodes for vaccines that will improve access and data quality at the practice and public health levels. Since 2009, CDC has supported 35 of its grantees to develop and/or implement strategic plans for billing of immunization services in health department clinics to ensure access to immunization services in those communities where public health departments serve as critical providers. CDC is identifying new and effective strategies to increase national vaccine coverage, such as adult immunization programs and school-located vaccination clinics. These partnerships will also help strengthen routine and emergency immunization services. In addition, CDC is using funds to support important evaluations of effectiveness and impact on disease for recent vaccine recommendations. This information is critical to informing the evidence-base for immunization programs and policies.

IMMUNIZATION REGISTRIES

The Committee remains concerned about the low rate of adult immunizations. The Committee urges CDC to continue supporting States that wish to establish and expand their use of immunization registries, with a particular focus on improving information sharing about patients' vaccination histories across different providers and generating reminders to providers and patients about recommended vaccinations, especially for adults.

Action taken or to be taken

The CDC Immunization Program shares the concern of the Committee regarding the low rate of reporting immunization data to immunization information systems (IISs). CDC is addressing this issue through several strategies. CDC is working with the Department of Health and Human Services to promote the reporting of immunizations administered at federal medical facilities to state and local immunization information systems. Steps have also been taken to facilitate the reporting of immunizations from Electronic Health Records (EHRs) located in adult clinic settings such as pharmacies to IISs.

CDC has also introduced new IIS functional standards that will facilitate continued development and implementation of IISs, including improved patient access to their immunization histories and the use of reminder and recall features for providers and patients.

DIVISION OF VIRAL HEPATITIS

The Committee intends that funding be used to continue CDC's viral hepatitis screening and testing initiatives, in support of the HHS goal to identify 65 percent to 75 percent of chronically infected persons who do not know their status. The Committee acknowledges the need to build an evidence base of effectiveness, and encourages the Division to ensure that outcomes continuously inform activities undertaken in the field. The Committee encourages CDC to focus on best practices that can be replicated in various jurisdictions with varying levels of resources.

Action taken or to be taken

With continued funding, CDC will maintain its support of viral hepatitis screening and testing initiatives. FY 2012 funds will allow CDC grantees to test about 66,000 persons and refer to care those persons who are identified as having chronic hepatitis B or hepatitis C viral infections. Data are currently being collected on existing activities to document effectiveness and to implement data-driven programs. Through technical assistance efforts, CDC has and will continue to share information on best practices for adaption across various localities.

HEPATITIS SCREENING GUIDELINES

The Committee notes that hepatitis B and hepatitis C testing guidelines are not aligned across HHS operating divisions, and expects CDC to work expeditiously with ASH, AHRQ, and the USPSTF to develop consistent national testing guidelines by January 1, 2013, to improve testing rates. In particular, hepatitis B guidelines should focus on the dramatic health disparity impacting the U.S. Asian and Pacific Islander populations and hepatitis C guidelines should address the prevalence of the disease in the baby boomer population.

Action taken or to be taken

In August 2012 CDC revised its hepatitis C virus testing recommendations to include one-time routine testing of persons born from 1945 through 1965. CDC worked closely with AHRQ, OASH, NIH and other parts of the Department of Health and Human Services in developing its revised recommendations, and also has participated to the extent possible in the development of draft hepatitis C virus screening recommendations by the U.S. Preventive Services Task Force (USPSTF), which is an independent panel of non-Federal experts in prevention and evidence-based medicine that is supported by AHRQ. While CDC's hepatitis C virus testing recommendations and USPSTF's recent draft recommendations are not fully aligned, both sets of recommendations support testing of persons with identified risk factors and agree that testing of persons born from 1945 through 1965 is beneficial. The draft USPSTF recommendations on hepatitis C screening were released for public comment from November 27 through December 24, 2012; they will be revised pending public comment in 2013.

In 2008, CDC expanded the list of persons for whom hepatitis B virus testing is recommended to also include:

- All people born in countries where hepatitis B is common (e.g., many African, Asian and Pacific Island countries)
- All people born in the United States, who were not vaccinated at birth, and who have at least one parent born in a country with high hepatitis B rates

The USPSTF currently recommends against testing asymptomatic persons in the general population for chronic hepatitis B virus (HBV) infection. However, it has recently begun the process of reviewing and possibly updating its HBV screening recommendations. CDC is working to provide data and information to USPSTF as requested to help complete its independent review.

INFERTILITY PREVENTION PROGRAM

The Committee bill provides a \$2,000,000 increase in the Infertility Prevention Program. Chlamydia is the most commonly reported STD in the United States, yet remains under-reported due to a lack of symptoms in most cases. It is entirely curable with simple antibiotics. Left untreated, chlamydia damages reproductive organs and can lead to infertility, ectopic pregnancies, and increased risk of acquiring HIV. Routine screening is critical for preventing the spread of this silent disease. The Committee strongly supports the partnership between State departments of public health and clinics that have a strong focus on reproductive health.

Action taken or to be taken

CDC appreciates the Committee's recognition of the importance of STD prevention program activities in preventing infertility. To expand infertility services outside of publicly-funded settings, CDC will continue to support and enhance state and local health department collaborations with organizations that serve adolescents and young women to prevent infertility caused by untreated chlamydial and gonorrheal infections, as well as support training of primary care providers on chlamydia and gonorrhea.

RAPID TESTING

The Committee notes that the use of rapid tests significantly increases the percentage of persons with newly identified HIV who receive their testing results. The Committee encourages CDC to continue expanding the use of rapid HIV tests.

Action taken or to be taken

HIV testing is a critical element of CDC's high-impact approach to its prevention programs. Rapid testing both extends the reach of HIV testing programs to people at highest risk for infection and increases the likelihood that individuals learn their status and link to care and treatment. CDC supports HIV testing activities through all of our funding opportunities for health departments and community-based organizations. We strongly encourage grantees to use those testing technologies that are most likely to ensure that tested persons receive their results, and if appropriate, are linked to care. In many cases, particularly in community-based, non-clinical testing programs, single-use rapid tests represent the best means for CDC grantees to extend testing to hard-to-reach populations and ensure that those tested, at a minimum, receive their preliminary test result. Single-use rapid tests with either fingerstick or oral fluid provide quick results with a high positive predictive value, and often are sufficient to initiate linkage to care activities.

In clinical settings such as hospitals and emergency departments, it is important to note that new testing technologies mean that some HIV antibody or antigen/antibody combination laboratory tests produce results within 30-60 minutes that can be provided during the same clinical visit. These tests are more sensitive for early infections (when HIV is most infectious) than any of the current single-use rapid tests, and are generally less expensive. CDC will continue to promote the use of both rapid and advanced laboratory testing for HIV to prevent new infections.

EMERGING INFECTION SURVEILLANCE

The Committee urges CDC to create strong partnership opportunities between this Center and the Center on Global Health in order to coordinate better the Nation's surveillance of emerging infections and monitoring activities at home and abroad.

Action taken or to be taken

CDC's National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) and the Center for Global Health (CGH) have developed a strong partnership to better coordinate surveillance of emerging infections and monitoring activities at home and abroad. NCEZID was active in the development of a

global health strategy for CDC led by CGH, which established the scope of CDC surveillance abroad. CGH and NCEZID partner to protect public health in the United States and globally through a number of emerging disease programs, including infection surveillance in refugee populations in Kenya and Thailand, determination of risk factors for Marburg virus and plague in Uganda, and clean water initiatives to prevent cholera in Haiti. The centers currently collaborate at five CGH overseas sites to monitor emerging animal pathogens infective to humans and to train veterinary epidemiologists and laboratorians within activities such as the One Health and the Field Epidemiology and Laboratory Training Programs.

VACCINE ADVERSE EVENT REPORTING SYSTEM [VAERS]

The Committee understands that a strong vaccine safety monitoring system is essential to ensure that our Nation's vaccines are safe, and to ensure the success of the national immunization program and a low incidence of vaccine-preventable diseases. VAERS, a national spontaneous reporting system co-administered by CDC and FDA, requires healthcare providers and vaccine manufacturers to voluntarily report certain vaccine adverse events to VAERS, accepts voluntary reports from the public, and requires this information be made available to the public. The Committee directs CDC and FDA to communicate with physicians about the importance of reporting vaccine adverse events, regardless of whether those events are already part of the Vaccine Injury Table.

Action taken or to be taken

In collaboration with the Food and Drug Administration (FDA), CDC is developing and implementing several automation enhancement initiatives that will make it easier for physicians to report vaccine adverse events to VAERS. These improvements also will improve reporting efficiency and data quality. CDC anticipates the following new initiatives will be implemented over the next several years: an updated VAERS form in a writable, savable PDF format; a new VAERS online reporting interface to facilitate Web-based reporting; an electronic file upload and automated data extraction capability for VAERS reporting; and fully electronic VAERS reporting for vaccine manufacturers. When the new VAERS form is available, it will be posted on the CDC website and presented during regular conference calls with national professional partner organizations including the American Academy of Pediatrics, American Medical Association, American College of Obstetricians and Gynecologists, and the American College of Physicians.

In addition, CDC is conducting the following research to evaluate innovative Information Technology (IT) enhancements that have potential value for improving electronic reporting to VAERS: prototype smart phone application software for VAERS reporting targeted to providers; and automated electronic prompts in electronic health record systems to facilitate provider reporting of possible adverse events to VAERS through secure electronic transmissions.

ANTIBIOTIC RESISTANCE

The Committee commends CDC's antimicrobial stewardship efforts, such as the GetSmart program, but remains concerned about the lack of available data on both resistance trends and antibiotic use in the United States for both humans and animals. The Committee requests a report from CDC, in coordination with its partners on the Interagency Task Force on Antimicrobial Resistance, regarding the type and scope of data collected in the United States on antibiotic consumption and resistance trends. The report should compare this level of data with the level and scope of data collected around the world and the benefits or drawbacks of collecting such data. In addition, the report should identify what statutory and other obstacles exist in the United States that might prevent the collection of more comprehensive data.

Action taken or to be taken

CDC appreciates the Committee's continued support of our efforts to combat antimicrobial resistance (AR). CDC is committed to producing a report regarding the type and scope of data collected in the United States on antibiotic consumption and resistance trends. CDC currently is developing a report of its activities pertaining to the type and scope of data collected in the United States on antibiotic consumption and resistance trends in human health. CDC's Antimicrobial Resistance (AR) office is working with agency programs to identify and fill gaps in knowledge and would produce regular updates on the state of antibiotic resistance in the United States as well as describing gaps in AR surveillance, AR prevention, and antibiotic stewardship. Collecting this information in one place and evaluating how to make improvements would have an added value to policymakers, the public, and CDC. CDC estimates that, working with our partners on the Interagency Task Force, the agency could produce another report covering human and animal health in 18 to 24 months following passage of a 2014 Budget. The timeframe would allow each agency to develop and review its section and then review the final report for accuracy before submission to Congress.

FOOD SAFETY

The Committee remains strongly supportive of CDC's system of surveillance and outbreak response on food-borne illness. The Committee is very concerned about changes in private lab testing that reduce the ability of State labs to identify quickly the fingerprint of a particular outbreak. The Committee intends that the recommended funding increase be used to support upgrades to PulseNet and develop new laboratory tools. In addition, CDC should enhance and integrate surveillance of disease, improve outbreak and response timeliness, and help address deficits in local capacity to prevent and stop illness. The Committee supports the expansion of the number of Foodborne Diseases Centers for Outbreak Response Enhancement [FoodCORE] and Food Safety Centers of Excellence. These centers will serve a critical role through the development and dissemination of best practices and tools for food safety surveillance and outbreak response.

Action taken or to be taken

CDC appreciates the Committee's continued support of CDC's foodborne illness surveillance and outbreak response systems, and CDC continues to prioritize these key food safety-related public health activities. CDC shares the Committee's concerns that recent changes in clinical laboratory testing practices and related trends in the use of faster diagnostic laboratory tests, which do not result in the bacterial samples being available for public health tracking activities, will reduce the ability of state laboratories to quickly identify foodborne outbreaks. Unless addressed promptly, PulseNet—the primary detection system for multi-state foodborne illness outbreaks and the associated investigation infrastructure present in all 50 states—will become less effective and the safety and health of Americans will be diminished, as outbreaks will go undetected. CDC is committed to working with partners to address this problem and currently is looking at long-term solutions and methods for PulseNet-based surveillance that are compatible with these new diagnostic tests being used by physicians. CDC is developing an interim plan to continue to receive samples of bacteria until newer technologies are capable of matching or exceeding the performance of culture-based tests currently in use at CDC and in all 50 states.

The CDC FY 2014 President's Budget request includes a \$40 million increase for an Advanced Molecular Detection and Response initiative. The investment will enable CDC to re-tool PulseNet and other laboratory-based surveillance systems to use new molecular technologies for more rapid and accurate detection and response to foodborne illnesses and other infectious threats. One component of the initiative will expand DNA sequencing and other molecular techniques and analysis capabilities and expertise at CDC. The component will enable rapid progress towards modernizing PulseNet and other critical laboratory-based systems that are threatened by the move from older, culture-based diagnostic methods.

CDC is striving to fulfill the critical provisions of the Food Safety Modernization Act designed to improve the public health system by enhancing and integrating foodborne illness surveillance systems. CDC is consulting with state and local public health partners, food regulatory agencies, consumer groups, the food production industry, and academic experts on ways to improve these surveillance systems. In 2012, CDC designated and provided start-up funding to establish five Centers of Excellence (CoEs), which are based in state health departments. With CDC's leadership, the CoEs will work to identify and implement best practices in foodborne diseases surveillance and will serve as a resource for public health professionals at state, local, and regional levels. Following the designation, CDC will begin to work with all CoEs to identify strategic priorities, individually and as a group, to avoid overlap or gaps in work between Centers. Future efforts will include implementing these strategic priorities and expanding the network to gain greater geographic coverage.

CDC also continues to support FoodCORE efforts, which have shown successes in faster outbreak detection and response. CDC now is working to increase the capacity for foodborne diseases outbreak detection and response in states by implementing a new IT tool in all FoodCORE centers, FoodNet sites, and in all 50 states that allows for faster identification of multi-state foodborne illness outbreaks, using PulseNet data and related case information.

ALZHEIMER'S AND HEALTHY AGING

The Committee commends the Healthy Brain Initiative [HBI] for its leadership in bringing attention to the public health crisis of Alzheimer's disease and for its work on cognitive impairment surveillance in 38 States. The Committee notes that developing a population-based surveillance system with longitudinal follow-up is a key recommendation in the National Public Health Road Map to Maintaining Cognitive Health. The increase provided in the Committee recommendation is intended to further develop this system and to develop effective public health messages to promote cognitive health in older adults, as recommended in the recent progress report on the HBI.

Action taken or to be taken

CDC recognizes that maintaining cognitive health is one of the top issues affecting older adults and especially remains a concern as the U.S. population ages. CDC's public health response to Alzheimer's disease, the Healthy Brain Initiative, funds surveillance efforts to understand the burden of disease, builds the evidence for interventions that improve cognitive health, and disseminates research to states and communities to put effective interventions into practice.

CDC's Alzheimer's work includes supporting the Alzheimer's Association to promote knowledge and awareness of the disease as a public health issue, as well as better understand the burden of both cognitive impairment and caregiving. This includes new and ongoing data collection on cognitive impairment through the state-based Behavioral Risk Factor Surveillance System. CDC also serves as a federal member on the National Advisory Council on Alzheimer's Research, Care, and Services. This Council is developing a national plan to address Alzheimer's and related disorders.

CARDIOMYOPATHY

The Committee is aware of CDC estimates that sudden cardiac arrest [SCA] is the leading cause of death on school property, with one student athlete falling victim to SCA every 3 to 4 days. The risk of SCA is highest among those with undiagnosed cardiomyopathy. The Committee is pleased with the information that CDC has developed for schools, coaches, and parents on prevention of concussion in student athletes, and encourages CDC to augment this effort with information about how to identify children with cardiomyopathy and how to respond appropriately and quickly to SCA. CDC is further encouraged to disseminate this information through the CDC Web site and the Division on Adolescent School Health.

Action taken or to be taken

CDC concurs with the Senate regarding the need to identify cardiomyopathy and determine how best to respond appropriately and quickly to sudden cardiac arrest (SCA). Among persons ages 5–14 years in any location, there are approximately 200 heart disease related deaths per year (National Vital Statistics Reports, Deaths: Preliminary Data for 2010).

CDC continues to support projects and research designed to improve quick and early treatment of cardiovascular related events. For example, the Cardiac Arrest Registry to Enhance Survival (CARES) demonstration project, funded by CDC between 2004 and 2012, collected data on sudden cardiac arrest in both adults and children. CARES utilized data and tracking which focused on treatment and opportunities to improve care between the time of event and arrival at the hospital. According to a 2011 MMWR Surveillance Summary on CARES (http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6008a1.htm?s_cid=ss6008a1_w), between 2005 and 2010, there were 79 out-of-hospital cardiac arrests in the CARES registry that occurred at educational institutions.

CDC supports public education and awareness efforts with broader application as it pertains to SCA, such as knowing the signs and symptoms of heart attack and stroke and the benefits of AED use. CDC also continues to be available to consult with partners such as the American Heart Association regarding appropriate public health strategies to improve awareness of sudden cardiac arrest.

Beginning in 2005, CDC provided support to the Michigan Department of Community Health (MDCH) in their work to assess the burden, impact, and causes of sudden cardiac death of the young (SCDY) and identify action steps for prevention. An expert mortality review system was used to investigate in detail recent cases of SCDY to identify patient-, provider-, and system-level changes to prevent future deaths. Formal recommendations by MDCH together with partners to the Michigan High School Athletic Association resulted in revisions to the sports participation screening and physical form implemented in 2011 to include personal history, family history, and physical exam questions on SCDY risk factors.

CHRONIC KIDNEY DISEASE [CKD]

The Committee continues to support early detection of CKD, particularly among high-incidence minority populations. The Committee urges CDC to continue early detection activities and the CKD Health Evaluation and Risk Information Sharing project.

Action taken or to be taken

More than 10% of people, about 20 million, aged 20 years or older in the United States have chronic kidney disease (CKD) and most are unaware of their condition. CKD has serious health consequences including cardiovascular disease, end stage renal disease or kidney failure (ESRD), and premature death. CKD and ESRD are very expensive health conditions accounting for 17% and 6% of the Medicare budget, respectively, and both of these costs continue to increase.

CDC is completing a three-year screening demonstration project for early identification of CKD in the U.S. population in conjunction with the National Kidney Foundation. The project, CKD Health Evaluation and Risk Information Sharing (CHERISH), identified individuals at high risk for CKD. The screening program was conducted in four states in the United States (two sites each in California, Florida, Minnesota, and New York) to optimize sample diversity (e.g., Hispanics, African Americans, Native Americans, and Asians/Pacific Islanders). Nearly 900 people were screened and researchers used a history of diabetes, hypertension, or being 50 years or older as the selection criteria. A preliminary analysis shows that the prevalence of undiagnosed CKD is high in this population; more than one-third of people screened based on these criteria had undiagnosed CKD. Researchers conducted a patient follow-up survey and a health provider survey in addition to the screening program. The project is in its final year of data analysis and publication of findings has led to significant enhancements of other screening programs in use in the United States.

In addition to CHERISH, CDC has established a comprehensive National Chronic Kidney Disease Surveillance System to track and monitor the burden (incidence and prevalence), awareness, risk factors, health capacity and health care consequences of CKD in the United States. This work is being conducted in conjunction with the University of California-San Francisco and the University of Michigan. The surveillance system is national in scope, using various data from the CDC and the Department of Veteran Affairs, among other data sources.

GLAUCOMA

The Committee continues to believe that education and screening programs for glaucoma and other age-related eye diseases are a low-cost means of preventing and reducing the risk of blindness, especially in minority populations.

Action taken or to be taken

Over two million Americans aged 40 years and older have glaucoma, an eye disease that is asymptomatic 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. Research findings show that routine detection and treatment of glaucoma may prevent visual impairment and is cost-effective. In FY 2012, CDC funded the University of Alabama at Birmingham and Willis Eye Institute at approximately \$950,000 each through a two-year cooperative agreement to improve glaucoma screening, referral, and treatment for populations experiencing disparities in access to care. In addition, in late FY 2012 Westat was awarded an evaluation contract in the amount of \$250,000 to conduct a rigorous and comprehensive evaluation of the glaucoma projects described above. The evaluation will identify accomplishments, needs, and best practices for improving glaucoma screening, referrals, and treatment for populations at the greatest risk for glaucoma.

LUPUS

The Committee applauds the completed development of five lupus patient registries across the country meant to identify reliable epidemiological and burden of illness data on lupus. The Committee recommendation is sufficient to conduct cohort studies of registry patients to study further long-term outcomes, socioeconomic burdens, and mortality associated with the disease. Studies should be designed to follow an established, population-based cohort with lupus to determine over time the treatment, healthcare access, and natural history (severity, morbidity, mortality, etc.) of cohort members and the factors (including genetic and other biological factors such as antibody levels) associated with these outcomes.

Action taken or to be taken

Lupus registries were developed for epidemiologic purposes. CDC reports on registry programs at NIH/NIAMS-sponsored meetings of the Lupus Federal Working Group. NIH scientists show interest in CDC's lupus registries for potential follow-up biomedical research studies. In addition, NIH-funded research could support biomedical research using a cohort assembled as part of CDC's registries, while CDC's focus continues to be epidemiologic topics, such as morbidity, mortality, and disparities in socioeconomic status, race, and geography.

By using the registry data to develop a core longitudinal cohort, CDC can replicate the successful model of the Johnston County Osteoarthritis Project, funded by CDC for 22 years, which has addressed a great variety of public health and biomedical research questions, with specialized studies added through CDC, NIH, and other funding sources.

MATERNAL MORTALITY REVIEWS

State-based maternal mortality reviews identify deaths, review associated factors, and take action to institute changes to decrease pregnancy-related mortality. A uniform pregnancy mortality dataset tool, which includes an electronic comprehensive case abstraction form, would ensure that the information needed for review and action would be consistent for public health purposes. The Committee encourages CDC, in consultation with relevant State and national stakeholders, to develop a uniform pregnancy mortality dataset tool for guidance to States on data collection, review, and analysis, and make such a tool available to State maternal mortality review committees.

Action taken or to be taken

CDC is in the process of developing a common core set of data elements to be abstracted from medical records by state maternal mortality review committees. The uniform pregnancy mortality dataset has been proposed and is being reviewed by representatives of state maternal mortality review committees. When finalized, this dataset tool will be made widely available for all states to use. CDC anticipates finalizing the core set of data elements by the end of FY 2013.

OBESITY

The Committee is aware of the importance of diet and nutrition in reducing obesity rates among targeted populations, from school-aged children to seniors. Critical to the success of this effort is training individuals how to prepare foods that are healthful, flavorful, and delivered in the most cost-effective manner. In accomplishing these objectives, the Committee encourages CDC to support strategies that engage institutions with demonstrated culinary training expertise in the areas of ingredient selection, culinary technique, flavor development, and menu development across a wide range of volume food service operations, including institutional foodservice. The Committee encourages the Center to support strategies that engage such institutions throughout its nutrition and health promotion programs.

Action taken or to be taken

Population-level approaches that support healthy eating offerings and activity opportunities in multiple places where Americans live, work, learn and recreate have contributed to observable improvements in health outcomes. From healthy community change we are observing increases in early nutrition such as breastfeeding and plateaus in rates of obesity among many population groups in a number of communities. CDC recognizes that some segments of the population (e.g., institutional food preparers and very low-income individuals) require assistance to make healthful food choices or to prepare a variety of fruits and vegetables. To address this issue, CDC incorporates educational efforts around meal preparation and menu development into initiatives aimed at improving the food environment in schools and early care and education facilities, such as teaching providers how to procure, store, prepare, and serve nutritious foods. In FY2012, CDC provided funding support to Nemours, a non-profit organization serving children and their families, to engage early care and education providers in initiatives to reduce obesity among children 0 to 6 years of age. Among the various issues addressed in the collaboratives are training on the nutritional quality of foods and beverages procured and served in their facilities and how to make and purchase healthy food options for children in their care.

In addition, CDC is currently in the process of collaborating with national groups, and in FY 13 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 provide the scientific expertise to support these projects.

OFFICE ON SMOKING AND HEALTH [OSH]

The Committee is pleased with the initial reported results of the OSH media campaign. In the first 2 weeks of this campaign, calls to State quitlines more than doubled and the number of hits to www.smokefree.gov, the Government's Web site offering quit assistance, more than tripled. In addition, previous experience from State and local media campaigns promoting quitlines shows at least 5 to 6 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 2013 for a media campaign and quitlines as it did in fiscal year 2012.

The Committee commends the Environmental Health Laboratory for its ongoing work on tobacco products, including its successful partnership with the FDA in implementing the Family Smoking Prevention and Tobacco Control Act. The Committee expects OSH to transfer the same amount it did in fiscal year 2012 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.

Action taken or to be taken

Media Campaign: Implementation of the National Tobacco Education Campaign in fiscal year 2012, titled *Tips from Former Smokers*, increased awareness of the dangers of tobacco use and promoted the use of quitlines. The total quitline call volume during the *Tips from Former Smokers* campaign was 365,194 calls, compared with 157,675 calls during the corresponding 12 weeks the previous year. This means there were a total of 207,519 additional calls, or a 132% increase. Further, almost 80% of smokers reported having seen any Tips ad during the campaign. As the National Tobacco Education Campaign efforts continues, it is projected that the increase in calls to the quitline and persons provided cessation counseling/medications will continue. CDC is in the process of evaluating the impact of the *Tips* campaign. Final evaluation results from a longitudinal pre-post survey of smokers and nonsmokers are expected to be available by early 2013.

Additionally, on March 4 CDC launched the next phase of the campaign, which continues to highlight the health consequences of smoking. The next phase of the campaign will feature people with a variety of smoking-related health conditions such as chronic obstructive pulmonary disease, diabetes complications exacerbated by smoking, and asthma across a diverse set of racial/ethnic groups, including African Americans, and American Indian/Alaska Natives. CDC anticipates the size and scope of the second phase of the campaign will be similar to the initial phase.

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 2013, of the same amount as FY 2012. 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.

ORAL HEALTH

The Committee is greatly encouraged by pilot programs across the country demonstrating new disease management interventions, public health media campaigns, and prevention strategies that can reduce the rate of dental caries. The Committee intends that no less than \$150,000 be available for CDC to engage in planning and technical assistance to improve and expand joint public-private media campaigns at the national, State, and local levels. This may include an oral health literacy program in response to a report

from the IOM which noted that “individuals and many healthcare professionals remain unaware of the risk factors and preventive approaches for many oral diseases, and they do not fully appreciate how oral health affects well-being.”

In addition, the Committee has included sufficient funding for CDC to convene a conference examining innovative strategies to address early childhood caries [ECC] and to update the agency’s previous work on an ECC consensus statement. Through this conference, CDC in collaboration with leading researchers, clinicians, payors, and consumer groups will identify the most recent science and research advancing ECC disease management.

Action taken or to be taken

In FY 2012, CDC began the development of a communications plan which will test messaging meant to inform the public regarding the benefits of community water fluoridation as a cost saving intervention to prevent tooth decay. CDC will monitor state and national oral health literacy efforts to determine which programs have shown positive results with regard to increasing people’s understanding of the public and personal measures they can take to improve their oral health. CDC will expand an existing CDC media resource center making these materials available to other states.

The Children’s Dental Health Project is expected to convene the EEC conference in late FY2013 to highlight early childhood caries prevalence data and trends and discuss its role in promoting evidence-based interventions. A primary objective of the conference is to identify promising prevention strategies as well as potential funding sources to pilot and evaluate these interventions. As a part of this effort, CDC will provide technical and scientific support related to surveillance and evidence-based oral health prevention.

OVARIAN CANCER

The Committee understands that women with the BRCA1 and BRCA2 genetic mutations are at elevated risk for both breast and ovarian cancers. Therefore, the Committee encourages CDC to explore ways in which the risk of ovarian cancer can be integrated into the larger public health system in cancer prevention and treatment, particularly in public health programs aimed at women at risk for breast cancer.

Action taken or to be taken

CDC is supporting a variety of activities which address women at elevated risk for ovarian cancer, including activities that can enhance referral to appropriate genetic testing, counseling and education services. CDC is working to integrate these activities with cancer prevention and control programs including those focused on women at high risk for breast cancer.

As part of a broader effort to support breast cancer awareness in young women, CDC funded three states—Georgia, Michigan and Oregon—in 2011 through a three-year cooperative agreement to enhance breast cancer genomic practices through education, surveillance, and working with insurers and policymakers to improve the provision and quality of BRCA clinical services. Among other activities, Georgia is integrating the Breast/Ovarian Cancer Genetics Referral Screening Tool (B-RST) in several sites, including existing Breast and Cervical Cancer Early Detection Programs, to more effectively identify women at high risk and refer them to appropriate genetic services. As part of their cooperative agreements, Michigan and Oregon are providing targeted BRCA educational materials to the physicians of patients with early breast and/or ovarian cancer reported to their respective state cancer registries. These three states are working with their state cancer coalitions to integrate genomics objectives into state cancer plans.

Additionally, CDC has conducted a review of health insurance plans across the country to assess the extent of coverage for genetic counseling, testing, and follow-up procedures. CDC is developing an education module, which will be completed in the next two years, to educate students in medical and

allied health professional schools about ovarian cancer, including genomic aspects of the disease. As part of CDC's *Inside Knowledge: Get the Facts About Gynecologic Cancer* campaign, CDC educates the public and physicians about many aspects of ovarian cancer. Finally, CDC is developing a clinical decision support tool to increase the use of family history to assess risk for breast and ovarian cancer and to increase patient/provider counseling sessions regarding BRCA1/2 genetic testing and breast and ovarian cancer risk factors.

CDC anticipates the results of these efforts will enhance broader public health capacity to address ovarian cancer risk factors and facilitate the integration of evidence-based genomic applications among the clinical care system and public health programs.

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH [REACH]

The Committee is aware of the tremendous success of the REACH program. From 2001 to 2009, physical activity rates among minority populations in REACH communities increased from 7 to 12 percent, compared to a U.S. average in the general population of 2 to 5 percent. These outcomes are all the more impressive considering the high rates of obesity and obesity-related illness in REACH communities. The Committee strongly supports the REACH model of partnering with communities that are underserved and often disaffected, both to identify health disparities of concern to the community and then to implement community-based, evidence-based, and culturally competent approaches to reduce or eliminate those disparities.

Action taken or to be taken

CDC appreciates the Committee's recognition of the success of the Racial and Ethnic Approaches to Community Health (REACH) initiative in addressing health disparities. Although the FY 2014 budget request does not include funding for the REACH initiative, investments of the REACH initiative have established a foundation for addressing health disparities among racial and ethnic populations and contributed to the national capacity to reduce disparities. CDC's community health activities continue to promote the strategies implemented through REACH initiatives, particularly among those priority populations that experience the greatest health disparities. The Community Transformation Grant (CTG) Program, a five-year initiative that began in 2011, funds six National Networks of Community Based Organizations to support and amplify CTG's evidence-based strategies in communities that face significant health disparities. Additionally, in FY 2012, three-year awards were made to two organizations through the new REACH Obesity and Hypertension Demonstration project to support their work in reducing health disparities. CDC anticipates that the REACH Demonstration Project will provide valuable information on what obesity and hypertension prevention programs can do to reduce heart attacks and strokes in racial and ethnic populations. The Demonstration Projects incorporate activities that are replicable in communities across the nation.

SLEEP DISORDERS

Evidence is growing that chronic circadian disruptions and disorders can cause significant safety and health issues such as increased risk of cardiovascular disease, breast cancer, diabetes, obesity, motor vehicle crashes, and difficulty adhering to school and work schedules. CDC is encouraged to continue current surveillance efforts on sleep patterns that assist researchers in this area.

Action taken or to be taken

The 2014 Behavioral Risk Factor Surveillance System (BRFSS) survey will include a sleep duration question. By asking this question, CDC will be able to track progress towards the relevant Healthy People 2020 objective at state and local levels. CDC is funding a Prevention Research Center (PRC) in FY 2012 to assess the validity of the BRFSS sleep questions by measuring actual sleep patterns through a non-invasive device worn on the wrist, called wrist actigraphy. In addition to the current set of sleep-related

questions asked as part of the National Health and Nutrition Examination Survey (NHANES), the National Cancer Institute is sponsoring the incorporation of an objective measure of sleep (via actigraphy). In FY 2014, CDC aims to develop additional key sleep-related questions and refine the definition of healthy sleep duration with input from sleep experts and partner agencies and to implement these questions in various national surveillance systems. These combined multi-agency efforts will improve the value of sleep data collection in national surveillance systems.

CEREBRAL PALSY [CP]

The Committee commends CDC for releasing the first multisite, population-based study on the CP population in the country. In addition to updating prevalence estimates, this report provided estimates of co-occurring developmental disabilities, gross motor function, and walking ability among children with CP. The Committee encourages the CDC to update these figures regularly.

Action taken or to be taken

CDC acknowledges the importance of ongoing surveillance to identify trends in the prevalence and characteristics of cerebral palsy. To accomplish this, CDC continues to support CP surveillance activities in four areas of the United States through the Autism and Developmental Disabilities Monitoring (ADDM) Network. The CP report for 2008 will be available soon and will include updated estimates of prevalence, co-occurring developmental disabilities, including autism, gross motor function, and walking ability. Other CP activities are underway, including: 1) an analysis of CP attributed to potentially preventable causes such as postneonatal infection or injury; and 2) an analysis of the effect of migration on CP prevalence estimates, which has implications for comparisons of CP prevalence among different countries. Planned activities include assessing feasibility of enhancing our current population-based surveillance by collecting neuroimaging reports for children with CP.

FRAGILE X—FRAGILE X-ASSOCIATED DISORDERS [FXD]

The Committee encourages CDC to continue to focus its efforts on data collection to identify and define the population impacted by FXD and the public health impact of these conditions. CDC is further encouraged to support epidemiological research, surveillance, screening, and the promotion of early interventions and supports.

Action taken or to be taken

CDC acknowledges the importance of efforts to identify and define the population impacted by FXD and the public health impact of these conditions. CDC currently supports longitudinal data collection through the Fragile X Clinical and Research Consortium (FXCRC). Patient, parent, clinician, and laboratory reported data are being collected, analyzed, and will be disseminated. The data will be used to expand the knowledge of fragile X and help to improve the health, development, quality of life, and social participation of people with fragile X syndrome; In addition, the data will be used to increase understanding of contributors to adverse or positive outcomes, and possibly provide information that could benefit other groups affected by intellectual disabilities.

CDC continues to support ongoing epidemiological research and surveillance activities through the “Pilot for State-specific Cross-Sectional Surveillance of Persons with Rare Disorders and Longitudinal Assessment of Outcomes” project. This project includes Fragile X as a prototype condition. The goal of this project is to develop and evaluate a cross-sectional model based on linked administrative datasets and describe the well-being and service use of persons with rare disorders at the state level. In addition the project will initiate the implementation, and evaluation of a retrospective longitudinal study using linked administrative datasets to investigate factors that may have influenced the current well-being and service use of young adults with rare disorders. Analyses of these data should allow states to estimate prevalence of rare disorders among adolescents and young adults, their current status in terms of health,

education or work, and social participation. The data may further suggest ways to state officials changes in services (or in the quality or quantity of services) that could be associated with subsequently improved well-being for these young adults.

SPINA BIFIDA

The Committee intends the funding provided for the National Spina Bifida Program [NSBP] to be used to support the continuation of a data collection initiative to improve the efficacy and quality of care. Further, the Committee intends the NSBP to serve as a model for programs assisting other individuals living with similar complex conditions.

Action taken or to be taken

CDC acknowledges the importance of a data collection initiative to improve the efficacy and quality of care for individuals affected by spina bifida. The National Spina Bifida Patient Registry (NSBPR) was established in 2009 as a data collection initiative to improve the quality of care received at spina bifida clinics nationwide through the assessment of existing medical services for spina bifida patients. The National Spina Bifida Program is currently collaborating with 19 spina bifida clinics around the country, using NSBPR to collect demographic, treatment and outcome data on clinic patients and working to develop standards of spina bifida care and treatment. The clinics received a report of the data collected from the first three years of the NSBPR in the fall of 2012. Current analyses of registry data are underway to (1) describe the population participating in NSBPR, (2) compare the variation in urological surgeries performed among clinics, and (3) compare and investigate mobility and functional outcomes. Additional registry variables will be collected to provide more information regarding the trajectory of this chronic childhood onset condition. Birth Defects Research Part A published a paper describing the data collection initiative, using the National Spina Bifida Program's efforts as a model for programs assisting individuals living with similar complex conditions.

TOURETTE SYNDROME

The Committee intends that CDC continue to educate health professionals, educators, and the general public about Tourette syndrome and to expand the scientific knowledge base on prevalence, risk factors, and co-morbidities of this disorder.

Action taken or to be taken

CDC will continue efforts to effectively educate health professionals, educators, and the public about Tourette syndrome (TS), including training on standard diagnostic and treatment practices for TS and related disorders. As part of a strong collaborative relationship with the National Tourette Syndrome Association (TSA), CDC continues to support efforts to increase inclusion of people with TS, decrease negative impacts on families dealing with the disorder, and improve the health and education of children with TS. Over its entire 8 years, the TSA-CDC partnership has provided 694 programs reaching over 46,000 professionals and individuals in all fifty states. Current efforts are targeting those in underserved and minority populations. CDC acknowledges the importance of expanding the scientific knowledge base of TS. Through two recent publications, CDC documented increased health care needs and parental stress among those affected by TS. CDC continues to investigate the prevalence and impact of TS and related disorders through surveillance and epidemiologic studies. Utilizing data from the National Survey of Children's Health, the TS Impact Study, and the Project to Learn about ADHD in Youth, CDC will continue to document the prevalence of TS and co-occurring conditions, risk factors for TS, and the impact of TS on social competence and school functioning.

CHIEF DISABILITY AND HEALTH OFFICER

The Committee commends CDC for appointing a chief disability and health officer, as well as establishing a disability and health work group that recently prepared its 1-year progress report. The Committee encourages CDC to continue to support and strengthen public health research activities focused on people with disabilities. Specifically, CDC is encouraged to: recognize disability as a key determinant in national surveys and surveillance systems; address health disparities among people with disabilities; enhance health promotion and prevention and access to healthcare for people with disabilities; foster knowledge translation and communication efforts to bring persons with disabilities reliable health information; develop new disability research initiatives through partnerships across CDC centers and other Federal agencies; and develop public and private partnerships to support and advance disability issues.

Action taken or to be taken

CDC acknowledges the importance of including people with disabilities in public health surveillance, prevention, health promotion, and protection programs. To promote disability inclusion, CDC has formed a Disability Working Group with representation from the various Centers, Institutes and Offices within the agency. In 2012 Working Group established an inclusion implementation plan with four major strategies: (1) To improve public health surveillance of people of all ages with disabilities in order to identify health disparities. (2) To improve the understanding of disability as a risk factor in the onset and trajectory of preventable disease, injury, and loss of function (Epidemiology). (3) To improve the participation of people with disabilities in CDC conducted or supported non-research program activities. (4) To provide accessible health communications and messaging available to people with sensory or cognitive limitations.

SEXUAL AND GENDER IDENTITY INCLUSION IN HEALTH DATA COLLECTION

The Committee recognizes the steps CDC has taken to include questions relating to sexual orientation in the National Health Interview Survey. The Committee remains supportive of inclusion of gender identity questions. The Committee urges CDC to ensure that milestones established in the July 2011 national data progression plan are met.

Action taken or to be taken

CDC's National Center for Health Statistics (NCHS) has continued efforts to expand the National Health Interview Survey (NHIS) to include questions related to sexual identity. Consistent with the national data progression plan, NCHS conducted and completed field testing of new survey questions in 2012; beginning in January 2013, sexual identity questions became part of the NHIS. NCHS is also working with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to support the 2011 national data progression plan on collection of gender identity data. In September 2011 and February 2012, NCHS participated in ASPE-sponsored listening sessions with the LGBT research/advocacy community to discuss scientifically appropriate methods for obtaining transgender data on the LGBT community. Based on this input, ASPE and NCHS are working on approaches to gender identity data collection that take into account the challenges of obtaining gender identity data.

VITAL STATISTICS

The Committee recommendation includes sufficient funding to collect 12 months of vital statistics data within the calendar year.

Action taken or to be taken

Data from the National Vital Statistics System (NVSS) provide continuous and essential information to assess and track overall population health; to plan, implement, and evaluate health and social services for

children, families, and adults; and to set health policy at the national, state and local levels. Vital statistics data on access to prenatal care, maternal risk factors, pre-term delivery, infant mortality, cause of death, life expectancy, and other pregnancy and mortality indicators provide the foundation for public policy and programmatic debates on improving overall health status and health service delivery.

In FY 2012 CDC's National Center for Health Statistics (NCHS) entered into a new five-year contract with the states and territories, which are responsible for registering births and deaths. This contract provides for funding data collection and supporting other improvements to the NVSS, which include support for states to move to the 2003 revision of the U. S. Standard Birth Certificate and to pilot data transfer between electronic medical records systems and state vital registration systems.

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. In During FY 2012, these efforts have improved the ability of states and territories to provide 12 months of high quality vital statistics data to NCHS in a more timely manner in recent years, contributing to the production of national data more quickly.

The FY 2014 funding increase provides for further improvements to the NVSS. It will allow NCHS to phase in full implementation of electronic death records, moving as many jurisdictions as possible (initial target 15–17 states) from outdated systems. The web-based systems will provide for improved data quality and more rapid compilation and use of critical data sources.

ALS

The Committee commends the Center for launching a tool within the ALS registry to promote clinical trial enrollment and for exploring the addition of a biorepository. The Committee encourages CDC to work with stakeholders and researchers to help raise awareness of the registry in both the patient community and the research community, and to ensure that the registry collects information that is useful for ALS research and treatment development. The Committee further encourages CDC to work with CMS to explore how the registry may help improve care and promote standards of care for those living with the disease as well as other opportunities to advance ALS research.

Action taken or to be taken

The Agency for Toxic Substances and Disease Registry (ATSDR) manages operation of the ALS Registry through an interagency agreement with CDC. ATSDR and CDC acquire data from the Center for Medicare and Medicaid Services and the Veterans Administration, along with data from self-enrolling patients. Data collected quantifies the incidence and prevalence of ALS in the United States, describes the demographics of persons with ALS, and examines potential risk factors for the disease. ATSDR and CDC regularly promote the registry through scientific meetings, social media, patient and physician magazines, and ALS walks. Partnerships with the ALS Association, Muscular Dystrophy Association, and other organization increase awareness and use of the registry. For example, the relationship with the ALS Association helps reach patients in rural areas without internet or computer access. In FY 2014, ATSDR will awards grant to inform the scientific community about the risk factors of the disease.

ASTHMA

The budget request again proposes to consolidate CDC's National Asthma Control program with the Healthy Homes/Childhood Lead Poisoning program. The Committee notes that this proposal contains few details on how the consolidated program would bridge the different models and settings currently employed by the two individual programs. For that reason, the Committee again rejects the administration's proposal. The Committee directs CDC to continue its support of the asthma program, its approach to asthma control, its community partners, and its successful interventions.

Action taken or to be taken

Under the FY 2014 President's Budget, CDC maintains the National Asthma Control program and the Healthy Homes/Childhood Lead Poisoning Program as separate programs. CDC works with state health departments to implement community-based interventions, build partnership coalitions, and tracking the disease burden in the United States. In addition, CDC funds state health departments and national non-governmental organizations to conduct asthma surveillance and implement asthma management programs.

BLOOD LEAD REFERENCE VALUE

The Committee applauds CDC for doing away with the use of the "blood lead level of concern" methodology. The Committee encourages CDC to raise awareness of the new blood lead reference value. The Committee is interested in the potential for point-of-care screening devices, particularly in at-risk communities.

Action taken or to be taken

CDC no longer uses the term "blood lead level of concern" because it implies a level below which there is no concern. Instead, CDC uses "blood lead reference value" to indicate high exposure and a need for intervention to prevent additional exposure. In May 2012, CDC agreed with the Advisory Committee for Childhood Lead Poisoning Prevention's recommendation to use a childhood blood lead reference value based on the 97.5th percentile of the population blood lead level in children ages 1–5 (currently 5 µg/dL) to identify children and environments associated with lead-exposure hazards. The recommendation reiterates CDC's longstanding message that primary prevention is the key to protecting children from lead exposure.

The best way to end childhood lead exposure hazards is to control or eliminate exposures. Identifying the environments of children with the highest blood lead levels is part of CDC's strategy moving forward. Interventions that control or eliminate lead sources before children are exposed have demonstrated success in reducing the risk of elevated blood lead levels. CDC works with other federal agencies, states, and local communities to control lead sources and ensure physicians and parents have access to the resources they need. Additionally, CDC is evaluating the use of point of care instruments in settings where children at high risk for lead exposure receive services, such as nutrition projects.

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 addresses falls among older adults using the public health model and focusing on primary prevention. 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 develops, disseminates, and supports proven strategies that prevent older adult falls. This is done through research, capacity building, dissemination, and implementation of evidence-based programs, and by developing resources to help healthcare providers incorporate fall prevention into clinical care. CDC's current activities to prevent falls include supporting three states through the Core Violence and Injury Prevention Program to offer a comprehensive community fall prevention approach by connecting clinical care, public health, and the aging/community services network. CDC is also developing *Stopping Elderly Accidents, Deaths and Injuries (STEADI)*, a multifaceted resource for healthcare providers to address falls through

risk assessment, treatment, and referrals. CDC is partnering with ACL's Aging Services Network to disseminate and evaluate STEADI. With Prevention and Public Health Funds, CDC plans to expand our falls prevention research agenda to support evaluation and dissemination research to advance effective fall prevention approaches among community-dwelling people aged 65 years and older. This will include (1) enhancing surveillance and epidemiologic analysis of fall risk factors; (2) developing, adapting, disseminating, and evaluating evidence-based fall prevention interventions delivered through clinical practice and community programs; (3) addressing new and emerging opportunities in fall-related research (e.g., investigating promising alternative exercise approaches to reducing falls, and implementing and evaluating web-based provider training); and (4) and collaborating with ACL as appropriate.

TRAUMATIC BRAIN INJURY [TBI]

The Committee notes that TBI is a leading cause of death and disability worldwide, especially in children and young adults ages 1 to 44. Due to the high prevalence of TBI, the Committee believes there is a need for multidisciplinary approaches to rapid evaluation and diagnosis of injured patients who have the potential for the development of TBI, as well as the development of early intervention and treatment protocol for use in preventing TBI and improving patient outcomes. The Secretary is encouraged to support a competitively awarded program of academic centers focused on developing and implementing multidisciplinary approaches to the early diagnosis and innovative treatment models for TBI victims.

Action taken or to be taken

The Centers for Disease Control and Prevention (CDC) serves as a national leader for preventing, recognizing, and responding to TBIs. CDC competitively funds 11 multidisciplinary Injury Control Research Centers (ICRC), several of which conduct research related to TBI. For example, the ICRC at Nationwide Children's Hospital in Columbus, Ohio has conducted research on sports concussion among youth. One such project is designed to examine the relationship between clinical and epidemiological TBI-related variables so that in the future coaches and athletic trainers will better recognize and respond to symptoms of TBI. In addition to the ICRCs, CDC supports other TBI research projects through grants and contracts. One example is a project that is examining strategies to appropriately triage older adults with potential TBIs who are taking anticoagulants and platelet inhibitors. The goal of this research is to ensure these potential high-risk patients are taken to an appropriate treatment facility for timely and effective care. Finally, CDC is developing tools for preventing and mitigating TBI such as the *Heads Up* initiative, which provides education and training to physicians, coaches, parents, and athletes on appropriate recognition and response to concussions in sports.

MINING RESEARCH

The Committee requests that the fiscal year 2014 congressional budget justification include 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.

Action taken or to be taken

A 5-year funding history of National Institute of Occupational Safety and Health (NIOSH) mining research, both totaled and separated by type of mining, is displayed in the following table.

Fiscal Year	Total Mining		Coal		Metal/Non-metal ¹		Stone, Sand, & Gravel	
	Funding ²	FTEs	Funding ²	FTEs	Funding ²	FTEs	Funding ²	FTEs
2009	\$50.000	219	\$27.821	120	\$14.193	61	\$7.986	38
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 ³	\$52.687	223	\$25.572	109	\$15.722	68	\$11.393	46

¹ Non-metals include potash, trona, halite, and phosphate.

² Dollars in millions

³ FY 2013 figures are estimates

Other Occupational Safety and Health Research

The Committee requests that the fiscal year 2014 congressional budget justification include a 5-year history of the funding and FTE supported by this program, broken down by industry and location.

Action taken or to be taken

A 5-year history of the distribution of NIOSH's Other Occupational Safety and Health (OSH) program funding is displayed in the following table. This funding supports surveillance and exposure assessment activities, Health Hazard Evaluations, basic laboratory research, and training for occupational safety and health professionals. Funding for the majority of these efforts support the "All Sector" category, meaning the work conducted is related to multiple industry sectors. Funding for activities at other NIOSH locations, such as Pittsburgh, Pennsylvania, and Spokane, Washington, are provided through other programs: Mining Research, Personal Protective Technology, and the National Occupational Research Agenda.

Industry	FY 2009 ¹	FY 2010 ¹	FY 2011 ¹	FY 2012 ¹	FY 2013 ^{1,2}	Primary Location of Work	FTEs ³
Agriculture, Forestry and Fishing	\$2.179	\$4.052	\$3.518	\$0.950	\$0.950	AK, OH, WV, GA	5
Construction	\$3.327	\$3.117	\$3.839	\$4.104	\$4.200	OH, WV, WDC, GA	25
Healthcare and Social Assistance	3.861	\$3.165	\$3.025	\$3.043	\$3.250	OH, WV, GA	19
Manufacturing	\$7.946	\$6.785	\$7.460	\$9.646	\$9.800	OH, WV, GA	55
Mining	\$1.195	\$2.138	\$2.217	\$1.365	\$1.300	WV	6
Oil and Gas	\$0.327	\$0.260	\$0.269	\$0.388	\$0.500	AK, CO	2
Public Safety	\$2.448	\$3.542	\$3.333	\$3.199	\$3.200	OH, WV, GA	21
Services	\$4.511	\$4.432	\$5.143	\$3.549	\$3.500	OH, WV, GA	24
Transportation, Warehousing and Utilities	\$3.295	\$2.204	\$2.398	\$2.643	\$2.843	AK, OH, WV, GA	17
Wholesale and Retail Trades	\$0.992	\$1.272	\$1.233	\$1.232	\$1.200	OH, WV, GA	8
All Sectors	\$53.765	\$53.746	\$51.407	\$52.404	\$51.780	AK, CO, GA, OH, WV,	302

Industry	FY 2009 ¹	FY 2010 ¹	FY 2011 ¹	FY 2012 ¹	FY 2013 ^{1,2}	Primary Location of Work	FTEs ³
						WDC	
Total Other OSH	\$83.846	\$84.713	\$83.842	\$82.523	\$81.573	AK, CO, GA, OH, WV, WDC	483

¹ Dollars in millions.

² In FY 2013, Other Occupational Safety and Health was funded through PHS Evaluation Transfer. FY 2013 figures are estimates.

³ FTEs are based upon FY 2012 employees, but staffing has remained stable over this period of reporting.